Report to the Legislature

Certificate of Need Modernization

July 2025

Chapter 376, Laws of 2024, Sec. 222(138)

Prepared by
Certificate of Need Program
Health Systems Quality Assurance

Washington State Department of HEALTH

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For more information or additional copies of this report:
Health Systems Quality Assurance
Office of Community Health Systems
111 Israel Road SE
Tumwater, WA 98501

Report Authors
Eric Hernandez
Executive Director, Certificate of Need Program
Office of Community Health Systems
360-236-2956
eric.hernandez@doh.wa.gov

Ross Valore, JD
Executive Director (former), Certificate of Need Program
Office of Community Health Systems

BerryDunn Consultant and Research Team
Tyler Brannen
Valerie Hamilton
Dina Nash
Colleen Lally
Stefanie Hymovitch
Jill Wilson
Jennifer Elwood
Amanda Henson
Matt Kukla
Arisara Miller

Dennis E. Worsham
Secretary of Health

Contents

Tables

Figures

Maps

Acronyms and Abbreviations

ADI	Area Deprivation Index
AHRQ	Agency for Healthcare Research and Quality
APCD	All-payer claims database
ATSDR	Agency for Toxic Substances and Disease Registry (CDC)
BIPOC	Black, Indigenous, and other People of Color
BRFSS	Behavioral Risk Factor Surveillance System
CABG	Coronary artery bypass graft
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control and Prevention
CHARS	Comprehensive Hospital Abstract Reporting System
CHCS	Center for Health Care Strategies
CHIA	Center for Health Information and Analysis
CHNAs	Community Health Needs Assessment
CMS	Centers for Medicare and Medicaid Services
CN	Certificate of need
COAP	Cardiac Care Outcomes Assessment Program
DOC	Department of Corrections
DoN	Determination of Need
DPH	Department of Public Health
DSHS	Department of Social & Health Services
ED	Emergency department
ESRD	End-stage renal disease
FSED	Free-standing emergency department
GMCB	Green Mountain Care Board
HCA	Health Care Authority
HCIDAC	Health Care Information and Data Advisory Council
HCRIS	Healthcare Provider Cost Reporting Information System (Medicare)
HEIA	Health equity impact assessment
HPC	Health Policy Commission

HRAP	Health Resource Allocation Plan
HRSA	Health Resources and Services Administration
HRSNs	Health-related social needs
NHPRDA	National Health Planning and Resources Development Act of 1974
OFM	Office of Financial Management
OHS	Office of Health Strategy
PCI	Percutaneous coronary intervention
PCP	Primary care provider
PHC	Public Health Council
PHHPC	Public Health and Health Planning Council
PTCA	Percutaneous transluminal coronary angioplasty
RFP	Request for Proposal
RCW	Revised Code of Washington
RHINO	Rapid Health Information Network
RUCA	Rural-urban commuting area
SAC	Subarea health planning councils
SDOH	Social determinants of health
SEER	Surveillance, Epidemiology, and End Results
SHCC	Statewide Health Coordinating Council
SHP	State health plan
SHPDA	State Health Planning and Development Agency
SNF	Skilled Nursing Facility
SVI	Social Vulnerability Index
TME	Total medical expenditure
WA	Washington state
WAC	Washington Administrative Code
WHO	World Health Organization
ZCTA	Zip code tabulation area

1. Executive Summary

1.1 Overview

The Certificate of Need (CN) program is a regulatory program under the Department of Health (department) that approves proposals to establish or expand certain facilities or healthcare services. Washington's CN process ensures that proposed facilities or services are necessary to maintain quality patient care within a particular region or community. The goal is to ensure healthcare need is matched by an appropriate supply of high-quality care.

Modernizing the CN program in Washington is critical to ensure sustainability of the CN regulated market and access to high-quality care across Washington. This is more important than ever given the current CN program was modeled and continues to be tied to a nearly 40 year old state health plan. The healthcare landscape and systems have changed significantly since then, with the people of Washington facing new and more complex challenges, such as COVID-19, raising health care costs, consolidation of healthcare systems, a growing opioid epidemic, and climate change. The CN program plays a critical role in access to healthcare services and needs up be updated to best meet current patient and system needs.

Fully modernizing the CN program will require legislative action. The CN program is currently facing a revenue shortfall due to a decrease in CN applications and a fee structure that has not been updated since 2012. Updating the fee structure would create a stable funding structure that would allow the program to better improve access and equity by incorporating modern standards, analysis, and tools. Enhancing flexibility would allow the program to address urgent or special circumstances impacting access to care, such as in rural or underserved communities with unique healthcare needs.

Finally, action should be take to establish and encourage interagency coordination and planning. Better coordinating resources with other state agencies will help the CN program to draw on expertise, data, and complementary responsibilities to fulfull its mission and collaborate on policies to address healthcare affordability.

1.2 Background

In 2024, the department received funding under Chapter 376, Laws of 2024, Sec. 222(138)(proviso)[1] to conduct an analysis of the Certificate of Need (CN) program and submit findings and recommendations for modernizing the CN program through statutory updates to the Washington (WA) legislature and governor by June 30, 2025.

The proviso requires the report to provide recommendations on modernizing the CN program by researching the following areas:

- Approaches to CN programs in other states,

- CN program impact(s) on access to care, health equity, and cost, and,
- Strategies for identifying healthcare service needs at both statewide and community levels.

The proviso focuses on recommendations for statutory updates to modernize the Washington CN program. A comprehensive analysis of the program's administrative rules and whether provisions should be repealed was considered out of scope. For more information on the process used to carry out the requirements in the proviso, the department has included a discussion of the methods of data collection and limitations in Appendix A – Methods and Background.

1.3 Recommendations

Using funds appropriated through the proviso, the department retained BerryDunn[i] to assist the CN team with meeting the requirements of the proviso. The project scope included a review of published research on CN programs, Washington CN statutes, CN programs nationally, a survey and interviews with other states, and a more in-depth analysis of state CN programs that were identified as innovative and helpful for Washington to consider. The department's recommendations include:

1. **Develop a clear statutory purpose specific to CN:** Establish a clear statutory mandate for a CN program to address goals of improving access to care, enhancing health equity, and controlling the cost of health services.

2. **Create a planning entity and a requirement for interagency coordination:** Establish a public planning body with diverse interests and expertise to provide ongoing recommendations for achieving CN goals. The entity may be an advisory council or board and may play a role when CN application decisions are made or when larger health planning strategies are considered. This approach would help the state better identify health care services needs at the statewide and community levels.

3. **Enhance CN program flexibility:** Provide the CN program with the flexibility to readily address urgent or special circumstances impacting access to care.

[i] BerryDunn is a leading national professional services firm based in Maine. They provide consulting services to businesses, nonprofits, and government agencies across the U.S. and has expertise in health policy and analytics, economics, actuarial science, and data management.

4. **Reduce CN legal costs:** Statutorily define who has standing to intervene in CN litigation to reduce legal costs to the state.

5. **Enhance statutory provisions on access to healthcare services:** Incorporate the use of time and distance standards using modern analytical tools that consider travel patterns, roads, mountains, rivers, and other natural barriers to accessing healthcare services. The analysis and approach could incorporate policies designed to safeguard populations from unauthorized closures or reductions in essential services, particularly in rural areas where services like maternity care are critical, and well as better control health services costs.

6. **Expand CN oversight to include freestanding emergency departments (FSEDs) and urgent care facilities that charge facility fees:** Recognize the opportunity to evaluate the need for entities that may substantially influence access, cost of healthcare services, quality, and equity of the healthcare system.

7. **Incorporate and align statutory provisions specifically targeting health inequities, including establishing a "health equity" definition for CN:** Define health equity to guide CN efforts to address and measure progress toward equitable health outcomes and integrate statutory provisions and initiatives that explicitly address health inequities through proposed project evaluations, resource allocation, or both.

8. **Partner with sister agencies to develop clear policies on cost transparency and containment of healthcare services:** Using current data, partner with sister agencies involved in reducing state healthcare services costs to collaborate on policies to address healthcare affordability and how CN can be used to implement those strategies.

9. **Establish a stable CN funding structure that allows the CN program to adjust funding mechanisms regularly**: Explore options for reducing the dependency on application fees and encouraging health system investment when inequities exist. Potential solutions should promote the sustainability of the program over several years at a time.

10. **Integrate robust analytic resources to close data gaps:** Coordinate a robust analytic infrastructure to reduce reliance on external information sources, align CN with health planning functions, and enable more effective use of data to improve

decision-making. This would also help improve identification of specific needs at the state and community level.

Figure 1 provides a prioritization of each of the proposed recommendations for a modernized CN program in Washington by timing.

Figure 1: Report recommendations prioritization

IMMEDIATE RECOMMENDATIONS

- Develop a clear statutory purpose specific to CN
- Enhance CN program flexibility
- Reduce CN legal costs
- Incorporate and align statutory provisions specifically targeting health inequities, including establishing a "health equity" definition for CN
- Partner with sister agencies to develop clear policies on cost transparency and containment of healthcare services
- Establish a stable CN funding structure that allows the CN program to adjust funding mechanisms regularly

LONG-TERM RECOMMENDATIONS

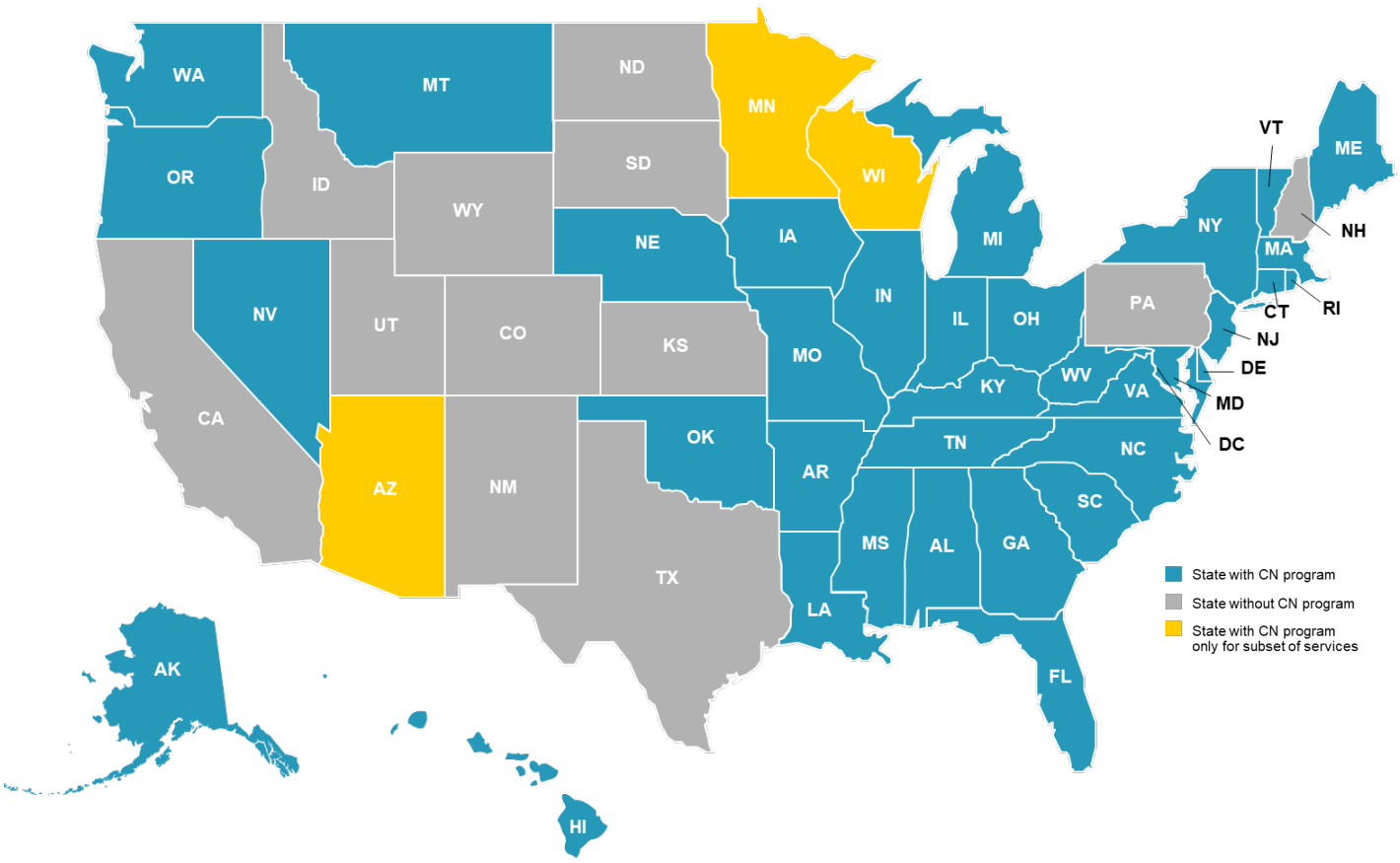
- Create a planning entity and a requirement for interagency coordination
- Reduce CN legal costs
- Enhance statutory provisions on access to healthcare services
- Expand CN oversight to include freestanding emergency departments (FSEDs) and urgent care facilities that charge facility fees
- Integrate robust analytic resources to close data gaps

2. Introduction

2.1 History of CN

Starting in the mid-1960s and into the early 1970s, states began adopting CN laws to serve as state regulatory mechanisms to align statewide health planning efforts, prevent duplication of services, improve quality of and access to care, and support healthcare cost containment.[2] In 1975, Congress passed the National Health Planning and Resources Development Act of 1974 (NHPRDA) that authorized federal funds to support CN programs, resulting in participation from 49 states (except Louisiana).[ii,3] In the 1980s, federal funding for CN programs dwindled,[4] and the NHPRDA was ultimately repealed in 1987. As a result, many states repealed or scaled down CN programs, resulting in 35 states and the District of Columbia (D.C.) with operational CN programs today.[5]

Map 1: CN Programs by State



[ii] Although Louisiana's program did not align with federal requirements, Louisiana did have a similar regulatory program called a "facility need review."

Map 1 indicates which states have a CN program and which do not.[6] Those that have a CN program are colored blue and those that do not are colored gray. 35 states, including Washington D.C., have a CN program and 12 states do not. Wisconsin, Minnesota, and Arizona, colored yellow, do not specifically have CN programs but have CN programs for a subset of services (e.g., ground ambulance services in Arizona[7]).

2.2 Overview of the Washington CN Program

The Washington CN program was established in 1971, and its major provisions have remained largely unchanged since then.[8] The CN program serves as a regulatory tool to implement statewide strategic health planning efforts related to public health, healthcare financing, access to care, quality of care, and cost containment.[9] Washington's CN program regulates certain new or expanded services as well as the construction, development, and establishment of certain healthcare facilities.[10]

Table 1: Facilities and tertiary health services requiring CN approval

Facilities Requiring CN approval include:	Tertiary health services requiring CN approval include:
• Hospitals, • Nursing homes, • Kidney dialysis centers, • Medicare or Medicaid home health agencies, • Medicare or Medicaid hospice agencies, • Ambulatory surgical centers, and • Hospice care centers.	• Level I rehabilitation programs, • Open heart surgery, • Therapeutic cardiac catheterization, • Organ transplantation specialty burn services, • Level II neonatal intensive care nursery and/or obstetric services, and • Level III specialized inpatient pediatric services

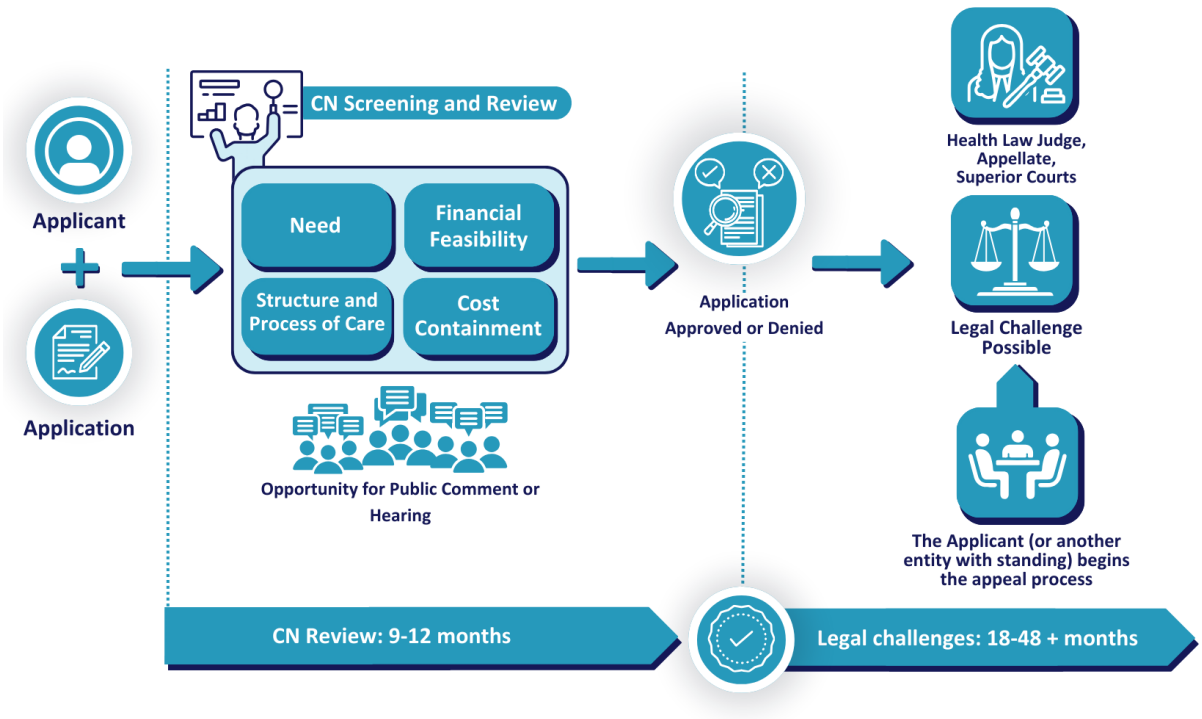
Other instances where a CN is required include: (1) increases in the number of stations at a kidney dialysis center, and (2) sale, purchase, or lease of all or part of an existing hospital, nursing home, or hospice care center.

2.2.1 CN Process

Washington's current CN program is a regulatory process requiring certain healthcare providers to obtain state approval before building certain types of facilities or offering new or expanded services. Washington's CN process ensures that proposed facilities or services are necessary to maintain quality patient care within a particular region or community, called "planning areas." The CN program uses demographic and utilization data to project need for healthcare services

in each planning area using various need projection methodologies. The goal is to ensure healthcare need is matched by an appropriate supply of high-quality care.

Figure 2: CN process



CN applicants identify a planning area they want to serve and apply for that area. The CN program assesses each applicant based on: (1) need, (2) quality, (3) financial stability, and (4) cost containment.

Built into the review process is an opportunity for public comment and awareness. If there are multiple applicants for the same planning area, the CN program uses a concurrent review process. If two applications meet the criteria above, CN approves the highest scoring application or the best alternative for the community.

After a CN is approved, applicants may launch a legal appeal through the courts. This can delay the implementation of the CN.

Appendix C has a list of estimated timelines per application activity.

2.2.2 Benefits of the CN Program in Washington

The CN program ensures approved providers have the necessary staffing, policies, stable financing, experience, and reliable projections to ensure longevity within the community without causing unnecessary disruption to the existing health care system. The goal of the CN program in Washington is to ensure that approved providers are financially stable enough to remain operating for many years to provide added access to the communities in which they are approved. A review of quality of care delivery is a core review component of CN application reviews and is frequently measured through review of CMS quality scores to ensure any trend of poor quality that is discovered is addressed by the applicant.[iii]

CN programs evaluate a planning area's capacity to take on additional health services. This ensures additions to the community health systems do not cause unintended destabilization of the existing system, which can lead to increased costs or loss of access. This also helps to reduce or eliminate unnecessary duplication of services within the community, which also can lead to increases in costs of care.

CN also requires a fully transparent and open public process, ensuring recognition of local community voice in the application process. The program gives a lot of consideration to the comments received by the local community,

Figure 3: CN value to the public health system

[iii] Quality of care delivery is reviewed by the CN program at the time of application. The CN program reviews CMS quality reports, proprietary data the department purchases, survey information, and reports submitted by applicants with their application. Quality of care review criteria are promulgated in WAC 246-310-230.

and they often give the program valuable insight into whether a particular provider is the best alternative for the community.

Additionally, CN is the only regulatory program that reviews facilities prior to them initiating care. The CN program works to create an environment where negative outcomes are prevented or avoided; making the CN program the first line of defense against poor quality care for the residents of Washington.

As a result of the CN statutes not keeping up with the rapidly changing health care landscape, the CN program is frequently constrained by the existing statutory limitations. Modernizing the statutes would allow for modernization of regulations and lay the foundation for the CN program to be far nimbler in the future as the landscape continues to change as care modalities improve and become more efficient in healthcare resource utilization.

3. General CN Structure

3.1 Discussion

The first set of recommendations this report covers are focused on a holistic analysis on the general structure of CN programs themselves. A strong CN program structure helps ensure that program implementers, applicants, and communities have a clear understanding of what the CN program is for and the priorities of legislators. For example, in Washington, having a robust and clear CN structure will help facilitate program strategies focused on the legislative priorities elevated in the 2024 proviso – access to care, health equity, and cost control of healthcare services.

3.2 Recommendations

3.2.1 Develop a clear statutory purpose specific to CN

A clearly defined statutory purpose for the CN program would establish a solid framework and foundation for program decision-making, improving access, enhancing equity, and controlling costs. This would also help modernize the program to better meet the current needs of Washingtonians and the current healthcare marketplace. The statutory purpose could also address the need to prevent excess health care costs driven by provider-generated demand.

Recommendation 1: Develop a clear statutory purpose specific to CN

State Examples: Massachusetts, Vermont

Washington CN Program

RCW 70.38.015(2) states that Washington's CN program is a "component of a health planning regulatory process that is consistent with the statewide health resources strategy and public policy goals that are clearly articulated and regularly updated."[11] A more robust purpose that explicitly emphasizes legislator priorities around access, health equity, and cost containment would serve as the foundation for a program structure, helping to ensure work and priorities are aligned with these goals.

State Examples

Massachusetts and Vermont offer strong models for Washington to consider when refining its CN statutory purpose. Both states include explicit goals related to access, equity, and cost in their CN program purposes. These purposes are broad enough to allow flexibility in addressing the evolving needs of the healthcare landscape. While Washington statutes currently

incorporate public health planning goals that encompass CN, adopting a purpose similar to Massachusetts and Vermont, but reflecting the priorities of Washington, could enhance its effectiveness.

Massachusetts

> *To encourage "competition and the development of innovative health delivery methods and population health strategies within the health care delivery system in order to ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the lowest reasonable aggregate cost, advancing the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation."*[12]

Massachusetts' Determination of Need[iv] (DoN) program purpose effectively addresses healthcare access, equity, and cost by incorporating clear language that includes these areas. The purpose aligns program actions and procedures to advance the Commonwealth's[v] overall healthcare goals. While many opponents of CN argue that CN discourages competition and contributes to increased healthcare costs,[13,14] Massachusetts' use of explicit language addressing competition highlights that Massachusetts sees DoN as an important tool that facilitates competition and contains costs, while simultaneously advancing other goals of the program.

Vermont

> *"The purpose of this Rule is to prevent unnecessary duplication of healthcare facilities and services, promote cost containment, guide the establishment of health facilities and services which will best serve public needs, ensure the provision of high quality services and resources, and ensure access to and equitable allocation of such facilities and services in this State."*[15]

Vermont's CN program purpose is effective because its language specifically addresses access, equity, and cost. The purpose provides clear scope and direction for administration of the program. The program purpose highlights the primary intentions of the program, including facilitating increased access to healthcare services, equitable allocation of healthcare resources, access to preventive and medically necessary healthcare, preventing unnecessary oversupply of healthcare facilities and services, and helping ensure access to high quality healthcare services and resources.[16]

[iv] Massachusetts' CN program is referred to as a Determination of Need (DoN)

[v] Massachusetts is legally a Commonwealth because the state constitution uses this term. A Commonwealth is defined as a whole body of people constituting a nation or state.

3.2.2 Create a planning entity and a requirement for interagency coordination

Another way to support a strong CN structure is to establish a public planning body with diverse interests and expertise to provide ongoing recommendations for achieving CN goals. The entity may be an advisory council or board and may play a role when CN application decisions are made or to support larger health planning strategies.

Recommendation 2: Create a planning entity and a requirement for interagency coordination

State Examples: Massachusetts, Vermont, Hawaii

The CN program would benefit from a public planning body that brings together diverse interests and expertise, fostering collaboration and representing perspectives from various groups across the state. A planning body would help center Washingtonians and patients seeking care in the CN program's work. This provision would also guide the department in coordinating resources with other state agencies by drawing on expertise, data, and complementary responsibilities to address healthcare access, inequities, and cost. This coordination would enable a more proactive approach to healthcare system resource planning and implementation. Subcommittees similar to the setup under the Washington Healthcare Cost Transparency Board could allow CN staff to leverage varied health planning expertise, including medical, public health, economic, and data analytic resources. The planning body would have well-defined authority, specialized expertise, lived experience, and sufficient resources to influence CN decisions, compliance, and outcomes for approved projects. The structure could be a board or advisory council and include characteristics that can be found with Vermont's Green Mountain Care Board (GMCB) and structures in Massachusetts.

"…It's going to be really important to think about where the impacts of Certificate of Need decisions connect to other regulatory agencies, roles and responsibilities whether that's…[the] insurance commissioner and network adequacy questions, whether it's you know, Medicaid contracting, which would be HCA or the Cost Transparency Board…[or] how DSHS intersects with the Certificate of Need processes currently for skilled nursing facilities, etc."

– Comment from interested party at July 30th, 2024 proviso workshop

Washington CN Program

Washington does not currently utilize a board or council to oversee CN-related health planning efforts. Currently, the CN program operates largely independently from other state agencies. The creation of a planning board is a concept that has garnered interest among the

department's CN program and other Washington state agencies.[17] Washington uses boards for other health planning activities, including the Washington Health Care Cost Transparency Board and the State Board of Health. While Washington CN program analysts have expertise in interpreting and applying relevant laws and methodologies to CN application reviews, a planning body would enable additional individuals to share perspectives, experience, and specialized knowledge to inform CN decisions. It would also position the CN program to be more proactive in working with partners to address unmet need, particularly in rural or disadvantaged areas. This would also enable the CN program to dive deeper with communities on better ways the CN program can improve access, reduce healthcare costs, and promote equity. The Washington CN program does not currently have adequate resources to fully monitor compliance and outcomes of CN-approved projects, and the creation of a planning entity could offer perspectives on the importance, value, and cost of creating capacity for this.

State Examples

Planning boards in other states support health planning efforts by incorporating diverse perspectives and expertise. They also foster collaboration with other state agencies, leveraging their expertise, data, and complementary functions. Table 2 below includes examples of board and planning entity structures from other states. More information on state examples is included in Appendix B.

Table 2: Examples of other state boards/planning entity structures

State	Board/Planning Entity Structure
Alabama	The Statewide Health Coordinating Council (SHCC) advises the State Health Planning and Development Agency (SHPDA) on the administration of health planning and resource development functions.[18] Through the use of committees, review of health systems agency budgets, and other responsibilities, the health planning structure in Alabama represents a comprehensive approach for CN to meet goals related to access, equity, and cost.
Connecticut	The health planning structure in Connecticut involves the Health Systems Planning Unit (HSP) with oversight by the Office of Health Strategy (OHS).[19] This structure creates clear responsibilities, goals, and authority for each department and unit, allowing for efficiency in facilitating Connecticut's health planning goals. HSP oversees and coordinates health planning and implementation of healthcare reforms for the state.[20] Connecticut's approach to health planning includes collaboration among Stakeholder Advisory Groups, the Health Care Cabinet, government officials, and external stakeholders.[21]
Hawaii	The State Health Planning and Development Agency (SHPDA) in Hawaii promotes accessibility for all Hawaii residents to quality healthcare services at a reasonable cost.[22] The SHPDA supports the most economical and efficient use of the Hawaii healthcare system resources through coordinated community planning of new healthcare services.[23,24] Through collaboration with subarea health planning councils (SACs), the

State	Board/Planning Entity Structure
	Statewide Health Coordinating Councils (SHCC), and CN Review Panel, the CN program in Hawaii incorporates a diverse range of perspectives to ensure CN equitably represents the healthcare needs and interests of all residents in the state.
Massachusetts	The Massachusetts health planning structure utilizes input from various state agencies including the Department of Public Health (DPH), the Center for Health Care Information and Analysis (CHIA), the Health Policy Commission (HPC), state and appropriate regional comprehensive health planning agencies, and other agencies as needed.[25] The Public Health Council (PHC), which is part of DPH and responsible for DoN decisions, includes representation from schools of medicine and public health, healthcare providers, healthcare advocates, and healthcare workers to ensure health planning decisions and actions are made considering multiple perspectives.[26] This approach allows the state to coordinate resources to best address healthcare access, inequities, and prices. In addition to the various councils which help oversee health planning, Massachusetts' DoN program has the authority, expertise, and resources to consistently monitor compliance outcomes.[27] The clear authority and resource allocation, in addition to the coordinated approach among other agencies and councils,[28] help contribute to the success of the Massachusetts DoN program and state health planning activities within the state.
New York	The CN process in New York is administered by the Department of Health, with some oversight from the Public Health and Health Planning Council (PHHPC).[29] The PHHPC is required to represent various geographic areas and population densities throughout the state and is made up of 26 governor-appointed members.[30] The goals and responsibilities of the PHHPC include advising the health commissioner on matters pertaining to the preservation and improvement of public health, reviewing and issuing decisions or recommendations on CN applications, adopting and amending the state sanitary code, and considering complaints from health providers who have had their hospital privileges terminated, suspended, or denied.[31] In carrying out its powers and duties, the council is required to consider the quality, accessibility, efficiency, and cost-effectiveness of healthcare in the state.[32]
Vermont	The Green Mountain Care Board (GMCB) in Vermont serves as a strong example of a health planning structure that effectively addresses healthcare access, equity, and cost. The GMCB is responsible for regulating major areas of Vermont's healthcare system, serving as the steward of state health data and data analysis pertaining to health system performance, as well as monitoring and evaluating healthcare payment and delivery system reform.[33,34]

Massachusetts, Vermont, and Hawaii provide particularly strong examples of health planning structures that support goals of improving access, enhancing equity, and controlling costs of healthcare services. Each of these states has unique health planning structures and processes that could be useful models for Washington to consider.

Table 3 provides further details related to health planning bodies and their structures in Massachusetts, Vermont, and Hawaii, adding dimensions on improving access, enhancing equity, and controlling cost.

Table 3: Examples of health planning bodies in the context of access, equity, and cost

	Massachusetts	Vermont	Hawaii
Access	• The Public Health Council (PHC) represents diverse interests and perspectives, including representation of various geographic and demographic groups.[35,36]	• The Green Mountain Care Board (GMCB) oversees administration and service delivery and maintains healthcare quality.[37] • The Health Resource Allocation Plan is updated by the GMCB.[38]	• The State Health Planning and Development Agency (SHPDA) promotes accessibility to quality healthcare services for all Hawaii residents.[39] • The SHPDA promotes sharing of facilities or services by healthcare providers to achieve economies of scale.[40] • The SHPDA conducts health planning activities and determines statewide health needs.[41]
Equity	• The PHC requires representation for veterans and the elderly.[42] • The Health Policy Commission (HPC) represents diverse interests and expertise.[43] • The PHC has representation from various parts of the healthcare sector.[44]	• The GMCB utilizes advisory groups to represent the public.[45] • Core values of GMCB related to equity:[46] ○ Non-partisan ○ Transparent ○ System-wide view ○ Public-Interest ○ Accountable ○ Data-Driven	• The SHPDA promotes accessibility to quality healthcare services for all Hawaii residents.[47] • Subarea Health Planning Councils (SACs) provide input and representation for different geographic areas across the state.[48]
Cost	• The HPC requires representation from individuals with experience in health economics.[49] • The PHC can require an applicant to have an independent cost-analysis conducted, at the applicant's own expense, to demonstrate	• The GMCB oversees the development, implementation, and evaluation of the effectiveness of healthcare payment and delivery systems reforms.[51] • Reimbursement rates are set by the GMCB.[52]	• The SHPDA promotes accessibility for all Hawaii residents to quality healthcare services at a reasonable cost.[54] • The SHPDA conducts studies and investigations regarding factors contributing to healthcare costs.[55]

	the proposed project is consistent with state cost containment goals.[50]	• The GMCB reviews and establishes hospital budgets and healthcare spending estimates.[53]	• The SHPDA promotes sharing of facilities or services by healthcare providers to restrict expensive services.[56]

3.2.3 Enhance CN program flexibility

Adopting statutory language that enables the CN program to have increased flexibility will enhance its ability to support more efficient health planning, achieve objectives, and respond to emergencies that threaten access to care. One advantage of permitting regulatory flexibility is that it allows the CN program to consider special access circumstances unique to various urban and rural settings or to quickly respond to events that might diminish access to care. For example, the Washington legislature passed Substitute Senate Bill 5569 in the 2023 legislative session giving the CN program explicit authority to provide kidney dialysis centers temporary emergency situation exemption to support access to care in times of emergencies. Providing greater clarity on how the CN program can approve requests for waivers or exemptions would foster more innovative and effective approaches to healthcare delivery and support ongoing access to care in times of emergencies.

Providing flexibility around CN requirements must be done carefully to avoid creating statutory loopholes and inviting frequent requests to deviate from CN requirements. Narrowly defining when an exemption or waiver can take place and providing the program with a clear scope of discretion would help to alleviate potential issues.

Recommendation 3: Enhance CN flexibility

State Examples: Massachusetts

Washington CN Program

Washington will benefit from clearer authority to waive specific CN requirements or grant exemptions aimed at fostering investment and improving access in rural and underserved communities. Examples could include incorporating a transparent public decision-making process and requiring applicants to demonstrate that Washington's statewide health resources strategy (the strategy) does not accurately reflect community needs. These provisions should be broad enough to necessitate the development of rules guiding applicant requests while enabling the CN program to operate independently of the strategy. For example, when Washington passed Substitute Senate Bill 5569 (2023), it allowed the CN program to develop rules to allow the temporary approval of dialysis stations under specific circumstances without

the need for a full application review. This allowed the dialysis provider to respond to emergencies within their respective communities that may necessitate the need for rapid expansion or relocation of stations. This statute also provided for the program to work with the dialysis community to establish regulations to implement this statute, while maintaining patient safety, development of a transparent approval process, and provisions to prevent these approvals from negatively impacting need calculations for providers seeking to permanently add stations within the same county. Additionally, other states also allow for similar processes. For example, Massachusetts does not rely explicitly on a state health plan or strategy for CN decisions. Instead, it evaluates applications based on state health priorities, guidelines, and goals.[57]

Washington could update CN statutes to guide the CN application process to reflect common practices observed in other states. Some states employ broad evaluation criteria, offering flexibility for both applicants and reviewers while maintaining accountability to high standards. This approach allows for adaptation to the evolving needs of state residents and applicants. Additionally, many states incorporate CN criteria specifically targeting key priorities. For example, some require applicants to address access, quality, equity, and cost in their proposals. Clarifying statutory requirements for applicants to explain in their applications how their projects will advance these priorities would simplify and improve outcome tracking for health planning purposes.

3.2.4 Reduce CN legal costs

The Washington CN program incurs substantial legal costs from appeals that represent about one third of the total program budget. The department is fully responsible for the costs associated with litigation, unlike in some states where the entity appealing must cover some of the legal costs. The CN program currently does not have a dedicated revenue source specifically to support ongoing legal costs.

Recommendation 4: Reduce CN legal costs

Washington CN Program

The department recognizes that the current administrative costs associated with litigation are overly burdensome to the state and the CN program. Opportunities to reduce the risk of litigation should be explored. If the department focused less on litigation and legal costs, it would allow a greater share of the CN resources to be dedicated to other important activities, including, but not limited to: effective health planning activities, monitoring and enforcement,

assessing and better addressing need and health care deserts, implementing equitable process improvements, and developing CN education materials for the public. Furthermore, reductions in litigation costs would also lead to lower application fees as overall program costs would be reduced. This would also shorten the average length of time before healthcare organizations are allowed to implement project plans, as most CN decisions are delayed by legal appeals.

4. Access to Care

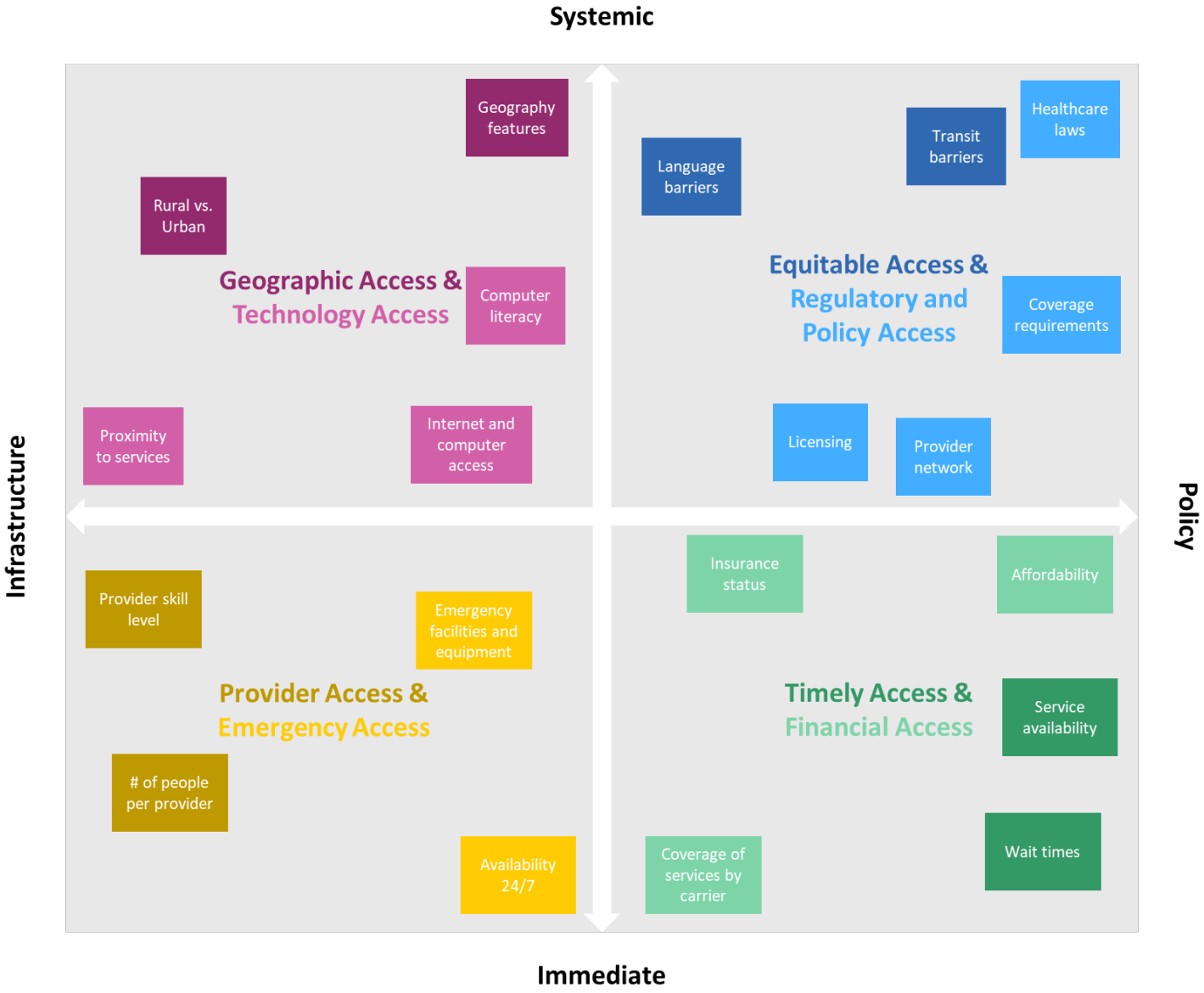
4.1 Defining access

Access is a key priority in health planning and can be evaluated from multiple perspectives, as shown in Figure 4. At its core, access reflects the ease in which patients can receive healthcare services. Efforts to enhance access should consider its various dimensions, recognizing that many of these are interconnected.

CN is based on the concept of restricting the expansion of healthcare providers when there is not a demonstrated need. An appropriate level of intervention would result in a delivery system that effectively balances access, cost, and quality. CN programs influence access to healthcare services in several ways. They were designed to reduce provider overcapacity and minimize the incentives for providers to deliver expensive and unnecessary healthcare services.[58] This helps to control inflationary pressures on healthcare costs and may reduce potential health risks to patients. To understand where Washington is today, the department and policymakers need to have access to accurate and objective data that are actionable, allowing for effective decision making when considering policy changes or approval of CN applications.

This analysis primarily focuses on geographic access; specifically, the time and distance required to reach healthcare providers and services. As medical advances and specialized treatment options have increased, healthcare services have become more specialized and certain types of care have become more like a statewide utility. As a result, patients may need to travel longer distances to access care from specialized centers of excellence instead of having access to a full range of services at their local hospital.

Figure 4: Dimensions of access



4.1.1 Communities experiencing greater access to care barriers

Rural Communities

One indicator,[vi,59] or dimension of access to care, is accessibility to a usual source of care[vii,60] or primary care provider (PCP).[61,62] This is especially relevant for rural communities who often face

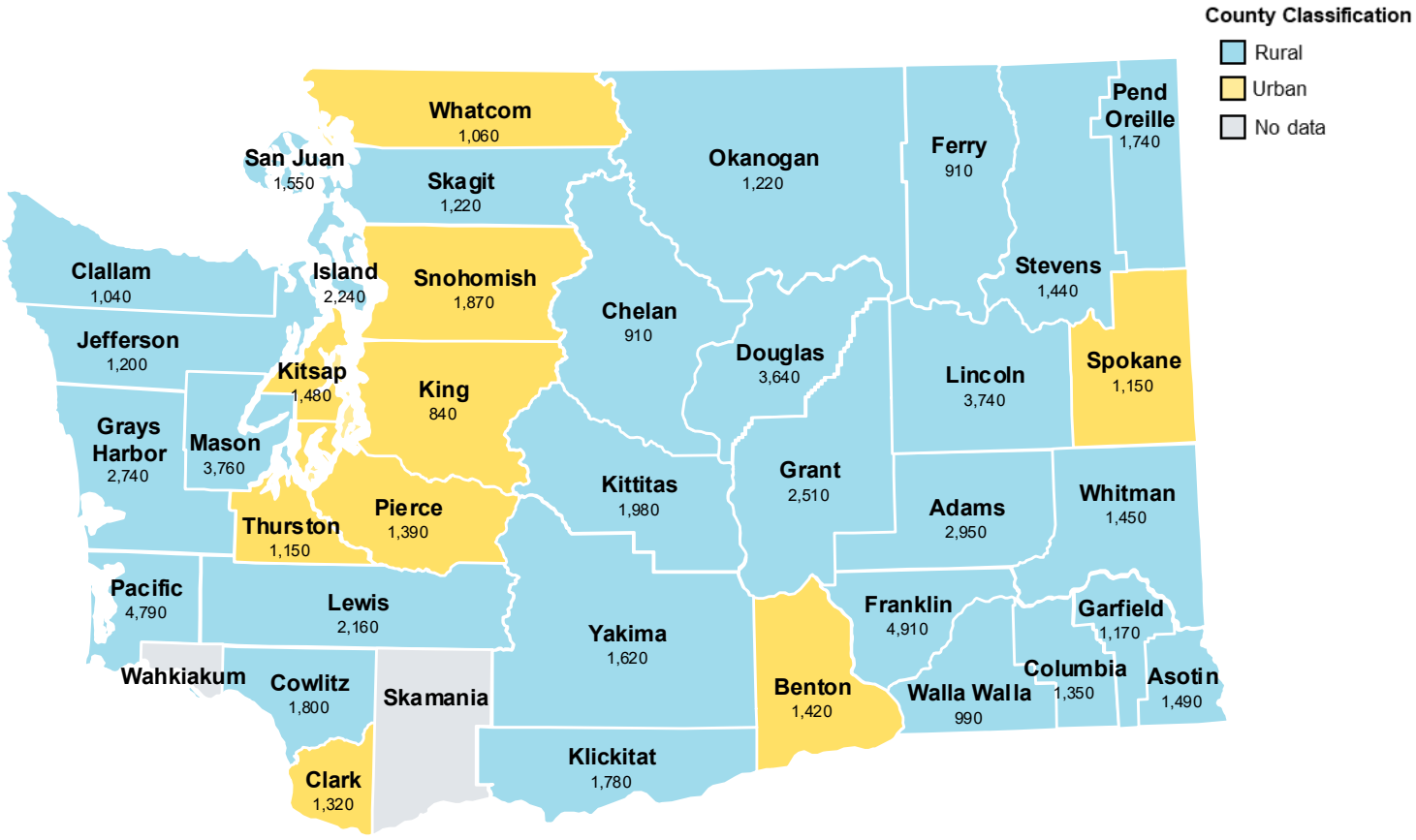
[vi] An indicator is something that points to a phenomenon or a change in a phenomenon over time. Indicators are used to measure or operationalize an area of interest and are often used as a proxy for a variable of interest.
[vii] Usual source of care is the place (e.g., medical office, clinic, health center) or healthcare provider that an individual or family goes to when sick or in need of health-related advice.

geographic barriers to care and need to travel long distances to get that care. "Rural" can be defined by many factors such as population thresholds (e.g., >50,000 people is considered urban), population density, and amount of land use.[63] People who live in rural areas experience greater health risks (e.g., higher rates of obesity, high blood pressure, diabetes, smoking, cancer) compared to their urban counterparts, leading to poorer health outcomes.[64,65]

Across the U.S., people living in rural areas experience worse health outcomes in part due to barriers in accessing healthcare.[66] Over half of healthcare workforce shortages occur in rural areas, and rural residents are less likely to receive preventive services.[67] In Washington, most counties are rural, with only nine out of 39 counties classified as urban.[68] In a study that surveyed Washingtonians across the state, residents of small rural areas[viii] were less likely to receive preventive care, lacked access to a PCP, and had to travel longer distances to receive care.[69] This can also lead to increases in the cost of healthcare for people in rural areas. For example, delayed care can lead to worse health outcomes requiring a deeper level of care that can be more costly. Long travel times can lead to high costs related to transportation, childcare, and time off work.

[viii] Small rural area is defined by the Rural-Urban Commuting Area (RUCA) 3.10 framework and coding scheme, developed by the Office of Rural Health within the Washington State Department of Health. In the study, small rural area was defined as RUCA 7-10, with a population density of less than 100 residents per square mile.

Map 2: Washington Ratio of PCPs per Population by Rural and Urban Counties
County Health Rankings, University of Wisconsin Population Health Institute, 2025[ix]



Map 2 shows the ratio of individuals per PCP[70] in each county, stratified by rural and urban counties. Rural counties are depicted in light blue and urban counties are shown in yellow. Data was not available for counties in gray (i.e., Skamania, and Wahkiakum). King County has the lowest ratio of 840:1, indicating people in King County may have greater access to primary care. Pacific County has the highest ratio of 4,790:1. This indicates patients in Pacific County may have a harder time accessing primary care.

[ix] The 2025 Annual Data Release used data from 2021 for this measure.

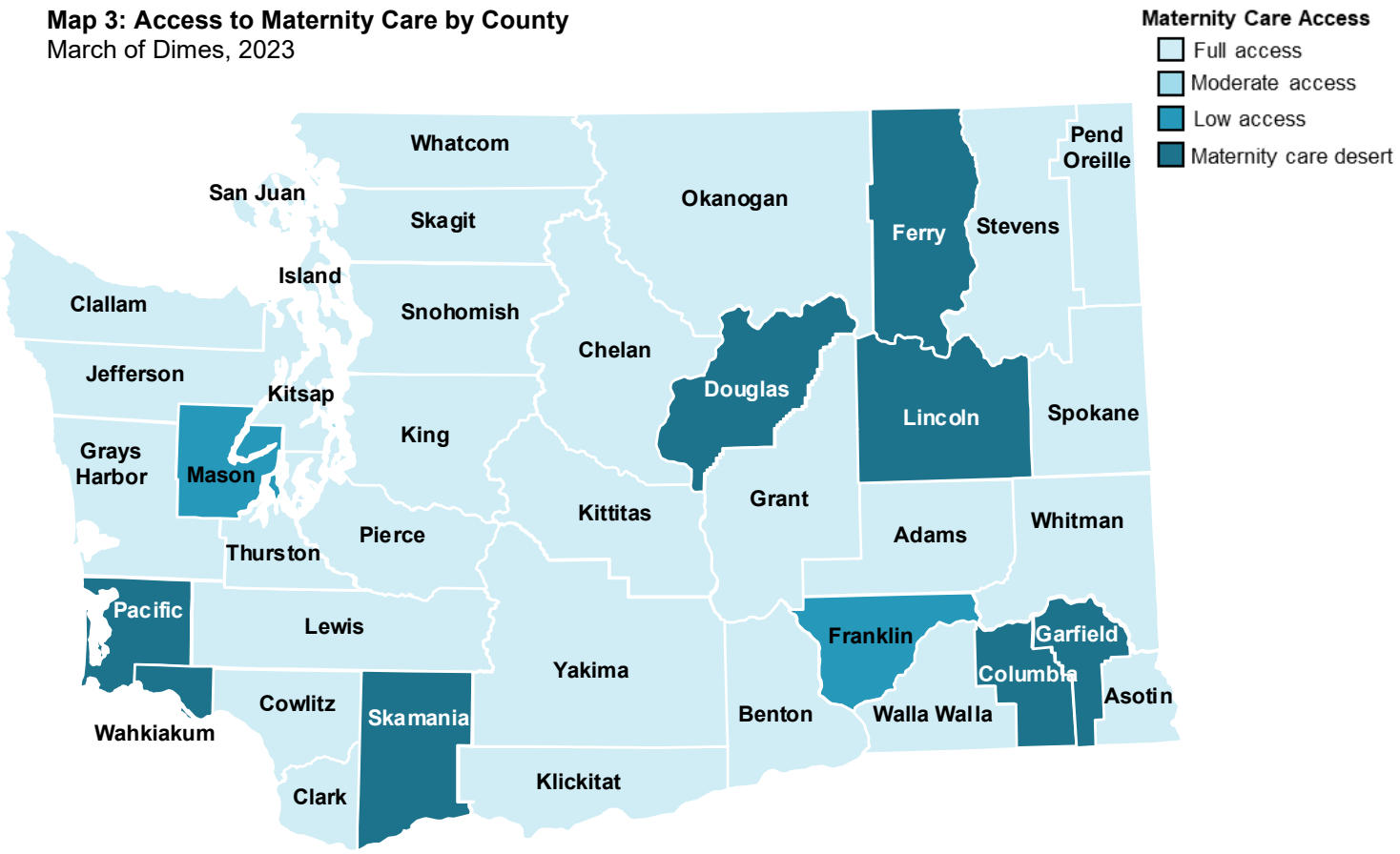
Populations Needing Obstetric and Other Pregnancy-Related Services

Lack of access to needed healthcare remains a top barrier and top contributor to preventable pregnancy-related deaths in Washington.[71] The U.S. has the highest maternal death rate among high-earning countries, with greater disparities existing for Black women compared to white women.[72] In Washington, disparities persist across race, ethnicity, age, and education, and are particularly notable among black, indigenous, and other people of color (BIPOC), and people living with low incomes.[73] Between 2014-2020 maternal mortality rates in Washington were lower than national rates, but 80% of pregnancy-related deaths were deemed preventable.[74] 51% of pregnancy-related deaths involved a lack of access to care, in both rural (43% of cases) and urban (52% of cases) settings.[75] Birthing units across the U.S. have been closing at high rates, sometimes leading to "maternity care deserts,"[x,76] especially in rural areas.[77] In recent years, some hospitals in Washington have stopped providing obstetric services or closed maternity centers.[78]

Map 3 depicts access to maternity care by county.[79] Counties in light blue have full access to maternity care services and counties in navy blue are maternity care deserts. Eight Washington counties (Columbia, Douglas, Ferry, Garfield, Lincoln, Pacific, Skamania, and Wahkiakum) are considered maternity care deserts, meaning they have no hospitals or birth centers providing obstetrics and no obstetric providers in the county. Two Washington counties (Franklin and Mason) are considered low access, meaning there are fewer than two hospitals or birth centers providing obstetric care, fewer than 60 obstetric providers in the county, and 10% or more of women 18-64 in the county who do not have health insurance.

[x] Maternity care deserts are counties without hospitals or birth centers that offer obstetric care and do not have obstetric providers (OB/GYNs, and certified nurse midwives/midwives).

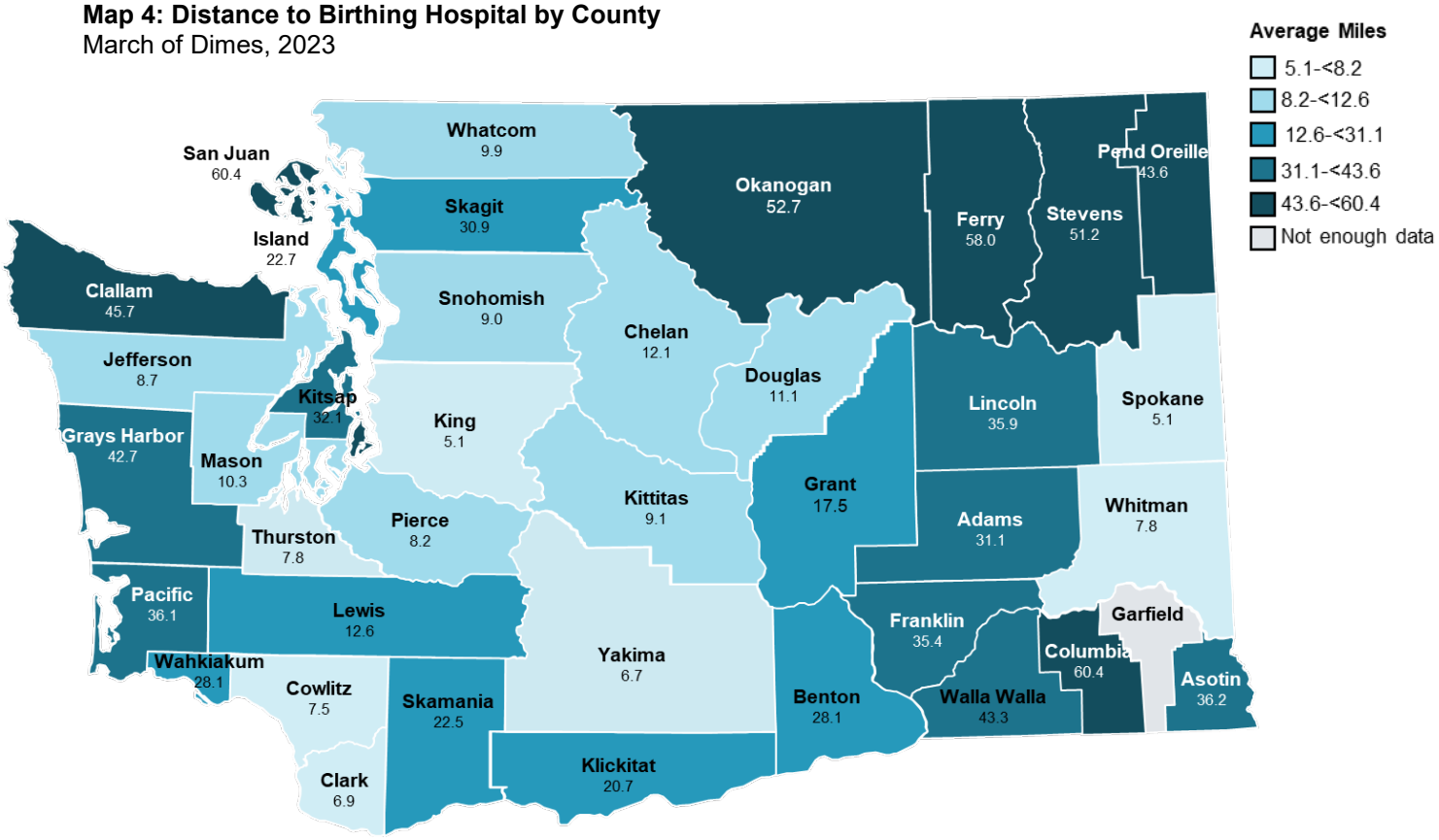
Map 3: Access to Maternity Care by County
March of Dimes, 2023



Definitions	Hospitals and birth centers offering obstetric care	Obstetric providers (obstetrician, family physician, certified nurse midwives/ certified midwives per 10,000 births)	Proportion of women 18-64 without health insurance
Maternity care deserts	Zero	Zero	Any
Low access to maternity care	<2	<60	≥10%
Moderate access to maternity care	<2	<60	<10%
Full access to maternity care*	≥2	≥60	Any

Map 4 depicts the distance to the nearest birthing hospital by county. The lightest blue indicates people in that county have to travel between 5.1 miles and 8.2 miles to the nearest birthing hospital, and the darkest blue indicates people in that county must travel between 43.6 and 60.4 miles to the nearest birthing hospital. The map illustrates that travel times are significantly higher in more rural areas, indicating travel time as a barrier to access to care for these counties.

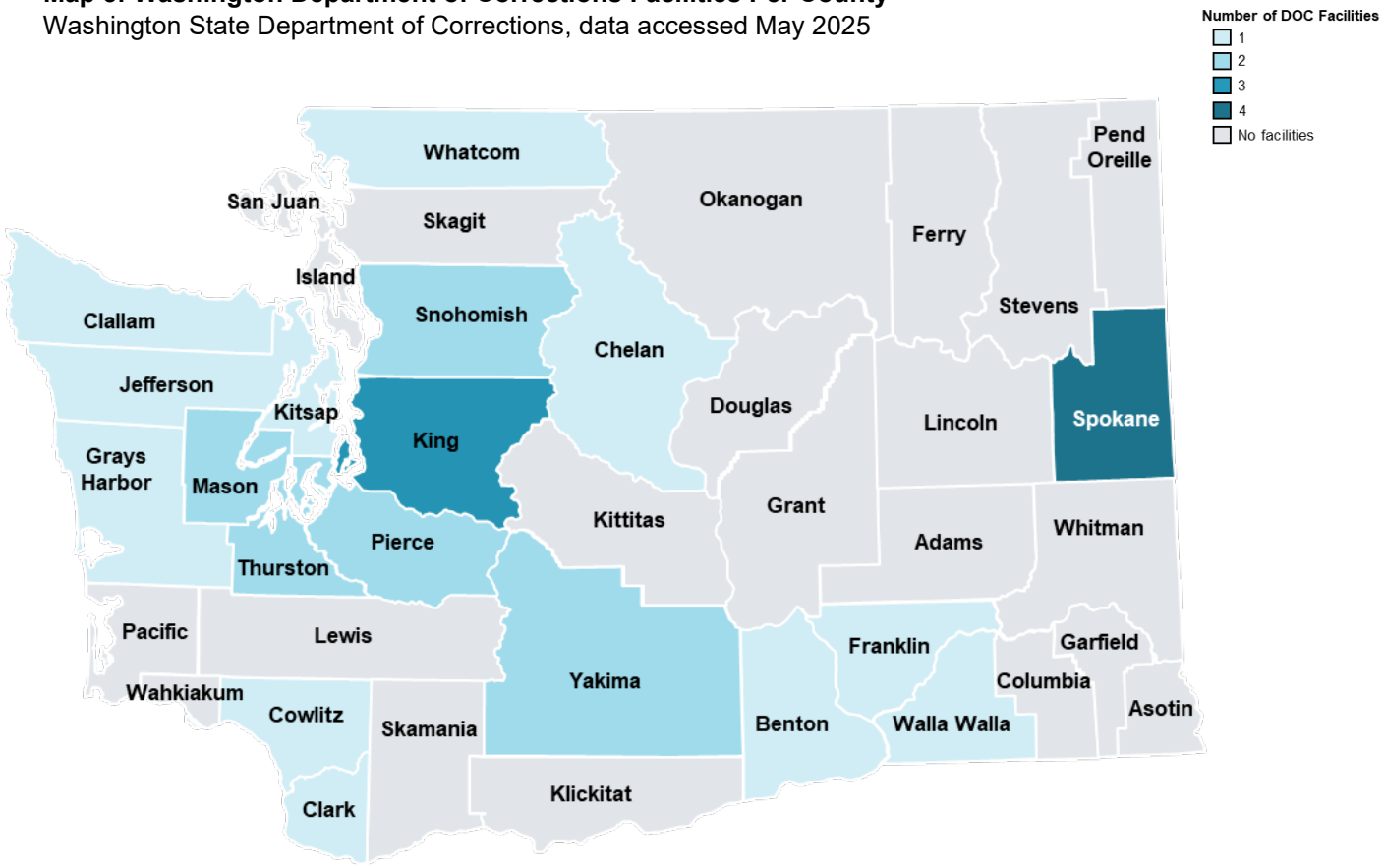
Map 4: Distance to Birthing Hospital by County
March of Dimes, 2023



People who are incarcerated

People who are incarcerated face systemic access issues across the four quadrants of access dimensions referenced in Figure 4. CN programs could play a critical role in addressing these gaps in access by including the people who are or have formerly been incarcerated in their calculations of healthcare demand within a community. Currently, the exclusion of this population skews demand estimates, leading to inadequate resource allocation and perpetuating disparities in care. Upon reentry into their home communities, people who have been incarcerated may find they do not have access to critical healthcare services (e.g., hospice), requiring them to travel for services, and potentially face longer wait times. By helping ensure that the unique needs of incarcerated people are considered, CN programs can foster a more equitable healthcare system, improve access for this underserved population, and promote successful reentry into the community.

Map 5: Washington Department of Corrections Facilities Per County
Washington State Department of Corrections, data accessed May 2025



Map 5 shows the number and location of Department of Corrections (DOC) facilities across Washington by county. DOC facilities include prisons, community justice centers, and reentry facilities. Counties shaded in gray do not have any DOC facilities. Eleven counties have one DOC facility, and five counties have two DOC facilities. King county has three DOC facilities, and Spokane has the most in the state with four DOC facilities.

4.2 Literature review related to CN and access

The CN structure provides a legal means of market allocation, improving the likelihood that a sustainable provider business model will endure and that the services will meet the needs of the community.[80] In some cases, especially in rural communities, there are not enough patients to support two providers competing for the same patient base. Additionally, there may be a shortage of local clinical staff with the necessary expertise to serve two provider organizations. Antitrust laws prohibit competing providers from making agreements to allocate services among themselves. For instance, competitors cannot legally agree that only one of them will provide a certain service, as such arrangements could violate antitrust regulations. By creating a

competitive CN application process, a CN program can effectively create the same outcome within a geographic region.

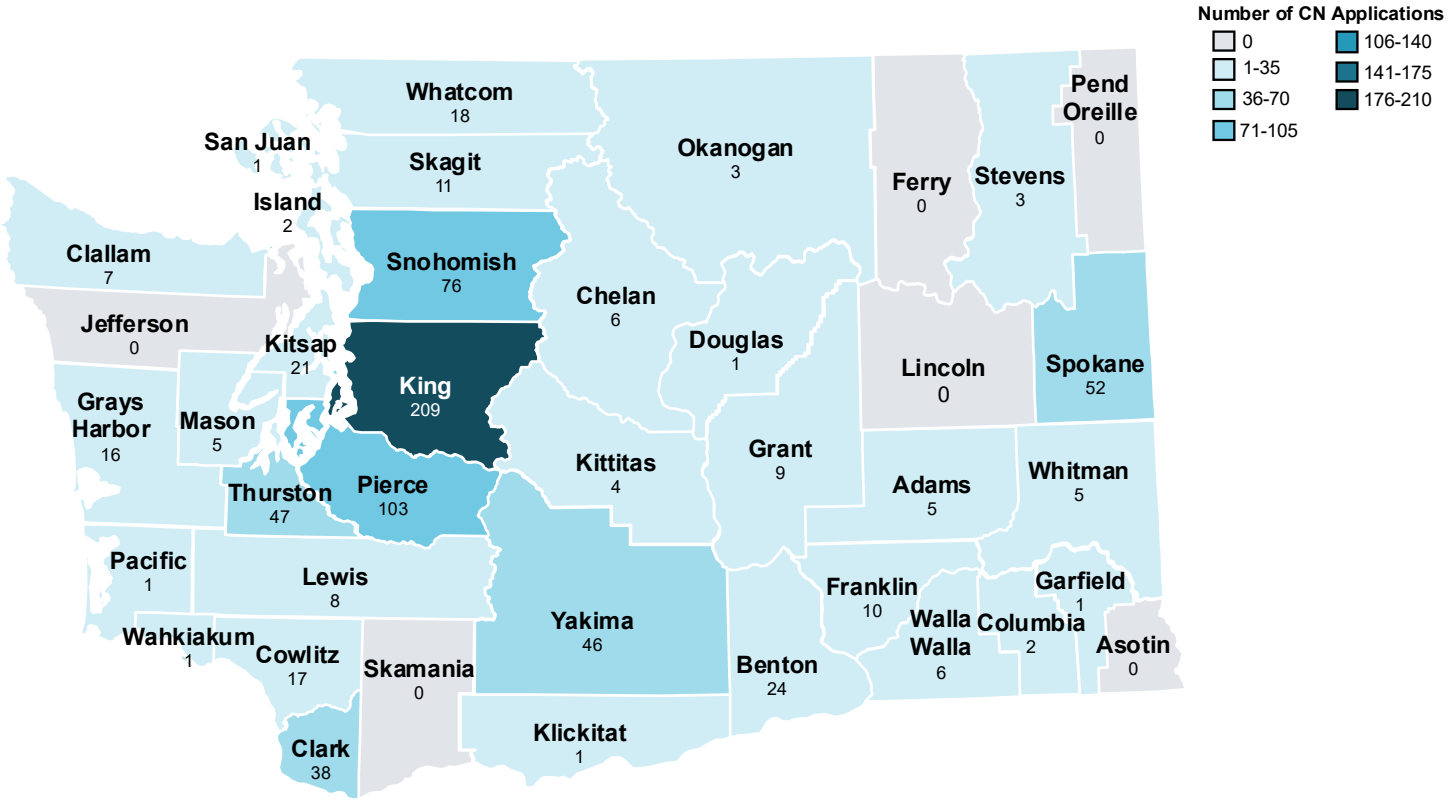
To ensure local health care resources are accessed and used in an effective manner, the CN application process allows for public scrutiny of proposals. The process maintains transparency at every stage of the application process—making applications, supporting documentation, public comments, and rebuttals openly accessible. The public also has opportunities to participate in the process. Especially when healthcare systems are seen as charitable trusts or public organizations, there is substantial interest in maintaining a public process where members of the community and the rest of the healthcare system have the opportunity to participate and voice their needs. The public process typically emphasizes the importance of maintaining or improving access to key services, encouraging organizations to consider a public response to any changes that could be seen as detrimental.

> *"There is a caution against being too restrictive and not having enough programs to achieve the priorities of access and choice, and there's also a problem with being too lax…The issues with being too lax are included to, but are not restricted to, having insufficient volume for individual programs to be able to afford hiring staff. And again, specifically in hospice, this means that patients experience symptoms on nights, weekends, and after hours that there is insufficient staff to address and there are some nationally reported examples of breakdowns when programs are too small to hire sufficient staff."*
>
> – Comment from an interested party at August 6th, 2024 proviso Workshop

There are some disadvantages for access associated with CN programs. The administrative burden and the risk of an adverse outcome might discourage interest in some projects.[81] These could be projects that are important to the communities the healthcare organization serves.

Map 6 depicts the number of CN applications by county between 2016 and 2024. King County had the most applications at 670, while three counties (Ferry, Lincoln, and Pend Oreille) had zero applications. Examining population density could help anticipate which counties are more likely to generate higher or lower application volumes. A lower-than-expected number of applications in a county could suggest less unmet need, whereas a higher-than-expected number may indicate significant unmet demand, offering an opportunity to explore contributing factors.

Map 6: CN Applications by County, 2016-2024



4.3 Discussion

Washington state CN requirements related to access may include need determination formulas that do not accurately reflect current healthcare dynamics, particularly in rural areas. These methods, which are based on existing models, may not anticipate future healthcare delivery trends or community needs. As a result, the CN framework may hinder projects from proceeding, thereby limiting access to important healthcare services.

One approach that could inform improvements to the CN program related to access to healthcare services is the concept of network adequacy, currently used in the oversight of private insurance companies.

The insurance legal requirement for a provider network is a minimum standard, and most insurance products include more providers than is necessary to meet the standard. An insurance company's ability to negotiate with, and choose a subset of, available providers allows them to apply competitive forces that can help keep healthcare prices lower when they choose providers for network participation. If one provider is unwilling to negotiate reasonable reimbursement provisions, the insurance company can choose another provider to include in the network. Health system planning may seek an ideal number of providers and geographic coverage and prefer to offer something more than an insurance minimum standard, but the

same tools can be used for both purposes. As CN seeks to avoid an excess capacity of providers, network adequacy regulatory approaches can provide unique insight and create an opportunity to improve health system planning efforts and ensure access to healthcare services.

Most state network adequacy requirements make use of the federal government standards for qualified health plans (QHPs). Other federal programs such as Medicare Advantage also include network adequacy requirements. The infrastructure around evaluating networks represents a critical mass of users and applications that has made implementing regulations and use of data analytic tools very common. In addition to reviewing time and distance, these regulations and oversight are now considering appointment wait times. The National Conference of State Legislators offers an overview of network adequacy requirements and state-level approaches.[82]

4.4 Recommendations

4.4.1 Enhance statutory provisions for considering access to healthcare services

Strengthening statutory provisions related to healthcare facility closures and services provided could help mitigate access gaps and help ensure community needs are considered in the CN process. Some states require a CN application or an action plan for entities that close facilities or stop providing services in any area. Hawaii requires applicants to submit a CN for modifying healthcare facilities and substantially modifying the scope or type of health services.[83] While Massachusetts does not impose the same requirement as Hawaii, hospitals must submit notice to the DPH at least 90 days in advance when closing essential health services, (e.g., outpatient mental health services, outpatient reproductive health services)[xi] including an assessment of the anticipated impact of the closure in the community and a public hearing.[84,85] Washington could consider similar provisions that support access to care by requiring certain healthcare services to be offered or by requiring notification and a process to close certain healthcare services.

Recommendation 5: Enhance statutory provisions for considering access to healthcare services

[xi] Essential health services, per 105 CMR 130.020, are any services that a hospital is license for that that are not explicitly exempted. Excluded services consist of (1) skilled nursing facility service; (2) intermediate care facility service; (3) cardiac catheterization service; (4) chronic care service; (5) electrophysiology; (6) hematopoietic progenitor/stem cell collection, processing, and transplant service; (7) hematopoietic progenitor/stem cell transplantation program or clinical transplantation program; (8) trauma service as a designated trauma center; (9) primary stroke service; and (10) medical control service.

Network adequacy standards are designed to protect consumers from purchasing health insurance plans that lack sufficient local provider networks to ensure reasonable access to care. These standards typically include specific time and distance metrics, requiring insurance networks to include a range of provider types within a defined radius or travel time from the populations they serve. The Washington CN program could identify gaps in provider capacity, and therefore access, using modern, sophisticated tools and approaches by making use of time and distance analyses similar to those used for network adequacy. The current approach of measuring and evaluating access to providers at the county-level could be enhanced by incorporating approaches that consider travel routes, rivers, mountains, and other barriers independently from county or state lines. In the insurance industry, if there are no in-network providers that perform a specific service available to a population within a time and distance standard, the insurance company fails to meet the network adequacy standard. Similarly, if there are no existing healthcare providers within specified time and distance parameters, Washington could determine that existing access to certain healthcare services does not meet the needs of a community. By leveraging such tools and approaches, CN regulators can strike a balance between avoiding overcapacity and ensuring equitable access to care.

Statutory changes would provide legislative direction that would result in an improved understanding of current healthcare system capacity and the need for healthcare providers and services in certain regions. Health planning efforts would improve if the CN program could quantify the number of specific providers and services available within a reasonable distance from people living in both urban and rural communities. High rates of providers might suggest to regulators that additional providers may not be necessary. Calculations for other communities could indicate an unmet need when there are no providers available within a reasonable time and distance from the population center.

Using time and distance-based standards would allow for an objective approach to determining healthcare access needs and can enhance the current process that is heavily reliant on a county-based analysis. Many of the lessons learned by incorporating a new tool, software, and analytical approach have already been experienced by state and federal regulators looking at private insurance company provider networks for compliance. These analyses take place for virtually every community in the country today. Advancements in data analytics and mapping technologies have enhanced the ability to proactively identify and address gaps in access.[xii,86]

A limitation of the existing CN process is that without a coherent statewide health resources plan or strategy, the program and staff must generally react to applications instead of engaging in prospective health systems planning. Resource constraints are a constant challenge, but the

[xii] Tools like Optum's GeoAccess® GeoNetworks® software enable organizations to assess provider networks against time- and distance-based access standards, helping ensure that healthcare services are within reach for the populations they serve.

opportunity to be more proactive might come if resources were applied to new modeling approaches. Current analysis tools and procedures to evaluate provider networks are being used across the country to ensure compliance with federal and state network adequacy laws, and the economies of scale associated with the extensive modeling efforts offer an objective and low-cost option for applying a highly sophisticated approach to understanding where delivery system and access gaps in healthcare exist. A better understanding of the current provider environment, capacity, and travel times for residents would pave the way to identify future interventions to improve access to care.

Statutory requirements for considering the time and distance between populations and providers would prioritize analysis of data to identify providers by specialty and lead to an understanding of service availability and accessibility. There are national databases that include information on providers, and Washington may also be well served by considering the use of the Washington APCD.

Including the use of network adequacy tools might result in identifying both geographic areas where CN standards could be raised or lowered, encouraging a more cost-effective and accessible healthcare system.

4.4.2 Expand CN oversight to include FSEDs and urgent care facilities that charge facility fees

Under current Washington CN statute, hospitals, ambulatory surgery centers, hospices, nursing homes, and home health agencies must obtain a CN before establishing a facility or effectuating other CN activities.[87] Health systems wishing to establish a facility type not specified in CN statute are not required to obtain a CN and therefore have the flexibility to establish such facilities when and where desired without oversight from CN. Requiring a CN for specific facilities that charge facility fees[88] would expand the scope of the CN program to include some currently unregulated facility types, including urgent care centers and freestanding emergency departments (FSEDs), among other immediate care facilities that may emerge in the future. The department does not require CN review for urgent care centers or FSEDs.

Recommendation 6: Expand CN oversight to include FSEDs and urgent care facilities that charge facility fees

Washington's CN program prioritizes equitable access to healthcare services for everyone in the state. Expanding the program to include select organizations that bill facility fees could help ensure that new developments prioritize underserved areas, such as rural or geographically isolated areas where services are limited. Simultaneously, CN oversight could discourage the

unnecessary concentration of facilities in more profitable areas, such as urban centers or wealthy regions with disproportionally higher numbers of commercially insured individuals. Additional oversight might promote a more balanced distribution of healthcare resources across the state and improve access to healthcare services.

Cost containment of healthcare services, along with access, is a key objective in Washington's CN program and the proviso. With the rapid growth in the use of facility fees—a significant driver of rising healthcare costs[89]—extending CN oversight to these facilities could strengthen the program's cost containment efforts and help protect patients from surprise bills. Additional regulatory oversight may potentially discourage the further development of excessive healthcare business models that include facility fees when patients only expect professional bills, and lower cost-sharing in the form of copayments, deductibles, and coinsurance. Insurance plans often impose higher cost-sharing requirements when services are delivered by an organization billing facility claims rather than in standalone professional settings. By discouraging the expansion of unnecessary sites that would otherwise bill a controversial facility claim, the CN program can help to control costs without the need for specialized billing expertise among staff. Many FSEDs and urgent care sites are hospital-affiliated providers, but that is not a requirement in Washington. When affiliated with a hospital, the claims originating from FSEDs or urgent care centers are frequently indistinguishable from those generated by a hospital. As a result, insurance companies tend to process these claims in the same manner as they would for hospital services, leading to higher out-of-pocket costs for patients.

Health systems may have anticipated the substantial revenues associated with facility billing off the hospital campus and made investments in buildings and technology that more typically reflect the offerings at a hospital. This expansion of the hospital footprint may be putting inflationary pressure on healthcare costs but could be considered an integral part of hospital system planning efforts today. The state should recognize the substantial business interests that exist and ensure the balance between cost and access.

Freestanding Emergency Departments (FSEDs)

In Washington, FSEDs can be extensions of an existing hospital emergency department that are physically separate from the main hospital emergency department, or completely independent facilities, as long as they provide comprehensive emergency medical, surgical, and trauma care services 24 hours a day, seven days a week.[90] When located in an underserved area, FSEDs can provide access to urgent, emergency, and stabilizing care for communities without a nearby hospital.

FSEDs are an example of a facility type that is not currently subject to CN regulation, but could benefit from inclusion under CN oversight. This lack of oversight means there are limited

restrictions on where FSEDs can be established, enabling hospital systems to set up facilities in locations where they may not be necessary. For example, organizations may target areas with higher concentrations of commercially insured individuals, regions where the organizations lack a strong presence, or locations near competitor facilities. Bringing FSEDs under CN regulation would allow the state to work to ensure these facilities are established only in areas where they address genuine community needs while maintaining equitable access to care for all residents.

Table 4 considers the advantages and disadvantages of bringing FSEDs under CN oversight.

Table 4: Advantages and disadvantages of CN regulation of FSEDs

Advantages	Disadvantages
• Can help manage excess facility supply.[91]	• Could limit access to emergency care for people who are not equitably served by health systems.[92]
• Can be used to tailor efforts to reflect and address community priorities.[93]	• May inhibit innovation and competition.[94]
• May improve existing healthcare infrastructure.[95]	• May create administrative burdens and delays.[96]
• Allows monitoring of quality standards by the CN program.[97]	• May restrict the ability of healthcare providers to react quickly to urgent needs and emergencies (e.g., natural disasters).[98]
• Reduces the risk of market exploitation (e.g., strategically targeting affluent areas).[99]	• Likely to create a legacy status for organizations already established. This may create a loss of competitive forces with these providers and services.
• Potentially reduces the cost for healthcare consumers due to more efficient use of existing facilities and emergency transportation.[100]	
• Can improve state oversight in maintaining access to services.[101]	

State Regulation of FSEDs

No other state was identified as focusing on FSEDs and urgent care facilities that impose facility fees. However, facility billing by providers operating off-hospital campuses has generated national controversy, prompting both state and federal governments to work on restrictions to address such billing practices. Table 5 outlines which focus states regulate FSEDs under CN oversight.

Table 5: FSED regulation in focus states

State	FSEDs under CN Oversight
Alabama	Yes[102]
Connecticut	Yes[103]
Hawaii	Yes[104]
Massachusetts	No, unless the capital expenditure exceeds $43,438,134.73[105]
New York	Yes[106]
Vermont	Yes[107]

4.5 Conclusion

Through regulation of additional facilities that charge facility fees, Washington would be able to maintain oversight of facilities such as FSEDs and urgent care centers, and work to ensure they meet community access needs while not exacerbating health care costs. This could restrict organizations from intentionally establishing unnecessary facilities in profitable areas, promote efficient use of existing facilities, and provide increased transparency for Washington's efforts to maintain access to healthcare services. CN oversight of such facilities would also create an avenue for the state to monitor service quality, compliance, and healthcare outcomes for these facilities, which could support the state in working to ensure patient access to quality healthcare. With the inclusion of these facilities under CN regulation, Washington could consider establishing different processes for facilities based on geography to help ensure the facilities are accessible and best meet the unique needs of their service areas.

5. Equity

Health equity is a cornerstone of just and effective healthcare systems and helps ensure that everyone can attain their full potential for health and well-being. Achieving health equity requires addressing historical and current injustices, removing economic and social barriers, and eliminating preventable disparities in health outcomes. Central to this effort is recognizing and addressing the influence of social determinants of health (SDOH)- nonmedical factors such as economic stability, education, community context, healthcare access, and the built environment- that profoundly shape health outcomes.

CN programs have a growing role in advancing health equity. Massachusetts and New York have adopted approaches that embed equity considerations into the CN process. Washington has an opportunity to integrate equity-focused provisions into its CN program such as leveraging health equity frameworks to assess project impacts and aligning CN applications with existing statutes prioritizing trauma-informed and culturally responsive practices. By embedding equity into the CN process, Washington can better address systemic disparities, prioritize people underserved by health systems, and help ensure a fair and just healthcare system.

This section explores how CN programs can serve as a critical lever for advancing health equity by addressing SDOH, promoting community engagement, and driving systemic change in the allocation and delivery of healthcare resources.

5.1 Defining health equity

Health equity broadly refers to the absence of socially unjust or unfair health[xiii] disparities.[108] According to the National Institute on Minority Health and Health Disparities, health disparities mean "largely preventable health differences that adversely affect populations who experience greater challenges to optimal health."[109] They are also "closely linked with intergenerational social, economic, and/or environmental disadvantages – primarily based on identification as an individual from a racial and/or ethnic minority group and/or by low socioeconomic status (SES) in society."[110]

Health equity is both an outcome and a process, achieved when everyone has the opportunity to be as healthy as possible,[111,112] regardless of race, culture, identity, or where someone lives.[113] Underlying efforts to address health equity are three main domains: access to care, quality of care, and affordability or cost of care. These components make up the "Triple Aim" construct which asserts that population health (i.e., access and quality), patient experience (i.e.,

[xiii] Per Braveman and Gruskin (2003), health means both physical and mental well-being, not just the absence of disease.

quality), and cost control are interconnected and mutually reinforcing components of the healthcare system.[xiv,114] The most recent iterations of healthcare improvement include population health, patient experience, cost control, minimizing provider burnout ("Quintuple Aim"),[115] and health equity ("Quadruple Aim").[116] While the first three aims are important components of mitigating health disparities and working toward health equity, the three aims do not inherently equate to health equity efforts. Researchers assert that the Triple Aim cannot be achieved without prioritizing health equity.[117] In addition to measuring population health, patient experience, and cost control, researchers suggest considering underlying inequities in conjunction with stratifying the first three aims by race, ethnicity, and other demographics.[118]

Both individual and population-level approaches are necessary for mitigating health disparities and to achieve health equity. SDOH are nonmedical factors that influence health outcomes and quality-of-life, and refer to the conditions in which people live, learn, work, play, and age.[119] At the individual level, an unequal distribution of SDOH is the root cause of health-related social needs (HRSNs).[120] HRSNs are "individual-level nonmedical resource needs related to SDOH that must be met for individuals to achieve good health outcomes and for communities to achieve health equity."[121] Growing research supports the development of health policies which go beyond investment in clinical care and expand to address "upstream" factors (i.e., SDOH). In addition, effective implementation of policy, including sufficient funding, is essential for achieving optimal population and individual health outcomes.[122]

5.2 Literature research

CN programs can impact health equity by supporting equitable geographic distribution of services, requiring entities to provide a broad range of healthcare services regardless of insurance or insurance type, regulating quality of providers, addressing community health needs, and incentivizing equity-focused projects.[123,124] CN can be used to promote health equity by regulating healthcare beyond existing need criteria. Other CN review criteria may include accessibility, cost, financial feasibility, and quality.[125]

Within the equity portion of the public presentations, the department received questions on the influence of CN on mortality rates and hospital quality. Across the U.S., the impact of CN regulations on mortality rates and hospital quality is mixed, with studies showing positive, neutral, and adverse effects.

> **Positive effects**: Three studies found that CN is associated with a reduction in mortality.[126] Two national studies found that CN regulations were associated with lower mortality following coronary artery bypass graft (CABG) surgeries.[127] By increasing patient volumes

[xiv] The Triple Aim is a "retooling" of William Kissick's Iron Triangle which places access, cost, and quality in opposition to the other rather than as complimentary (e.g., increasing quality also increases costs of care). Kissick's Iron Triangle has shaped much of the U.S. healthcare systems and reforms, including the Affordable Care Act.

and regionalizing care, CN regulations improved outcomes. One study reported that states with CN regulations had a 6% lower 30-day mortality risk for coronary revascularization procedures.[128]

Neutral effects: Several studies indicated no statistically significant impact of CN on mortality, even though CN regulations increased procedure volumes. These studies, including those on CABG and percutaneous transluminal coronary angioplasty (PTCA), showed that higher volumes did not consistently result in better mortality outcomes.[129]

Adverse effects: Some research suggested that stringent CN regulations might contribute to higher mortality rates. For example, one study reported a 5–6% increase in mortality rates across several diagnoses in states with stricter CN laws. Additionally, another study noted that states which repealed CN laws experienced lower CABG mortality rates, though this effect was temporary.[130]

Overall, while CN regulations may enhance care by centralizing procedures, evidence of their impact on mortality and hospital quality is mixed, suggesting that the effects of CN laws may depend on the context and implementation.

In looking deeper into the research on CN laws, some studies suggest that CN laws may have a negative impact on equity. Some examples include that CN laws can: (1) limit the establishment of new facilities and acquisition of advanced medical equipment, which can increase travel and wait times; (2) contribute to higher mortality rates and potentially lower hospital quality due to limited competition; and (3) may prevent new healthcare providers from entering the market, limiting service availability in areas underserved by health systems.[131]

To ensure that CN law in Washington state better supports equitable access and outcomes, the CN program believes there are opportunities to improve access to care for populations who are underserved by health systems, help promote geographic and economic access to healthcare facilities, and help improve resources allocation and decrease social costs due to lack of access to care.

How CN Can Impact Health Equity

Geographic Distribution of Services: The CN process can help ensure that healthcare services are distributed more evenly across different regions, particularly in rural and underserved areas. Without a CN, providers may concentrate services in more profitable urban areas, exacerbating disparities in access to care.

Demographic Equity: CN regulations can promote equal access to healthcare facilities and services for people underserved by health systems by helping ensure availability of a broad range of healthcare services to meet the diverse needs of this population, including specialty and primary care services.

Access to Specialized Services: By requiring approval for the establishment of specialized healthcare services and facilities, CN laws can help ensure access to essential services like neonatal intensive care units, dialysis centers, and cancer treatment facilities are available in areas that might otherwise be neglected.

Financial Barriers: CN regulations can help control healthcare costs by preventing the overbuilding of facilities and the unnecessary duplication of services. This helps to contain overall healthcare spending and makes care more affordable for people underserved by health systems.

Quality of Care: CN programs can promote higher standards of care by ensuring that only providers who meet specific criteria are allowed to offer new services or expand existing ones. This can lead to better health outcomes for people underserved by health systems by preventing lower-quality providers from entering the market.

Community Health Needs: CN processes often require applicants to demonstrate how their proposed services will meet the specific health needs of the community. This helps ensure that new healthcare projects are aligned with the actual needs of the population, rather than being driven solely by market forces.

Regulatory Oversight: By creating a regulatory framework that includes specific requirements intended to reduce inequities, CN can help foster a more equitable and competitive environment that benefits all patients, including people who are underserved by health systems.

Incentives for Equity-Focused Projects: Some states use the CN process to incentivize projects that specifically aim to reduce health disparities and improve access to care for people underserved by health systems.

5.3 Recommendations

5.3.1 Incorporate and align statutory provisions specifically targeting health inequities, including establishing a "health equity" definition for CN

Recommendation 7: Incorporate and align statutory provisions specifically targeting health inequities, including establishing a "health equity" definition for CN

State Examples: Massachusetts and New York

Health equity works to ensure everyone has a fair and just opportunity to achieve their highest level of health. Achieving equity requires addressing both historical and present injustices, removing economic and social barriers,

and eliminating preventable disparities in health outcomes. To best guide and measure CN efforts that address health equity, Washington should consider adopting a health equity definition. While there is no unanimous health equity definition, many agencies share general themes and build off each other. This report recommends using a combination of the department of health and the Governor's Office of Equity's definitions of health equity, as they enhance the CDC and WHO definitions included below:

- **The Centers for Disease Control and Prevention (CDC):** Achieving health equity requires valuing everyone equally and focused efforts aimed at overcoming systemic injustices and dismantling economic and social barriers that impede well-being.[132]
- **The World Health Organization (WHO):** Health equity is the absence of unfair, avoidable differences among groups, allowing everyone to reach their full health potential. These disparities are deeply influenced by social, economic, and geographical conditions.[133]
- **Washington State Department of Health:** Health equity ensures that all individuals, regardless of socioeconomic factors, can attain their full health potential. Health inequities are systemic, avoidable, unfair, and unjust differences in health outcomes.[134,135]

Figure 5: Health equity definitions

CDC Definition:	WHO Definition:	Washington Definition:
• Fair and just opportunity for everyone to attain their highest level of health. • Requires addressing historical and contemporary injustices, overcoming economic and social obstacles, and eliminating preventable health disparities.	• Absence of unfair, avoidable differences among groups. • Health equity is achieved when everyone can attain their full potential for health and well-being. • Determined by social, economic, and environmental conditions.	• Opportunity to achieve full health potential, regardless of various socioeconomic factors. • Health inequities are systematic, avoidable, unfair, and unjust differences in health outcomes.

In addition to using definitions from the CDC, WHO, and Washington DOH, Washington should consider adopting a health equity definition that incorporates other state initiatives and/or Washington statutes to best align state resources and goals. Other definitions and initiatives that could be considered include:

- Using the Office of Financial Management's Glossary of Equity definition:[136] "The act of developing, strengthening, and supporting procedural and outcome fairness in systems, procedures, and resource distribution mechanisms to create equitable (not equal)

opportunity for all people. Equity is distinct from equality which refers to everyone having the same treatment without accounting for differing needs or circumstances. Equity has a focus on eliminating barriers that have prevented the full participation of historically and currently oppressed groups."

- Using the Department of Health's Community Engagement Guide Definition:[137] "[Health equity] exists when all people can attain their full health potential and no one is disadvantaged from achieving this potential because of the color of their skin, ancestry, level of education, gender identity, sexual orientation, age, religion, the job they have, the neighborhood in which they live, socioeconomic status, or whether they have a disability."
- Using equity provisions listed in the establishment of the Office of Health Equity in RCW 43.06D.020.[xv,138]
- Incorporating the Office of Equity's "Equity Lens"[xvi,139] into CN criteria, as defined by RCW 43.06D.010, including providing consideration to RCW 49.60.030 "Freedom from discrimination,"[xvii,140] as well as immigration status and language access.
- Incorporating consideration for Health Equity Zones,[xviii] as defined in RCW 43.70.595.[141]
- Incorporating special consideration for "Vulnerable populations"[xix,xx] as described in RCW 70A.02.010(14)(b).[142]
- Incorporating trauma-informed and culturally appropriate services, such as in accordance with RCW 43.71B.030 [Indian health improvement advisory plan]. [143] This would help ensure improved access to care and that that care is better suited to the needs of people underserved by health systems. This also acknowledges the complex challenges faced by communities impacted by adverse experiences and seeks to build

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[xv] Per the Office of Health Equity statutes: "Equity requires developing, strengthening, and supporting policies and procedures that distribute and prioritize resources to those who have been historically and currently marginalized, including tribes; (ii) Equity requires the elimination of systemic barriers that have been deeply entrenched in systems of inequality and oppression; and(iii) Equity achieves procedural and outcome fairness, promoting dignity, honor, and respect for all people."

[xvi] An "Equity lens" means providing consideration to the RCW 49.60.030 "Freedom from discrimination," as well as immigration status and language access.

[xvii] Applicable language includes: "The right to be free from discrimination because of race, creed, color, national origin, citizenship or immigration status, sex, honorably discharged veteran or military status, sexual orientation, or the presence of any sensory, mental, or physical disability or the use of a trained dog guide or service animal by a person with a disability is recognized as and declared to be a civil right."

[xviii] Health Equity Zones are defined as: "A contiguous geographic area that demonstrates measurable and documented health disparities and poor health outcomes which may include but are not limited to high rates of maternal complications, newborn health complications, and chronic and infectious disease, is populated by communities of color, Indian communities, communities experiencing poverty, or immigrant communities, and is small enough for targeted interventions to have a significant impact on health outcomes and health disparities."

[xix] "Vulnerable populations" means population groups that are more likely to be at higher risk for poor health outcomes in response to environmental harms, due to adverse socioeconomic factors (see Footnote 6). These groups include racial or ethnic minorities and low-income populations, among others.

[xx] As defined in RCW 70A.02.010, adverse socioeconomic factors include unemployment, high housing and transportation costs relative to income, limited access to nutritious food and adequate healthcare, linguistic isolation, and other factors that negatively affect health outcomes and increase vulnerability to the effects of environmental harms and sensitivity factors, such as low birth weight and higher rates of hospitalization.

trust within these populations by ensuring healthcare settings are safe, respectful, and responsive to their specific experiences and needs. Implementing culturally appropriate and trauma informed services also directly supports equitable care by recognizing and bridging gaps in cultural, linguistic, and social needs experienced by different communities or individuals, thereby reducing disparities.[144, 145, 146]

- Incorporate existing CN review criteria for nursing home beds for ethnic minorities[147] into a health equity definition for CN that applies to all applicants. Applying this to more facility types could promote culturally tailored services in other healthcare settings, further improving access for communities underserved by health systems. For example, this would broaden the reach of culturally tailored services beyond long-term care to other healthcare settings. This could promote a more inclusive healthcare infrastructure that prioritizes services for communities underserved by health systems, fostering greater access to care and continuity for individuals who may otherwise face systemic barriers to treatment.

As the CDC and WHO definitions support the current definitions of health equity currently used by Washington, the Department of Health and the Governor's Office of Equity, this report recommends combining the definitions of health equity currently used by the department and the Governor's Office of Equity to establish a current and comprehensive definition of health equity.

In addition to defining health equity for CN and aligning this definition with other Washington state definitions and initiatives, Washington should consider adding statutory provisions which explicitly address health inequities through criteria which improve both direct community and statewide health. Both New York and Massachusetts offer health equity provisions as part of their programs. Both program approaches have strengths, yet they serve different purposes. Thus, Washington could consider incorporating elements from New York's approach and Massachusetts' model to focus both on the evaluation of each new project's impact on health equity and on the proactive allocation of resources to community health.

Other state approaches

Two states, Massachusetts and New York, include provisions within their CN programs that require applicants to consider the health equity implications of proposed projects. Both states utilize CN, in addition to other initiatives, to align statewide goals that promote health equity. While New York is the only state to statutorily require health equity provisions, Massachusetts' regulations have provided sufficient authority for the CN program to successfully implement health equity provisions over the last seven years.

Massachusetts Community-Based Health Initiative (CHI) Overview

Massachusetts utilizes the CHI as a condition of its DoN program to focus on improving health beyond clinical care. The CHI program "supports DoN Applicants and their community-based partners in focusing on [SDOH], the conditions where people live, work, and play that influence health outcomes, and which in turn, provide a significant opportunity for long-term health care cost savings."[148] This effort was based on DoN rules requiring DoN applicants to include plans on and funding for projects focused on SDOH and addressing state-defined health priorities.

> *By focusing on the social determinants of health, CHI resources are directed toward strategies that change the conditions which promote or hinder opportunities for health. Consistent with major trends in health care, …. this [SDOH] represents a significant opportunity to address health inequities, improve health outcomes, and to realize substantial long-term health care cost savings for Applicants, patients, and the Commonwealth.*
>
> – Massachusetts Department of Public Health

Massachusetts' CHI utilizes ongoing monitoring, is integrated with other state initiatives (e.g., Medicaid 1115 waiver delivery system transformation), leverages federal requirements (i.e., Community Health Needs Assessments), engages the community and addresses inequities outside of clinical care, and redistributes funding to community organizations via grants to promote health equity. The CHI requirement highlights Massachusetts' statewide and DoN program goal of improving public health outcomes via innovative health delivery methods and population health strategies.

Among many initiatives, highlights from the Massachusetts DoN CHI requirement include funding toward projects which address healthy food access,[149] invest in housing and housing stability,[150] improve educational attainment,[151] and strengthen community policies, systems, and networks to improve the well-being and health of children.[152] The 2024 cohort of statewide funds includes 82 awardees, over 110 community partners, and $46.1 million dollars distributed across the state.[153]

Washington currently requires nonprofit hospitals to submit Community Health Improvement Services (CHIS) addendums to the federally required Community Health Needs Assessments (CHNAs).[154] The CHIS addendums report which hospital activities address the needs identified within CHNAs. The Massachusetts CHI model collects funds through the DoN program to distribute both locally and statewide to address health needs outlined in CHNAs and to support health initiatives across the state. Washington's current approach is separate from CN health planning activities and operates primarily as a reporting mechanism rather than a statewide health fund.

New York Health Equity Impact Assessment (HEIA)

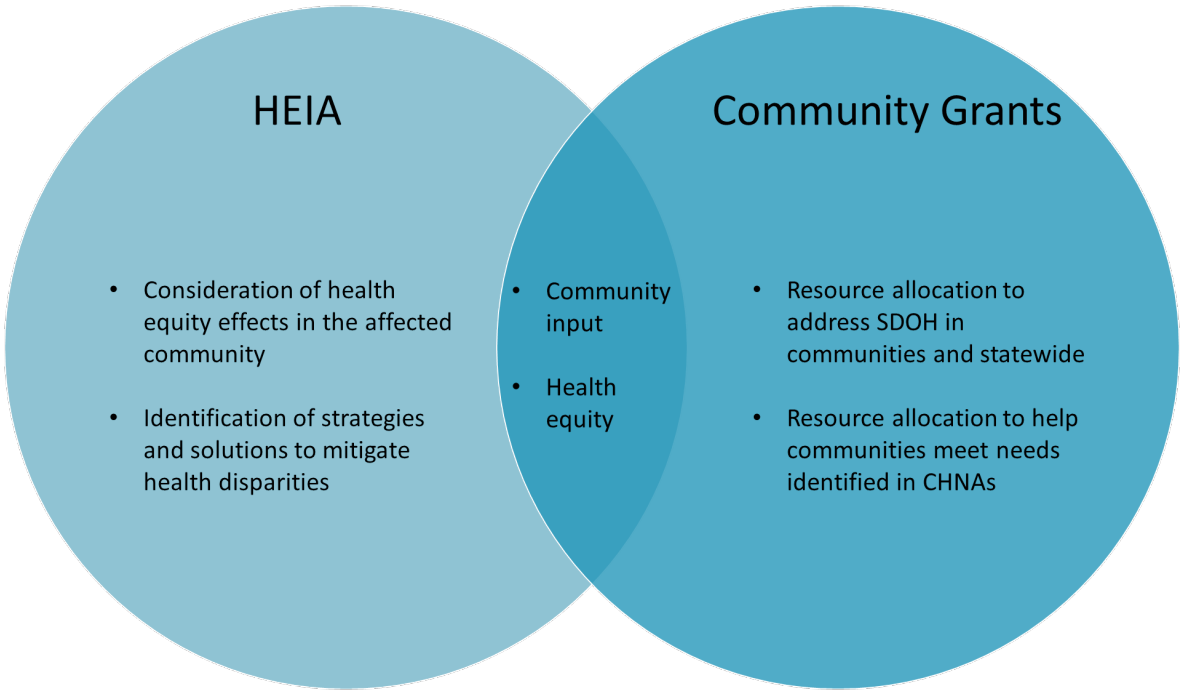
New York's HEIA requirement aims to advance health and racial equity by engaging key community members and experts in the decision-making process. New York utilizes the HEIA requirement for larger facility types, referred to as Article 28 facilities,[xxi,155] in addition to other CN requirements to understand the health equity impacts of proposed projects. The purpose of the HEIA requirement is to understand (1) how proposed projects affect access to and delivery of healthcare services and (2) health equity impacts including impacts specific to medically underserved groups[xxii] to ensure that community input is considered[xxiii,156] and to identify strategies and solutions that may contribute to mitigating health disparities.[157]

A Hybrid Approach: Utilizing Both New York and Massachusetts' Models

Washington could incorporate elements from New York's HEIA approach and Massachusetts's CHI model to focus on both the evaluation of each new project's impact on health equity and on the proactive allocation of resources to community health.

[xxi] Article 28 facilities are those regulated by article 28 of New York's public health laws and include general hospitals, nursing homes, certain diagnostic and treatment centers, ambulatory surgery centers, and midwifery birth centers.
[xxii] Medically underserved groups refer to low-income people, racial and ethnic minorities, immigrants, women, lesbian, gay, bisexual, transgender, or other-than-cisgender people, people with disabilities, older adults, people living with a prevalent infectious disease or condition, people living in rural areas, people who are eligible for or receive public health benefits, people completely without or with inadequate third-party health coverage, and other people who are unable to obtain healthcare.
[xxiii] Meaningful engagement includes advocacy groups, elected officials, community members and leaders, public health experts, residents and patients, and existing relationships the applicant has. The degree of engagement must be commensurate with the size, scope, duration, and complexity of the facility project.

Figure 6: Effect of HEIA vs. community grants Venn diagram



As shown in Figure 6, both approaches intend to address and mitigate health inequities but have different approaches to achieve their respective program goals. These approaches are not mutually exclusive and can be used together to facilitate CN-related health equity goals.

Potential Indicators/Sources

In implementing a hybrid of the Massachusetts and New York equity models, the Washington CN program can demonstrate the positive impacts of CHIs and HEIAs on equity using key data indicators, including, but not limited to:

- **Health Outcomes**: Trends in chronic disease rates, preventable emergency department (ED) visits, and disease-specific outcomes in targeted communities.
- **Access to Care**: Metrics on new healthcare facilities in areas underserved by health systems, appointment availability, wait times, and transportation options.
- **Health Disparities Indices**: Changes in indices like the Area Deprivation Index (ADI) or Social Vulnerability Index (SVI) in areas with CHI or HEIA interventions.

- **Patient Experience**: Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data on patient satisfaction, especially among groups underserved by health systems, and measures of perceived discrimination or cultural sensitivity.
- **Community Economic Indicators**: Local improvements in employment, housing, and education due to CHI investments.
- **Population Health**: Public health data on vaccination rates, preventive screenings, and mortality across demographics.
- **Utilization of Preventive Services**: Increased use of preventive and behavioral health services among people underserved by health systems, reflected in claims data trends.

Expanding HEIAs for All Facilities

Washington could require HEIAs across all new facility projects to address health disparities before a project's approval. In line with New York's model, Washington's HEIA process could require all facilities to assess their impact on health equity, addressing factors such as racial and socioeconomic disparities, rural access, and specific population needs. The policy could specify minimum standards for equity impact, allowing facilities to demonstrate compliance through direct interventions or contributions to local CHI programs if equity scores fall short.

Establishing an Independent HEIA Review Entity

To maintain consistency and impartiality in HEIA evaluations, Washington could also establish an independent entity to conduct these assessments. By issuing a Request for Proposals (RFP) for a qualified organization, the state could create a standardized, transparent HEIA process that remains aligned with state health goals. A portion of the CN application fee could be allocated for the assessments, while the independent entity would help ensure that all evaluations adhere to Washington's health equity standards and minimize variation across assessments. Washington could also include a provision to periodically review the entity's performance and update criteria as community health needs evolve, maintaining responsiveness to emerging health challenges.

Integrating Community Health Initiatives (CHIs) for Select Facilities

In addition to requiring HEIAs for all new facilities, Washington could consider applying CHI requirements to specific facility types within the CN process. Similar to Massachusetts's CHI requirements, Washington's policy could mandate that facilities with a significant projected impact on community health (such as large hospitals or high-traffic health centers) allocate a portion of their budget toward CHIs. By prioritizing projects that directly address SDOH, such as access to nutritious food, housing stability, or mental health services, Washington would enable healthcare facilities to play an active role in enhancing community well-being. This requirement would help ensure that benefits from new health services are shared broadly, particularly

among people underserved by health systems, aligning facility growth with equity-focused health improvements.

Together, these approaches would ensure Washington's health facility expansions are aligned with the state's health equity objectives and community needs while minimizing administrative burdens. Washington could implement a public feedback phase for each HEIA finding, which would also create an inclusive, community-driven approval process that enables residents to actively voice their health priorities.

5.4 Conclusion

Achieving health equity requires a multifaceted approach that incorporates systemic change, community engagement, and targeted interventions. The CN process serves as a vital tool for advancing equity by addressing SDOH and prioritizing resources for people underserved by health systems. Integrating trauma-informed care, cultural humility, and data-driven decision-making helps ensure that healthcare systems are responsive to diverse community needs. By embedding these principles, states can create a more equitable healthcare landscape that promotes the well-being of all individuals.

6. Cost implications of CN

6.1 Defining cost

There are two types of "costs" that this report covers, both of which have been touched on briefly earlier in this report. One is explicitly from the proviso, which focuses on "cost control of healthcare services." For this definition of cost, the department focused on costs as the price paid to healthcare providers by insurance companies and patients, as well as the total medical expenditure (TME) that results from the price paid and the frequency of services provided. Essentially, TMEs are calculated by multiplying price by frequency. By controlling the flow of available providers, CN programs can also reduce the likelihood of overcapacity and disincentivize unnecessary services. The second type of "cost" in this report is related to the cost of the CN program itself, including program staff, litigation, and operational costs.

6.2 Literature review related to CN and cost control

The available literature on the impact of CN on cost control of TME is mixed, with no definitive conclusion on whether CN programs increase or decrease healthcare costs. Comparison of costs across states for broad health systems like CN are also rare in the literature and difficult to draw conclusions from given different focuses of and enforcement by CN programs. For the CN studies that are available, most only focus on the impact of CN for certain types of procedures, mostly cardiac. The majority of the CN literature is also dated, often citing and using data from the late 1970s through the 1990s.

In a 2022 literature review of CN programs, the authors concluded that the evidence of CN impacts on cost control were so mixed, "one could credibly conclude that the weight of this evidence is that CON [certificate of need] has no impact on health costs overall." [158] Because of this uncertainty, the literature review authors concluded that the costs of CN laws slightly outweigh the benefits.

Another difficulty in comparing research on CN and cost control is the disparate ways costs are considered. For example, one study of Medicare spending at health facilities found that CN laws seem to result in a ~5% decrease in acute care spending but had no impact on healthcare spending.[159] This finding is similar to one of the most recent pieces of research, performed in 2021, which found that per-patient costs for home health agencies were lower in CN states, but total home health agency costs in those states were higher because of the increase in caseloads per agency.[160]

Understanding the impacts of CN on cost control is further complicated by variations between fields and their ability to respond to the complexity and breadth of state-level CN laws. States without CN requirements may have a "draining" effect on resources in more regulated neighboring states. One study on the availability of high-cost and easily movable MRI devices in

the U.S. that border states without CN law found that 6.4 fewer MRIs per million people were available in CN-requiring counties that border unregulated states.[161]

Given the complicated and often contradictory findings present in the literature, the impact on CN on total healthcare costs is either too small or too dependent upon other factors to be reliably said to be positive or negative. This is further complicated by the fact that, given how intertwined state and national health systems care, at a national level, the U.S. has not been able to control healthcare costs on a national level.

6.3 Recommendations

Fully addressing healthcare prices and cost drivers more generally is an initiative that goes well beyond the scope of the CN program, but CN can play an important role when coordinating with other state agencies and in efforts to address inflationary pressures. A statutory emphasis on coordination, roles, and responsibilities is an important step, as is ensuring that the resources are available when needed to support larger state initiatives. For Washington's CN program to effectively fulfill its role in preventing provider oversupply and curbing the continued growth of healthcare costs, the program would benefit from a stable and sustainable funding structure.

6.3.1 Partner with sister agencies to develop clear policies on cost transparency and containment of healthcare services

There are several Washington state agencies that are directly involved in ensuring healthcare affordability in Washington. The establishment of the Health Care Authority's Healthcare Cost Transparency Board[162] in 2020 represented a proactive step toward improving cost transparency and accountability. This past legislative session, the legislature passed Senate Bill 5568,[163] which requires the Office of Financial Management (OFM) to update the state health plan by developing a statewide health resources strategy. Through the updated state health plan, OFM must establish statewide health planning policies and goals related to the cost of care. Finally, the Office of the Insurance Commissioner (OIC) also recently issued a report on improving healthcare affordability.[164]

Recommendation 8: Partner with sister agencies to develop clear policies on cost transparency and containment of healthcare services

Given the current healthcare environment, especially compared to when CN programs were initially started, the time is ripe for exploring ways that CN can best address cost containment

and transparency of healthcare services in the new century. State legislators are clearly interested and committed to addressing rising healthcare costs and exploring creative ways through current systems, such as CN, to do so.

While this would take additional staffing and resources for the CN program, there are a variety of opportunities to help address ways that CN can better contain healthcare costs and help implement cost containment strategies and policies developed in collaboration with sister agencies. On a foundational level, collaboration and development of strategies and policies will require access to healthcare cost data and ensuring the data is up-to-date and refreshed on a timely basis.

Important areas of focus in the collaborative development of policies and strategies[xxiv] to reduce healthcare costs and which the CN program can then help implement include:

- Increased transparency of healthcare facility mergers and acquisitions and ensuring they do not increase the costs of healthcare services in communities or reduce available services,
- Targeting specific healthcare services that drive up healthcare costs as a whole for communities,
- Better utilization of Medicaid and Charity Care to keep healthcare costs down for patients, and
- Addressing geographic barriers and facility restrictions that can increase travel times to healthcare services care that lead to increased healthcare costs for patients.

The above focus areas also overlap with access and equity considerations, which leads to a holistic approach across multiple agencies in addressing healthcare costs.

6.3.2 Establish a stable CN funding structure that allows the CN program to adjust funding mechanisms regularly

The department's current funding model—reliant on application fees— poses challenges to its long-term sustainability, effectiveness, and ongoing enforcement monitoring requirements. As healthcare systems continue to evolve, the responsibilities of regulatory bodies are becoming more complex, underscoring the need to reevaluate the financing of the CN program. Exploring diversified and adaptive funding strategies can help maintain program integrity, support equitable access to care, and promote responsible health system growth.

Recessions, staffing shortages, supply chain issues, and general economic changes will influence the number of applications in any given year. With fluctuating litigation, enforcement and monitoring activity, and other unpredictable cost factors, Washington would benefit from a CN

[xxiv] Noting that some of these strategies may require future legislation.

funding structure that does not solely rely on application fees. A more stable approach could incorporate multiple funding sources, in addition to application fees, such as general-fund state dollars. The department also recommends considering other fees to cover the costs to operate the program, such as ongoing monitoring fees.

The CN program currently monitors approved projects, until they are completed, to ensure they continuously work towards completion of the project but also works towards compliance with any conditions placed on the approval. This monitoring allows the program to partner with approved applicants to detect any issues in the project that may result in delays of completion, or issues that may require an amendment to the application or certificate to be submitted. The program currently has no funding structure to support monitoring requirements, which lasts the life of the project, which can extend over 10 years.

Recommendation 9: Establish a stable CN funding structure that allows the CN program to adjust funding mechanisms regularly

To effectively prevent provider oversupply and control rising healthcare costs, Washington's CN program must be supported by a stable and sustainable funding structure. Achieving long-term sustainability will require a shift away from solely relying on application fees, the introduction of regular monitoring and funding adjustments, and fee modifications that reduce barriers for smaller providers. Together, these changes can help ensure consistent program operations and better serve healthcare providers and communities across the state.

Key Observations:

- Application volumes have varied drastically over recent years, with revenue often failing to cover expenditures.
- Over the past five fiscal years, only one year saw revenues exceed program costs, and the fund balance was negative in the last two years.
- Alabama, Hawaii, Massachusetts, and Vermont collect a small percentage of project costs as opposed to a fixed application fee.

Proposed Strategies:

1. Incorporate multiple funding sources including state general fund contributions, broad-based assessments, and billing applicants for specialized external expertise to prevent service disruptions.
2. Carry over excess revenue by allowing unspent funds from high-application years to support operations during low-application periods.
3. Track trends by regularly analyzing application volumes and revenue patterns to identify funding gaps and refine funding policies to help ensure adequate staffing and consistent operations.

A fully funded ongoing monitoring process for completed projects would allow the program to periodically require CN holders to submit updated information and quality measures to the CN

program to ensure the holders continue to verify ongoing adherence to conditions of CN approval, including quality of care, staffing, and access standards.

A modernized fee structure would enable the CN program to be more flexible when establishing fees, potentially advancing efforts to promote access and equity. It would also provide the CN program the revenue necessary to meet its statutory obligations and ensure ongoing access to high-quality care across Washington.

Several states have adopted similar diversified and flexible funding practices, including:

- **State General Fund Appropriations:** Providing additional funding when application revenues are low.
    - In Vermont, the CN program is funded through application fees pooled with funds from the GMCB and the GMCB can account for application revenue shortfalls from other sources, including grant funding.
    - The CN program in Alabama primarily relies on application fees, supplemented by state legislative funding.[165]
- **Broad-Based Assessments:** Assessing entities like payers, providers, and others benefiting from CN regulations.
    - Connecticut's CN program funding comes from a mix of application fees and billing applicants for services such as compliance monitoring and independent expert consultations.[166,167]
- **Billing Applicants for External Expertise:** Charging applicants when outside expertise is required during the CN review process.
    - The GMCB can account for application revenue shortfalls from other sources, including grant funding.[168] The GMCB also contracts with external consultants, billing applicants for specialized services when necessary.[169]
- **Revenue Carry-Over:** Allowing excess revenue from high-application years to be carried over and used in future years with low application numbers.
    - Alabama allows the CN program to carry over excess funding for future years when applications are low, providing financial stability during times of reduced revenue.[170]

Align Application Fees within a Sustainable Funding Model

As part of a more sustainable funding approach, Washington could refine its application fee structure to both generate reliable program revenue and help ensure equitable access for all applicants. Application fees should be structured to support CN program costs while not

deterring participation from small, rural, or safety-net providers. Some entities have shared with the department that the current fees associated with CN are a significant financial barrier.

> *"But as we go through this process, how do we ensure that the administrative fees are not a barrier for those who do have an interest in addressing access, especially in some of our rural communities?"*
>
> – Comment from an interested party at August 6th, 2024 Proviso Workshop

Washington could consider utilizing a reduced fee structure, a percentage of project costs, or both to incentivize smaller organizations to enter the healthcare market, encourage community-driven projects, and decrease fixed costs and potential associated cost-sharing (e.g., entities which obtain a CN and build facilities pass building costs onto patients via charging higher prices for care). Each focus state has a unique approach to application fees that appears to balance program funding, level of program oversight, type of project review, and consideration for other costs associated with proposed projects (e.g., construction, licensing, other regulatory compliance). Among six focus states, most utilize a percentage of proposed project cost,[xxv] a minimum or maximum fee, or both for CN application fees. Alabama and New York CN programs have reduced fees for facilities serving higher Medicaid populations and/or for facilities located in rural areas.[171,172] Connecticut and New York both utilize a fixed tiered application fee structure, with decreased fees for smaller project types,[173] and decreased complexity of a project,[174] respectively. New York's CN program also charges a construction fee which is a percentage of project costs, but these additional fees are only levied on approved proposals and are not paid until the application is approved.[175] These reduced fees may eliminate fiscal barriers for entities and improve access to facilities serving low-income and/or rural populations.[xxvi]

Reduced application fees could decrease the financial burden for smaller or less well-funded entities and increase diversity of competition in the market.[176,177] Reduced application fees may incentivize more entities, including critical access hospitals, to provide services and build facilities in rural areas. Reduced application fees may decrease the total project costs, encouraging investment. A tiered application fee structure or the ability to apply for reduced fees under certain conditions could encourage (1) smaller organizations to enter the market, (2) community-driven projects that might be deterred by high fees, and/or (3) projects focused on underserved populations that might have lower returns on investment.

[xxv] Alabama, Hawaii, Massachusetts, and Vermont all collect a small percentage (ranging from 0.05% to 0.2%) of project costs as opposed to a fixed application fee.

[xxvi] Additional considerations for reduced application fees include: (1) States with reduced fees also maintain lower costs associated with CN review by utilizing volunteer boards or planning entities that oversee the CN program; (2) If some fees are reduced, additional state funds may need to be allocated to maintain budget neutrality; (3) Lower application fees may increase the volume of applications overall, requiring additional CN program resources.

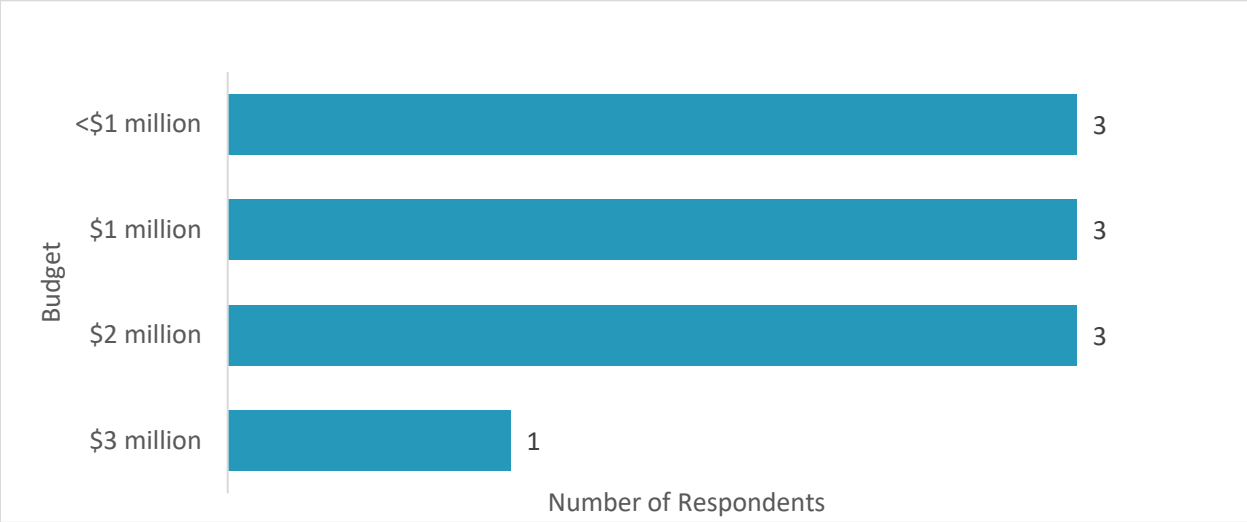
Survey Insights on State CN Program Funding

Maintaining a sustainable funding model for the CN program requires balancing financial stability with flexibility to accommodate fluctuations in application volumes. While application fees are a key revenue source, relying solely on fees may lead to funding instability, particularly in years with fewer applications.

To gain a better understanding of how CN programs are funded across the country, BerryDunn conducted a survey of 35 states and received responses from 16, providing valuable insight and comparison. The results suggest that a combination of revenue sources can offer stability and flexibility for CN programs, particularly when application volumes fluctuate.

The 10 respondents who provided basic information about their CN program budgets indicated to the nearest $1M increment are included below in Figure 6. Including submitted values that rounded to $0 million, the average reported budget was approximately $1 million, with values ranging from $0 to $3 million (see Figure 7). The states submitting $0 million indicated that they receive support from the general fund, but additional information was not provided.

Figure 7: Respondents' CN program budgets



The operational costs of CN programs, both in Washington and nationally, are relatively small compared to state budgets and overall healthcare expenditures; therefore, these costs are not a major factor in influencing healthcare prices or TME.

BerryDunn's survey of other states found that the average annual budget for CN programs is approximately $1 million. The survey also revealed that seven respondents rely on multiple funding sources, while nine states have a single funding source (see Table 6). This suggests that diversified funding is becoming a more common strategy for maintaining the stability of CN

programs. Some states implement unique funding practices, such as application fees based on a percentage of capital expenditures in Montana or an annual assessment of hospitals in Connecticut (see Table 6). These findings underscore the importance of having multiple funding sources to ensure the sustainability of CN programs, especially during periods of fluctuating application volumes. By considering these practices, Washington could develop a more resilient and adaptable funding structure for its own CN program.

Table 6: Respondents' CN program funding sources

	Funding Source			
State	**State General Fund**	**Fixed Fee (paid upfront at start of CN process)**	**Variable Fee**	**Other[xxvii]**
Alabama		✓	✓	
Alaska	✓			
Arkansas	✓	✓		
Connecticut		✓		✓
Delaware	✓			
Florida		✓	✓	
Illinois	✓	✓		
Massachusetts		✓		
Missouri	✓			
Montana	✓			✓
Nebraska		✓		
Nevada		✓		
North Carolina	✓			
Oregon		✓		
Tennessee		✓	✓	

[xxvii] Connecticut (CT) uses an annual hospital assessment and Montana (MT) uses applications feed based on a percentage of capital expenditures.

	Funding Source			
State	**State General Fund**	**Fixed Fee (paid upfront at start of CN process)**	**Variable Fee**	**Other[xxvii]**
Virginia			✓	

Washington could regularly monitor the CN program's funding and expenditures to promote the sustainability of the program. Historical data indicates expansive fluctuations in CN application volumes and funding levels, highlighting the need for a flexible, responsive funding structure. By tracking application trends and adjusting funding mechanisms as necessary, Washington can avoid funding shortages and help ensure the CN program can continue meeting the needs of healthcare providers and residents.

As reflected in Table 7, over the past five years, the Washington CN program's annual revenue has covered expenditures for only one year, and the cumulative balance was negative for the most recent two years.

Table 7: Washington CN program funding FY2020 - FY2024

Fiscal Year	FY20	FY21	FY22	FY23	FY24
Beginning Fund Balance	**1,279,579**	**960,472**	**1,040,349**	**475,243**	**(81,958)**
Revenue	1,394,464	1,941,302	1,097,476	1,055,542	672,111
Expenditure	1,713,571	1,861,424	1,662,581	1,612,743	1,788,745
Cumulative Balance	**960,472**	**1,040,349**	**475,243**	**(81,958)**	**(1,198,591)**

Figure 8: Total CN applications received, 2016-2024

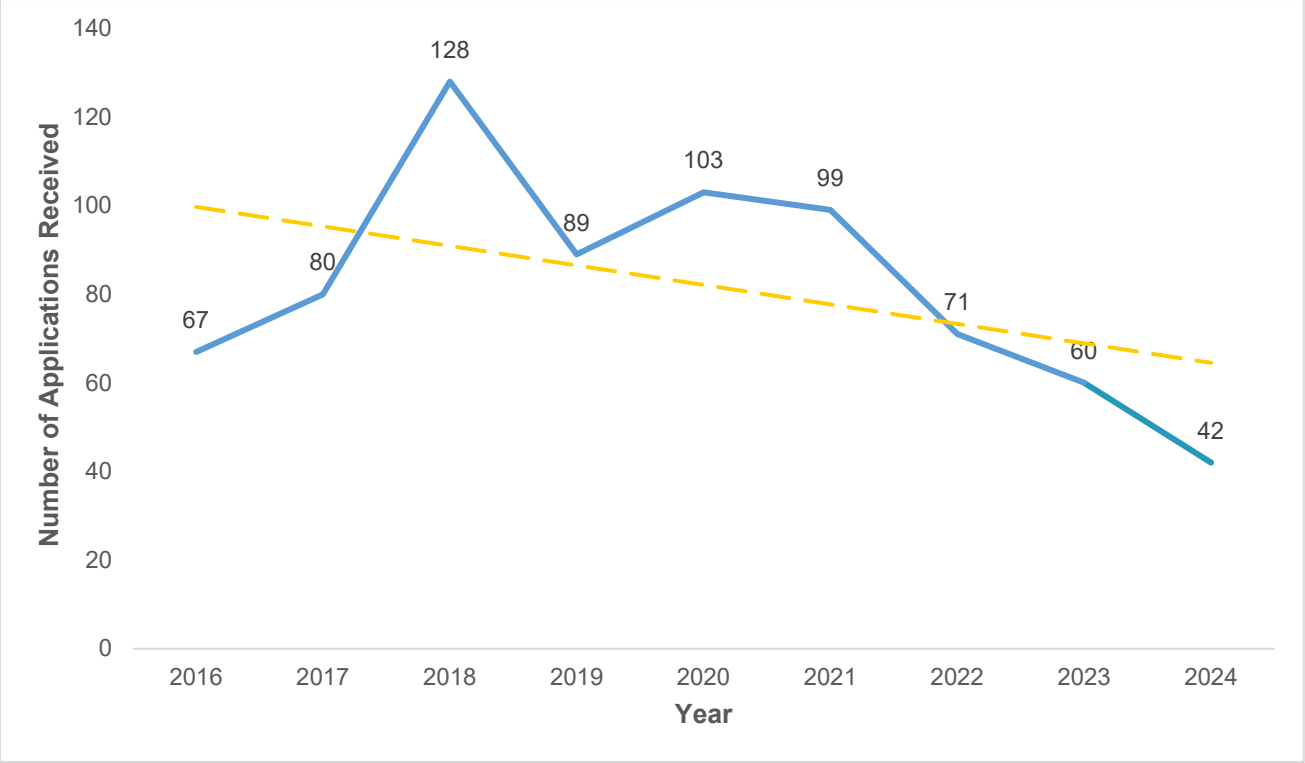


Figure 8 depicts the number of CN applications received by year between 2016 and 2024, and a trend line showing a steady decrease in the number of applications each year. 2018 was a peak year with 128 applications, but that was significantly higher than any other year. In 2024, the CN program received only 42 applications. As reflected in the data, the number and type of application fees in any given year are unpredictable. The Washington CN program would benefit from using other funding sources to maintain staffing, avoid ongoing fee adjustments, and support enforcement monitoring.

6.4 Conclusion

Through partnership and collaboration with sister agencies, the Washington CN program would be best poised to implement policies and strategies that support cost containment of healthcare services and reduce costs to patients. This would also be a way for the state to take a united and holistic approach in addressing healthcare affordability, which is a top concern of both Washingtonians and the nation as a whole.

In looking at costs as they relate to the CN program itself, a diversified funding approach for Washington's CN program that incorporates mechanisms such as state support, broad-based assessments, and revenue carryover could provide financial stability and reduce reliance on application fees alone. Examples from other states, such as Vermont, Connecticut, and Alabama, demonstrate the feasibility and benefits of such approaches.

To help ensure the long-term sustainability of Washington's CN program, regular monitoring and adjustment of funding mechanisms could be implemented. This could include tracking application trends, evaluating program expenditures, and aligning funding strategies with broader healthcare cost containment and transparency initiatives. Scaling application fees to be proportionate to project size could allow for a more diverse health care market and increased flexibility for existing entities wanting to make small changes to their CN. By adopting these practices, Washington could strengthen its CN program's capacity to contribute to a well-regulated, equitable, and sustainable healthcare system.

7. Data Limitations and Future Research

Accurate and reliable data is the backbone of effective health planning and equitable resource allocation. The lack of a robust and timely data infrastructure poses challenges for CN programs. Without sufficient financial and staffing resources, and a reliance on applicants and external sources for critical information, Washington CN program's ability to independently assess the necessity and impact of proposed projects is more limited than it could be. Addressing these data limitations is essential for enhancing Washington CN program's effectiveness and creating greater efficiencies. Statutorily required health data collection, as demonstrated by leading practices in states like Connecticut and Vermont, can provide decision-makers with actionable insights to promote transparency, assess geographic disparities, track healthcare spending and utilization, and inform health policy priorities. By establishing a more robust, independent data infrastructure and in-house analytics team, the CN program could reduce its dependency on external sources, improve decision-making processes, and help ensure that healthcare investments are aligned with community needs. In doing so, the CN program could better address legislative priorities of healthcare access, equity, and cost containment of healthcare services.

7.1 Current data limitations and gaps

Statutorily required health data collection can "promote price transparency, assess geographic variation in spending and healthcare utilization, track spending, promote public health, assess policy changes, and improve the provision of healthcare."[178] Although "the development and maintenance of adequate healthcare information" is statutorily required in Washington, the CN program does not currently collect nor have direct access to information regarding healthcare financing, access, and quality needed to facilitate both program and state public policy goals.[179] Additionally, although statutory provisions in RCW 43.370.030 provide a good foundation,[xxviii] gaps in data needs remain.

[xxviii] RCW 43.370.030 outlines required elements of a statewide health resources strategy including data collection authority and development of a state plan. Applicable data provisions include:

- The development and maintenance of accurate (1) cost and quality healthcare information and statistics, (2) all health facilities and services need projections, (3) a health system assessment which describes state and regional population demographics, health status indicators, and trends in health status and healthcare needs, (4) an inventory of each geographic region's existing healthcare facilities and services, and (5) an assessment of the availability of healthcare providers, public health resources, transportation infrastructure, and other considerations necessary to support healthcare facilities and services.
- A healthcare data resource plan that identifies which health planning and other data elements, both public and private, are necessary for planning activities and CN application review. The plan should include inpatient and outpatient utilization data, outcome information, and financial and utilization information related to quality, cost, and free care. The plan should identify any existing data gaps needed to conduct comprehensive health planning activities. The plan allows the OFM the authority to access existing data sources and conduct appropriate data analyses or that other agencies expand their data collection activities as statutory authority permits. The plan may identify any computing infrastructure deficiencies that

In a 2010 report from the Office of Financial Management (OFM), four main health planning questions[xxix] and database gaps were identified.[180] According to the report, the main databases needed include:

- A census of active healthcare professionals,
- A census of health services facilities conducted on a routine periodic basis,
- An all-payer claims database (APCD), and
- A population-based socioeconomic and health database similar to the California Health Interview Survey or an expanded Behavioral Risk Factors Surveillance System (BRFSS)[181] for Washington.

Of these four databases, two have been established in Washington: a census of active healthcare professionals and an APCD.

1. Beginning January 1, 2025, all professionals licensed by the department are required to complete a demographic data survey when they apply for licensure and provide updates to the submitted data at renewal.[182] Data collected in this survey include race, ethnicity, gender identification, languages spoken, provider specialty, practice location, and whether the provider is currently practicing or not. This data collection is in its infancy but may ultimately help the department identify gaps in availability of care, or culturally and linguistically competent care, in Washington communities.
2. The Washington APCD was established by the legislature in 2014[183] and became publicly available in 2018.[184] The Washington APCD includes claims beginning in calendar year 2014 from Medicaid, Medicare, and private insurers regulated in the state. However, the database does not include claims for most self-insured employer plans, claims from federal employees[xxx] living in Washington, claims for those who pay for healthcare services in cash, or claims for care provided for people without health insurance.[185]

impede the proper storage, transmission, and analysis of health planning data. The plan should provide recommendations for increasing the availability of data related to health planning to provide greater community involvement in the health planning process and consistency in data used for CN applications and determinations.

[xxix] Questions referenced include: What facilities exist in what locations and with what capacity to provide which services? What is the availability of health services professionals of various types and specialties in different areas of the state? Are there areas where people have difficulty obtaining health services because of travel time and/or cost? What is the health status of the population and how does it vary geographically?

[xxx] Federal employees include active-duty military and dependents and Veterans Affairs services.

> *"What I'm proposing is some sort of data gathering mechanism or reporting cycle [for hospices]….I think we need to gather more data and close that loop."*
>
> – Comment from interested party at July 30th, 2024 proviso workshop

These data sources are vital for state health planning activities. They can help provide information on service location, service capacity, health service professional availability, barriers to accessing care, and the health status of the Washington population, including subpopulations across the state. Information derived from this data will help the CN program to better understand health needs and to effectuate health policy goals.

The other data sources identified as necessary to inform state health planning are: (1) a census of health services facilities conducted on a routine periodic basis, and (2) a population-based socioeconomic and health database similar to the California Health Interview Survey, or an expanded BRFSS for Washington.

While other states did not explicitly note using population-based socioeconomic and health databases, other states have authority within their respective CN programs or boards to directly collect needed health planning data. Additionally, Alabama[186] and Connecticut[187] are required to maintain inventories of facilities, services, and utilization rates for health planning activities, including CN.

RCW 43.370.030 directs OFM,[xxxi] to develop a statewide health resources strategy, with which the CN program is required by law to ensure CN determinations are consistent. Resource constraints and competing legislative priorities have meant that Washington does not have a current statewide health resources strategy and the CN program has experienced challenges operating consistently with the goals of the statute. To promote policy goals, other states facilitate health resource planning and strategies either within CN programs, state departments of health, or boards overseeing CN, which may provide more flexibility and efficiency for CN programs.

7.2 Recommendations

7.2.1 Integrate robust analytic resources to close data gaps

To improve the accuracy and effectiveness of the Washington CN program's evaluations, the integration of statutorily directed analytic resources would be beneficial. The current reliance on applicant-provided information, external reports, and volunteer assistance from other state agencies limits the program's ability to independently assess healthcare needs and the potential impact of proposed projects. Establishing a dedicated, well-resourced analytics team

[xxxi] The OFM is external to the DOH.

to support the CN program would reduce the inconsistent dependence on external sources, enhance decision-making, and align investments more effectively with community needs.

Connecticut's CN program, a part of the Office of Health Strategy (OHS) within their Department of Public Health,[188] offers a strong model, with its Health Systems Planning (HSP) Unit empowered to collect patient-level data, oversee and coordinate health systems planning, monitor health costs, and implement and oversee health care reform.[189] The HSP Unit must also biennially establish and maintain a statewide healthcare facilities and services plan which assesses availability of care, provides an evaluation of unmet needs for vulnerable groups, projects demand for future healthcare services, and develops recommendations for expansion, reduction, or modification of

Recommendation 10: Integrate robust analytic resources to close data gaps

Washington's CN program could benefit from a robust analytic infrastructure. Use of comprehensive and regularly updated databases would improve CN evaluations, support broader health policy goals, and enhance system transparency. Empowering the CN program with data-driven health planning authority would align reviews with statewide goals while ensuring data-driven and responsive healthcare investments. These changes would also help align healthcare investments with community needs and reduce dependency on external sources, fostering a more transparent and data-driven CN process.

Key Observations:

- Reliance on applicant-provided data limits Washington's ability to independently assess healthcare needs.
- Washington lacks a routinely updated census of healthcare facilities and a socioeconomic and health database.
- Health planning authority enhances the ability to assess geographic disparities, align investments, and promote equity.

Recommendations:

- **Build dedicated analytic capacity:** Establish a specialized team within the CN program to collect and analyze data independently.
- **Adopt comprehensive planning models:** Create a statewide healthcare facilities and services plan, similar to Connecticut, to guide CN decisions.
- **Utilize population-based data:** Incorporate data on access disparities, unmet needs, and condition prevalence to ensure equity in healthcare investments.
- **Expand data collection authority:** Conduct routine censuses of healthcare facilities to maintain accurate resource inventories and require entities to report utilization, financial, and service area data.
- **Enhance data accessibility:** Create an online system for CN applicants to submit required data, modeled after Alabama's SHPDA system.
- **Enhance collaboration with existing agencies:** Partner with agencies like the Washington HCA to access existing datasets and use shared data to inform CN reviews and develop actionable health plans.

healthcare facilities or services.[190] The plan serves as a blueprint for healthcare delivery, contributes information and guidelines for evaluation of CN applications, and also highlights trends and policies which impact utilization of healthcare within the state.[191] In addition to inventory and utilization data, the OHS also uses population-based data[192] to evaluate differences in utilization, condition prevalence, access to care, and other factors which may impact utilization, and therefore projected need, across the state, to inform CN methodology.

This approach supports accurate assessments of unmet needs, particularly for populations underserved by health systems, and provides actionable insights for CN decision-making. A similar approach in Washington could enable a more independent, data-driven process.

Address Gaps in Healthcare Data Collection

Closing gaps in key healthcare databases could be a critical component for effective state health planning. While Washington has made progress with the establishment of a healthcare profession census and an APCD, notable gaps remain. These include the lack of a routine census of healthcare facilities and the absence of a population-based socioeconomic and health database.

States like Vermont demonstrate the benefits of robust data collection authority. Vermont's GMCB maintains a unified healthcare database that includes patient, provider, utilization, cost, and quality data, along with CN-specific information such as applicant financial data and service area demographics.[193,194] Additionally, the GMCB has authority to collect:

- Hospital financial[195] and utilization data,[196]
- Annualized data from ambulatory surgical centers,[197] and,
- Data from community mental health and developmental disability agencies.[198]

The GMCB also has authority to collect CN-specific information such as:[199]

- Population based descriptions of the institution's service area,
- Applicant financial statements,
- Third-party reimbursement data, and,
- Annual reports.

The authority to maintain data sources allows the Board to enhance health system transparency, implement board and CN program goals, effectively regulate assigned entities and processes, and help address statewide healthcare improvements.[200]

Similarly, Alabama's SHPDA collects utilization data and maintains an inventory of existing resources to guide health planning. Although the Alabama CN program does not have statutory authority to collect data, the SHPDA, the entity which oversees CN, has regulatory authority to do so via rulemaking.[201] Additionally, the Alabama Health Planning Facilitation Act of 2015 assigned additional data-related responsibilities to the SHPDA including:[202]

- Designating the SHPDA as the agency responsible for collecting, compiling, and analyzing healthcare reporting,
- Providing authority to issue penalties to entities for failure to comply, and,
- Establishing the Health Care Information and Data Advisory Council (HCIDAC), which reviews survey instruments, reviews and authorizes data publication, and oversees the development and implementation of an online filing system for CN.

Data submitted to the HCIDAC, in addition to other data submitted to and collected by the Alabama Department of Health, inform the State Health Plan.[203] The Alabama SHCC, a part of the SHPDA, is responsible for updating and reviewing the State Health Plan every three years.[204] The Alabama State Health Plan requires an accurate inventory of existing resources and accurate utilization statistics in order to accurately project need for additional healthcare facilities, equipment, and services.[205] While the HCIDAC collects utilization data, it is unclear how the SHCC acquires information necessary to maintain an inventory.

While the department currently collects extensive hospital financial data, Washington could adopt similar practices utilized by these other states to build a more comprehensive database that supports CN evaluations and broader health policy goals.

Empower the CN Program with Data-Driven Health Planning Authority

To maximize the CN program's impact, Washington could consider coordinating health planning functions directly within the CN program or the department itself. This would align with models seen in Connecticut and Vermont, where health planning authorities oversee data collection, analysis, and strategic planning to support CN processes and broader policy goals.

In Connecticut, the OHS uses population-based data to assess geographic disparities in healthcare access and utilization. These insights guide CN methodologies and help ensure alignment with statewide health priorities. Vermont's statutory authority enables the collection and analysis of financial, utilization, and quality data, working to ensure the CN program is informed by transparent data.

Additional state CN programs vary in their ability and capacity to collect and utilize healthcare data for planning purposes, with examples from Hawaii, Massachusetts, and New York, highlighting differing approaches and limitations in data-driven health planning.

The SHPDA housed in the Department of Health in Hawaii oversees the CN program in addition to other state health planning activities. Healthcare providers in the state are statutorily required to submit certain information to the SHPDA,[xxxii,206] but it is unclear how this information is used in health planning activities.

The Massachusetts DoN program does not have statutory authority to collect data but must consult with two state agencies which collect and analyze data, CHIA and the HPC. [207] In a recent report from the HPC, the Commission recommended that the DoN program conduct "focused, data-driven assessments of the supply and distribution of services based on identified needs or disparities in outcomes." [208]

New York also maintains locations of CN regulated facilities[209] through their state department of health, although the statutory authority to do so and the team responsible for maintaining the facility inventory are unclear. The New York department of health and the Public Health and Health Planning Council (PHHPC) both utilize data[xxxiii] in CN review, but the statutory authority to collect and analyze data for this purpose is unclear.

Incorporating similar authority into Washington's CN program, as well as ensuring sufficient funding for this work, could streamline the collection of critical data, promote transparency, and align CN reviews with statewide goals such as improving access, health equity, and cost containment. Such an approach would also facilitate more frequent updates to the statewide health resources strategy, working to ensure the strategy remains responsive to evolving healthcare needs. By addressing these data limitations and adopting best practices from other states, Washington's CN program could become a more effective tool for promoting equitable, efficient, and needs-driven healthcare investments.

7.3 Conclusion

Addressing data gaps and empowering the CN program to coordinate with planning entities could enhance Washington's ability to meet statewide healthcare goals. Incorporating robust analytic resources, collecting missing data, and integrating health planning functions directly into the CN program are critical steps toward achieving this vision. Models from Connecticut, Vermont, and Alabama illustrate how data collection and strategic planning can improve transparency, inform policy decisions, and align resources with community needs. With appropriate funding, Washington's CN program could also benefit from statutory enhancements that enable better data-driven decision-making and facilitate equitable

[xxxii] Reporting includes change in bed usage, implementation of services, and replacement of existing equipment. Also, insurers must provide available statistical, financial, and other reports of information that the state agency finds necessary to perform its functions, which may inform access, cost, and utilization of care.

[xxxiii] Data collected pertaining to public need includes but is not limited to population demographics, service utilization patterns, epidemiology of selected diseases and conditions, and access to services.

healthcare investments. By adopting these recommendations, Washington could help ensure its CN program becomes a more effective and impactful tool for addressing healthcare disparities and improving system-wide outcomes.

8. Conclusion

The Washington CN program has an essential role in shaping the state's healthcare landscape. The CN program's impact extends across the interconnected domains of access, equity, and cost. The recommendations included in this report, as a response to the proviso and legislative priorities, provide a blueprint for the state to implement a modernized CN program. A modernized CN program based on these recommendations, will enable the CN program to better respond to the complex and overlapping challenges facing Washington's healthcare system, as well as enhancing the current values the CN program brings to the public health system, such as patient safety, quality of care, and community sustainability.

The CN program recommends a solid statutory foundation to set the program up for success in ensuring the program best meets community needs. Developing a clear statutory purpose, establishing a planning entity, and reducing CN legal costs will lay the groundwork for modernizing the CN program, making it more effective at addressing healthcare access, costs, and equity.

The CN program also recommends embedding equity in CN applications and leveraging the CN program to have greater impacts in addressing community needs and social determinants of health. By implementing improvements that are already working in Washington, as well as adopting effective equity strategies from other states, Washington's CN program can be successfully modernized, inspiring greater and deeper community partnership.

This report focuses on two types of costs – the cost of the CN program itself and how the CN program can be used to contain healthcare costs. Both issues are vital to sustaining healthcare affordability and ensuring community needs are met. Partnering and collaborating with sister agencies to implement cost containment strategies, as well as ensuring a diverse funding stream for the CN program will increase the value and sustainability of CN program and establish a more aligned state-wide approach to healthcare affordability.

Finally, the CN program also recommends leveraging current data systems and integrating them to close data gaps. Ensuring the CN program has current, community-based data will empower the CN program to target specific areas where improvements are needed, especially those focused on access, equity, and cost containment, leading to greater effectiveness and efficiencies.

Together, these recommendations will modernize the Washington CN program, ensuring it is a model for other states in how to address the healthcare issues of today. Not only will these recommendations improve patients' access to quality care health, advance health equity by better addressing SDOH, and more effectively contain healthcare costs, it will also lead to new and enhanced ways the CN program adds value to Washington's public health system. These

recommendations will ensure that the CN program remains a vital, responsive tool that can be used in conjunction with broader health planning efforts to achieve policy goals across the state.

Appendix A: Methods and Background

1. Methods

1.1 Data sources

In its analysis, the department drew upon a variety of data sources to develop recommendations consistent with the requirements of the proviso and resources available nationally. These included:

- A review of academic literature, including national studies, state-level reports, and peer-reviewed articles;
- Discussions with representatives from other Washington state agencies;
- Feedback collected during an array of web-based and in-person public sessions with interested parties, including providers and agencies;
- Information from state-specific sources, including interviews with representatives from CN programs in other states; and
- A survey designed to gather insights into other states' oversight and processes and follow up interviews with states willing to have a more detailed discussion.

Washington's CN program differs from what exists in many other states. By integrating practical insights from interested parties with evidence-based research, the department developed recommendations that could inform legislative changes to Washington statutes.

Table 8: Comparison of CN program approaches

	Topic	Washington CN Current Approach	Focus States' Approaches
General Structure	Develop a clear statutory purpose specific to CN.	"…[the CN program] is a component of a health planning regulatory process that is consistent with statewide health resources strategy and public policy goals."	Statutory purpose(s) specifically mention equity, cost, quality, and access.
	Create a planning entity and a requirement for interagency coordination.	No board or council utilized to oversee CN program.	Planning boards support health planning efforts by incorporating diverse perspectives, expertise, and coordinating resources.
	Enhance CN program flexibility.	Limited statutory ability to waive requirements or grant exemptions. Statutorily required use of need methodologies in the state health plan.	Evaluates applications based on state health priorities, guidelines, and goals.
	Reduce CN legal costs.	WA CN is fully responsible for litigation costs.	No state comparison used for this recommendation.
Access	Enhance statutory provisions on access to healthcare services.	Current analysis tools and procedures may limit full understanding of WA's health care needs including WA's provider environment, capacity, and patient travel times.	Some states require CN for facility/service closure.
	Expand CN oversight to include FSEDs and urgent care centers that charge facility fees.	FSEDs and urgent care centers are currently unregulated by CN.	No state comparison used for this recommendation.
Equity	Incorporate and align statutory provisions specifically targeting health inequities, including establishing a "health equity" definition for CN.	No explicitly defined health equity definition and no current health equity specific criteria.	Utilize CN to address social determinants of health and to identify and mitigate potential health equity implications of proposed projects.
Cost	Partner with sister agencies to develop clear policies on cost transparency and containment of healthcare services.	Limited guidance and resources to better address modern challenges in reducing healthcare services costs through CN.	No state comparison used for this recommendation.
	Establish a stable CN funding structure that allows the CN program to adjust funding mechanisms regularly.	CN program depends solely on application fees, does not have a formal program funding mechanism for monitoring and adjustments, and uses fixed application fees that do not take project costs into consideration.	Utilize diversified funding streams and flexible funding practices, including receiving general funds, conducting assessments, charging applicants for external expertise, and allowing excess revenue from high-application years to carry over into other years. Use a percentage of project costs for CN and/or reduced fee structures for facilities serving higher proportions of Medicaid populations and/or rural areas.
Data	Integrate robust analytic resources to close data gaps.	WA CN lacks authority and capacity to collect and analyze all needed data. Current reliance on applicant-provided information, external reports, and volunteer information from other state agencies, contributing to gaps in facility inventories and socioeconomic health data.	Collect information related to provider, utilization, cost, quality, applicant financial data, and service area demographics to inform CN decisions via internal health planning resources and coordination with health planning authorities.

1.2 Analysis approach

As required by the proviso, this analysis focused on assessing Washington CN program's impact on access, equity, and cost, as well as developing actionable recommendations. Omitted from the proviso was the program's impact on healthcare quality, but Washington's CN program has consistently maintained a strong interest in ensuring that Washington's healthcare systems prioritize quality in the delivery of healthcare services.[xxxiv]

Reviews of other states' CN programs were central to the analysis, highlighting successful practices and forward-thinking approaches. The analysis also considered Washington's program in relation to other states to identify gaps and opportunities for improvement. Incorporating information obtained from the diverse data sources was critical for creating an analysis reflective of a wide range of perspectives and empirical evidence. This combination of sources enriched the analysis and fostered the development of recommendations that are both actionable and grounded in real-world experience.

1.3 Iterative approach

To support this report, the department and BerryDunn staff facilitated over 10 listening sessions to share findings and collect feedback from interested parties. In addition, staff connected with CN program leads from six different state programs.

The research for this report focused on Washington and other state CN programs, including findings from a detailed review of existing Washington CN policies, state comparisons, interested parties' feedback, and relevant literature, providing a foundation for understanding the key themes and challenges related to access, equity, and cost. The department publicly shared preliminary findings aimed at addressing identified statutory gaps and enhancing the CN program's effectiveness. Throughout the process, the department collected feedback from interested parties and decision-makers. The department incorporated this feedback into the analysis, helping to refine the approach, and shape the subsequent recommendations of this report.

[xxxiv] The impact of the CN program on quality of care was not included in this analysis, as it was not included in the proviso. However, the department established processes to review quality indicators of facilities seeking a CN. These measures help ensure that facilities meet stringent quality standards before approval, reinforcing the program's commitment to high quality healthcare services. Additionally, the CN team assesses financial viability separately to help encourage the long-term sustainability of approved facilities.

1.4 Limitations

This analysis of individual state CN programs is subject to several limitations:

1. **State variability and generalizability:** While recommendations from other states' CN programs provide valuable insights, their applicability to Washington cannot be assumed to yield identical results. Variations in state healthcare systems, population needs, and policy environments mean that strategies effective in one state may not be directly transferable or equally effective elsewhere.
2. **Selection bias in state engagement**: The information gathered on other states' CN programs is skewed toward those states that agreed to participate in discussions, responded to the survey, and/or provided data. States that declined to engage or did not respond to meeting requests are not represented, potentially leading to an incomplete understanding of the range of CN strategies and outcomes. This selection bias limits the breadth of the comparative analysis. When the term “focus states” is used in the report, it refers to Alabama (AL), Connecticut (CT), Hawaii (HI), Massachusetts (MA), New York (NY), and Vermont (VT).
3. **Data gaps and missing context**: Some states provided limited information or lacked detailed documentation about the implementation and outcomes of their CN programs. This lack of standardized data across states may hinder accurate comparisons and the ability to draw definitive conclusions.
4. **Temporal limitations**: The timing of this analysis may not account for recent changes or evolving trends in CN programs in certain states. Policies and practices may have shifted since the information was gathered, impacting the relevance of findings.
5. **Unique local conditions**: Each state’s healthcare market and population health needs are shaped by unique social, economic, and regulatory conditions. As a result, recommendations drawn from other states must be carefully adapted to reflect local circumstances, and their impact should be evaluated within the specific state context.

1.5 Recommendations

Recommendations were informed by extensive literature research, a survey of other states, and meetings with other states, agencies, and interested public parties. These recommendations were further refined based on an analysis of access to care, equity, and cost control of health services, along with key insights from public listening sessions. The recommendations are structured to address a wide breadth of priorities related to CN and health systems planning more generally. The work was performed with recognition that the Washington CN statute[210] is

currently designed to work in conjunction with a current statewide health resources strategy, but Washington does not currently have such a strategy in place. The last time the strategy was updated was in 1987. The recommendations presented in this report are organized to progressively build on one another. They begin with foundational changes and then shift to targeted improvements addressing access, equity, and cost. Finally, the recommendations focus on enhancing program sustainability and efficiency through stable funding structures, robust data resources, and strategic alignment with broader health planning initiatives.

The domains of access, equity, and cost are deeply interconnected, with each influencing and reinforcing the others; therefore, the recommendations presented in this report often contain elements that span multiple domains, reflecting the multifaceted nature of the issues that a well-rounded and resourced CN program can address. A robust CN program would leverage this overlap and assist in the holistic evaluation and implementation of initiatives to maximize their impact across all three domains.

2. Background – Budget Proviso

In the 2024 Washington legislative session, legislators passed a budget proviso requiring the department of health to conduct a report on how to modernize the CN program, with a specific focus on access to care, cost control of health services, and equity. The CN program strives to promote broad access to care across all communities, ensure quality, and promote financially stable projects, but with an outdated state health plan, limited statutory direction, and staffing and resources challenges, the department was eager to conduct this modernization report and provide input on how to better meet the needs of Washingtonians. Over the years, the department has received feedback from legislators and external partners on a variety of CN topics, including:

(1) How can we reduce CN program costs?
(2) How can CN improve healthcare costs and access for communities?
(3) How can CN better incorporate and apply equitable principles?

This report is the perfect opportunity to elevate and further explore these issues in a deeper context and provide actionable next steps to best address them. The department appreciates this legislative report request and is eager to modernize this critical program.

Appendix B: Additional Information on Focus States

This appendix provides additional information for creating a planning entity and a requirement for interagency coordination based on examples from focus states.

Massachusetts

The CN-related health planning structure in Massachusetts facilitates state resource coordination to optimally address healthcare access, inequities, and prices. The Massachusetts Determination of Need (DoN) program is a division of the Bureau of Health Care Safety and Quality within the Department of Public Health (DPH).[211] DoN program staff administer the DoN process, review DoN applications, and provide application decision recommendations to the Public Health Council (PHC), which is also part of DPH.[212]

The PHC is responsible for issuing DoN decisions, adopting most health-related regulations, advising the Department of Public Health (DPH) on major policy decisions, and granting authority to the Commissioner of Public Health to take necessary actions during public health emergencies.[213] The PHC includes 14 members, 12 of whom are appointed by the governor and one appointed by each of the Secretary of Elder Affairs and the Secretary of Veterans' Services.[214] Each PHC member holds varying expertise, including medical, public health, nursing, long-term care management, home or community-based care management, acute care hospital management, health economics, emergency medicine, community health, and clinical quality and patient safety perspectives.[215,216] The inclusion of various experts from the Massachusetts healthcare sector helps ensure that the needs and perspectives of different geographic groups, demographic groups, and provider types are considered when a DoN application is reviewed.

Among the various duties[217] of the PHC include approval of DoN applications.[218] Additionally, the PHC has authority to monitor DoN compliance.[219] In statute, Massachusetts also has a Health Planning Council that is responsible for developing a state health plan (SHP), a responsibility that was shifted to the Massachusetts Health Policy Commission (HPC) in 2024.[220,221] The Massachusetts SHP has not been published in recent years; therefore the DoN program and PHC do not currently use a SHP in their decision-making. However, within the HPC, Massachusetts has established the Office of Health Resource Planning which has recently begun developing Massachusetts' first state health resources plan in over a decade.[222] The HPC does not have direct involvement in the DoN process but may provide public comment on DoN applications and conduct expenditure analyses as requested by the DoN program.[223]

More recently, Massachusetts passed House Bill 460, "An Act Enhancing the Market Review Process,"[224] on January 8, 2025. This legislation aims to improve the oversight and regulation of

the healthcare market. The legislation includes enhancements for health planning, such as establishing an Office for Health Resource Planning within the HPC. This office is tasked with developing a state health resource plan to assess and guide the allocation of healthcare resources across Massachusetts. The legislation also requires at least one annual public hearing. These hearings intend to provide a platform for interested parties and residents to offer input on the development of the state health resource plan and any focused assessments.[225]

Vermont

The Green Mountain Care Board (GMCB) has a planning approach that involves multiple sectors of the health system. The GMCB is comprised of four to five governor-appointed members: one physician, one or two healthcare economists, one lawyer, and one healthcare advocate who represents the public.[226,227]

The CN program in Vermont is administered by the GMCB, which also regulates major areas of Vermont's healthcare system. Part of GMCB's duties include serving as the steward of state health data (including the all-payer claims database [APCD]) and data analysis pertaining to health system performance, and monitoring and evaluating healthcare payment and delivery system reform to provide public transparency.[228] The board strives to be non-partisan, transparent, and aims to adopt a system-wide decision-making approach.[229] Board members must: have knowledge or expertise in healthcare policy, healthcare delivery, or healthcare financing; be open to alternative approaches to healthcare; and have knowledge, expertise, or experience that complements those of the existing board members.[230]

The GMCB, along with the GMCB General Advisory Committee,[xxxv] collaborates with many state agencies including the Agency of Human Services to develop and publish the Health Resource Allocation Plan (HRAP).[231] This collaboration across state agencies enables Vermont to reduce duplicative efforts, use state resources more efficiently and be strategic in public policy initiatives and investments. Along with the General Advisory Committee, the GMCB has two other subcommittees: the Primary Care Advisory Group and the Data Governance Council, which support and advise the GMCB.[232]

Vermont statutes provide clear authority for the GMCB to carry out its duties and responsibilities including the authority to:

- Exercise duties and powers to implement the CN program, including adopting rules;[233]
- Consult with hospitals and other healthcare facilities, professional associations and societies, the state Secretary of Human Services, the Office of the Health Care Advocate,

[xxxv] The GMCB General Advisory Committee includes consumers, patients, businesses, and healthcare professionals that provide input and make recommendations to the board regarding the Board's duties outlined in 18 V.S.A. § 9375.

and other interested parties on policy affecting the administration of CN and health planning;[234]

- Enforce compliance with state regulations and CN conditions, including sanctions related to violation(s) of CN statutes and regulations;[235] and
- Authority to carry out other health planning activities.[236,237]

Hawaii

The health planning structure in Hawaii promotes representation and coordination of diverse perspectives through various committees and councils.

The State Health Planning and Development Agency (SHPDA) is the health planning body responsible for administrative aspects of the CN program. The SHPDA promotes accessible, quality healthcare for all Hawaii residents at a reasonable cost.[238] It works to ensure the most economical and efficient use of healthcare resources through coordinated community planning for new healthcare services,[239,240] among other responsibilities.[241] The SHPDA is part of the Hawaii Department of Health and led by a governor-appointed administrator.[242] The SHPDA relies on the Statewide Health Coordinating Council (SHCC),[xxxvi] subarea health planning councils (SACs),[xxxvii] and the CN Review Panel[xxxviii] to inform CN decisions. Additionally, the SHCC prepares the Health Services and Facilities Plan, last updated in 2009.

Hawaii statutes empower the health planning bodies with clear authority to issue CN decisions.[xxxix] The SHCC, SACs, and CN Review Panel review CN applications and advise the SHPDA on its final decision. This coordination across councils and representation of various geographic and demographic groups, allows the Hawaii CN program to render decisions that account for the differing needs of demographic and geographic groups throughout the state. This collaboration helps ensure state resources can be used most effectively and creates an efficient process for applicants and the community. The SHPDA also has clear statutory

[xxxvi] The SHCC is a 20-member panel that is representative of the various ethnic and other demographic groups that make up the population of the State. The Council includes representation of each of the SACs, as well as businesses, healthcare providers, and consumers.

[xxxvii] Each SAC represents a subarea of the state (e.g., different islands) and includes members appointed by the Governor. Nominations for SAC members are solicited from health-related and other interested organizations, health planning councils, healthcare providers within the specific subarea, and other interested individuals. The SACs provide insight into the interests and needs of the specific subarea they represent.

[xxxviii] The CN Review Panel is appointed by the SHCC and must include one member from each county. A majority of this panel must be consumers and members of the review panel may also be members of the SHCC.

[xxxix] HI Rev Stat § 323D-14 gives the SHCC the authority to prepare and revise the state health services and facilities plan, advise the state agency, appoint the CN review panel, and review and comment on state agency actions before they are made final, which includes review of CN applications. HI Rev Stat § 323D-22 gives SACs the authority to review, seek public input, and make recommendations related to health planning for the specific subarea each one serves, which includes many similar duties to those of the SHCC.

authority to monitor CN compliance and outcomes, [243] enforcing provisions by withdrawing the CN when conditions are not met, although implementation of such provisions has been challenging due to insufficient funding and staff.[244] The SHPDA also collaborates with several other state agencies to develop and maintain their state APCD.[xl, 245]

[xl] Agencies and organizations involved in the development and maintenance of the APCD include the Pacific Health Informatics and Data Center, the SHPDA, the Department of Health, the Department of Human Services Med-QUEST Division, the Hawai`i Employer-Union Health Benefits Trust Fund, the Office of Enterprise Technology Services, the Department of Commerce & Consumer Affairs, the Department of Budget and Finance, and the University of Hawai`i.

Appendix C: Additional Figures

This appendix includes figures and maps developed during the research process that, while not directly referenced in the report, provide additional insights into the CN landscape.

Table 9: General timelines for CN applications[xli]

Application Activity	Regular Review[xlii]	Expedited Review[xliii]	Concurrent Review[xliv]
Submission of letter of intent	Minimum of 30 days prior to applications submission (six-month validity from date of receipt).	Minimum of 30 days prior to applications submission (six-month validity from date of receipt).	Submitted in conformance with published schedule for type of project under review. Good for only one review cycle.
Application submission	After 30 days has lapsed and no later than six months after the department's receipt of Letter of Intent.	After 30 days has lapsed and no later than six months after the department's receipt of Letter of Intent.	Submitted in conformance with published schedule for type of project under review.
Application screening	Within 15 working days after application submission.	Within 15 working days after application submission.	Within 30 days after application submission.
Applicant response (Applicant may request the screening and response activity be conducted a second time.)	Within 45 days of receiving department's request for additional information. (Additional responses to screening letters will be accepted up to 10 days after the notice of Beginning of Review.)	Within 45 days of receiving department's request for additional information. (Additional responses to screening letters will be accepted up to 10 days after the notice of Beginning of Review.)	Within 30 days of receiving department's request for additional information.
Formal review period (Formal review begins on the fifth working day after applicant's request to begin review, or the department declares the application fee complete.)	A total of 90 days First 35 days open to general public comment and conducting a public hearing if requested. Last 10 days open for applicant/ interested persons rebuttal statements submitted during first 35 days of public comment period Last 45 days ex parte period. Department is preparing written analysis and decision.	A total of 50 days First 20 days open to general public comment. Last 10 days open for applicant/ interested persons rebuttal statements submitted during first 20 days of public comment period. No public hearing conducted on projects qualifying for expedited review. Last 20 days ex parte period. Department is preparing written analysis and decision.	A total of 135 days First 60 days open to general public comment and conducting a public hearing if requested. Last 30 days open for applicant/ interested persons rebuttal statements submitted during first 60 days of public comment period Last 45 days ex parte period. Department is preparing written analysis and decision.

[xli] While the CN program strives to meet these timelines, recent staffing cuts have impacted this work.
[xlii] Used for any application unless the department has determined the emergency, expedited, or concurrent review process will be used.
[xliii] Used for any application with: (1) Projects proposed for the correction of deficiencies, except projects for the repair to or correction of deficiencies in the physical plant necessary to maintain state licensure, which are exempt from review, if they do not substantially affect patient charges; (2) Demonstration or research projects: provided, that such projects do not involve a change in bed capacity or the provision of a new tertiary health service; (3) acquisition of an existing health care facility, or (4) projects limited to predevelopment expenditures.
[xliv] Used for all applications determined to be competing under WAC 246-310-120.

Table 10: Data source descriptions

This table lists the data sources along with a description of the source.

Data Source	Description	Availability
CDC Places Data[246]	Database storing SDOH measures by county, census tract, place, and ZIP code tabulation area (ZCTA)	Publicly available
CDC/Agency for Toxic Substances and Disease Registry (ATSDR) Social Vulnerability Index (SVI)[247]	Place-based index database and mapping application used to identify and quantify social vulnerability	Publicly available
Agency for Healthcare Research and Quality (AHRQ) SDOH Database[248]	Database that compiles ZIP code and county-level data corresponding to five key SDOH domains	Publicly available
Neighborhood Atlas[249]	Population-level data on socioeconomic status (SES), demographic information, social environment, healthcare access and quality, physical environment, transportation, and infrastructure	Publicly available
APCD[250]	Database of health care claims in WA that can be used to determine need, identify disparities in access, understand current healthcare costs, and identify trends	Access fee
Medicare Healthcare Provider Cost Reporting Information System (HCRIS)[251]	Cost reporting system that can be used to analyze financial health, assess utilization rates of services, examine indicators of care quality, and forecast future needs	Publicly available
HRSA Area Health Resource Files[252]	Files that include clinician demographics, population, and location data.	Publicly available
BRFSS[253]	Comprehensive health-related telephone survey system managed by the CDC that collects several types of health-related information	Publicly available
CDC Wonder[254]	Ad hoc query system managed by the CDC that contains data on population, births, deaths, AIDS/cancer statistics, and environment	Publicly available
Surveillance, Epidemiology, and End Results (SEER)[255]	Cancer incidence database that includes patient demographics and other information	Publicly available

Office of Financial Management (OFM) State Population Forecast[256]	Report containing population data by age and sex	Publicly available
Cardiac Care Outcomes Assessment Program (COAP)[257]	Data that aims to improve quality of care for patients with heart disease who receive cardiac interventions All hospitals in Washington that perform open heart surgery or percutaneous coronary interventions (PCI) are required to participate	Publicly available
Hospital Discharge/Comprehensive Hospital Abstract Reporting System (CHARS)[258]	Hospital discharge data that can provide insight on current healthcare utilization, identify service gaps, and forecast future needs	Some publicly available files, some files are available for purchase
Rapid Health Information Network (RHINO)[259]	Syndromic surveillance (real-time population-based monitoring) data that is primarily used in Washington for behavioral health impact	Available to public health professionals for a fee

Figure 9: Data sources

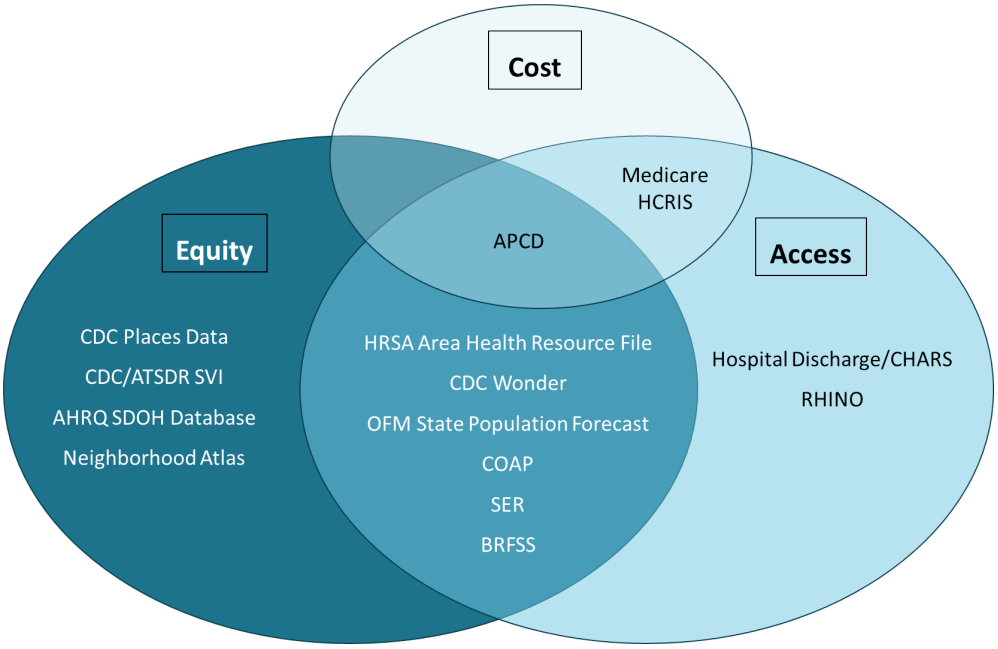
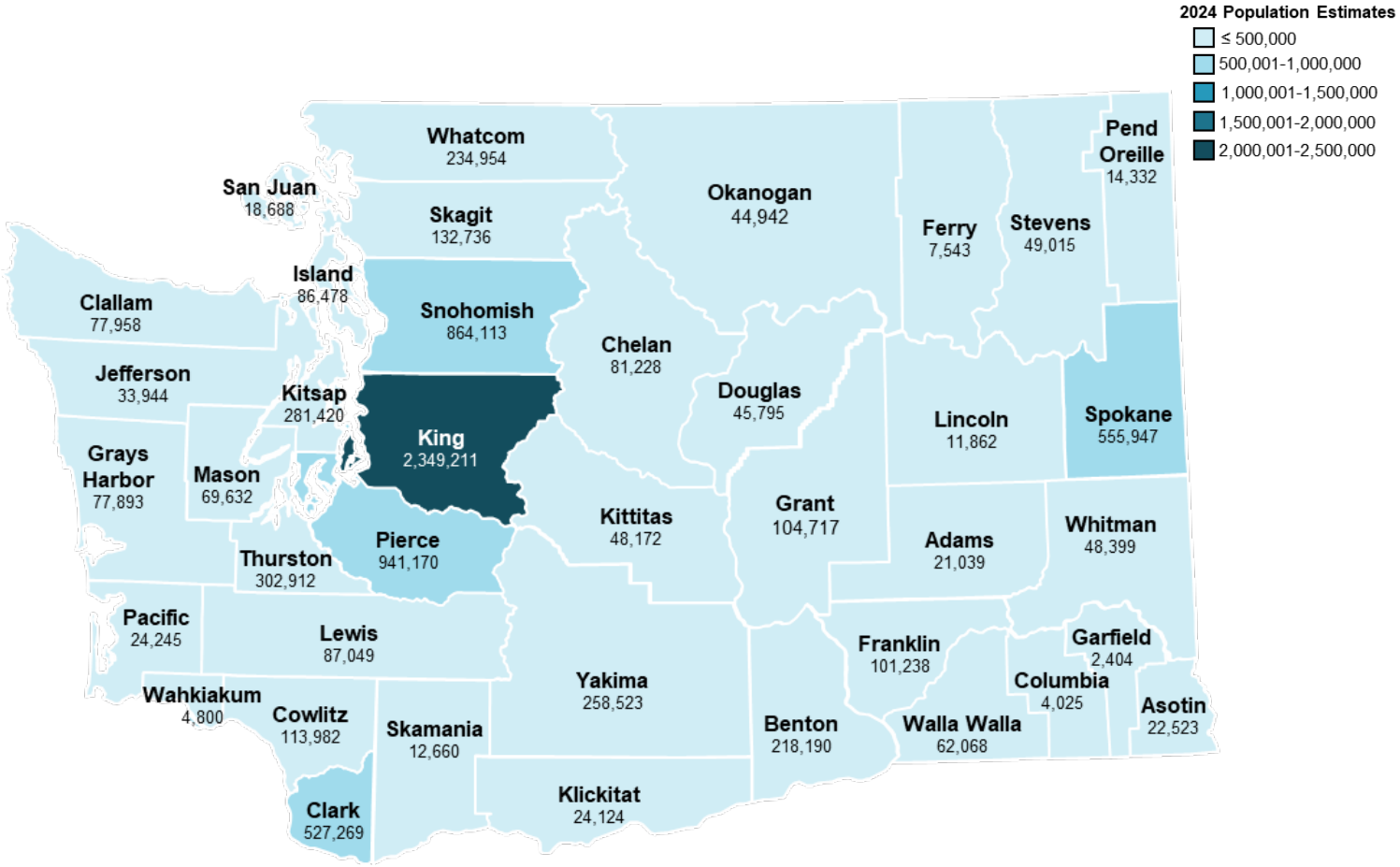


Figure 9 presents data sources that the Washington CN program could consider for its CN application analysis, categorized into three interconnected domains: access, equity, and cost. Because these domains overlap, many data sources are applicable across multiple areas. Sources within the equity domain support analysis related to SDOH, social vulnerability, and population health needs. Data sources included in the cost domain can help identify cost trends, cost drivers, and other factors related to healthcare costs. Sources within the access domain provide insights into current healthcare utilization, identify healthcare trends, and forecast future healthcare needs.

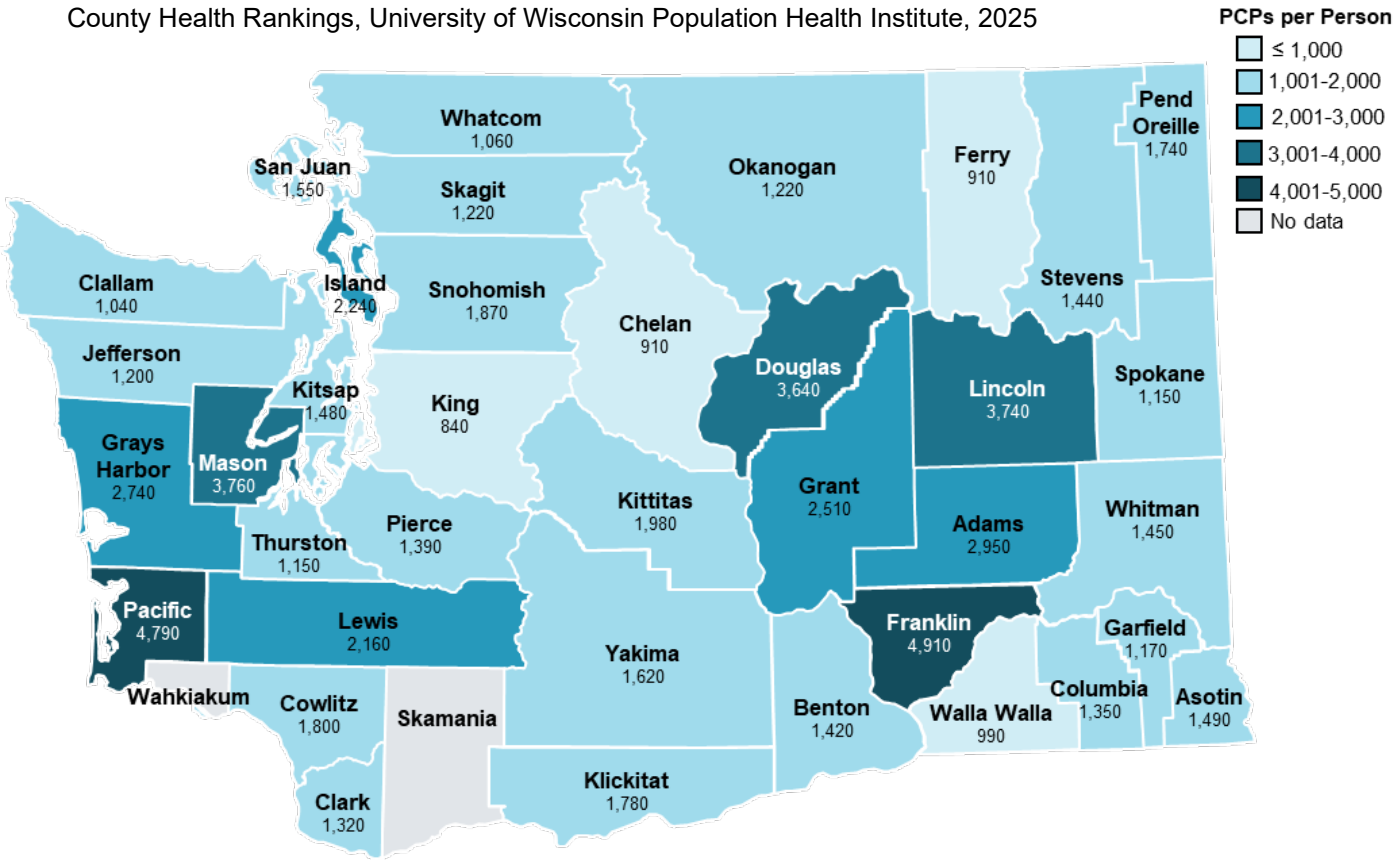
Map 7: 2024 Estimated Population by County, Washington State

U.S. Census Bureau, Annual Estimates of the Resident Population by Counties in Washington, April 1, 2020 to July 1, 2024 (March 2025)



Map 7 depicts current population by county. The least populated counties are shaded light blue, with darker shading depicting higher populated counties. King County has the highest population with 2,349,211 people, and Garfield County is the least populated with 2,404 people.

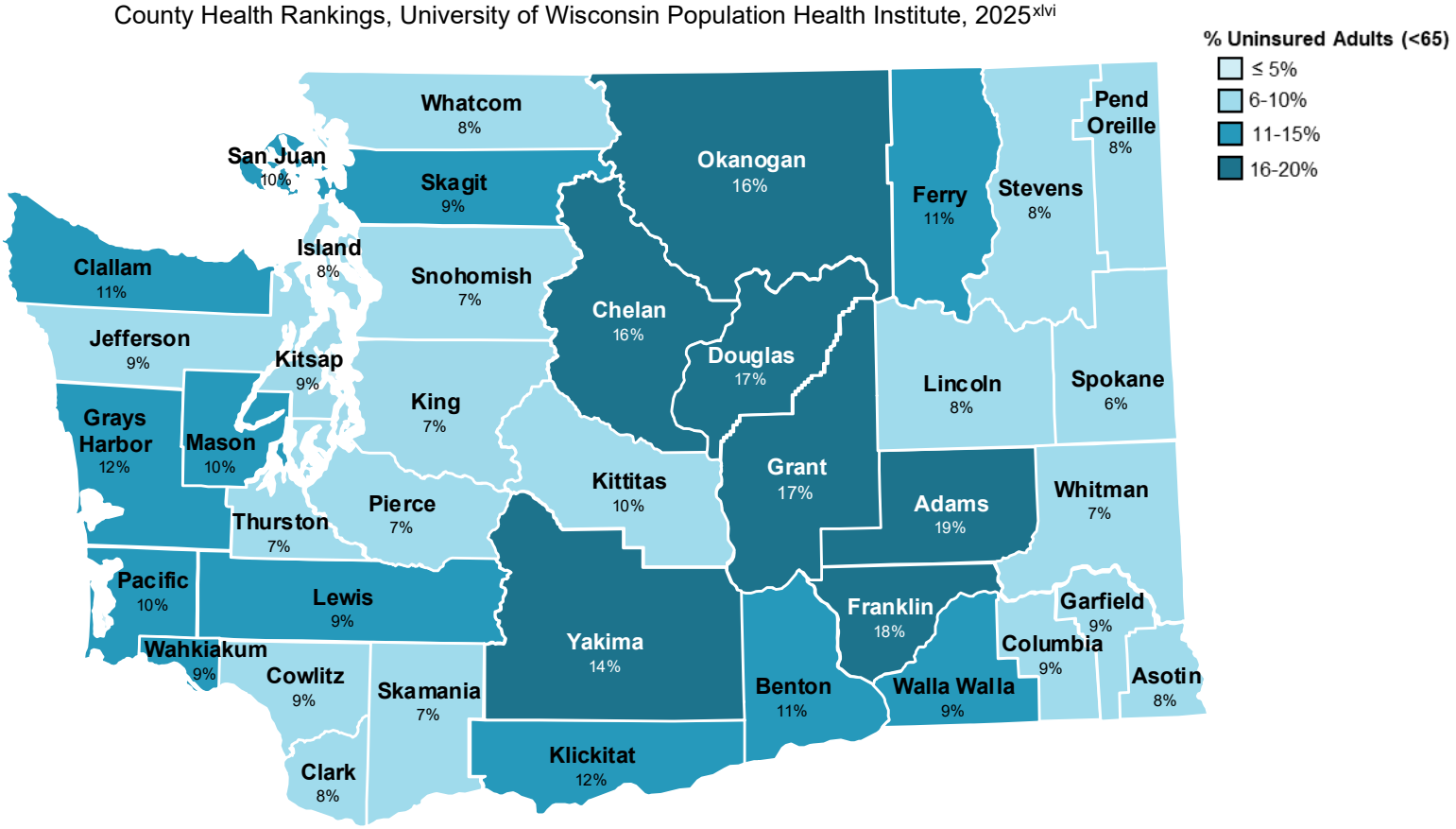
Map 8: PCPs per Person by County
County Health Rankings, University of Wisconsin Population Health Institute, 2025



Map 8 shows the distribution of PCPs per person throughout Washington by county.[xlv] Urban areas generally have a higher number and concentration of PCPs, such as King and Pierce Counties, which can positively affect the likelihood of residents having access to primary care in these areas. Conversely, rural areas have fewer PCPs overall, such as Pacific, Lincoln, and Franklin Counties, which suggests provider availability may be a potential barrier to access to care for residents in these areas.[260]

[xlv] Data from 2024 County Health Rankings Washington Data report analyzing PCP data from 2021.

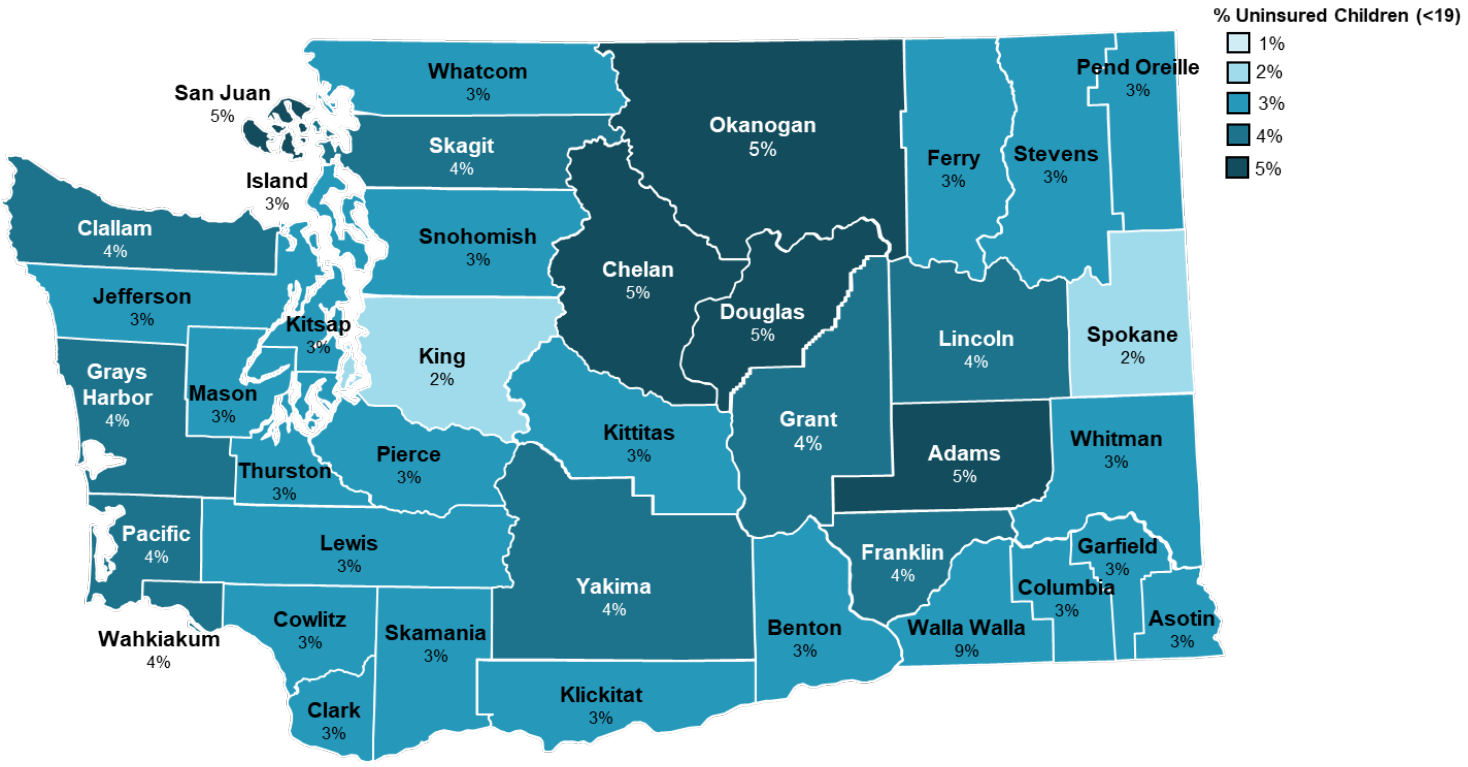
Map 9: Percent of Uninsured Adults (<65) by County, Washington State
County Health Rankings, University of Wisconsin Population Health Institute, 2025[xlvi]



Map 9 shows the percentage of uninsured adults under 65 years old by county.[xlvii] Adams County has the highest percentage of uninsured adults at 19%. In general, counties that are more urban (e.g., King and Pierce Counties) have a lower percentage of uninsured adults and rural counties (e.g., Adams and Okanogan Counties) tend to have a higher percentage of uninsured adults.[261]

[xlvi] The 2025 Annual Data Release used data from 2022 for this measure.
[xlvii] Data from 2024 County Health Rankings Washington Data report analyzing uninsured adult data from 2021.

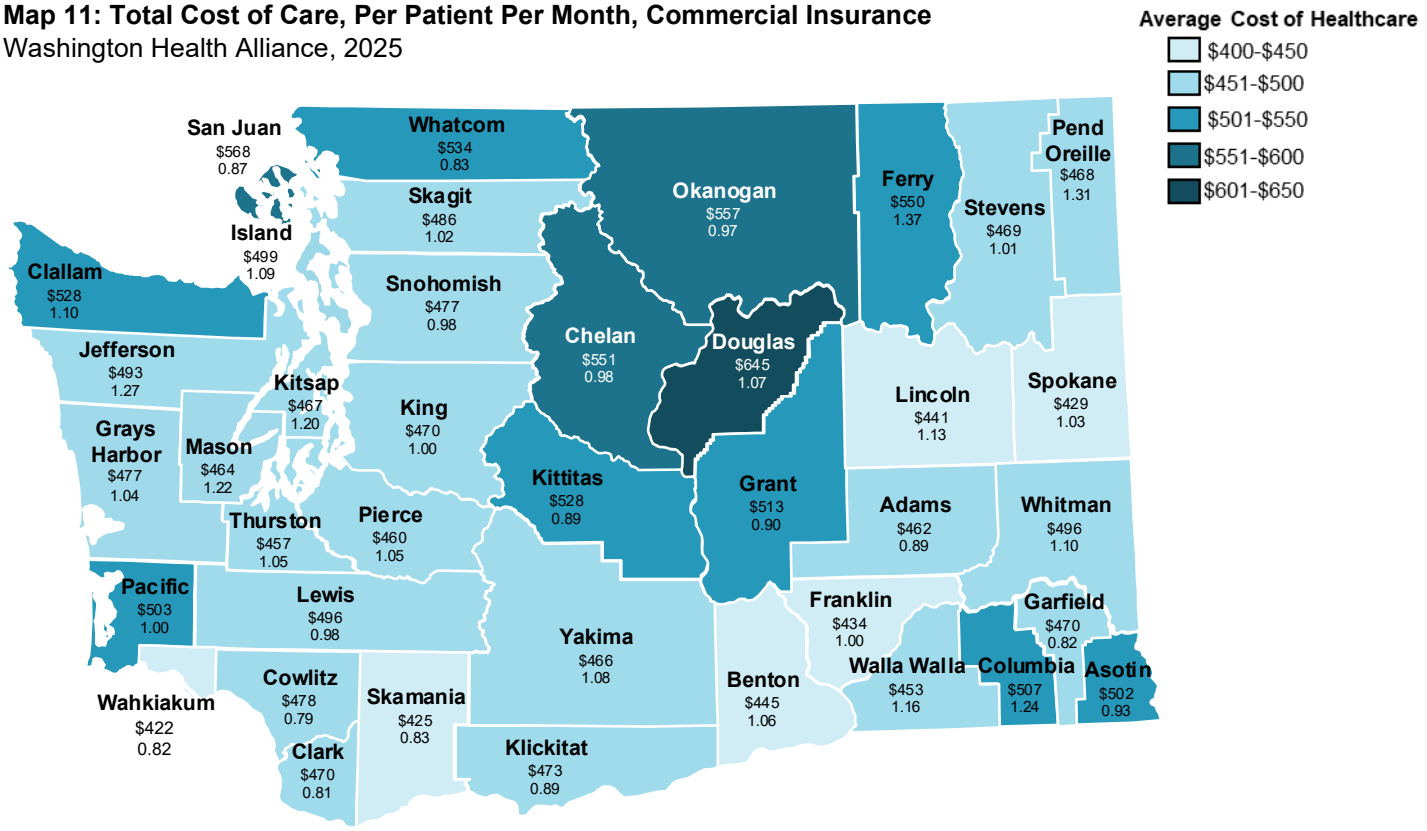
Map 10: Percent of Uninsured Children (<19) by County, Washington State
County Health Rankings, University of Wisconsin Population Health Institute, 2025[xlviii]



Map 10 shows the percentage of uninsured children younger than 19 years old per county.[xlix] Adams, Okanogan, Chelan, Douglas, and San Juan Counties have the highest percentage of uninsured children at 5%. King and Spokane Counties have the lowest percentage of uninsured children at 2%. Similar to uninsured adults, urban counties (e.g., King and Pierce Counties) are more likely to have a lower percentage of uninsured children. Rural counties (e.g., Adams and Okanogan Counties) tend to have a higher percentage of uninsured children.[262]

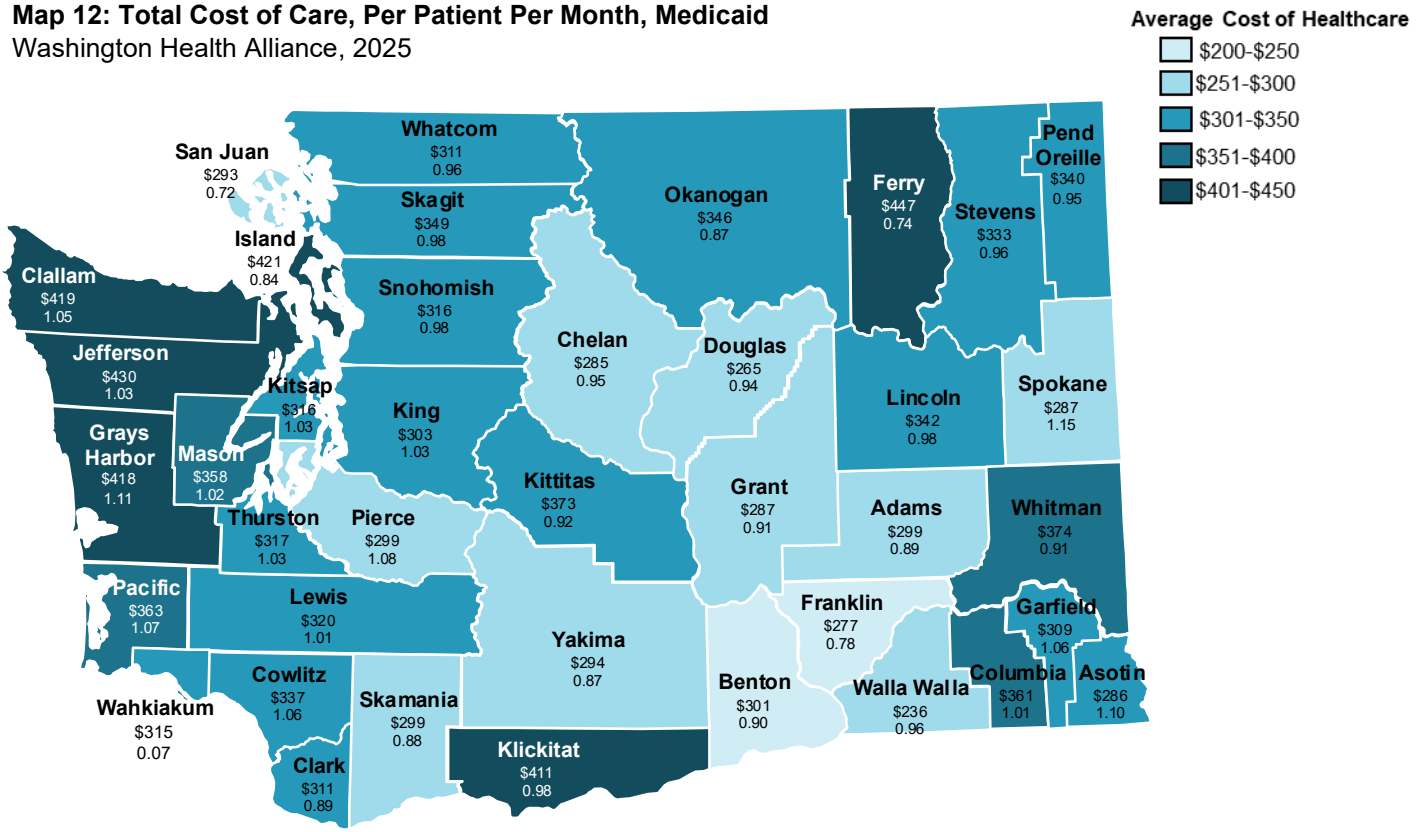
[xlviii] The 2025 Annual Data Release used data from 2022 for this measure.
[xlix] Data from 2024 County Health Rankings Washington Data report analyzing uninsured children data from 2021.

Map 11: Total Cost of Care, Per Patient Per Month, Commercial Insurance
Washington Health Alliance, 2025



Map 11 depicts the cost of care per month that each patient pays on average through commercial insurance in each county. Counties in light blue have the lowest average costs between $400-$450 per month per patient. Counties with darker shading have higher costs, with Douglas County having the highest costs per patient per month at $645.

Map 12: Total Cost of Care, Per Patient Per Month, Medicaid
Washington Health Alliance, 2025



Map 12 depicts the total cost of care per month paid by patients on average through Medicaid. Counties shaded in light blue have the lowest average cost, and darker shading indicates higher costs. Benton and Franklin Counties have the lowest per patient per month costs at $301 and $277 respectively. Klickitat, Ferry, Clallam, Jefferson, Island, and Grays Harbor Counties have the highest per patient per month costs ranging between $411 and $447.

Figure 10: Proviso workshop feedback themes

Future CN Direction

- Incorporate industry reimbursement and quality drivers as part of individualized CN processes (e.g., value-based purchasing).
- Allow CN to be flexible/adapt to future delivery models, payer trends, and care settings.
- Develop and use objective CN criteria for qualitative reviews.
- Increased oversight for mergers and acquisitions.
- Greater compliance measures for CN and increased enforcement of CN conditions.
- Differentiate applications/fees for new facilities vs. expanding or replacing current ones.
- Create the ability for the CN program to gather data (e.g., hospice).
- Provide more information to the public about the benefits of CN.
- Greater coordination among state and federal initiatives (e.g., ESRD feedback, other state boards).
- Increased partnership with affected communities.
- General concern about lack of underlying statewide health resources strategy.
- Incorporate successes from the recent hospice methodology update as a framework for other regulated areas.
- Add innovation projects to CN.

Application Process

- Updated, refined, and reduced length of CN applications (e.g., behavioral health services applications).
- Shorter/timelier application review.
- Additional staff for CN decisions and program updates.
- Revised fees to be proportionate to project scope.
- Account for inflation for CN applicants in the review process.
- Increased application efficiency and accessibility to the public.
- More local input/discussion before issuing CNs.
- No "one size fits all" CN applications/individualized applications per industry/field.
- Increased transparency on CN decision rationale.

Facility-Specific

- Increased support/attention for rural providers.
- Concerns about hospice deserts.
- Suggestion to allow dialysis centers to pre-build out chairs.
- Exclude ambulatory-based services from CN.

Rulemaking

- Reflect on continued use of need methodologies.
- Continue updating need methodologies (e.g., home health).
- More routine rule review/increased review cadence (e.g., tertiary services).
- Continued expert involvement in rulemaking.
- More public participation in the CN process, including rulemaking.
- Increased flexibility in rules across service and facility types.
- Caution for rules to not be too restrictive or too lax.

Figure 10 summarizes themes shared by attendees of the seven public listening sessions held July 30th, 2024 through October 9th, 2024 and the three feedback sessions held November 13th, 2024 through November 20th, 2024.

Appendix D: Washington Comparison to Other States

The purpose of Table 11 in this appendix is to provide a summary that shows how the CN program structure and characteristics compare to programs in other focus states.

Table 11: Washington CN characteristics compared to focus states

Note: Cells containing a '-' indicate that information was unavailable based on research findings.

	CN Statutory Purpose	Board/Planning Entity	Regulatory Flexibility	Oversight of FSEDs under CN	Health Equity Provisions	Application Fee Structure	CN Funding Structure	Data Collection/Authority
Washington	The CN program is part of the general health planning process.[263]	CN is administered by program staff within DOH.	Applications are reviewed using established numeric need methodologies with limited flexibility.[264]	No[265]	-	Fixed fee based on type of project[266]	Application fees[267]	The CN program can consult with other state agencies for data related needs.
Alabama	The CN program aims to prevent the construction of unnecessary and inappropriate facilities through review of new health services.[268]	CN is administered by SHPDA with advice and consultation from the SHCC.[269] SHPDA membership includes three consumers, three providers, and three representatives of the Governor.[270] The SHCC must have at least 16 members, all nominated by health systems agencies in the state.[271]	Applications are reviewed using the SHPDA.[272]	Yes[273]	-	Fees based on percentage of project costs Lower fees for projects serving higher Medicaid populations or rural areas.[274]	Application fees and state funding[275, 276]	The SHPDA collects utilization data and maintains an inventory of existing resources. The SHPDA is granted the authority to collect data through rulemaking.[277]
Connecticut	No purpose specific to CN.	CN is administered by the HSP within the OHS.[278] OHS is a state department with oversight and regulatory responsibilities including health planning and data collection/analysis.[279]	Reviewers have some flexibility in determining if a project meets criteria.[280]	Yes[281]	-	Fixed fee based on project size and complexity[282]	Application fees, general fund, and external assessments[283]	The HSP is authorized to collect patient-level outpatient data and establish data collection requirements.[284]

	CN Statutory Purpose	Board/Planning Entity	Regulatory Flexibility	Oversight of FSEDs under CN	Health Equity Provisions	Application Fee Structure	CN Funding Structure	Data Collection/Authority
Hawaii	No purpose specific to CN.	CN is administered by SHPDA with recommendations from SACs, the CN Review Panel, and the SHCC.[285] SHCC includes 21 Governor-appointed members.[286] SACs include Governor-appointed members for each subarea.[287] The CN Review Panel is selected by the SHCC.[288] The CN Review Panel includes at least one member from each county and a majority of the group are consumers.[289]	Applications are reviewed using the SHP.[290]	Yes[291]	-	Fees based on percentage of project costs[292]	Application fees and state funding[293]	Facilities are required to submit certain information to SHPD.[294]
Massachusetts	DoN aims to encourage competition and innovation to ensure resources are available at the lowest cost, and support Massachusetts' goals of cost containment, improved health outcomes, and delivery system transformation.[295]	The DoN program is administered by DPH staff with recommendations from the PHC.[296] PHC membership includes representatives from higher education, healthcare providers, healthcare organizations, and healthcare consumers.[297]	Projects must contribute to the state's health priorities and goals.[298]	No, unless capital expenditure exceeds $43,438,134.73[299]	*CHIs:* Certain applicant types must dedicate a percentage of the total project cost to an initiative that addresses health needs in the community.[300, 301, 302]	Fees based on percentage of project costs[303]	Application fees[304]	The DoN program can consult with other state agencies that collect and maintain data.[305]
New York	The CN program aims to protect and promote health, ensure high quality care, and ensure proper utilization at a reasonable cost.[306]	CN is administered by the DOH with some oversight from the PHHPC.[307,308] PHHPC membership includes 26 members representing various geographic and demographic groups in New York.[309]	-	Yes[310]	*HEIAs:* Certain applicant types must have an independent assessment completed that evaluates whether the project has impact on access or delivery of health services in the area and medically underserved groups.[311]	Fixed fee based on project type, size, and complexity Lower fees for projects serving higher Medicaid populations or rural areas.[312]	-	The DOH maintains an inventory of facilities and other public health data.[313]

	CN Statutory Purpose	Board/Planning Entity	Regulatory Flexibility	Oversight of FSEDs under CN	Health Equity Provisions	Application Fee Structure	CN Funding Structure	Data Collection/Authority
Vermont	The CN program aims to prevent excessive duplication of health facilities, promote cost containment, establish facilities to serve public needs, ensure high quality services and resources, and ensure access to and equitable allocation of facilities and services.[314]	CN is administered by the GMCB with some consultation from groups representing the public.[315] GMCB membership includes five individuals nominated by the GMCB Nominating Committee and appointed by the Governor.[316]	Applications are reviewed using the SHP.[317]	Yes[318]	-	Fees based on percentage of project costs[319]	Application fees and GMCB funds[320]	The GMCB maintains a unified healthcare database and has the authority to collect several types of data.[321]

Table 12: 50-State Scan of Certificate-of-Need Programs
National Academy for State Health Policy (NASHP), Updated December 12, 2004, Information Current as of August 2024

Note: Broken/outdated links were updated by Department staff. Blue text indicates a hyperlink.

State	CON Review Required?	Facilities Covered by a CON	Activities That Trigger a CON Review	Capital Expenditure Threshold	Reviewing Agency	Agency Rules and Regulations, Guidance	Board Make-Up and Appointment	Criteria Considered in a CON Review
AL	Yes, see Alabama's State Code §22-21-260	• General and specialized hospitals and related facilities such as laboratories, outpatient clinics, or central service facilities • Skilled or intermediate care facilities • Skilled nursing facilities • Rehabilitation centers • Public health centers • Outpatient surgical centers • Kidney disease treatment centers, including free-standing hemodialysis units • Community mental health centers and related facilities • Alcohol and drug abuse facilities • Facilities for the developmentally disabled	• Constructing, developing, acquiring or establishing a new health care facility or HMO • Capital expenditure exceeding threshold • Sale, lease, or transfer or change in control of an existing facility or service if the transaction involves implementing one or more new institutional health service • Change in bed capacity • Relocation of beds • Conversion of beds (to general medical surgical, inpatient psychiatric, inpatient/residential alcohol and drug abuse, inpatient rehabilitation, or long-term care)	CON Thresholds	Certificate of Need Review Board, State Health Planning and Development Agency (in coordination with Statewide Health Coordinating Council)	Rules and Regulations of the State Health Planning and Development Agency Chapter 410-1-1	Three consumers, three health care providers, and three representatives of the governor All appointments are made by the governor	Alabama State Code §22-21-264

		• Hospice service providers • Home health agencies and health maintenance organizations	• Addition of services					
AK	Yes, see Alaska Statutes Chapter 18.07	• Hospitals • Psychiatric hospitals • Independent diagnostic testing facilities • Residential psychiatric treatment centers • Tuberculosis hospitals • Skilled nursing facilities • Kidney disease treatment centers, including freestanding hemodialysis units • Intermediate care facilities • Ambulatory surgical facilities	• New health care facility • Alteration of bed capacity • Addition of service category • Conversion of a building to a nursing home	$1.5 million	Division of Health Care Services, Department of Health and Social Services	7 Alaska Administrative Code (AAC) 07	Review conducted by the Department of Health and Social Services	Alaska Certificate of Need Review Standards and Methodologies
AZ	No							
AR	Yes, limited to certain non-hospital facilities; referred to as Permit of Approval, see Ark. Code Ann.	• Nursing facilities • Residential care facilities • Assisted living facilities • Home health and hospice agencies • Psychiatric residential care facilities	• Nursing home construction • Adding long-term care (LTC) beds or expanding bed capacity • Adding or expanding home health services	Nursing home construction - $1 million	Health Services Permit Agency, Health Facility Services Section, Arkansas Department of Health	Arkansas Permit of Approval Rulebook	Nine-person Health Services Permit Commission; made up of industry representatives and others	Arkansas Permit of Approval Rulebook

	§20-8-101 et. seq.	• Intermediate care facilities for the intellectually disabled	• New hospice programs • Increase in cost of an approved project, cost of renovation, construction or alteration of a health facility • Relocation of LTC beds • Movement of site location of permit of approval • Transfer of permit of approval, legal title, or right of ownership				Appointments are made by the governor	
CA	No							
CO	No							

CT	Yes, see: Connecticut General Statues Chapter 368z Sec.19a-638 (General Facilities) Connecticut General Statutes Chapter 319y Sec.17b-352 (Long-Term Care Facilities)	General Facilities: • Hospitals • Specialty hospitals • Freestanding emergency departments • Outpatient surgical facilities • Hospitals or other facilities/institutions operated by the state that provide services eligible for reimbursement under Medicare and Medicaid • Central service facilities • Mental health facilities • Substance abuse treatment facilities • Parent companies, subsidiaries, affiliates, or joint ventures of such facilities Long-Term Care Facilities: • Residential facilities for persons with intellectual disabilities certified to participate in the Medicaid program • Nursing homes • Rest homes	General Facilities: • Establishment of a new health care facility • Transfer of ownership of a facility • Transfer of ownership of a large group practice to another entity other than a physician/physician group • Establishment of a freestanding emergency department • Termination of hospital inpatient or outpatient services • Establishment of an outpatient surgical facility (including as established by a short-term acute care general hospital) • Termination of surgical services in an outpatient facility • Termination of an emergency department by a short-term acute general hospital	N/A Long-Term Care Facilities - $2 million, or $1 million to increase facility square footage	General Facilities: Health Systems Planning Unit, Office of Health Strategy Long-Term Care Facilities: Department of Social Services	General Facilities: Office of Health Strategy Certificate of Need Guidebook Long-Term Care Facilities: Department of Social Services Certificate of Need Laws/Regulations	General Facilities: Director of the Office of Health Strategy and Health Systems Planning Unit makes CON decisions Some facilities (such as nonprofit hospitals) must also receive approval from the attorney general Long-Term Care Facilities: Commissioner of the Department of Social Services makes CON decisions Office of the Long-Term Care Ombudsman receives notification of submitted applications	General Facilities: Connecticut General Statutes Chapter 368z Sec. 19a - 639 Long-Term Care Facilities: Connecticut General Statutes Sec.17b-352 - 17b-354

		• Residential care homes	• Establishment of cardiac services, including inpatient and outpatient cardiac catheterization, interventional cardiology, and cardiovascular surgery • Acquisition of CT, MRI, PET, or PET/CT scanners • Acquisition of non-hospital based linear accelerators • Increase in the licensed bed capacity of a health care facility • Acquisition of equipment using new technology • Increase of two or more operating rooms within any three-year period for an outpatient surgical facility or short-term acute care general hospital • Termination of inpatient or outpatient services offered by a hospital/facility that provides services that are eligible for					

			Medicare or Medicaid reimbursement *Exemptions listed Long-Term Care Facilities: • Transfer of ownership • New or expanded functions or services • Termination of a service including facility closure or a substantial decrease in total bed capacity • Relocating all or a portion of a facility's beds to a new or replacement facility • Capital expenditures exceeding either $2 million or $1 million with an increase in facility square footage by 5,000 square feet or 5% of existing square footage • New facilities associated with a continuing care facility (excludes Medicaid program) • Licensing a new residential care facility or intermediate care facility for the					

			intellectually disabled • Addition of beds restricted to use by residents with AIDS or traumatic brain injuries • Relocating Medicaid certified beds between nursing facilities to meet a priority need *Exemptions and Moratoria listed					

DC	Yes, See D.C. Official Code § 44-401	• Private general hospitals • Psychiatric hospitals • Other specialty hospitals • Rehabilitation facilities • Skilled nursing facilities • Intermediate care facilities • Ambulatory care centers or clinics • Ambulatory surgical facilities • Kidney disease treatment centers • Freestanding hemodialysis facilities • Diagnostic health care facilities • Home health agencies • Hospices • Other comparable health care facilities with an annual operating budget of at least $500,000	• Construction, development, or other establishment of a new health care facility, health care service, or home health agency • Capital expenditure of $6 million or more in connection with a hospital and $3.5 million in connection with a health service or health facility • Capital expenditure of $3.5 million or more by a hospital, or $2 million by a health care facility to acquire major medical equipment • Acquisition by lease, purchase, donation, or other arrangement of a single piece of diagnostic or therapeutic equipment for a physician or group of physicians, or an independent owner or operator, exceeding $350,000 • Relocation of beds • Redistribution of beds by 10 or 10%,	CON Thresholds	State Health Planning and Development Agency (SHPDA), District of Columbia Health	Title 22B, DC Municipal Regulations, Sec. 4000, et seq.	State Health Planning and Development Agency (SHPDA) administers, operates, and enforces the CON program and monitors compliance by health care facilities. SHPDA establishes a Statewide Health Coordinating Council (SHCC), which includes 15 members appointed by the Mayor, with the advice and consent of the Council of the District of Columbia. The SHCC may make recommendations to the SHPDA on CON applications.	D.C. Official Code § 44-410

			whichever is less, in any two-year period • Offering any health service • Increases in renal dialysis stations in a facility, or movement of stations from one facility to another • Acquisition of an existing facility or major medical equipment by purchase, lease, or other arrangement *Exemptions listed					
DE	Yes (called Certificate of Public Review), see Delaware State Code Title 16 Chapter 93	• Hospitals • Nursing homes • Freestanding birthing centers • Freestanding surgical centers • Freestanding emergency centers • Freestanding acute inpatient rehabilitation hospitals • Continual care community and other non-traditional long-term care facilities	• New health care facility (hospitals included) • Acquisition of a nonprofit health care facility • Capital expenditures exceeding threshold • Change in bed capacity that increases the total number of beds (or distributes beds among various categories, or relocates beds) by more than 10 beds or more than 10% of total bed capacity,	Any expenditure by or on behalf of a health care facility, not including a medical office building, in excess of $5.8 million	Health Resources Board, Delaware Health Care Commission, Delaware Department of Health and Social Services	Delaware Health Resources Board Certificate of Public Review Health Resources Management Plan	Fifteen members are appointed by the governor	CPR Criteria (listed in 16 Del. Code § 9306)

			• whichever is less, over a 2-year period • Acquisition of major medical equipment					
FL	Yes, see Florida Statutes Sections 408.031-408.045	• Hospices • Skilled nursing facilities • Intermediate care facilities for the developmentally disabled • Class II hospitals (specialty hospitals for women or children) • Class III hospitals (specialty medical, rehabilitation, psychiatric, or substance abuse hospitals) • Class IV hospitals (intensive residential treatment programs for children and adolescents)	• Addition of beds in community nursing homes or intermediate care facilities for the developmentally disabled • Construction of new facilities • Conversion of a facility from one type to another (including conversion of general hospital or long-term care hospital to a Class II, III, or IV specialty hospital) • Establishment of hospice or hospice inpatient facilities	N/A	Florida Agency for Health Care Administration (AHCA)	Certificate of Need Rules- Florida Administrative Code Chapter 59C	Review conducted by the agency	Florida Administrative Code Rule 59C-1.010
GA	Yes, see Georgia Code § 31-6-40	• Hospitals • Destination cancer hospitals • Other special care units, including podiatric facilities • Skilled nursing facilities • Intermediate care facilities • Personal care homes	• Construction, development or establishment of a new, expanded, or relocated health care facility • The purchase or lease by or on behalf of a health care facility or a diagnostic,	CON Thresholds	Department of Community Health	Georgia Department of Community Health State Health Plans and CON Rules	Review is conducted by the Department of Public Health; there is an independent panel to review appeals The appeals panel is appointed by the governor	GA Code § 31-6-42

		• Ambulatory surgical centers or obstetrical facilities • Freestanding emergency departments or facilities not located on a hospital's primary campus • Health maintenance organizations • Home health agencies • Diagnostic, treatment, or rehabilitation centers • Providers of new perinatal services	treatment, or rehabilitation center of diagnostic or therapeutic equipment • Increase in bed capacity • Clinical health services through a health care facility • Conversion or upgrading of any general acute care hospital to a specialty hospital (or conversion of a facility type not covered by CON to any of the types of health care facilities covered by CON) • New clinical health services offered in a diagnostic, treatment, or rehabilitation center including radiation therapy, biliary lithotripsy, surgery/ambulatory surgery, and cardiac catheterization • Conversion of a destination cancer hospital to a general cancer hospital					

HI	Yes, see Hawaii Revised Statutes §§ 323D-41-323D-55	• Hospitals • Facilities that provide inpatient medical care and other related services for surgery or acute medical conditions or injuries • Extended care and rehabilitation centers • Nursing homes • Skilled nursing facilities • Intermediate care facilities • Hospices • Kidney disease treatment centers, including freestanding hemodialysis units • Outpatient clinics • Ambulatory health care facilities • Emergency care facilities and centers • Home health agencies • Health maintenance organizations	• Construction, expansion, alteration, conversion, development, initiation, or modification of a health care facility or health care services exceeding the capital expenditure threshold • Substantial modification or increase in the scope or type of health service rendered • Increase, decrease, or change in the class of usage of the bed complement of a health care facility, or relocation of beds from one facility to another • Relocation of beds	Capital expenditures - $4 million New or replacement medical equipment - $1 million Used medical equipment- $400,000 Bed or service changes with capital expense of $1 million or less and have an increased annual operating expense of less than $500,000	State Health Planning and Development Agency (SHPDA)	Hawaii Administrative Rules Chapter 11-186	Three bodies review CON applications before SHPDA's final decision - CON Review Panel; Subarea Health Planning Council (SAC - geographic councils); Statewide Health Coordinating Council (SHCC) Subarea Health Planning Council and Statewide Health Coordinating Council (SHCC) are appointed by the governor The CON Review panel is appointed by the SHCC	State Health Planning and Development Agency Certificate of Need Criteria Checklist
ID	No							
IL	Yes, see Illinois Compiled Statutes Chapter 20 § 3960/1	• Ambulatory surgery centers • Hospitals • Skilled and intermediate long-term care facilities	• Construction, modification, or establishment of a health care facility or alternative health care model	CON Thresholds	Health Facilities and Services Review Board (staff support from the Division of Health Systems	No additional guidance or agency rules are available online	Board is made up of 11 voting members appointed by the governor and confirmed by the state senate, and 3	ILCS Chapter 20 § 3960/1

		• Hospitals, nursing homes, ambulatory surgical treatment centers, or kidney disease treatment centers maintained by the state • Kidney disease treatment centers, including freestanding hemodialysis units certified for participation in Medicare and Medicaid • Outpatient surgical facilities that are leased, owned, or operated by or on behalf of an out-of-state facility • Facilities used to provide certain categories of service, including cardiac catheterization and open heart surgery • Facilities housing major medical equipment whose project cost exceeds the capital expenditure threshold	• Acquisition of major medical equipment • Capital expenditure exceeding threshold • Substantial change in bed capacity by: increasing the total number of beds, distributing beds among various categories of service, or relocating beds by more than 20 beds or more than 10% of total bed capacity, whichever is less, over a 2-year period • Substantial change in the scope or function of a facility *Exemptions listed		Development, Department of Public Health)		non-voting ex-officio members: the secretary of Human Services, the director of Healthcare and Family Services, and the director of Public Health Additional requirements apply regarding residency, party affiliation, and specific knowledge	
IN	Yes, see Indiana Code 16-29-7	• Comprehensive care facilities (includes nursing homes)	• Relocation of existing comprehensive care beds from a county	N/A	Long-Term Care/Nursing Home Division, Indiana State	Article 40. Certificate of Need Program	Estimate of need and review process is conducted by the Department of	Indiana Code 16-29-7

			that has an excessive comprehensive care bed supply to a county with comprehensive care bed need • Construction of a new comprehensive care health facility consisting of transferred beds *Prohibition on adding or transferring beds, adding or transferring certification to participate in the state Medicaid program, building new facilities, and converting beds to comprehensive care		Department of Health		Health commissioner or designee	
IA	Yes, see Iowa Code §10A.711	• Hospitals • Health care facilities (includes residential care facilities, nursing homes, intermediate care facilities for individuals with intellectual disabilities, and intermediate care facilities for persons with mental illness) • Organized outpatient health facilities • Ambulatory surgical centers (exemption:	• Construction, development, or other establishment of a new institutional health facility • Capital expenditure, lease, or donation exceeding expenditure threshold • Permanent change in bed capacity • Expenditure exceeding $500,000 for health services	Medical equipment costing $1.5 million or more	State Health Facilities Council, Department of Public Health	641 Iowa Administrative Code Chapter 202 Certificate of Need Program	Five-member council appointed by the governor	Iowa Code §10A.714

		cosmetic, reconstructive, or plastic surgery services) • Community mental health facilities • Birthing centers *Exemptions listed	• Deletion of health services • • Acquisition of major medical equipment valued above expenditure threshold (includes replacement equipment) • New air transportation services • Mobile health services valued above expenditure threshold, including: transplantation services, open heart surgery, cardiac catheterization, and radiation therapy services using megavoltage external beam equipment					
KS	No							
KY	Yes, see Kentucky Revised Statutes Chapter 216B	• Hospitals (including acute care hospitals associated with the state's schools of medicine) • Psychiatric hospitals • Physical rehabilitation hospitals • Chemical dependency programs • Nursing	• New health care facility (including hospitals) • Capital expenditure that exceeds threshold • Substantial change in bed capacity • Substantial change to health services	CON Threshold	Division of Certificate of Need, Office of Inspector General, Kentucky Cabinet for Health and Family Services	900 Kentucky Administrative Regulation Ch. 6	Review process is conducted by the cabinet	900 Kentucky Administrative Regulation 6:070

		facilities • Nursing homes • Personal care homes • Intermediate care facilities • Assisted living communities • Family care homes • Outpatient clinics • Ambulatory care facilities • Ambulatory surgical centers • Emergency care centers and services • Ambulance providers • Hospices • Community mental health centers • Home health agencies • Kidney disease treatment centers and freestanding hemodialysis units *Exemptions listed	• Substantial change to a project • Acquisition of major medical equipment • Altering a location that has been designated on a certificate of need or license • Transferring an approved certificate of need to establish a new facility or replace a licensed facility					
LA	No							
ME	Yes, see Maine Revised Statutes Tile 22, Chapter 103-A	• Hospitals • Psychiatric hospitals • Nursing facilities • Kidney disease treatment centers, including freestanding hemodialysis facilities • Rehabilitation facilities • Ambulatory surgical facilities	• Transfer of ownership or acquisition of a facility by lease, donation, or transfer • Acquisition of major medical equipment • Capital expenditures exceeding threshold for existing health care facilities, new health care facilities,	CON Thresholds	Health Care Oversight, Division of Licensing and Certification, Department of Health and Human Services	Maine Department of Health and Human Services Rules	Commissioner of the Department of Health and Human Services makes the determination of need	Maine Revised Statutes Title 22, Chapter 103-A

		• Independent radiological service centers • Independent cardiac catheterization or center cancer treatment centers • Operating rooms, recovery rooms, waiting areas, any space with major medical equipment, and supporting spaces in an ambulatory surgical facility that also functions as the office of a health care practitioner	and new nursing facilities • Offering or development of a new health service • Establishment of a new facility • Increasing the existing licensed bed complement or the licensed bed category by more than 10% (exempts nursing facilities) • Addition or new nursing facility beds to the state inventory of such beds • Use of major medical equipment to serve inpatients of a hospital, if the equipment is not located in a health care facility and was acquired without a CON • Addition of a health service not previously subject to review at the time it was established, with operating costs in its 3rd year exceeding the expenditure threshold					

MD	Yes, see MD. Health Code §19-120	• Hospitals • Limited service hospitals • Related institutions (overnight domiciliary, personal, or nursing care) • Ambulatory surgical facilities • Rehabilitation facilities • Home health agencies • Hospices • Freestanding medical facilities *Exemptions listed	• New health care facility (including hospitals) • Relocation of a facility • Change in bed capacity • Change in type or scope of services • Capital expenditure exceeding threshold *Exemptions listed	Hospitals - $50 million or 25% of annual gross regulated charges	Maryland Health Care Commission (MHCC)	Code of Maryland Regulations 10.24.01	Fifteen members appointed by the governor with input from state senate	MHCC Overview of CON Program
MA	Yes, see Massachusetts General Laws Title XVI, Chapter 111, Section 25C (Determination of Need)	• Hospitals or clinics • Long-term care facilities • Convalescent or nursing homes • Rest homes or charitable homes for the aged • Clinical laboratories • Public medical institutions (includes institutions for people with mental illness or intellectual disabilities) • Government-licensed facilities that require a notice of determination of	• Substantial capital expenditure for construction of a health care facility or substantial change in services offered by a facility • Acquisition of a unit of medical, diagnostic, or therapeutic equipment for more than $250,000 • Acquisition of an existing health care facility leading to significant changes in services offered or bed capacity	CON Thresholds	Department of Public Health	105 Code of Massachusetts Regulations (CMR) 100	Public Health Council (14 members) with 12 members appointed by the governor and two nonprovider members appointed by the secretary of Elder Affairs and the secretary of Veteran Affairs	105 Code of Massachusetts Regulation (CMR) 100

		need (DON) as a condition of licensure	• Issuance of an original license to establish or maintain listed facilities • Transfer of ownership of a health care facility's license • Transfer of site of a health care facility, DON-required service, or DON-required equipment resulting in a substantial capital expenditure or substantial change in service • Change to the designated location of an original license *Exemptions listed					
MI	Yes, see Public Health Code Act 368 of 1978 § 333.22201	• Hospital • Psychiatric hospital or unit • Nursing home or hospital long-term care unit • Freestanding surgical outpatient facility • Health maintenance organization (only for limited projects)	• Acquisition of an existing health facility • Beginning operation of a health facility at a site that is not currently licensed for that type of health facility • Change in the bed capacity of a health facility • Initiation, replacement, or	CON Thresholds	Certificate of Need Commission, Department of Health and Human Services	Department of Health and Human Services Administrative Rules Section 325.9101 - 325.9553	Eleven members appointed by the governor with the advice and consent of the senate	Department of Health and Human Services Certificate of Need Review Standards

			• expansion of a covered clinical service • Covered capital expenditure • Relocation of licensed beds from a hospital (if not otherwise exempted) • Relocation or replacement of an existing health facility *Exemptions listed					
MN	Yes, but limited; referred to as Public Interest Review See Minnesota Statutes 144.552	• Hospitals • Organizations seeking to obtain a hospital license *Moratorium for several health facilities and a public interest review process for facilities seeking an exemption from the moratorium	• Increase in number of licensed hospital beds • New hospital license	N/A	Department of Health	Public interest review guidance for hospitals	Public interest review is conducted by the Department of Health	Minnesota Statutes 144.552
MS	Yes, see Mississippi Code Ann. § 41-7-171	• Hospitals • Psychiatric hospitals • Chemical dependency hospitals • Skilled nursing facilities • End-stage renal disease facilities, including	• Construction, development or other establishment of a new health care facility, including reopening a facility that has been closed for 60 months or more • Relocation of a health care facility	CON Thresholds	Office of Health Policy and Planning, Mississippi Department of Health State Health Planning and Development Agency	No additional guidance or agency rules are available online.	Department of Health conducts analysis, State Health Officer makes the final decision.	Review Criteria found in the CON Manual (Ch. 8) Need criteria and Standards found in State Health Plan

		freestanding hemodialysis units • Intermediate care facilities • Ambulatory surgical facilities • Intermediate care facilities for the intellectually disabled • Home health agencies • Psychiatric residential treatment facilities • Pediatric skilled nursing facilities • Long-term care hospitals • Comprehensive medical rehabilitation facilities, including facilities owned or operated by the state or a political subdivision *Exemptions listed	or portion of, or of major medical equipment • Change in bed complement • Offering new services (including open heart surgery, cardiac catheterization, inpatient rehabilitation, psychiatric services, chemical dependency services, radiation therapy, diagnostic imaging, nursing home care, home health services, swing-bed services, ambulatory surgical services, MRI, long-term care hospital, PET) • Relocation of health services • Acquisition of major medical equipment • Change of ownership of existing healthcare facilities, major medical equipment, or a health service Capital expenditure that exceeding threshold Contracting of a					

			health care facility to establish a home office, subunit, or branch office in the space through an arrangement with an existing health care facility *Moratoria listed					
MO	Yes, see Missouri Revised Statutes Title XII, 197.300 - 197.366	• Hospitals • Residential care facilities • Assisted living facilities • Intermediate care facilities • Skilled nursing facilities • Long-term care (LTC) beds in a hospital • LTC hospitals *Exemptions listed	• Development of a new health care facility • Acquisition, including by lease, of any health care facility or major medical equipment exceeding expenditure threshold • Capital expenditures by or on behalf of a health care facility exceeding expenditure threshold • Predevelopment activities costing more than $150,000 • Change in the licensed bed capacity of a health care facility by more than 10 beds or more than 10% of total bed capacity, whichever is less,	Beds in existing or proposed health care facilities and long-term care beds in a hospital - $600,000 for expenditures, $400,000 for major medical equipment Other health care facilities, new institutional health services, or beds- $1 million for expenditures or for major medical equipment	Missouri Health Facilities Review Committee, Department of Health and Senior Services	Rules of Department of Health and Senior Services Division 60, Chapter 50 19 CSR 60-50.010 to 19 CSR 60-50.900	Nine members - Missouri Health Facilities Review Commission Two appointed by the president of senate, two appointed by the speaker of house, five appointed by the governor	Missouri Certificate of Need Law (197.300)

			over a two-year period • New health service (excluding home health services) • Reallocation by an existing facility of licensed beds among major types of services or reallocation of licensed beds from one facility to another by more than 10 beds or more than 10% of the total licensed bed capacity, whichever is less, over a two-year period					
MT	Yes, see Montana Code Annotated 50-5-301-310	• Long-term care facilities	• Changes in bed capacity through an increase in number or relocation • Addition of health services with annual operating expenses of $150,000 or more • Capital expenditure to acquire 50% or more of an existing facility • Construction, development, or establishment of a facility	Annual Operating Expenses of Health services - $150,000 or more	Licensure Bureau of the Office of Inspector General, Montana Department of Public Health and Human Services	Administrative Rules of Montana 37.106.101-140	Department conducts review	Montana Annotated Code 50-5-304

			• Use of more than 5 hospital beds to provide skilled nursing care, intermediate nursing care, or intermediate developmental disability care (swing beds) • Provision of long-term care by hospitals *Exemptions listed					
NE	Yes, but limited; See Nebraska Health Care Certificate of Need Act §71-5801 - 71-5870	• Skilled nursing facilities • Intermediate care facilities • Nursing facilities • Long-term care hospitals • Rehabilitation beds	• Establishment of long-term care beds or rehabilitation beds • Increase in long-term care beds* • Increase in rehabilitation beds* • Conversion of any type of hospital beds to long-term care beds* • Conversion of any type of hospital beds to rehabilitation beds* • Relocation of rehabilitation beds *By more than 10 beds or 10% of total bed capacity, whichever is	N/A	Licensure Unit, Division of Public Health, Department of Health and Human Services	No additional guidance or agency rules are available online	Department of Health and Human Services conducts review	Nebraska Health Care Certificate of Need Act §71-5801 - 71-5870

			less, over a two-year period					
NV	Yes, but limited; Approval of Director See Nevada Revised Statutes 439A.100	• New health care facilities in rural areas (counties with population below 100,000)	• New construction of health care facilities in rural areas with expenditures exceeding $2 million (includes increases in square footage of an existing facility or the redesign or renovation of an existing building not currently used as a health facility)	$2 million	Office of Health Planning and Primary Care, Division of Public and Behavioral Health, Department of Health and Human Services	Adopted Regulations for the Certificate of Need LCB File No R022-20	Staff in the Health Planning and Primary Care Office conduct the CON review process and make a recommendation to the Director of the Department of Health and Human Services The director has the responsibility for final approval	Nevada Revised Statutes 439A.100
NH	No							
NJ	Yes, See NJ Rev Stat § 26:2H-5.8 AND NJ Rev Stat § 26:2H-7	• General hospitals • Special hospitals • Mental hospitals • Public health centers • Diagnostic centers • Treatment centers • Rehabilitation centers • Extended care facilities • Skilled nursing homes • Intermediate care facilities • Assisted living residences • Comprehensive personal care facilities	• Initiating new health care services • Modification, replacement or expansion of any health care service or facility • Reopening of beds, facilities or services in a health care facility which has closed or substantially ceased operation of any of its beds, facilities or services • Transfer of ownership of a general hospital	Major medical equipment $2 million or more Capital expenditures exceeding $2 million	Certificate of Need and Licensure Division, New Jersey Department of Health/Health Facilities	New Jersey Administrative Code (NJAC) 8:33	State Health Planning Board (13 members) - Commissioners of HHS, Children and Families and Human Services as ex officio nonvoting members; the chairpeople of the Health Care Administration Board and the Public Health Council as ex officio voting members; and nine public members (five consumers, four providers) who are	New Jersey Administrative Code (NJAC) 8:33

		• Tuberculosis hospitals • Chronic disease hospitals • Maternity hospitals • Outpatient clinics • Dispensaries • Home health care agencies • Residential health care facilities • Bioanalytical laboratories • Central services facilities	• Transfer of ownership that will result in a new Medicare provider number for the hospitals involved • Increase or conversion of licensed beds by licensure and/or health planning category • For services with a specific licensed bed complement, relocation of a portion of a facility's licensed beds or the entire service from one licensed facility to another facility located in the same planning region • Establishment of a new health care facility • Relocation of an entire licensed facility that is subject to the certificate of need requirement to a location in the same planning region • Closure of a general hospital • Discontinuance of a component service of a health care				appointed by the governor with the advice and consent of the state senate The Department of Health presents its recommendation on each Certificate of Need to the State Health Planning Board, which acts as an advisory panel to the Commissioner of Health concerning recommendations on certificate of need applications The Commissioner of Health makes the final decision to approve or disapprove applications and receives recommendations from both Department of Health staff and the State Health Planning Board for applications under full review; the Department of Health can recommend	

			facility or satellite emergency department (if required by the Department) • Initiation of full service or low risk invasive adult cardiac diagnostic services • Purchase of major moveable equipment (cardiac catheterization equipment) exceeding $2 million • Capital expenditure exceeding $2 million				applications under expedited review	
NM	No							
NY	Yes, see Public Health Law § 2802	• Hospitals • Nursing Homes • Diagnostic and Treatment Centers • Midwifery Birth Centers • Ambulatory Surgery Centers • Certified Home Health Agencies • Long Term Home Health Care Programs • Hospices • Adult Care Facilities (the CON process for ACFs is different from	• Establishing and/or constructing new facilities, agencies, programs, or hospices • Renovating existing facilities, agencies, programs, or hospices • Acquiring major medical equipment • Adding or deleting services • Changing ownership of facilities, agencies, programs, or hospices	CON Thresholds	New York State Department of Health	No additional guidance or agency rules are available online	Public Health and Health Planning Council (25 members) - Commissioner, the chair of the Minority Health Council, two members of the Behavioral Health Services Advisory Council, four representatives from general hospitals or nursing homes; one representative	Certificate of need review criteria

		the process for other facilities) • Adult Day Health Care Programs • Certain health programs associated with the Office of Mental Health, Office of Mental Retardation & Developmental Disabilities and the Office of Alcoholism and Substance Abuse Services	• Modifying service areas for agencies or hospices *All of these activities trigger a full CON review; other actions may require an administrative or limited review process, depending on activity and facility type				from each: home care agencies, diagnostic and treatment centers, health care payers, labor organizations for health care employees, and health care consumer advocacy organizations Appointed by the governor with the advice and consent of state Senate	
NC	Yes, see North Carolina General Statutes Chapter 131E - Article 9	• Hospitals • Long-term care hospitals • Psychiatric facilities • Rehabilitation facilities • Nursing home facilities • Adult care homes • Kidney disease treatment centers, including freestanding hemodialysis units • Intermediate care facilities for individuals with intellectual disabilities • Home health agency offices	• Construction, development, or establishment of a new health service facility • Capital expenditure exceeding threshold to develop or expand a health service or health facility • Change in bed capacity (including relocation of beds or dialysis stations) • Offering of dialysis or home health services • Change in a project that was subject to certificate of need	CON Thresholds	Healthcare Planning and Certificate of Need Section, Division of Health Service Regulation, North Carolina Department of Health and Human Services	10A NCAC Chapter 14 Subchapter C	Department conducts review.	North Carolina General Statutes § 131E-183

		• Chemical dependency treatment facilities • Diagnostic centers • Hospice offices • Hospice inpatient facilities • Hospice residential care facilities • Ambulatory surgical facilities (exempted in certain counties)	requirements (if over 15% of approved expenditure) • New health services • Acquisition of major medical equipment • Purchase, lease, acquisition, or controlling interest of a health service facility or portion of, if the facility was developed under a certificate of need • Conversion of non-health service beds to health service beds • Construction development or other establishment of hospice facilities • Opening of an additional office by an existing home health agency or hospice • Relocation of a health service facility • Conversion of a specialty ambulatory surgical program to multispecialty surgical program • Furnishing of mobile medical equipment					

			• Construction, development, establishment, increase, or relocation of an operating room, gastrointestinal endoscopy room • Change in designation of an operating room to a gastrointestinal endoscopy room (or the reverse)					
ND	No							
OH	Yes, but limited See Ohio Revised Code 3702.51	• Long-term care (LTC) beds and facilities • Licensed nursing home • The portion of any facility containing a certified skilled nursing facility or a nursing facility (including a county home or county nursing home) • The portion of any hospital that contains beds registered as skilled nursing beds or long-term care beds	• Establishment, development, or construction of a new LTC facility • Replacement of an existing LTC facility • Renovation of or an addition to a LTC facility that involves a capital expenditure of $4 million or more (not including expenditures for equipment, staffing, or operational costs) • Increase in bed capacity • Relocation of beds • Any failure to conduct a reviewable activity	$4 million or more (not including equipment) on renovation or addition to a long-term care facility	Certificate of Need and Health Care Services Section, Office of Health Assurance and Licensing, Bureau of Regulatory Operations, Ohio Department of Health	Ohio Administrative Code Chapter 3701-12	Director of health conducts review	Ohio Administrative Code Chapter 3701-12-20

			in accordance with an approved certificate of need application, including a change in the site, if the failure occurs within 5 years after implementation of the activity for which the certificate was granted					
OK	Yes - but limited. Long-Term Care facilities: Okla. Stat. tit. 63 § 1-850 - 1-860: Psychiatric and chemical dependency facilities: Okla. Stat. tit. 63 § 1-880.1 - 1-881:	Long-term care facilities, including: • Nursing facilities or specialized facilities (including facilities for individuals with intellectual or developmental disabilities) • Skilled nursing care provided in a distinct part of a hospital • The nursing care component of a continuum of care facility or of a life care community	Long-term care: • Capital investment or lease of $1 million or more (including predevelopment activities) • Acquisition of ownership or operation of a facility • Increase in licensed beds through establishment of a new facility or expansion of an existing facility Psychiatric and chemical dependency treatment facilities: • Capital investment or lease of $500,000 or more	Long-Term Care Facilities- $1 million Psychiatric and chemical dependency treatment facilities- $500,000	Health Facility Systems, Oklahoma Department of Health	Certificate of Need Regulations OAC 310:4	Commissioner of health conducts reviews	See review criteria in the statutes linked for 1) long-term care facilities and 2) psychiatric and chemical dependency facilities on Oklahoma's CON webpage. (Select facility type, then "Law")

			• Acquisition of a facility • Inpatient services for children under 18 offered or provided by a hospital or other facility, including any conversion of existing beds, increase in bed capacity and new beds • Transfer of ownership or operation of a facility. *Exemptions listed					
OR	Yes, see Oregon Revised Statutes Chapter 442	• Hospitals • Skilled nursing facilities • Intermediate care services or facilities • Long-term care (LTC) facilities • Health facility developed or established by a health maintenance organization *Exemptions listed	• Offering or development of any new hospital, skilled nursing, or intermediate care services or facilities • Development or establishment of a health care facility of any new health maintenance organization • Replacement, rebuilding, or relocation of an existing hospital that involves a substantial increase or change in the	N/A	Health Care Regulation and Quality Improvement Program, Public Health Division, Oregon Health Authority	Oregon Administrative Rules Chapter 333	Public Health Division conducts review	Certificate of Need Rules and Statutes

			services offered (includes any increase in the total facility or hospital service bed capacity by more than 10 beds or more than 10% of bed capacity) • Establishment of any new health service • Initiation of inpatient skilled nursing or intermediate care services by a new facility or an existing health care facility • Increase in the skilled nursing or intermediate care bed capacity of a LTC facility by more than 10 beds or more than 10% of bed capacity, whichever is less, within two years of the most recent previous increase in beds • Rebuilding of an existing LTC facility • Relocation of an existing LTC facility building to a new site					

			• Relocation of existing LTC beds from one licensed health care facility to another • New hospital service with annual operating expenses exceeding $500,000 in the first full year of operation *Exemptions listed					
PA	No							
RI	Yes, see Rhode Island General Laws Chapter 23-15	• Hospitals • Nursing facilities • Home nursing-care providers • Home-care providers • Hospice providers • Inpatient rehabilitation centers (including drug and/or alcohol abuse treatment centers) • Freestanding emergency care facilities • Facilities providing surgical treatment to patients not requiring hospitalization (surgical-centers, multi-practice, physician ambulatory-surgery centers, and multi-	• Construction, development, or other establishment of a new health care facility • Capital expenditures by or on behalf of an existing health care facility exceeding threshold (including for services, renovation, construction, development, or new equipment) • Capital expenditures for acquisitions that increase bed capacity, redistribute beds among services, or add or terminate health services	CON Thresholds	Center for Health Systems Policy Regulation, Rhode Island Department of Health	216 Rhode Island Code of Regulations (RICR) 40-10-22	Health services council (12 members) - one health econ/policy expert, one insurance representative, one business community representative, one general public representative, three specified government representatives, the rest assorted Four appointed by the house speaker, four by the senate president, four by the governor	Rhode Island General Laws Chapter 23-15-4

		practice, podiatry ambulatory-surgery centers) • Facilities providing inpatient hospice care	• Acquisitions by or on behalf of a health care facility or HMO under lease or through donation • Capital expenditures for predevelopment activities exceeding threshold • Except for licensed nursing facilities, any capital expenditure that increases the total number of beds in a health care facility • Increase in bed capacity of a licensed nursing facility in excess of 10 beds or 10% of bed capacity, whichever is greater, and for which the related capital expenditures exceed $2 million • New health service with expenditures exceeding threshold • Any new or expanded tertiary or specialty care service					
SC	Yes, see South Carolina Code	• Nursing homes • Hospitals (excluding acute hospital care at-home programs	• Construction or establishment of a new nursing home or hospital	CON Thresholds	South Carolina Department of Health and	Department of Health and Environmental	Department conducts reviews.	Regulation 61-15 Certification of Need for

	§§ 44-7-110 - 44-7-230	and services delivered by a licensed acute care hospital) • Medical University of South Carolina (for acquisitions of new hospital facilities)	• Change in bed complement of a nursing home or hospital through the addition of beds or change in licensure classification • Capital expenditure by a nursing home exceeding threshold (if not otherwise exempted) • Capital expenditure by a nursing home to add or substantially expand health services • New health service in a nursing home • Acquisition of medical equipment with total project cost exceeding threshold *Exemptions listed		Environmental Control	Control Regulations 61-15[l]		Health Facilities and Services (Ch. 8)
SD	No							
TN	Yes, see Tennessee Code Annotated § 68-11-1607	• Hospitals • Nursing Homes Ambulatory Surgical Treatment Centers	• Construction, development, or other establishment of a healthcare institution	N/A	Administration of Certificate of Need program - Tennessee Health Services and			

[l] On July 1, 2024, the South Carolina Department of Health and Environmental Control (DHEC) became two separate agencies: the South Carolina Department of Environmental Services (SCDES) and South Carolina Department of Public Health (DPH). The South Carolina Certificate of Need Program is now under the South Carolina Department of Public Health.

		• Intellectual Disability Institutional Habilitation Facilities • Home Care Organizations (including home health and hospice) • Outpatient Diagnostic Centers • Rehabilitation Facilities • Residential Hospices • Nonresidential Substitution-based Treatment Centers for Opiate Addiction	• Change in the bed complement that increases nursing home beds, redistributes beds from any category to acute, rehabilitation, or long-term care, or relocates beds to another facility or site • Initiation of services including: burn unit, neonatal intensive care unit, open heart surgery, organ transplantation, cardiac catheterization, linear accelerator, home health, hospice, or opiate addiction treatment provided through a nonresidential substitution-based treatment center for opiate addiction • Change in the location of existing or certified facilities		Development Agency[li] Development of Certificate of Need criteria and standards - Tennessee Department of Health | Division of Health Planning, Health Services Development Agency[lii]			

[li] As of 2021, Tennessee established the Health Facilities Commission, which combined the Health Services Development Agency, which administers the Certificate of Need Program, and the Board of Licensing Health Care Facilities.

[lii] As of 2021, Tennessee established the Health Facilities Commission, which combined the Health Services Development Agency, which administers the Certificate of Need Program, and the Board of Licensing Health Care Facilities.

			and healthcare institutions • Initiation of MRI or services or increasing the number of MRI machines • Initiation of PET scanners in a county with a population of 175,000 or less • Establishment of a satellite emergency department facility *Exemptions listed					
TX	No							
UT	No							
VT	Yes, see Vermont Statutes Annotated 18 V.S.A. § 9434	• Hospitals • General hospitals • Mental hospitals • Chronic disease facilities • Birthing centers • Maternity hospitals • Psychiatric facilities • Nursing homes • Health maintenance organizations • Home health agencies • Outpatient diagnostic or therapy programs • Kidney disease treatment centers • Mental health agencies or centers	• Construction, development, purchase, renovation or other establishment of a health care facility with costs exceeding $1.8 million for a non-hospital facility and $3.6 million for a hospital (includes any capital expenditure for a hospital) • Change in number of licensed beds through addition, conversion or relocation	CON Thresholds	Green Mountain Care Board	Green Mountain Care Board (GMCB) Rule 4.000: Certificate of Need	Five state employees (one chair and four members) Members are nominated by a committee (composed of two gubernatorial appointments, two state senators, two House members, one Senate President appointment, and one House Speaker appointment) and	Vermont Statutes Annotated 18 V.S.A. § 9437

		• Diagnostic imaging facilities • Independent diagnostic laboratories • Cardiac catheterization laboratories • Radiation therapy facilities • Any inpatient or ambulatory surgical, diagnostic, or treatment center	• Offering of any home health service or the transfer or conveyance of more than a 50% ownership interest in a health care facility other than a hospital or nursing home • Purchase or lease of diagnostic or therapeutic equipment with costs exceeding $1.2 million for a non-hospital and $1.8 million for a hospital • Offering a health care service or technology with annual operating expense exceeding $600,000 for a non-hospital and $1.2 million for a hospital • Construction, development, purchase, lease, or other establishment of an ambulatory surgical center *Increase in monetary thresholds has been drafted				appointed by the governor	

VA	Yes, see Code of Virginia Title 32.1-102.1	• Any facility licensed as a hospital • Any hospital licensed as a provider • Any facility licensed as a nursing home • Intermediate care facilities established primarily for the medical, psychiatric, or psychological treatment and rehabilitation of individuals with substance use disorder • Intermediate care facilities for individuals with intellectual disabilities (except those in areas of need and with up to 12 beds) • Specialized centers or clinics or that portion of a physician's office developed for the provision of certain specialty services	• Establishment of a medical care facility • Increase in beds or operating rooms • Relocation of beds • Addition of new nursing home services • New diagnostic, therapeutic, and surgical services • Conversion of beds to medical rehabilitation or psychiatric beds • Addition of any new medical equipment for the provision of certain specialty services • Capital expenditure of $15 million or more for a facility other than a general hospital • Conversion of psychiatric inpatient beds to nonpsychiatric inpatient beds	CON Thresholds	Office of Licensure and Certification, Division of Certificate of Public Need, Virginia Department of Health	Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations	Review process conducted by the Virginia Department of Health State health commissioner is the sole decision authority	Virginia Department of Health - Criteria for Determining Need
WA	Yes, see Washington Rev. Code §70.38	• Hospices • Hospice care centers • Hospitals and psychiatric hospitals • Nursing homes • Kidney disease treatment centers	• Construction, development, or establishment of a new health care facility, including hospitals constructed, developed, or	CON Threshold for Nursing Homes	Department of Health, Certificate of Need	Chapter 246-310 Washington State Administrative Code	Review process is conducted by the Department of Health	Washington State Administrative Code (WAC) 246-310-200

		• Ambulatory surgical facilities • Home health agencies • Medicare or Medicaid home health agencies • Medicare or Medicaid hospice agencies *Exemptions listed	established by a health maintenance organization • Sale, purchase, or lease of part or all of an existing hospital, regardless of profit/nonprofit status and including hospitals sold, purchased, or leased by a health maintenance organization • Capital expenditure for the construction, renovation, or alteration of a nursing home that changes services or exceeds the expenditure threshold (includes predevelopment expenditures) • Change in bed capacity of a health care facility (or rural facility) that increases the number of beds or redistributes beds among acute care, nursing home care, and assisted living facility care for over 6 months • New tertiary health services offered in a					

			health care facility or rural facility • Increases in the number of dialysis stations in a kidney disease center • Increases in the number of licensed beds at a hospital, nursing home or hospice care center DOH may grant exemptions until June 30, 2028, for: • Adding new psychiatric beds to a hospital • Changing the use of beds within a hospital to increase the number of psychiatric beds; or • Constructing, developing, or establishing a new psychiatric hospital					
WV	Yes, see West Virginia Code §16-2D	• Health care facilities, meaning: public or private facilities, agencies, or entities that offer or provide health services, whether for-profit or nonprofit and whether licensed, or required to be	• Construction, development, acquisition, or other establishment of a health care facility • Partial or total closure of a health care facility with capital expenditure • Activities exceeding capital expenditure	CON Threshold	West Virginia Health Care Authority	Health Care Authority Legislative Rules on Certificate of Need: W.Va. C.S.R. § 65-29-1, § 65-32-1, § 65-13-1	West Virginia Health Care Authority: five-member board No more than three of the same party One health economist, one human	West Virginia Code §16-2D-12

		licensed, in whole or in part *Exemptions listed	threshold including acquisition of a facility, contract for the construction, acquisition, lease, or financing of a capital asset, construction projects, and donated property • Substantial change to bed capacity or health services with or without capital expenditure • Addition of ventilator services by a hospital • Elimination of services with capital expenditure • Acquisition of major medical equipment • Substantial change in an approved health service • Service area expansion for hospice or home health agency • Addition of new services • Various health services regardless of minimum expenditure				services/business administrator, one health care administrator, one provider, one consumer All appointments are made by the governor with the advice and consent of the senate	
WI	No							
WY	No							

* On NASHP website: “At the time of publication, Alabama, Georgia, North Carolina, and South Carolina were still in the review process.


Washington State Department of
HEALTH

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