

**MODERNIZING CERTIFICATE OF NEED
LAWS TO MATCH THE POST-
AFFORDABLE CARE ACT LANDSCAPE:
USING MISSISSIPPI AS A CASE STUDY
FOR REFORM IN HEALTHCARE COSTS
AND ACCESS TO RURAL CARE**

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INTRODUCTION

“[I]t’s hard to find a list where Mississippi doesn’t rank last”¹ So begins an article about the implementation of the Affordable Care Act (“ACA”) in Mississippi. The hyperbolic statement does not miss the mark by much concerning healthcare coverage in the state. As of 2017, Mississippi ranked 49th in access to and affordability of healthcare.² Mississippi’s lack of coverage is exacerbated by executive and legislative refusal to expand

¹ Sarah Varney, *Mississippi Burned: How the Poorest, Sickest State Got Left Behind by Obamacare*, POLITICO MAGAZINE, Nov./Dec. 2014, <https://www.politico.com/magazine/story/2014/10/mississippi-burned-obamacare-112181> [<https://perma.cc/CF5K-WHSK>].

² Susan L. Hayes et al., *A Long Way in a Short Time: States’ Progress on Health Care Coverage and Access, 2013–2015*, THE COMMONWEALTH FUND (Dec. 21, 2016), https://www.commonwealthfund.org/publications/issue-briefs/2016/dec/long-way-short-time-states-progress-health-care-coverage-and?redirect_source=/publications/issue-briefs/2016/dec/state-progress-coverage-and-access [<https://perma.cc/Y9LD-WFFJ>].

Medicaid coverage under the ACA.³ Mississippi has always been slow to change, and the state's approach to certificate of need ("CON") laws in light of the ACA is no exception. The state developed its CON program in response to the Health Care Planning and Resources Development Act of 1974. The program has remained largely the same for the past fifty years. While the probability of Medicaid expansion is low in the near future, the Mississippi legislature has the opportunity to increase access to and affordability of healthcare for its citizens by modernizing its CON program.

For example, healthcare providers in Mississippi are still required to file CON applications with the state office in Jackson, Mississippi; the types of providers regulated by the CON program remain mostly the same year after year without regard to market changes caused by an increased insured patient base under the ACA; distrust in the CON program runs rampant in light of rumors of a politicized review process⁴; and rural citizens do not see an increase in access to healthcare providers as promised by the CON program.

Using modernization techniques from other states' CON programs, while recognizing that Mississippi has a different reality than these states, will allow the Mississippi legislature to maintain regulation over healthcare providers through the CON program while also adjusting to the increased healthcare market created by the ACA. While focused on Mississippi as a case study, the modernization techniques expressed in this Article are applicable in additional states that have not expanded Medicaid, have large rural populations, or have not modernized their CON programs after the passage of the ACA. The modernization techniques proposed can be used in singularity or in combination to combat the rising healthcare costs and the lack of rural care in any state. This Article also provides examples of healthcare

³ Mary Caffrey, *Mississippi Doctors Want Medicaid Expansion, but Don't Call It That*, AM. J. OF MANAGED CARE: IN FOCUS BLOG (Aug. 13, 2016), <https://www.ajmc.com/focus-of-the-week/mississippi-doctors-want-medicaid-expansion-but-dont-call-it-that> [https://perma.cc/T2PM-ZHQJ].

⁴ See generally Anna Wolfe, *Health care expansion regulation pro or 'con' for Mississippi?*, THE CLARION-LEDGER (Jackson, Miss.) (Sept. 9, 2017), <https://www.clarionledger.com/story/news/politics/2017/09/09/health-care-expansion-regulations-pro-con-mississippi/645899001/> [https://perma.cc/CED8-PUJ3].

reform that would benefit rural care and minimize healthcare costs even if the state chose either to maintain its current CON program without any modernizations or to repeal its CON program.

The research conducted for this Article shows the time is ripe for reform of CON laws. While proponents and opponents of the CON process disagree on the way to approach reform, sometimes in antagonism to the highest degree, the continued discussion among policymakers exemplifies that reform is needed in some shape for CON programs to match the needs of United States citizens in the changing healthcare landscape after the ACA.

A. Summary of Argument

Certificate of need programs were created to lower healthcare costs and to increase access to healthcare for rural citizens. However, research shows that CON laws at best have no effect on the costs of healthcare services for patients and at worst increase costs.⁵ Further, research shows that CON laws have an adverse impact on non-hospital providers' ability to deliver MRI, CT, and PET scans to their patients.⁶ For these reasons, state CON laws in their original form are inconsistent with the federal policies for which they were created. The likelihood of repeal, however, remains low. Recognizing the unlikelihood of repeal in the near future, Mississippi and other states with similar makeups should take steps to modernize CON programs.

While the U.S. Department of Justice stated there is "no economic justification"⁷ for CON programs, states have exemplified policy justifications for maintaining and modernizing CON programs. From the CON process's formation at the federal

⁵ DANIEL SHERMAN, FED. TRADE COMM'N, *THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS*, at 17 (1988).

⁶ Thomas Stratmann & Matthew C. Baker, *Are Certificate-of-Need Laws Barriers to Entry?: How They Affect Access to MRI, CT, and PET Scans* 19 (Mercatus Ctr., Geo. Mason U., Working Paper, 2016), <https://www.mercatus.org/system/files/Stratmann-CON-Barriers-to-Entry.pdf> [<https://perma.cc/4LAT-QWT5>].

⁷ *Competition in Healthcare and Certificates of Need, Statement of the Antitrust Division, U.S. Department of Justice Before the Florida Senate Committee on Health and Human Services Appropriations* 2 (Fla. 2008) (statement of Joseph M. Miller, Litigation Section Assistant Chief, U.S. Dep't. of Justice), <https://www.justice.gov/sites/default/files/atr/legacy/2008/06/09/233821.pdf> [<https://perma.cc/99M4-PJ4D>].

level, states used CON programs as “reactive” laws, adapting to fit the changing healthcare landscape of the United States.⁸ Congress forever altered the structure of healthcare in the United States with the passage of the ACA. The United States government responded to a similar change in the healthcare market following an influx of new patients after World War II and ensured the construction of hospitals in areas where they were needed the most with the Hill-Burton Act. Similarly, states should respond to the changing reality of healthcare in light of the ACA using the “reactive” nature of CON programs to make the policy goals of the CON programs a reality.

This Article will discuss modernization techniques applicable to Mississippi’s current CON program as a case study for other states who similarly have not expanded Medicaid, have large rural populations, or have not modernized their CON programs after the passage of the ACA. Before addressing these modernization techniques, Section One of this Article will discuss: (1) the history of CON programs at the state and national level, including the federal policies that laid the foundation for their creation; (2) current data on the effectiveness of CON laws to decrease costs associated with healthcare and to increase access to healthcare in rural communities; (3) information on states that currently maintain CON programs; and (4) the ACA’s implications on the healthcare industry as a whole as well as the implications of the ACA’s value-based payment systems on the policy justifications given for the retention of CON laws. Section Two will discuss Mississippi’s current CON program, from the application process to political concerns associated with reform versus repeal. Section Three will dive into examples from eight states with successful modernization measures taken to update the CON application process in light of the ACA.

Section Four will lay out potential modernizations to Mississippi’s CON program from the most radical to the easiest to implement, starting with (1) a single-payer healthcare system within the state⁹; (2) the removal of MRI and PET scanners from

⁸ James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3, 20.

⁹ See generally Ari Shapiro, *All Things Considered: Why Bernie Sanders’ Single-Payer Health Care Plan Failed in Vermont*, NPR (Sept. 13, 2017, 4:31 PM),

CON review; (3) the formation of greater objectivity and transparency in the drafting of CON laws and the oversight of CON applications by creating a review committee comprised of an appointed commission of “representatives of hospitals, physicians, other health care providers, employers and labor”¹⁰; (4) an expedited review process for programs shown to have greater need in the geographic area¹¹; (5) an expanded overview of the implementation of the charity and/or rural care promised in CON applications, including a requirement for providers to track and report their levels of charity care to the review committee¹²; and (6) an adaptation from a written application system to an electronic filing system.¹³ Section Five will address how a more direct payment structure could provide greater access to rural care in Mississippi than the CON’s indirect formula. These more direct program structures include: (1) implementing a single-payer system; (2) expanding Medicaid; (3) directing more funding to the implementation of telehealth; (4) utilizing uncompensated care pools; and (5) setting up an all-payer rate-setting program.

While some of the proposed modernizations might seem far-reaching for a state slow to change in other areas, CON programs are suitable for review in the current climate of the healthcare industry following the implementation of the ACA.¹⁴ Further,

<https://www.npr.org/2017/09/13/550757713/why-bernie-sanders-single-payer-health-care-plan-failed-in-vermont> [<https://perma.cc/Y593-33NU>].

¹⁰ Tracy Yee et al., *Health Care Certificate-of-Need (CON) Laws: Policy or Politics?*, NAT’L INST. FOR HEALTH CARE REFORM (May 2011), <https://nihcr.org/analysis/improving-care-delivery/prevention-improving-health/con-laws/> [<https://perma.cc/L58T-ANMA>].

¹¹ See Emily Whelan Parento, *Certificate of Need in the Post-Affordable Care Act Era*, 105 KY. L.J. 201, 250-51 (2017).

¹² See generally Yee et al., *supra* note 10 (This section will use recommendations from South Carolina and Georgia.).

¹³ See generally *Submit a CON Application*, MICH. DEP’T OF HEALTH & HUM. SERV’S., https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5106-120981--,00.html [<https://perma.cc/9LFA-GP94>] (last visited Jan. 5, 2020); *New York State Electronic Certificate of Need*, N.Y. ST. DEP’T OF HEALTH, <https://www.health.ny.gov/facilities/cons/nysecon/> [<https://perma.cc/Y8DJ-YCK7>] (last visited Jan. 5, 2020).

¹⁴ See Wolfe, *supra* note 4 (“If it looks like a number of states are reevaluating their CON laws right now, that’s because they feel their hands are tied on doing much else, such as making major adjustments to coverage mandates or other insurance regulations,” said Jameson Taylor, Mississippi Center for Public Policy vice president for policy.”).

states with similar apprehensions toward altogether repeal of CON laws have successfully modernized their CON programs with positive feedback from both sides of the political aisle. The avenues proposed to increase access to rural care in Mississippi and similar states with large rural populations are also applicable regardless of the state's final decision to modernize, maintain, or repeal its current CON program.

B. History of CON Programs

“Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.”¹⁵ While the same message echoed throughout President Barack Obama's speech to Congress in support of the Affordable Care Act in 2009,¹⁶ Harry S. Truman delivered the former statement to Congress in 1946 while advocating for federal loans to construct hospitals in response to the changing landscape of a demilitarized population after World War II's end.¹⁷

Congress passed Truman's initiative and named it the “Hill-Burton Act.” Following World War II, portions of the United States experienced an influx of new patients. The Hill-Burton Act enabled healthcare providers to build in communities with faster-growing populations. If the provider could prove “viability – based on . . . [the community] population and per capita income,” then the Act gave the hospital the funds it needed for construction through federal grants and loans.¹⁸ The Act was quantitatively

¹⁵ Harry S. Truman, *Special Message to the Congress Recommending a Comprehensive Health Program*, HARRY S. TRUMAN PRESIDENTIAL LIBR. & MUSEUM (Nov. 19, 1945), <https://www.trumanlibrary.org/publicpapers/index.php?pid=483&st=&st1> [<https://perma.cc/V52K-6LLD>].

¹⁶ See generally Barack Obama, Speech to Congress (Sept. 9, 2009), in *Obama's Health Care Speech to Congress*, N.Y. TIMES (Sept. 9, 2009), <https://www.nytimes.com/2009/09/10/us/politics/10obama.text.html> [<https://perma.cc/5W7B-BY89>].

¹⁷ John Henning Schumann, *A Bygone Era: When Bipartisanship Led To Health Care Transformation*, NPR (Oct. 2, 2016, 6:00 AM), <https://www.npr.org/sections/health-shots/2016/10/02/49577518/a-bygone-era-when-bipartisanship-led-to-health-care-transformation> [<https://perma.cc/WG9H-HWB2>].

¹⁸ *Id.*

successful, boasting the addition of 6,800 healthcare facilities, ranging in practice from hospitals to rehabilitation centers, by 1975.¹⁹

The Hill-Burton Act also provided a starting point for similar federal programs that would offer funds to hospitals that agreed to provide “free or subsidized care to a portion of their indigent patients,” including healthcare for uninsured citizens in the surrounding area.²⁰ Further, the Hill-Burton Act exemplified how the federal government could use federal funds to promote its policy objectives of increasing access to rural care at the state level.²¹

The healthcare market exacerbated the need for free or subsidized care beginning in the 1960s. Starting in 1966, healthcare spending in the United States increased at the national level by “an average rate of 13.0 percent per year,” or approximately 6.5 percent per year once adjusted for inflation.²² Reports of providers performing unnecessary and costly procedures and of uneven distribution of providers also increased.²³ Congress reported that “neither ... public nor private” healthcare providers had adequately responded to the increased costs or the uneven distribution.²⁴ The federal government first attempted to stifle increasing healthcare costs and unnecessary procedures by amending Section 1122 of the Social Security Act of 1972. The amendment aimed to control costs following the introduction of Medicare and Medicaid by withholding federal funds from healthcare providers who were either (1) “not approved

¹⁹ *Id.*

²⁰ *Id.*

²¹ Kenneth R. Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 B.C. L. REV. 577, 578 (1982).

²² Aaron C. Catlin & Cathy A. Cowan, *History of Health Spending in the United States, 1960-2013*, CTRS. FOR MEDICARE AND MEDICAID SERVS., at 8 (Nov. 19, 2015), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHEPaper.pdf> [https://perma.cc/A85E-S9EC]; see also National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, § 2 (a)(4), 88 Stat. 2225, 2226 (1975).

²³ National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, § 2 (a)(3)(A)-(C), 88 Stat. 2225, 2226 (1975).

²⁴ Elmer B. Staats, U.S. GEN. ACCT. OFF., *Status of the Implementation of the National Health Planning and Resources Development Act of 1974*, at 3 (Nov. 2, 1978), <https://www.gao.gov/assets/130/124716.pdf> [https://perma.cc/8PKC-HREN].

by a state health planning agency” or (2) were providing services the federal government considered unwarranted.²⁵

This action alone, however, was not enough to decrease costs and unnecessary procedures. Congress then used the ideas developed in the Hill-Burton Act as a launching pad for the National Health Planning and Resources Development Act (“NHPRDA”) of 1974.²⁶ The NHPRDA aimed to (1) restrain costs for patients and (2) expand access to healthcare in rural communities.²⁷ The Act required medical providers that wanted to construct a new hospital, expand an existing hospital, spend more than \$150,000, add ten beds to an existing facility or change the beds by ten percent, whichever was less, within a two year period, or move beds to another portion of the healthcare facility, to file a request with the state.²⁸ In the request, the healthcare provider was required to show there was a need for the addition within the area and that the addition would not harm existing facilities.²⁹ The state would then approve or deny the provider’s request.

The federal Act created state-centered agencies to implement the program’s goals.³⁰ States were required to implement the

²⁵ W. John Thomas, *Connecticut’s Certificate of Need Statute: Time for Reevaluation*, 69 CONN. B.J. 405, 412 (1995); *History*, ALA. ST. HEALTH PLAN. & DEV. AGENCY, http://www.shpda.state.al.us/shpda/history.aspx?sm=a_d#3 [<https://perma.cc/6HBC-RNXB>] (last visited Jan. 5, 2020).

²⁶ See generally National Health Planning and Resources Development Act of 1974, Pub. L. No. 93–641, 88 Stat. 2225 (1975).

²⁷ See CHAYET & SONNENREICH, P.C., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT 1 (1978) (“The principle purpose of CON laws is to help control upward spiraling charges for health care by preventing the construction of facilities or initiation of programs which are unneeded. . . . The assumption underlying these is that whenever a health facility is constructed or modified, the costs involved in that construction or modification will be passed on to the consumer or other entities responsible for paying for the consumer’s health care, and that increased competition in the health care field does not lead to effective decreases in charges for services.”).

²⁸ *Id.* at 21-25; Blumstein & Sloan, *supra* note 8, at 22.

²⁹ National Health Planning and Resources Development Act of 1974, Pub. L. No. 93–641, 88 § 2 (a)(2), Stat. 2225, 2226 (1975) (“The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.”).

³⁰ Staats, *supra* note 24, at 4.

policies of the NHRDA or face “severe financial penalties.”³¹ The NHRDA also focused heavily on indigent care, similar to its Hill-Burton predecessor.³²

Early advocates of the CON programs also argued for their use under the rationalization that CON programs were necessary to offset the costs of treating patients who were not able to pay for services by subsidizing those costs with paying patients. The CON laws allowed this subsidy to occur by ensuring the provider did not have to worry about unnecessary competition drawing away paying patients.³³ Proponents also argued that the healthcare industry was so distinct from other regulated business areas that the ordinary levels of competitive control were not enough to keep healthcare prices from continuing to rise.³⁴ Under either argument, states enacted their own CON laws following a similar hypothesis that “whenever a health facility is constructed or modified, the costs involved in that construction or modification will be passed on to the consumer”³⁵

Even before the NHRDA’s creation at the federal level, states were already implementing similar programs to control costs and ensure access to all areas of the state. For example, New York created a program similar to current-day CON laws in 1964 called the Metcalf-McCloskey Act. The Act required providers to file with the state before beginning construction to ensure that the area needed the hospital.³⁶ Citing similar concerns as the Metcalf-McCloskey Act, the NHRDA was successful in implementation, with every state but Louisiana enacting a CON program by the end of 1982.³⁷ Despite its practical success in implementation, however, the NHRDA declined in popularity within those states in part due to the broad acceptance of Ronald Reagan’s “anti-

³¹ James B. Simpson, *State Certificate-of-Need Programs: The Current Status*, 75 AM. J. PUB. HEALTH & L. 1225, 1225 (1985), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.75.10.1225> [<https://perma.cc/7M44-E94D>].

³² See Wing, *supra* note 21, at 579 n.14 (“The National Health Planning and Resources Development Act of 1974 included two provisions that created charity care obligations virtually identical to those in the original Hill-Burton legislation.”).

³³ Parento, *supra* note 11, at 238.

³⁴ CHAYET & SONNENREICH, P.C, *supra* note 27, at 1.

³⁵ *Id.*

³⁶ Pamela C. Smith & Kelly Noe, *Is the Community Health Needs Assessment Replacing the Certificate of Need?*, J. HEALTHCARE FIN., at 3 (June/July 2014).

³⁷ Simpson, *supra* note 31, at 1225.

regulatory platform” which advocated for “using market incentives rather than regulatory controls to restrain the costs of federal health programs.”³⁸ The popularity of the federal Act also declined after reports showed the program was not controlling healthcare costs.³⁹ In response, Congress repealed the requirement for states to maintain a CON program, including the federal funding linked to the programs, in 1987.⁴⁰ However, the federal government allowed states to maintain CON programs with their state budgets.⁴¹ Twelve states chose to repeal the CON programs, three states maintained CON programs with variations, and thirty-five states continue to use CON programs today.⁴²

There are conflicting reports on the effects of early repeals of CON laws following the end of the federal Act. For example, CON advocates use California as an example of increased costs and unnecessary construction when CON laws are repealed.⁴³ Pete Stark, a U.S. Representative for the state of California, advocated to keep the CON program in his state, citing the overabundance of certain providers, like cardiovascular surgery centers, in the early years of the repeal.⁴⁴ In his example, Stark highlighted that California maintained one hundred and nineteen cardiovascular centers, with twenty-five added quickly after the state removed its CON review process.⁴⁵

C. *Research on CON Laws Effect on Cost and Access to Care*

Critics of current state-funded certificate of need programs frequently point to a lack of proof that CON laws control costs. The research cited by critics is best summed up in a report by the Federal Trade Commission (“FTC”). The FTC performed an

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ Richard Cauchi & Ashley Noble, *CON-Certificate of Need State Laws*, NAT’L CONF. ST. LEGISLATURES, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx> [<https://perma.cc/HS5T-KUBN>] (last visited Jan. 5, 2020).

⁴¹ *Id.*

⁴² *Id.*

⁴³ Laretta Higgins Wolfson, *State Regulation Of Health Facility Planning: The Economic Theory And Political Realities of Certificates of Need*, 4 DEPAUL J. HEALTH CARE L. 261, 272-73 (2001).

⁴⁴ *Id.*

⁴⁵ *Id.* at 272.

executive review of CON programs in 1988 and found that costs associated with healthcare were not lowered in states that enacted CON programs.⁴⁶ Further, the FTC found potential for higher costs in states using CON programs.⁴⁷ First, the report stated the potential delays associated with filing a CON and waiting for approval or denial could lead to decreased competition in the healthcare market and “may lessen the incentive of hospitals to reduce costs.”⁴⁸ Second, the FTC found that hospitals might simply circumvent the CON process by bypassing equipment that needed to be passed through the approval process in favor of “unregulated inputs such as nursing services and laboratory tests,” which would keep healthcare costs high for patients even in the face of regulation.⁴⁹

In addition to the FTC’s report, advocates of CON repeal reason that the ACA provided insurance to a large majority of previously uninsured citizens, reducing the need for safe-havens for healthcare providers to off-set costs on uninsured patients.⁵⁰ Critics of CON laws also argue that there is little evidence that higher levels of competition within the healthcare industry leads to a reduction in access to healthcare for indigent communities.⁵¹ CON programs in their current form also do not include “any entitlements or subsidies to assist the poor”⁵² With this, the CON programs require applicants to show indigent care will be provided but fail to provide any structure to ensure the availability of “primary care physicians in medically underserved areas”⁵³ or to provide any direct funds to increasing rural care.

⁴⁶ Sherman, *supra* note 5, at 78.

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ Parento, *supra* note 11, at 238-39.

⁵¹ Christopher Garmon, *Hospital Competition and Charity Care 2* (FTC Bureau of Econ., Working Paper No. 285, 2006), available at <http://www.ftc.gov/be/workpapers/wp285.pdf> [<https://perma.cc/5LZM-29M9>] (last visited Nov. 13, 2018).

⁵² Andreas G. Schneider & Kenneth R. Wing, *National Health Planning and Resources Development Act of 1974: Implications for the Poor*, 9 CLEARINGHOUSE REV. 683, 686 (1976).

⁵³ *Id.* Schneider and Wing further explain that the goal of the NHPRDA to increase access for the poor cannot be left to the CON regulation process alone. *Id.* (“[T]hese benefits will only be realized, if at all, to the extent that adequate funds are appropriated and obligated, and only to the extent that broad-based consumer health

Data also shows that while there might not be a significant difference between access to general healthcare services in states that maintain CON programs and states that do not use CON programs, CON laws have been shown to have an adverse impact on non-hospital providers' delivery of healthcare services like MRI, CT, and PET scans to their patients. For example, a report in 2016 showed "that non-hospital providers experience greater barriers to providing imaging services under CON laws than hospital providers do."⁵⁴

Advocates of CON programs argue that CON laws are necessary to promote healthy competition in the healthcare marketplace.⁵⁵ By mandating providers file with the state, the state is able to ensure there is no duplication of unnecessary services or a flooded healthcare market that could lead to increased costs for patients.⁵⁶ Further, proponents argue that some of the providers who are regulated under CON laws would not be regulated if CON laws did not exist. For example, some "outpatient specialty centers battling CON requirements" do not accept Medicaid and fall outside its regulation.⁵⁷ In these cases, the centers are able to treat only insured patients who have the ability to pay, sending an influx of uninsured patients to other facilities in the area that accept Medicaid. The proponents also argue that there is already an overabundance of health care providers and programs even in states with CON programs, proving CON laws are not as anti-competitive as they might seem.⁵⁸ In Mississippi, for example, the Mississippi Department of

organizations are developed at the community level to hold the new health planning bureaucracy accountable for its performance.").

⁵⁴ Stratmann & Baker, *supra* note 6, at 19.

⁵⁵ Yee et al., *supra* note 10 ("The rationale for imposing market entry controls is that regulation, grounded in community-based planning, will result in more appropriate allocation and distribution of health care resources and, thereby, help assure access to care, maintain or improve quality, and help control health care capital spending . . .") (internal quotations omitted).

⁵⁶ Am. Health Planning Ass'n, *Health Services Planning Certificate of Need Regulation Mississippi*, 11 (Oct. 2006), https://msdh.ms.gov/msdhsite/_static/resources/1845.pdf [<https://perma.cc/4JPN-2N93>].

⁵⁷ Mark Taylor, *States Scrutinizing Certificate of Need Programs*, HFMA (Feb. 18, 2017), reprinted in KENTUCKIANS FOR MORE HEALTHCARE OPTIONS (Feb. 28, 2017), <http://kyhealthnow.org/state-scrutinizing-certificate-need-programs/> [<https://perma.cc/P8EA-Q2ZD>] (last visited Jan. 5, 2020).

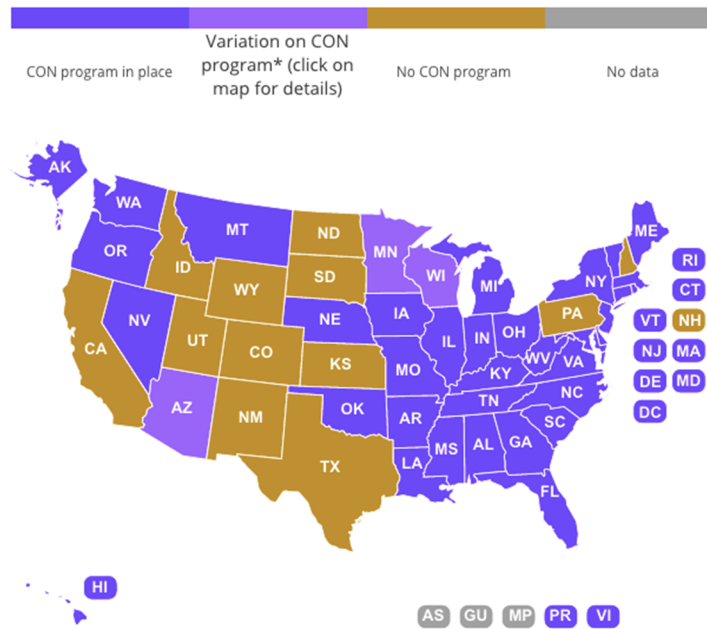
⁵⁸ *Id.*

Health only denies five percent of CON applications on average per year.⁵⁹

D. States that Currently Maintain CON Programs

While the NHPRDA was repealed at the federal level and the debate about the effectiveness of the Act continues, thirty-five states currently maintain certificate of need programs in some form. The map below shows the division as of 2019 between CON regulated states and states without CON regulation.

CERTIFICATE OF NEED STATE LAWS



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⁵⁹ Wolfe, *supra* note 4.

⁶⁰ *Interactive Map of State CON Laws*, NATIONAL CONFERENCE OF STATES LEGISLATURES, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#4> [https://perma.cc/R835-SNV5] (last visited Feb. 2019).

States that maintained CON programs after the fall of the NHPDA remain loyal to the programs. For example, in 2016, South Carolina's governor proposed either an amendment to coverage under the state's current CON program or for repeal of the state's CON program, requesting that the Federal Trade Commission ("FTC") and the Antitrust Division of the Department of Justice ("DOJ") review the state program's success in maintaining healthcare costs and in increasing access to rural care.⁶¹ After review, the FTC and the DOJ formally recommended that South Carolina repeal its CON program.⁶² The FTC and DOJ's report showed that CON laws "can prevent the efficient functioning of the health care markets[,] . . . limit consumer choice, and stifle innovation."⁶³ Despite these reports, the legislature chose to maintain the state's CON program in its entirety.⁶⁴ The FTC and DOJ followed their report in South Carolina with similar formal recommendations for Alaska, Florida, Georgia, and North Carolina to "drastically reduce or repeal their CON programs."⁶⁵ None of the states followed the instruction.⁶⁶

⁶¹ Travis G. Lloyd & Stephanie M. Hoffman, *FTC and DOJ Take Aim at State Certificate of Need Laws*, BRADLEY HEALTHCARE ALERT (Feb. 19, 2016), https://www.bradley.com/insights/publications/2016/02/ftc-and-doj-take-aim-at-state-certificate-of-nee_ [<https://perma.cc/LQZ9-SW8B>].

⁶² Fed. Trade Comm'n & U.S. Dep't of Justice, Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250, at 1 (Jan. 11, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf [<https://perma.cc/5TMB-DJE9>].

⁶³ *Id.*

⁶⁴ Katrina Helmer, *Pee Dee Hospital Officials Want Changes to Certificate of Need Law*, WMBF NEWS (July 21, 2016), <http://www.wmbfnews.com/story/32494127/grand-strand-pee-dee-hospital-officials-want-changes-to-certificate-of-need-law/> [<https://perma.cc/T8Q2-4SZB>](The bill, entitled HB 3250, passed in the state house of legislatures 103-1 but never made it to the Senate for a vote.).

⁶⁵ Lloyd & Hoffman *supra* note 61.

⁶⁶ See Lisa Schenker, *State certificate-of-need laws weather persistent attacks*, MOD. HEALTHCARE (Jan. 23, 2016), <https://www.modernhealthcare.com/article/20160123/MAGAZINE/301239964> [<https://perma.cc/3P9Y-KP6G>] ("For years, the Federal Trade Commission and the U.S. Justice Department have pressed states to abandon the laws, decrying them as bad for competition. Many states have also engaged in seemingly endless debates over the matter. But none of these efforts—whether through courts, politics of federal agencies—have led to much change.").

New Hampshire is the only state that has repealed its CON program since 1999.⁶⁷ However, even though the state disabled the CON board in its repeal, providers are still required to file requests for many projects with the state Department of Health.⁶⁸ Further, Indiana enacted a CON program as recently as July 1, 2018.⁶⁹ The law followed concerns from insurance brokers in Indiana that a recent increase in the construction of healthcare facilities could drive up healthcare costs for Indiana citizens, coupled with the state's already high healthcare costs compared to the national average.⁷⁰

The lack of movement in response to the DOJ and FTC's formal recommendations not two years ago, coupled with the fact that the vast majority of CON-regulated states have remained loyal to CON programs since the NHPRDA's creation in the 1970s, makes it unlikely that these states, including Mississippi, will chose to repeal their CON programs in the near future. However, several states modernized their CON laws in the eight years following the passage of the ACA. CON-loyal states seem more likely to implement similar modernizations. First, the modernizations do not negatively affect the practical goals of CON laws. Second, the modernizations create greater transparency between providers and the state and could increase the popularity of CON programs among providers. Third, the modernizations have been successful in other southeastern states like Kentucky, and would likely translate well into Mississippi's CON program.

E. The Affordable Care Act's Effect on Healthcare Coverage

The Affordable Care Act was enacted on March 23, 2010, under President Barack Obama's administration.⁷¹ The federal

⁶⁷ See Bob Sanders, *State pulls plug on NH Certificate of Need board*, N.H. BUS. REV. (June 15, 2016), <https://www.nhbr.com/June-24-2016/State-pulls-plug-on-NH-Certificate-of-Need-board/> [https://perma.cc/9M6G-F6Z6].

⁶⁸ *Id.*

⁶⁹ Senate Enrolled Act No. 190, Pub. L. No. 202-2018 (Ind. 2018) (codified as amended at IND. CODE ANN. § 12-8-1.5-6 (West 2018)).

⁷⁰ John Russell, *Hospital construction boom fans overbuilding fears*, INDIANAPOLIS BUS. J. (Feb. 22, 2018), <https://www.ibj.com/articles/67677-hospital-construction-boom-fans-overbuilding-fears> [https://perma.cc/DG2C-A9MX].

⁷¹ Christine L. Keller, *Affordable Care Act (ACA) Overview*, Practical Law Practice Note 7-502-3192 (West 2019).

program aimed to close gaps in insurance coverage for those who were either uninsured or underinsured.⁷² While the ACA is an expansive document, this Article will only touch on a fraction of the provisions necessary for context in the discussion of CON laws. To begin, the ACA at its core extended coverage by: (1) prohibiting insurance companies from denying service to citizens based on their preexisting conditions; (2) requiring every citizen, unless they fell into a small fraction of exempt citizens, to purchase health insurance or face a penalty;⁷³ and (3) offering a Medicaid expansion option to the states.⁷⁴ The Act also included a value-based payment system which pays hospitals based on the quality of service they provide to Medicare patients rather than the traditional fee-for-service payment program that paid hospitals based on the amount of services provided to the patient.⁷⁵ By 2017, the ACA helped almost 20 million people gain insurance.⁷⁶

Mississippi, along with sixteen other states, chose to not expand Medicaid under the ACA.⁷⁷ After *NFIB v. Sebelius* made

⁷² Steve Adams & Luke F. Delorme, *Understanding the Affordable Care Act*, AM. INST. ECON. RES. (May 8, 2014), <https://www.aier.org/research/understanding-affordable-care-act> [<https://perma.cc/4ARD-E7YY>].

⁷³ Mike Patton, *Obamacare: Seven Major Provisions and How They Affect You*, FORBES (Nov. 27, 2013), <https://www.forbes.com/sites/mikepatton/2013/11/27/how-obamacare-will-change-the-american-health-system/#75e41c54d030> [<https://perma.cc/VWL8-MJZV>].

⁷⁴ See *NFIB v. Sebelius*, 567 U.S. 519, 576, 579-80 (2012) (The ACA originally required states to expand Medicaid. The Supreme Court held the provision unconstitutional, agreeing with protesting states that the required expansion “crossed the line distinguishing encouragement from coercion.”).

⁷⁵ *What are the value-based programs?*, CTRS. FOR MEDICARE AND MEDICAID SERVS., <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html> [<https://perma.cc/JJT5-3MMT>] (The value-based program only applies to certain Medicare programs including the End-Stage Renal Disease Quality Incentive Program, Hospital Value-Based Purchasing Program, Hospital Readmission Reduction Program, Value Modifier Program, Hospital Acquired Conditions Reduction Program, Skilled Nursing Facility Value-Based Program, and Home Health Value Based Program.).

⁷⁶ See Nicholas Bakalar, *Nearly 20 Million Have Gained Health Insurance Since 2010*, N.Y. TIMES (May 22, 2017), <https://www.nytimes.com/2017/05/22/health/obamacare-health-insurance-numbers-nchs.html> [<https://perma.cc/TR3B-8QWP>].

⁷⁷ See Louise Norris, *A State-by-State Guide to Medicaid Expansion, Eligibility, Enrollment, and Benefits*, HEALTH INSURANCE.ORG, (Sept. 14, 2019), <https://www.healthinsurance.org/medicaid/> [<https://perma.cc/3K5U-RTK6>] (Seventeen states in addition to Mississippi have not fully expanded Medicaid, including: Idaho,

the expansion optional in 2012, the Mississippi Hospital Association, along with Democrats in Mississippi's House of Representatives, advocated for Medicaid expansion.⁷⁸ The Hospital Association stated the expansion would ensure payment for services hospitals provide to poorer Mississippians without insurance.⁷⁹ Governor Phil Bryant, the lieutenant governor, and Republican representatives argued against the expansion, asserting that the price of implementation would cause the state to go bankrupt if the federal government ever stopped paying its portion of the Medicaid program.⁸⁰ State hospitals and Democratic officials continue to advocate for expansion to no avail. For example, Democrats in Mississippi's House of Representatives presented a proposal to expand Medicaid in 2018.⁸¹ Proponents advocated for the expansion under an economic theory, arguing that hospitals in Mississippi were struggling to offset the costs of treating uninsured patients⁸² who cannot afford to buy insurance under the exchanges created by the ACA but are not poor enough to qualify for Medicaid. The proposal failed in the Republican-dominated House.⁸³

Utah, Wyoming, South Dakota, Nebraska, Kansas, Oklahoma, Texas, Missouri, Tennessee, Alabama, Georgia, South Carolina, Florida, and North Carolina. Maine voted to expand Medicaid, but the governor resisted implementation of the vote. Virginia's Medicaid expansion took effect in January 2019, and ballot initiatives passed in Utah, Nebraska, and Idaho calling for full expansion.).

⁷⁸ Linda Wertheimer et al., *Mississippi Reluctant to Expand Medicaid Eligibility*, NPR MORNING EDITION (July 2, 2012), <https://www.npr.org/2012/07/02/156099950/mississippi-reluctant-to-expand-medicaid-eligibility> [<https://perma.cc/KBV4-AHRH>].

⁷⁹ *Id.*

⁸⁰ *Id.* ("The state's lieutenant governor . . . warn[ed] that the expansion could cost close to \$2 billion. Other estimates put the price tag at a fraction of that amount, closer to \$400 million."); Charlie Mitchell, *Doctors' advice: It's time to opt in to Medicaid expansion*, THE SUN HERALD (Biloxi, Miss.) (Aug. 24, 2016), <https://www.sunherald.com/opinion/opn-columns-blogs/charlie-mitchell/article97484662.html> [<https://perma.cc/BY8B-X7BG>].

⁸¹ Bobby Harrison, *House rejects Medicaid expansion*, DAILY J. (Tupelo, Miss.) (Feb. 9, 2018), http://www.djournal.com/news/house-rejects-medicaid-expansion/article_5841535f-7dfd-5741-aec6-1e6a4b483dc9.html [<https://perma.cc/A4U7-CFB5>].

⁸² *Id.*

⁸³ *Id.*

I. MISSISSIPPI'S CURRENT CON PROGRAM AND THE LIKELIHOOD OF REPEAL

Mississippi enacted its CON program in 1979 under Miss. Code Ann. § 41-7-191 in response to the NHPRDA.⁸⁴ Until 1986, Mississippi maintained a separate “health planning commission” to keep up with the requirements of the NHPRDA.⁸⁵ After the Act was repealed, the Mississippi State Department of Health (“MDOH”) started reviewing CON applications.⁸⁶

To file for a CON in Mississippi,⁸⁷ one must first satisfy the general requirements of the state’s CON policies, including (1) proving the new facility will not create unnecessary resources in the area, (2) proving the facility will have a “cost containment” strategy, (3) showing the addition will “improve the health of [Mississippi] residents,” and (4) proving the new addition will increase access to health services.⁸⁸ From there, the healthcare provider must file a notice of intent to apply for a CON with the MDOH 15 days before filing its CON application. Second, the provider must file a CON application with the MDOH, including a filing fee of .5 percent of the proposed capital expenditure of the project.⁸⁹ Third, the MDOH’s Department of Health Planning and

⁸⁴ Am. Health Planning Ass’n, *supra* note 56, at 1.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Mississippi Certificate of Need (CON) Overview*, RESEARCH AND PLANNING CONSULTANTS LLP, <http://www.rpcconsulting.com/practice-areas/regulatory-services/certificate-of-need/mississippi-certificate-of-need-process-con/> [https://perma.cc/ZD85-ND6M] (last visited Jan. 5, 2020) (Mississippi currently requires CON approval of the following services: any capital expenditure over \$1,500,000 for equipment, \$2,000,000 for operation of a clinical health service, or \$5,000,000 for operation and maintenance of a non-clinical health service, construction or establishment of a new health care facility, reopening of a health care facility, relocation of a health care facility or a portion thereof, addition or conversion of beds, open heart surgery services, cardiac catheterization services, inpatient rehabilitation services, psychiatric services, chemical dependency services, radiation therapy services, invasive diagnostic imaging services, nursing home care, home health, swing beds, ambulatory surgery services, end stage renal disease facilities, MRI, PET, long-term care hospitals, acquisition of major medical equipment, change of ownership, acquisition of a medical office building, acquisition of a skilled nursing facilities, [and] freestanding emergency departments.).

⁸⁸ Am. Health Planning Ass’n, *supra* note 56, at 11.

⁸⁹ *Mississippi State Department of Health Application for a Certificate of Need*, at 1, MISS. ST. DEP’T OF HEALTH, https://msdh.ms.gov/msdhsite/_static/resources/1864.pdf [https://perma.cc/AB5B-F58S] (The filing fee cannot be less than \$500 or exceed \$25,000).

Resources must review the application for “completeness” within 15 days of receipt.⁹⁰ The application is not reviewable by the party until it is deemed complete.⁹¹ Once the application is deemed complete, a 30-day public comment period commences. The department will then issue a “staff analysis” on its initial findings, including whether they intend to approve or disapprove the application. After the staff analysis is published, an affected party has ten days to request an administrative hearing.⁹² If an administrative hearing is requested, a hearing must be scheduled within sixty days of the request.⁹³ If not, the State Health Officer must issue a final order within ninety days of receiving the application.⁹⁴ If a hearing is granted, the officer has forty-five days after the hearing ends to release the final order.⁹⁵ In either case, the final decision of the board will be announced at the next CON announcement meeting by the board.⁹⁶

While the state has held fast to the program since it was enacted in 1979, the CON program is not popular among all Mississippians. For example, during the legislative sessions from 2003-2006, “about seventy-five separate CON bills” were introduced, but “[n]early all died in committee.”⁹⁷ In fact, the debate covered in Section Two of this Article about the practicality of CON programs extends into Mississippi political discussion. In 2016, Representative Robert Foster (R) initiated HB 48 in an attempt to remove physician licensing, equipment purchases, and outpatient surgery centers from the CON review process.⁹⁸ Foster also cited concerns with the potential lack of objectivity in the review process. For example, Foster feared that the ability of large providers to step in on the process by filing letters with MDOH and request a hearing has the potential to keep smaller providers

⁹⁰ *The Certificate of Need Process*, MISS. ST. DEP’T OF HEALTH, https://msdh.ms.gov/msdhsite/_static/30,1567,84,214.html [<https://perma.cc/2SJT-GY4Z>] (last visited Jan. 5, 2020).

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Health Services Planning*, *supra* 56, at 2.

⁹⁸ Wolfe, *supra* note 4.

from coming in to the state, either from monetary concerns or from the smaller providers wishing to avoid the filing process altogether.⁹⁹

II. MODERNIZATION OF STATE LEVEL CON PROGRAMS

Other states, facing similar problems to those seen in Mississippi, recognized the need for modernization. This Section includes a compiled list of eight states who modernized their CON programs. This list is not exhaustive and does not include every state that has modernized its CON program after the ACA. Instead, this Article drew modernization techniques that can be adopted by states with similar realities to Mississippi.

A. New York

New York, the first state to enact a CON program in 1964,¹⁰⁰ has advocated for modernization of CON laws as late as 2014.¹⁰¹ For example, the New York State Department of Health (“NYSDOH”) proposal pushed for removal of some types of providers as well as a limited review process for some projects,¹⁰² similar to the limited review process followed in Kentucky.¹⁰³ The NYSDOH intended the limited review process to speed up project completion.¹⁰⁴ Under the proposal, “facility repair and maintenance projects will not require a CON review regardless of their cost.”¹⁰⁵ The proposal would also allow providers to have a limited review process for replacing existing equipment and would require that providers only notify the NYSDOH if they intend to perform maintenance on existing equipment or facilities.¹⁰⁶ In addition to the limited reviews, the providers would also be able to

⁹⁹ *Id.*

¹⁰⁰ Cauchi & Noble, *supra* note 40.

¹⁰¹ Arthur J. Fried & Lindsay Borgeson, *New York Announces Revisions to the Certificate-of-Need Process*, EPSTEIN BECKER & GREEN HEALTH CARE AND LIFE SCIENCES CLIENT ALERT (Oct. 29, 2014), https://www.ebglaw.com/news/new-york-announces-revisions-to-the-certificate-of-need-process/#_ftn1 [https://perma.cc/8XTW-PVED].

¹⁰² *Id.*

¹⁰³ *See generally* Parento, *supra* note 11.

¹⁰⁴ *See* Fried & Borgeson, *supra* note 95.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

submit their application through an electronic submissions panel on the NYSDOH's website.¹⁰⁷ The electronic filing process, in addition to speeding up the application process, was also pitched by the state as an opportunity to improve “communication and transparency” between providers and the reviewing board.¹⁰⁸

B. Kentucky

This section draws heavily on Associate Professor at the University of the Pacific McGeorge School of Law Emily Whelan Parento's research on Kentucky's modification of its CON program following the passage of the ACA.¹⁰⁹ Kentucky was the first state to modernize its CON program to fit the new quality rankings and “value-based payment programs” of the ACA.¹¹⁰ Following the ACA's enactment, Kentucky's governor called for a review of Kentucky's CON program.¹¹¹ The governor recognized that the state's healthcare market was likely to be saturated by an influx of citizens who could obtain healthcare coverage for the first time due to the implementation of the ACA.¹¹² The state employed an independent consulting firm to determine if Kentucky's current CON program could adequately meet the increased market demand.¹¹³ The consulting firm found that 640,000 previously uninsured citizens would gain insurance through the ACA in Kentucky alone.¹¹⁴ The report also tracked which healthcare providers would be most heavily affected by the increased coverage. For example, the report held that there would be a six percent increase in utilization of inpatient services and a three percent increase in utilization of outpatient services in the state by 2017.¹¹⁵

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*; *New York State Electronic Certificate of Need (NYSE-CON)*, N.Y. ST. DEP'T OF HEALTH, <https://www.health.ny.gov/facilities/cons/nysecon/> [<https://perma.cc/WT6A-H99Z>] (last visited Jan. 5, 2020).

¹⁰⁹ *See generally* Parento, *supra* note 11.

¹¹⁰ *Id.* at 208 (internal quotation marks omitted).

¹¹¹ *Id.* at 241.

¹¹² *Id.* at 243-44.

¹¹³ *Id.* at 244.

¹¹⁴ *Id.*

¹¹⁵ *Id.*

The report also showed a slow growth of ambulatory surgical centers in the state, caused in part by the state health plan's high refusal rates of applications for CONs to construct the centers.¹¹⁶ Because the data also showed that greater numbers of patients would use ambulatory surgical centers after gaining insurance through the ACA, the panel advised that the state should either remove ambulatory surgical centers from CON review altogether or lessen the application process needed to construct an ambulatory surgical center based on current market demand for those providers.¹¹⁷

The report also found the state had greater need for home health services as more patients were electing to use "community based services to support the transition of patient care from facilities to the community."¹¹⁸ The report further highlighted discrepancies between the CON application process for MRI providers.¹¹⁹ For example, if a provider in Kentucky already owned an MRI machine, the state allowed the provider to purchase additional MRI machines without filing a CON. The state required first-time purchasers of MRI machines, in contrast, to file a CON application.¹²⁰ This structure caused a disparity in the distribution of MRI machines across the state. The panel recommended that Kentucky remove MRI procurement from CON regulation altogether.¹²¹

The "revised State Health Plan" removed two of the programs, "adult day health programs and outpatient healthcare centers,"¹²² that were in high demand based on the number of newly insured Kentuckians. By "removing" these providers, the State Health Plan did not fully remove the providers from CON oversight. Instead, the new State Health Plan moved these providers that were in greater need in the area into an expedited review process.¹²³

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 244-45.

¹¹⁸ *Id.* at 244.

¹¹⁹ *Id.* at 245.

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.* at 250.

¹²³ *Id.* at 250-51.

Kentucky's legislature also directly responded to the impact of the value-based payment system implemented by the ACA by creating "new review criteria that effectively preference providers who meet objective quality metrics or participate in value-based payment programs."¹²⁴ The new criteria essentially weigh the quality standards of the provider. The previous application process required the filing provider to show there would be a certain number of new patients to open a facility in the area.¹²⁵ If the provider missed the patient number mark, then the board could not approve the application even if they met every other qualification.¹²⁶ Under the new review process, if the provider fails to show that a certain number of new patients will be available, the provider can still pass CON review if the provider follows the quality metrics proposed by the state.¹²⁷ Kentucky's approach exemplifies how a state health program can create a mutually beneficial outcome for the state and providers by using the new state health program to speed up the CON application process for providers while also boosting the state health plan's policy goal of increasing the use of value-based payment structures.

C. Report on Modernization in Six Additional States

In 2011, the National Institute for Health Care Reform conducted a six-state survey of CON programs.¹²⁸ The states included Connecticut, Georgia, Illinois, Michigan, South Carolina, and Washington. The survey concluded:

While CON regulations and their administration are by all accounts imperfect, most respondents believe that CON programs should remain in place in their state and would benefit from increased funding for evaluation, improved compliance monitoring and movement toward a process

¹²⁴ *Id.* at 251.

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ *Id.* at 251-52.

¹²⁸ *See* Yee et al., *supra* note 10.

driven more by data and planning rather than political influence.¹²⁹

D. Michigan

Michigan providers included in the survey did not believe the review process of the state was subjective. The state's respondents stated the unique makeup of its review board helped objectify the review process. Michigan splits the creation of CON application review guidelines and "the actual review of CON applications between an appointed commission and the state Department of Community Health."¹³⁰ Together, the commissions develop standards used in reviewing applications for a CON and are made up of "representatives of hospitals, physicians, other health care providers, employers and labor."¹³¹

In its modernization process, Michigan also moved to an electronic filing system. Respondents to the study stated the electronic system has garnered large success in the state, specifically praising the electronic filing system's ability to "increase[] transparency and efficiency of the process overall."¹³²

E. South Carolina and Georgia

While Michigan seemed to increase the popularity and efficiency of its CON program by including a two-part review system and an electronic filing system, South Carolina and Georgia's modernizations addressed concerns commonly cited about the lack of accountability for providers who are granted a CON to provide the rural care promised in their applications. South Carolina, for example, requires its CON grantees to "track and report" the charity care listed in the CON application.¹³³ The state, however, does not include a monetary penalty if any entity fails to do so. Georgia's approach has shown greater levels of success. There, if a provider promises to grant charity care in its

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.*

CON application and fails to do so, the provider must pay “the difference to the state.”¹³⁴

III. PROPOSED AMENDMENTS TO MISSISSIPPI’S CERTIFICATE OF NEED PROGRAM

While one could attempt to replicate Kentucky’s modernization process in Mississippi in light of the ACA, the differences between the two states should not be ignored. The states have similar poverty and education levels.¹³⁵ But, the reality of healthcare coverage in Kentucky is not the reality of Mississippians. As of 2018, Kentucky boasted a 6.7 percent-uninsured rate while Mississippi had more than double the number of uninsured patients at 14.4 percent.¹³⁶

Further, Kentucky’s government chose to expand Medicaid under the ACA, while Mississippi remains one of fourteen states that chose to block Medicaid expansion.¹³⁷ In Mississippi, the choice to not expand Medicaid left around 99,000 Mississippians in a “coverage gap.”¹³⁸ Under this, the citizens’ incomes “don’t exceed 27 percent of the poverty level,”¹³⁹ so they are not eligible for Medicaid, but they also cannot afford to buy coverage under the healthcare exchanges¹⁴⁰ developed under the ACA.

¹³⁴ *Id.*

¹³⁵ See *Quickfacts: Mississippi; Kentucky*, UNITED STATES CENSUS BUREAU (2018), <https://www.census.gov/quickfacts/fact/table/ms,ky/IPE120218> [<https://perma.cc/P7Z9-K9MD>] (The Census Bureau estimated that Kentucky had a 16.9 percent poverty rate, and Mississippi had a 19.7 percent poverty rate in 2018. The Census Bureau also estimated that Kentucky had an 85.7 percent high school graduation rate and that Mississippi had an 83.9 percent high school graduation rate from 2014-2018.)

¹³⁶ *Id.*

¹³⁷ *Where the states stand on Medicaid expansion*, ADVISORY BOARD (Apr. 1, 2019, 12:51 PM), <https://www.advisory.com/daily-briefing/resources/primers/medicaidmap> [<https://perma.cc/H2KE-FL7A>].

¹³⁸ Louise Norris, *Mississippi and the ACA’s Medicaid expansion*, HEALTH INSURANCE.ORG (Sept. 16, 2018), <https://www.healthinsurance.org/mississippi-medicaid/> [<https://perma.cc/W654-5ULK>].

¹³⁹ *Id.*

¹⁴⁰ Vanessa C. Forsberg, *Overview of Health Insurance Exchanges*, CONGRESSIONAL RESEARCH SERVICE 1 (June 20, 2018), <https://fas.org/sgp/crs/misc/R44065.pdf> [<https://perma.cc/V95F-7FYU>] (The ACA mandated every state develop healthcare exchanges. These “exchanges are virtual marketplaces in which consumers and small businesses can shop for and purchase private health insurance coverage.”); *The ‘metal’ categories: Bronze, Silver, Gold & Platinum*, HEALTHCARE.GOV, <https://www.healthcare.gov/choose-a-plan/plans-categories/> [<https://perma.cc/Y98G-7TDV>] (last

Even without the expansion discussion, Mississippi seems to be an outlier in its application of the ACA. In the first year of the ACA's implementation, only 61,494 of the 300,000 eligible citizens received coverage.¹⁴¹ With these numbers, Mississippi was the only state where healthcare coverage actually went down in the year following the ACA.¹⁴²

Proponents of maintaining the status quo of Mississippi's CON program will likely argue that Mississippi only turns down an average of five percent of applications for a CON per year.¹⁴³ Admittedly, these numbers are in stark contrast to the report conducted by the independent consulting firm in Kentucky which found, for reference, that approximately 90 percent of applications for ambulatory surgical centers in Kentucky were denied.¹⁴⁴ However, the means of modernization offered in this Article are not only concerned with the number of applications approved or denied. The modernizations are also directed at building a road to greater trust between healthcare providers, patients, and the CON review board in Mississippi. Further, the number of declined applications cannot account for the number of providers who simply decide to not apply for a CON due to the perceived unfairness and arduous nature of the current application process in Mississippi.¹⁴⁵

Keeping the reality of Mississippi in mind, this Article collected arguments from states that have modernized their CON programs after the ACA. The proposed modernizations range from reform to the highest degree, such as a single-payer system, to the easiest to implement. This Article admits that the modernizations proposed do not always work in harmony with each other. Some arguments work in direct antipathy to others. However, Mississippi's state legislatures and policy makers, as well as

visited Nov. 18, 2018) [hereinafter *Categories*] (Under the exchanges, coverage ranges from 90 percent under the platinum plan to 60 percent under the bronze plan. The cost of coverage varies depending on the state.).

¹⁴¹ Varney, *supra* note 1.

¹⁴² *Id.*

¹⁴³ Wolfe, *supra* note 4.

¹⁴⁴ Parento, *supra* note 11, at 244-45.

¹⁴⁵ See, e.g., Wolfe, *supra* note 4 (Matt Mitchell, researcher for Mercatus, stating, "How many people just don't even ask for it because they know it's a daunting process?").

states with similar concerns to Mississippi, may pull individual modernization recommendations or combine multiple recommendations to match their state's specific needs. Further, this Section intends to operate as a building block for discussions about Mississippi's current healthcare system as a whole. While some of these modernizations are unlikely to be implemented by Mississippi's legislature in the near future, the conclusion of this Section will address how each modernization would benefit Mississippi citizens and healthcare providers as a model for other states looking to modernize CON programs after the ACA.

A. *Implementing a Single-Payer System*

Advocates of CON programs commonly argue that the laws are needed to help offset costs of treating uninsured or underinsured patients with money from insured patients who can pay for services. This argument has merit. Even though the ACA made strides to provide healthcare to larger percentages of the United States' population, 30 million United States citizens remain uninsured. Problems also remain with maintaining healthcare coverage while transferring jobs. Further, "the average per capita cost of healthcare in the United States is twice that of other modern nations."¹⁴⁶ Even with the healthcare exchanges developed under the ACA, the patient is still required to pay a percentage of the cost of care, ranging from 40 percent to 10 percent depending on the plan.¹⁴⁷ In addition, some providers who are required to file CON applications simply refuse to accept Medicaid-covered patients in favor of high-paying privately insured patients.¹⁴⁸ When this provider refuses to accept Medicaid patients, they are pushed onto other providers within the state. Proponents argue CON laws operate, at some level, to combat this

¹⁴⁶ Ed Weisbart, *A Single-Payer System Would Reduce U.S. Health Care Costs*, AMA JOURNAL OF ETHICS (Nov. 2012), <https://journalofethics.ama-assn.org/article/single-payer-system-would-reduce-us-health-care-costs/2012-11> [<https://perma.cc/4234-TF93>].

¹⁴⁷ See *Categories*, *supra* note 140; see also Adam Gaffney et al., *Moving Forward From the Affordable Care Act to a Single-Payer System*, AM. J. PUB. HEALTH 987 (2016), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.303157> [<https://perma.cc/EFN8-A3C7>] (For example, those entitled to pay 40 percent under their exchange program bronze plan on average still pay around \$5,300 per year in copayments and deductibles.).

¹⁴⁸ Taylor, *supra* note 57.

pushover. In essence, CON laws make sure the Medicaid-accepting provider is not also operating in a flooded market where it struggles to attract more paying customers to offset the cost of uninsured patients.

From the view of many scholars, these policy justifications for CON programs would be invalidated if states chose to enact a single-payer system.¹⁴⁹ Under a single-payer system, the rationale for keeping CON programs to maintain competition and to offset the costs of uninsured patients with payments from insured patients would be rendered moot because every citizen would have healthcare insurance. A single-payer system would also eliminate co-payments for the patient, a concern that remains under the healthcare exchanges.¹⁵⁰

In a single-payer healthcare system, “a single public or quasi-public agency takes responsibility for financing healthcare for all residents.”¹⁵¹ The colloquial term “Medicare-for-all” is an accurate depiction of how the system would work in practice.¹⁵² Used in Canada as the “national health insurance program,” taxes from the general population fund the healthcare system, and providers collect payment for services rendered through “global budget payments” directly from the government-run insurance programs.¹⁵³ Similar to the current Medicare program, patients would be allowed to choose which providers to visit.¹⁵⁴ Further, Canada uses this system to minimize its healthcare expenses by setting “predetermined fees for physicians,”¹⁵⁵ which would alleviate some concerns associated with physicians ordering

¹⁴⁹ *Id.* (“[W]hat happens is that many providers only want to offer their services to well-insured people even as we have many Americans who can’t pay or don’t live where services are offered. . . . We have a system that depends on capitalism running the system even when there is a public need.”) (internal quotation marks omitted).

¹⁵⁰ Gaffney, *supra* note 147.

¹⁵¹ Andrea S. Christopher, *Single Payer Healthcare: Pluses, Minuses, and What It Means For You*, HARVARD HEALTH BLOG (June 27, 2016), <https://www.health.harvard.edu/blog/single-payer-healthcare-pluses-minuses-means-201606279835> [<https://perma.cc/4L26-8H62>].

¹⁵² *Id.*

¹⁵³ Goran Ridic et al., *Comparisons of Health Care Systems in the United States, Germany and Canada*, MATERIA SOCIO MEDICA JOURNAL OF THE ACADEMY OF MEDICAL SCIENCES OF BOSNIA AND HERZEGOVINA 112, 112 (2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3633404/pdf/MSM-24-112.pdf> [<https://perma.cc/MC88-6ZZ7>].

¹⁵⁴ Christopher, *supra* note 151.

¹⁵⁵ Ridic, *supra* note 153, at 113. .

unnecessary procedures and insurance companies having the power to bargain with providers for fee rates.

A single-payer healthcare system, like the one established in Canada, would project to provide “immediate systemwide savings of 8 to 12” percent and “more than \$2 billion over 10 years” in savings.¹⁵⁶ The immediate and incremental savings, however, have not been enough for states to implement the system. For example, Vermont was the first state to try to implement a single-payer system at the state level. The program failed due to budgetary concerns and the politicized nature of the plan.¹⁵⁷ The plan would require employers and citizens to pay higher taxes that would eventually replace their premiums, deductibles, and co-insurance payments. However, as the Vermont government approached implementing the single-payer system, the state recognized the increase in taxes were not “politically palatable.”¹⁵⁸

Vermont’s failure at the state level seems to match the opinion of some experts who believe adopting a single-payer system at the state level would be more difficult than implementing the program at a federal level, at least when only taking funding into consideration. These experts reason that while richer states would have less difficulty transferring their healthcare funds to a government-run single-payer system, poorer states would struggle to keep up with costs of a single-payer system at the state level.¹⁵⁹ For example, in Mississippi, because of the number of uninsured citizens, there are simply not as many citizens moving their private insurance payments into the single-payer model for the system to become fully functional.¹⁶⁰

B. Removing MRI and PET Scans from CON Review

States like Mississippi contend regulation of imaging technologies like MRI and PET scanners under a CON program is necessary because MRI and PET scans are distinct from other

¹⁵⁶ John E. McDonough, *The Demise of Vermont’s Single-Payer System*, THE NEW ENG. J. OF MED.1584 (April 23, 2015), https://mfprac.com/web2019/07/literature/literature/Misc/SinglePayerVermont_McDonough.pdf [<https://perma.cc/7YRH-P3FM>].

¹⁵⁷ *Id.*

¹⁵⁸ Shapiro, *supra* note 9.

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

healthcare services.¹⁶¹ As outpatient procedures, healthcare providers may offer these services “outside of community hospitals,” increasing the concern that if CON review was removed, small hospitals would suffer.¹⁶² Further, healthcare providers profit greatly from outpatient procedures like MRI and PET scans, which raises concerns that an increase in the procedures due to lack of CON regulation would create an increase in patient costs.¹⁶³

Even with these concerns in mind, Mississippi’s legislature should consider removing MRI and PET scans from review, similarly to the removal of CT scanners from CON review in recent years when the costs of each scanner decreased.¹⁶⁴ While data conflicts about whether access to ordinary medical services is hindered by the CON process, data shows that access to MRI and PET machines is more limited for patients of nonhospital providers in states with CON laws than patients of nonhospital providers in non-CON regulated states.¹⁶⁵ While MRI and PET scans could possibly be overused, the potential for overuse for economic gain is lessened by the value-based payment system implemented under the ACA, because the government will only pay for necessary services. Further, the limitation of access to MRI and PET scans in rural areas is exacerbated by Mississippi’s high percentage of rural communities. As of 2016, 79 percent of Mississippi counties were considered rural “as defined by the federal Office of Management and Budget.”¹⁶⁶

In both the original federal Act and Mississippi’s current CON statute, access to indigent care is a primary focus. However, data shows patients of nonhospital providers have less access to MRI and PET scans in CON-regulated states. Because the CON regulation of MRI and PET scans seems to work in opposition to the policy justification for which the CON programs were formed, MRI and PET scans should be either (1) removed from

¹⁶¹ Am. Health Planning Ass’n, *supra* note 56, at 25.

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.* at 34.

¹⁶⁵ Stratmann, *supra* note 6, at 18.

¹⁶⁶ *Office of Rural Health and Primary Care Needs Assessment March 2016*, at 3, MISS. ST. DEP’T OF HEALTH (Mar. 2016), https://msdh.ms.gov/msdhsite/_static/resources/7357.pdf [<https://perma.cc/V47U-SH49>].

Mississippi's CON review or (2) placed under the expedited review process discussed in subsection (d) of this Section so the services can reach the rural populations of the state faster.

C. Implementing an Updated Review Committee Structure

In Mississippi, as well as in other states, providers cite concerns about a politicized review process, including a lack of objectivity and transparency throughout the filing process.¹⁶⁷ For reference, Mississippi's current State Board of Health is made up of "an 11-member Board appointed for staggered terms by the Governor."¹⁶⁸ Other states, including Kentucky and Michigan, have addressed similar concerns about the politicized nature of the review process with success by shifting to a two-part committee.

For example, Kentucky addressed apprehensions about the lack of objectivity in the review process and a lack of understanding of the needs of the medical community by allowing stakeholder input into the state's modernization of its CON application process.¹⁶⁹ The state allowed hospitals, community-based service providers, and stakeholders to submit their problems with the current CON review program for the board to take into consideration when drafting the modernizations to the State Health Plan.¹⁷⁰

In a study on CON programs across six states, Michigan was the only state where applicants believed the CON review process added to "greater objectivity and transparency."¹⁷¹ Instead of being overseen by a single division under their State Health Plan, Michigan set up a two-fold review board. This board is made up of the state department of health as well as a commission with members including "representatives of hospitals, physicians, other health care providers, employers and labor."¹⁷² First, the two-part

¹⁶⁷ See Wolfe, *supra* note 4.

¹⁶⁸ *Mississippi State Board of Health*, MISS. ST. DEP'T OF HEALTH, https://msdh.ms.gov/msdhsite/_static/19,0,124.html [<https://perma.cc/KJ8D-2RW5>] (last visited Jan. 5, 2020).

¹⁶⁹ Parento, *supra* note 11, at 246-48.

¹⁷⁰ *Id.* at 248-49.

¹⁷¹ Yee et al., *supra* note 10, at 2.

¹⁷² *Id.* at 2-3.

committee worked to develop the criteria under which healthcare programs would be reviewed for a CON. Second, the committee oversees every CON application together.¹⁷³

Before Mississippi modernizes its CON process, the legislature should similarly ask providers, patients, and stakeholders for potential solutions to the problems associated with the current application process in the state. The two-part review process exemplified in Michigan provided a model for Mississippi to create greater transparency in the CON application process. Mississippi can also address concerns cited by small providers who have previously not filed for CONs in Mississippi based on their notion that the review process is prejudiced in favor of current providers with a similar two-part review system.

D. Creating an Expedited Review Process

Under Mississippi's current CON program, from filing the application to receiving notice of approval/denial, procuring a CON can run over the course of around eight months, including appeals.¹⁷⁴ Mississippi offers expedited review for "when the owner of a damaged health care facility applies to repair or rebuild . . . to alleviate an emergency condition."¹⁷⁵ Under an expedited review, a provider can expect a decision within 90 days.¹⁷⁶

The Mississippi State Health Plan defines an emergency condition as a need "caused by unforeseen or unpredictable events that may jeopardize the health and/or safety of the patients of

¹⁷³ *Id.*

¹⁷⁴ See *The Certificate of Need Process*, MISS. ST. DEPT' OF HEALTH, https://msdh.ms.gov/msdhsite/_static/30,1567,84,214.html [https://perma.cc/68JJ-EHBF] (last visited Jan. 5, 2020) (showing a provider must file a "notice of intent" 15 days prior to filing a CON application; the board is given 15 days to review with an additional 15 days if any portion of the application is incomplete; a 30-day "public comment period"; a staff analysis within "45 days after receipt of application"; a 10-day filing period for a hearing by any affected parties; a hearing that must be within 60 days of the request; a 45-day wait period for the hearing outcome; and any appeals to the chancery court within 20 days after the final results are released).

¹⁷⁵ See MISS. CODE ANN. § 41-7-207 (West 2015).

¹⁷⁶ *CON Review Manual*, at 26, MISS. ST. DEPT' OF HEALTH, https://msdh.ms.gov/msdhsite/_static/resources/7167.pdf [https://perma.cc/PAR5-E3RN] (last visited Jan. 5 2020).

such health care facility.”¹⁷⁷ Other states have extended the expedited review process further, allowing for an expedited review process for services that might not meet the definition of an “emergency” but are needed in greater numbers in the state. In Kentucky, for example, the state health program offers expedited review for providers who use a value-based payment system and for providers of services that an outside board determined were in high demand after the increase of insured patients under the ACA.

While Kentucky can offer different standards of review for providers who agree to use the value-based payment system developed in the ACA, Mississippi has not been as successful in its application of the ACA. Mississippi, therefore, has greater numbers of uninsured or underinsured patients. The number of uninsured patients does not work against the need for reform of CON laws. In contrast, the number of uninsured and underinsured patients creates a stronger argument to keep CON programs in some form as safety nets for hospitals, needed to offset the costs of paying for services provided to uninsured patients with patients who have the ability to pay.

Mississippi’s legislature is unlikely to create an expedited review process to encourage the use of a value-based payment system because it has not chosen to embrace the ACA in the same manner as Kentucky. However, Mississippi can and should hire a third party to conduct a review of the current needs in Mississippi to determine if the providers in the state match the current need of Mississippi citizens with increased coverage under the ACA.

Based on the results from the third-party audit, the State Health Plan board members will determine which providers are being used in greater quantities by patients who gained coverage under the ACA and which providers Mississippi citizens utilize less. For the providers that are currently being used more, the panel can either (1) recommend removal of that provider from CON regulation altogether, or (2) recommend the provider be placed on an expedited and limited review process. This limited review process will not remove the provider from all oversight. The application process will simply be more limited in scope and

¹⁷⁷ *Id.*

will allow for construction to begin in a shorter time frame. Mississippi could either expand its existing expedited review program, used now for emergency conditions only, to envelop the additional providers, or the state could elect to create a supplementary expedition process for the additional providers.

E. Expanding Overview of Rural Care Provisions in CON Applications

Section Nine of this Article covers how more direct payment systems could be more beneficial for rural care than the indirect system under CON laws. However, even if Mississippi elects to not follow any of the proposals in Section Nine, the legislature should modernize the provisions covering rural care in CON applications to ensure the CON's policy justification of increasing access to rural care is met.

Mississippi's current State Health Plan lists rural care as a subsection of the general policies for CON application approval. However, the plan does not provide a procedure for punishment or a penalty for applicants who fail to provide rural care after the provider's application has been approved.¹⁷⁸ To ensure increased access to rural care after CON approval, Mississippi may use one of two programs implemented by other states. First, Mississippi can follow Georgia's approach and require providers who do not provide the level of rural and/or charity care promised in their CON application to pay the value of those failed services back to the state.¹⁷⁹ The state would then funnel those payments into increasing access to care in rural communities. Second, the legislature could opt for the less dramatic approach illustrated by South Carolina. There, the state board requires providers to "track and report their levels of charity care" to the board without monetary penalties attached for violations.¹⁸⁰ South Carolina's

¹⁷⁸ *Id.* at 2 ("MSDH intends to disapprove CON applications which fail to confirm that the applicant shall provide a reasonable amount of indigent care or if the applicant's admission policies deny or discourage access to care by indigent patients. . . . The Department considers a reasonable amount of indigent care as that which is comparable to the amount of such care offered by other providers of the requested service within the same, or proximate, geographic area.").

¹⁷⁹ Yee et al., *supra* note 10, at 6.

¹⁸⁰ *Id.*

approach, however, has not had as much success as the penalty structure implemented by Georgia.

F. Implementing an Electronic Filing System

Mississippi needs to move to an electronic filing system to (1) speed up the application process, and (2) increase transparency by allowing providers to track their application as it moves through the review process. Under its current CON filing process, healthcare providers in Mississippi are required to mail, deliver, or email all application materials to the Mississippi Department of Health (“MDOH”) in the state’s capital.¹⁸¹

Michigan switched to electronic filing system for its CON applications in 2014.¹⁸² Michigan’s healthcare providers’ responses to the new system were “overwhelmingly positive because of increased transparency and efficiency of the process.”¹⁸³ The New York State Department of Health similarly boasts that its electronic filing system is meant “to streamline the processing of applications, while improving communication and transparency.”¹⁸⁴

By creating an electronic filing system, the MDOH could likewise increase communication with its healthcare providers. First, electronic filing systems in other states allow the applicant to track their application as it moves through the state department of health. MDOH would be able to send instant updates to providers. MDOH would also be able to alert providers of any potential issues with their application through the e-application portal, and the provider could fix the problem remotely without an additional visit to the state capital.

¹⁸¹ *Mississippi State Department of Health Application for a Certificate of Need*, at 1, MISS. ST. DEP’T OF HEALTH, https://msdh.ms.gov/msdhsite/_static/resources/1864.pdf [<https://perma.cc/LVH3-6VGU>] (last visited Jan. 5, 2020) (Filing requirements include a “substantive review” application and a “financial analysis spreadsheet.”).

¹⁸² See generally *The Michigan Electronic Records Standards Adopted by the Michigan Electronic Recording Commission* (Jan. 1, 2014), https://www.michigan.gov/documents/dtmb/Michigan_ERC_Report_FINAL_08272013_432138_7.pdf [<https://perma.cc/3ZX7-P2N7>].

¹⁸³ Yee et al., *supra* note 10, at 8.

¹⁸⁴ *New York State Electronic Certificate of Need*, N.Y. ST. DEP’T OF HEALTH, <https://www.health.ny.gov/facilities/cons/nysecon/> [<https://perma.cc/22YU-RH7P>] (last visited Jan. 5, 2020).

Second, an electronic filing system would expedite the application process by allowing applicants to submit remotely instead of personally traveling or paying a representative to deliver three paper copies of the application to the state capital in Jackson. Third, Mississippi would have the option to require its providers to complete a survey when they file electronically. The survey results would allow the state department to gauge technical and substantive concerns with the filing process and revise the application process as needed to match the providers' needs. While an electronic filing system admittedly will not fix all the providers' concerns with the CON application process, an electronic filing system could act as a first step toward greater transparency between the state and its healthcare providers.

IV. HOW A MORE DIRECT PAYMENT STRUCTURE COULD BENEFIT RURAL CARE MORE THAN CON PROGRAMS

All of the proposals below are applicable to use in addition to the modernization examples given above. However, because there is debate about the benefit of CON programs on access to rural care, these proposals could also be used independently from CON programs if the state either chooses to keep its current CON program structure or to repeal its CON program altogether.

As of 2016, 79 percent of Mississippi counties were considered rural "as defined by the federal Office of Management and Budget."¹⁸⁵ Of these counties, 84 percent are labeled as healthcare professional shortage areas for primary care.¹⁸⁶ Mississippi's CON program requires the applicant to document how indigent care will be provided. Historically, however, Mississippi has not provided any penalties for providers who fail to provide rural care after their CON application is approved. Further, the CON program does not provide any direct funds for implementation of rural care. In a largely rural state like Mississippi, a more direct payment structure could provide greater access to healthcare for rural citizens than the indirect and unenforced funding structure of the CON process.

¹⁸⁵ *Office of Rural Health and Primary Care Needs Assessment March 2016, supra* note 166, at 3.

¹⁸⁶ *Id.*

A. *Implementing a Single-Payer System*

Canada started its single-payer system after WWII caused an insufficiency of providers in rural areas of the country.¹⁸⁷ This Article discusses the benefits of a single-payer system in Section Four subsection (a). These arguments are equally beneficial for increasing rural care. Further, Canada's history of developing a single-payer system after facing a similar shortage of providers in rural communities after WWII could operate as a model for implementation of a single-payer system to combat lack of access in rural communities in Mississippi and similar rural states.

B. *Expanding Medicaid*

Mississippi's legislature is not likely to expand Medicaid in the near future based on the state's history with the program. For example, Governor Phil Bryant refused to expand Medicaid even after the Mississippi State Medical Association advocated in favor of expanding the program in 2016,¹⁸⁸ and the Mississippi Legislature rejected an amendment to expand Medicaid in February of 2018.¹⁸⁹

However, other states have used the optional Medicaid expansion to address problems with access to rural care. A report by Georgetown tracked access to rural care from 2009 to 2016, comparing states that chose to expand Medicaid after the ACA with states that rejected the Medicaid expansion option.¹⁹⁰ The report showed that the rate of uninsured citizens "dropped sharply from 35 percent to 16 percent in rural areas and small towns of Medicaid expansion states."¹⁹¹ The percentage of uninsured citizens in states who did not adopt the expansion was

¹⁸⁷ Ridic, *supra* note 153, at 112.

¹⁸⁸ *Medicaid Expansion Should Be Explored*, THE HATTIESBURG AMERICAN (Aug. 31, 2016, 6:18 AM), https://www.hattiesburgamerican.com/story/opinion/editorials/2016/08/31/explore-medicaid-expansion/89581806/_https://perma.cc/WVR4-F66L; Norris, *supra* note 138.

¹⁸⁹ Harrison, *supra* note 81.

¹⁹⁰ Jack Hoadley et al., *Health Insurance Coverage in Small Towns and Rural America: The Role of Medicaid Expansion*, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE (Sept. 25, 2018), <https://ccf.georgetown.edu/2018/09/25/health-insurance-coverage-in-small-towns-and-rural-america-the-role-of-medicaid-expansion/> [<https://perma.cc/JX2J-UFY3>].

¹⁹¹ *Id.*

considerably higher, with 38 percent of citizens being uninsured before the expansion and 32 percent of citizens remaining uninsured in 2016.¹⁹² Simply, “[u]ninsured rates for low-income adults in rural areas declined 3x faster in Medicaid expansion states compared to non-expansion states.”¹⁹³ Evidenced by the Georgetown report, states like Mississippi, with the country’s highest poverty rate,¹⁹⁴ need Medicaid expansion the most.

In addition to the increased healthcare coverage offered by Medicaid expansion, a report by the Kaiser Family Foundation found that states that expanded Medicaid boasted an increased workforce and economy.¹⁹⁵

While the increased income per citizen was not exponential, Mississippi cannot afford to dismiss any prospects brought to the state. As 50th in average household income and 1st in poverty level,¹⁹⁶ any increase in workforce would boost Mississippi’s economy.

C. Granting Additional Funding for Telehealth Implementation

While there is disagreement surrounding the helpfulness of CON programs in lowering costs and increasing rural access to healthcare, reports on telemedicine show that the new adaption “drives volume, increases quality of care, and reduces costs,”¹⁹⁷ the exact policy justifications given for the creation of CON programs. The definition of telemedicine is broad, covering services ranging from international medical communications to communications

¹⁹² *Id.*

¹⁹³ *Id.*

¹⁹⁴ Claire Hansen, *States With the Highest Poverty Rate*, U.S. NEWS (Sept. 26, 2017), <https://www.usnews.com/news/best-states/slideshows/the-10-states-with-the-highest-poverty-rate?slide=11> [<https://perma.cc/4MME-67SA>].

¹⁹⁵ Mitchell, *supra* note 80 (“In Kentucky, expansion resulted in 12,000 jobs in 2014 . . . Average household income in Colorado is up \$643 due to economic stimulation resulting from the expansion.”).

¹⁹⁶ Tami Luhby, *Mississippi has highest poverty and lowest income*, CNN BUSINESS (Sept. 20, 2012, 5:59 PM), <https://money.cnn.com/2012/09/20/news/economy/income-states-poverty/index.html> [<https://perma.cc/47DW-ZLDG>].

¹⁹⁷ JT Ripton & C. Stefan Winkler, *How telemedicine is transforming treatment in rural communities*, BECKER’S HEALTH IT & CIO REPORT (Apr. 8, 2016), <https://www.beckershospitalreview.com/healthcare-information-technology/how-telemedicine-is-transforming-treatment-in-rural-communities.html> [<https://perma.cc/H6F2-TKA7>].

between a patient and doctor within the same state.¹⁹⁸ The movement, at its core, allows doctors to “examine and treat patients remotely, in real time, using online streaming.”¹⁹⁹

The implementation of telemedicine is especially needed in rural states like Mississippi to provide adequate care for residents. At the national level, there is an average of one doctor per 335 citizens and one primary care doctor per 695 citizens.²⁰⁰ In Mississippi, that number drops to one doctor per 467 citizens, and one primary care doctor per 954 Mississippi citizens.²⁰¹ The disparity in Mississippi’s doctor-patient ratio is exacerbated in more rural areas of Mississippi, which “include[s] two counties without a single physician” as of 2018.²⁰²

Mississippi seems to recognize the need for telemedicine already. The University of Mississippi Medical Center, one of the two medical schools in the state, developed a Telehealth Center which was “one of only two such programs in the country to receive th[e] designation” of a Telehealth Center of Excellence.²⁰³ The program currently covers over half of the 82 counties in the state.²⁰⁴ Mississippi Senator Roger Wicker also joined forces with Commissioner Brendan Carr of the Federal Communications Commission to launch a “\$100 million pilot program to support telehealth for low-income Americans – particularly in rural areas like Mississippi.”²⁰⁵ If the state chooses to repeal its CON program, the state can channel funds previously used to oversee

¹⁹⁸ James B. Rosenblum, *A Telemedicine Primer*, 45 NO. 3 PRAC. LAW. 23, 24 (1999).

¹⁹⁹ *Telehealth Brochure*, UNIV. OF MISS. MED. CTR., CTR. FOR TELEHEALTH, https://www.umc.edu/Healthcare/Telehealth/files/telehealth_brochure.pdf [<https://perma.cc/7YA8-3LF5>] (last visited Jan. 5, 2020).

²⁰⁰ Robert Graboyes & Jennifer Skees, *The promise of telemedicine in Mississippi*, THE CLARION LEDGER (Jackson, Miss.) (Aug. 4, 2018, 12:01 AM), <https://www.clarionledger.com/story/opinion/columnists/2018/08/04/promise-telemedicine-mississippi/899146002/> [<https://perma.cc/4SU4-RMRH>].

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Telehealth Care at UMMC*, UNIV. OF MISS. MED. CTR., https://www.umc.edu/Healthcare/Telehealth/Telehealth_Home.html [<https://perma.cc/85L7-PX98>] (last visited Jan. 5, 2020).

²⁰⁴ *What is Telehealth?*, UNIV. OF MISS. MED. CTR., <https://www.umc.edu/Healthcare/Telehealth/What-is-Telehealth.html> [<https://perma.cc/GGB4-PGP3>] (last visited Jan. 5, 2020).

²⁰⁵ Graboyes & Skees, *supra* note 200.

CON applications into providing additional telemedicine services for rural citizens in the state.

D. Utilizing Uncompensated Care Pools

The costs of rural care could also be successfully offset, at least partially, by uncompensated care pools.²⁰⁶ Nine states currently use the pools.²⁰⁷ The care pools, created through Medicaid's Section 1115, offers direct payments to hospitals to help compensate providers in areas with heightened levels of uninsured patients or higher levels of charity care.²⁰⁸ The pools allow the Secretary of State to use Medicaid funds to fund any program she can prove "is an experimental, pilot, or demonstration project that is likely to assist in promoting the objectives of the program."²⁰⁹ Recently, some states have used the funding from these pools in efforts to modernize their programs and buildings.²¹⁰ To use the funds in this way, the states must file for a waiver. However, the types of waivers approved change in response to new Presidential administrations.²¹¹ Under the current administration, waivers have been approved "conditioning eligibility on meeting work requirements"; "to charge premiums up to "5% of family income"; and to impose "fees for missed appointments."²¹² Considering this reality with the political atmosphere of the current Mississippi administration, it is unlikely that the Mississippi legislature will apply to use 1115 waivers to fund additional rural services.

Further, the waivers are based on the policy of offsetting costs associated with treating uninsured patients. As the ACA is

²⁰⁶ Robert B. Hackey, *New Wine in Old Bottles: Certificate of Need Enters the 1990s*, HEALTH POLICY AND MANAGEMENT FACULTY PUBLICATIONS 927, 930 (1993).

²⁰⁷ Dee Mahan & Andrea Callow, *Explainer: Medicaid Uncompensated Care Pools*, FAMILIES USA (May 21, 2015), <https://familiesusa.org/resources/explainer-medicaid-uncompensated-care-pools/> [https://perma.cc/5PHE-Q3SH].

²⁰⁸ *Id.*

²⁰⁹ Elizabeth Hinton et al., *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers*, KAISER FAMILY FOUNDATION (Feb. 12, 2019), <https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/> [https://perma.cc/KUZ4-GJAC] (internal quotation marks omitted).

²¹⁰ Mahan & Callow, *supra* note 207.

²¹¹ Hinton et al., *supra* note 209.

²¹² *Id.*

further implemented, the number of uninsured patients will likely go down. Because of this, the Centers for Medicaid will likely allocate fewer funds into the uncompensated care pool system,²¹³ making this proposal a better argument for short-term changes in rural care. The programs seem too turbulent, however, for states to depend on them as a long-term solution for the lack of healthcare access in rural communities.

E. Developing All-Payer Rate-Setting Programs

An all-payer rate-setting program requires every insurance provider to pay an equal rate for equal treatments.²¹⁴ Maryland is the only state that currently uses an all-payer rate-setting system for all healthcare services.²¹⁵ All other states regulate public providers, meaning the provider may not charge over a preset amount for services payable by a public system.²¹⁶ Private insurance providers, however, are allowed to negotiate with the hospital on an individual basis to set rates for each procedure.²¹⁷ Austin Frakt, the director of VA Boston Healthcare System's Partnered Evidence-Based Policy Resource Center credits increasing healthcare costs with this current bartering-type system.²¹⁸

Maryland first enacted an all-payer system in 2014.²¹⁹ The current expanded all-payer system was issued on July 9, 2018, and is set to last for five years under a contract with the federal

²¹³ *Id.* at n.28.

²¹⁴ *Maryland All-Payer Model*, CTRS. FOR MEDICARE AND MEDICAID SERVS., <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/> [https://perma.cc/LNQ9-Y2BJ] (last visited Jan. 5, 2020).

²¹⁵ *Id.*

²¹⁶ Rich Barlow, *You've Heard of Single-Payer. What About All-Payer Health Care?*, BOSTON UNIV. TODAY (March 19, 2018), <http://www.bu.edu/today/2018/single-payer-vs-all-payer-health-care/> [https://perma.cc/5E47-957F]; Sarah Kiff, *All-Payer Rate Setting: America's back-door to single-payer?*, VOX (Feb. 9, 2015), <https://www.vox.com/2015/2/9/8001173/all-payer-rate-setting> [https://perma.cc/9YML-PV7H].

²¹⁷ *Id.*

²¹⁸ *Id.*

²¹⁹ *The Maryland All-Payer Model Progression Plan*, at 1 MD. DEP'T OF HEALTH AND MENTAL HYGIENE (Dec. 16, 2016), <http://www.hsrc.state.md.us/documents/md-maphs/pr/Maryland-All-Payer-Model-Progression-Plan.pdf> [https://perma.cc/B3MW-XT8B].

government.²²⁰ Under the model, the Health Services Costs Review Commission, “a quasigovernmental agency,” sets the rates paid to all providers.²²¹ To date, the program has boasted \$319 million in savings in Medicare costs.²²²

Mississippi will not likely adopt Maryland’s approach. But, the approach seems to find some middle ground between a single-payer system and the current rate-setting programs. Mississippi can also choose to use a partial all-payer system for the purposes of funding adequate rural care alone. For example, Pennsylvania uses a single-payer “rural health model.”²²³ The model aims to address concerns of unnecessary procedures and increased healthcare costs by paying rural hospitals through an all-payer system.²²⁴

Mississippi also seems more likely to implement Pennsylvania’s limitation of an all-payer system to rural providers based on the sunset provision included in the model. The payment system lasts seven years in Pennsylvania before renewal is required.²²⁵ The provision is also implemented on an opt-in basis.²²⁶ Under the system, the state pays providers a fixed amount that is set in advance for inpatient and outpatient hospital-based services, and is paid monthly by Medicaid fee-for-service and all other participating payers.²²⁷ The steady income is

²²⁰ Emily Rappleye, *Maryland expands all-payer model under 5-year federal contract*, BECKER’S HOSPITAL CFO REPORT (July 10, 2018), <https://www.beckershospitalreview.com/finance/maryland-expands-all-payer-model-under-5-year-federal-contract.html> [https://perma.cc/B369-FH7T].

²²¹ Gerard Anderson & Bradley Herring, *The All-Payer Rate Setting Model for Pricing Medical Services and Drugs*, 17 AMA JOURNAL OF ETHICS 770, 772 (Aug. 2015), <https://journalofethics.ama-assn.org/article/all-payer-rate-setting-model-pricing-medical-services-and-drugs/2015-08> [https://perma.cc/9DYU-FD9S].

²²² Nelson Sabatini et al., *Maryland’s All-Payer Model – Achievements, Challenges, and Next Steps*, HEALTH AFFAIRS BLOG (Jan. 31, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170131.058550/full/> [https://perma.cc/L9VM-VA4V].

²²³ *Pennsylvania Rural Health Model*, CTRS. FOR MEDICARE AND MEDICAID SERVS., <https://innovation.cms.gov/initiatives/pa-rural-health-model/> [https://perma.cc/87GG-GA6P] (last updated Sept. 20, 2019).

²²⁴ *Id.*

²²⁵ *Id.* (stating that the all-payer system started on January 1, 2017 and will end on December 31, 2024.).

²²⁶ *Id.*

²²⁷ *Id.*

intended to allow the rural hospitals to plan in advance for modernizations in care and facilities.²²⁸

CONCLUSION

Congress developed CON laws with noble goals in mind including (1) reducing healthcare costs for citizens and (2) increasing access to rural care. States have continued to use CON programs with similar goals at the forefront. Data shows, however, that CON laws have done little, if anything, to regulate healthcare costs. Opponents of CON laws have used this data to argue for repeal of CON laws altogether. But, while CON programs are controversial, “[n]o state has eliminated . . . a CON program in nearly a decade.”²²⁹ However, almost all the states that maintained “CON programs have narrowed their focus, reducing either the scope or intensity of regulation” in recent years.²³⁰ This trend shows that states have continued to use CON laws as “reactive” laws, intended to mold to fit the changing healthcare landscape of the states they serve.

From the research conducted for this Article, repeal of CON laws seems unlikely in the near future. Modernization is more realistic, bipartisan, and arguably more beneficial for states like Mississippi that have not expanded Medicaid following the ACA, have high rural populations, and have high levels of uninsured citizens. Using modernization techniques from eight states that have updated their CON laws after the ACA, Mississippi and states with similar healthcare experiences can maintain regulatory control over healthcare providers while combating the growing levels of distrust and disdain for the current CON review process. Further, because data found for this Article does not show that CON laws increase access to rural care, states should either (1) increase oversight and enforcement of indigent care promised in CON applications or (2) defer some of the resources allocated to CON regulation oversight directly into increasing healthcare access for rural citizens in the state.

²²⁸ *Id.*

²²⁹ Am. Health Planning Ass’n, *supra* note 56, at 4.

²³⁰ *Id.*

While some of the proposed modernizations might seem far-reaching for a state slow to change in other areas, the modernizations fit the historical basis of CON laws. From its Hill-Burton predecessor to the National Health Planning and Resources Development Act at the federal level to state-run programs, CON laws have been used as reflective programs throughout the decades to protect states' changing healthcare needs. By modernizing its CON program, Mississippi and other similarly situated states maintain this history of progress while creating a reality that not only benefits providers but also everyday consumers of healthcare services by lowering overall costs of healthcare and increasing access to rural care.

