Mississippi's Certificate of Need Laws: Options for Reform

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"By reforming Mississippi's Certificate of Need laws, we can root out anti-competitive behavior that blocks the formation of medical facilities and prevents the delivery of lifesaving healthcare to Mississippians."

Governor Tate Reeves, State of the State Address, January 2023

1. Executive Summary

Mississippi health care providers who wish to offer new or expand existing services must first obtain a certificate of need (CON) from the Office of Health Policy and Planning, a division of the state Department of Health. To do so, providers must prove to the satisfaction of the office that their services are "needed." A CON is required for 19 services and procedures, ranging from hospital beds and home-health services to PET scanners and psychiatric-care facilities. A CON is also required when a provider wishes to purchase a piece of medical equipment costing $1.5 million or more, a provider wishes to relocate services from one area of the state to another or a new owner wishes to acquire an existing facility ("CON Review Manual," n.d.).

The federal government encouraged states to adopt CON programs in 1974 in the hopes of reining in expensive and/or unwarranted procedures. By the 1980s, however, evidence was mounting that CON laws were failing to achieve their goals, so Congress repealed the mandate. For decades, federal antitrust authorities in the Department of Justice and the Federal Trade Commission have regarded CON regulations as anticompetitive and detrimental to patient care.[1] They and others point to several anticompetitive features of CON, including procedures that allow incumbent providers to object to applications from would-be competitors.

The regulation has been widely studied. To date, there have been 118 peer-reviewed academic analyses of CON laws, and they collectively contain over 400 tests assessing the effect of CON laws on spending, access, quality of care, and other factors.

In this paper, I summarize the key characteristics of Mississippi's CON program, considering them in the context of other state programs and national trends. I also summarize the extensive

[1] See, e.g., Federal Trade Commission and U.S. Department of Justice (2016).

research on CON laws. Finally, I discuss options for reforming the state's program to ensure greater access to lower-cost and higher-quality care. These options range from full repeal and partial repeal to administrative changes and increases in transparency.

2. CON Laws across the Country

A. History

The first CON law in health care was introduced by New York in 1964, but CON regulations were widely adopted after Congress passed the National Health Planning and Resources Development Act of 1974 (*National Health Planning and Resources Development Act of 1974* 1975). The federal legislation threatened to withhold funding from any state that failed to create a CON program. Legislators hoped that by requiring providers to prove that a service was needed, CON laws would rein in expensive and unnecessary health care spending. They also hoped that by centralizing the planning of the allocation of resources, the CON process would increase access to care, especially for underserved populations. Even though CON regulators do not typically assess a provider's qualifications or safety record, lawmakers also hoped the regulations would improve quality of care.[2]

Shortly after CON requirements were enacted across the country, however, evidence began to mount that they were failing to achieve these objectives.[3] At the same time, economists and other social scientists were coming to appreciate that regulations that limit supply can often be used by insiders to limit competition, resulting in diminished quality, higher costs, and lower consumer welfare.[4] Persuaded that CON laws were anticompetitive and counterproductive, federal lawmakers reversed course in 1986 and eliminated the federal CON inducement (*Pub. L. 99-660,*

[2] Although the initial architects of CON regulations had no explanation for how the regulations might increase quality of care, the more recent defenders of CON programs have supplied a purported rationale. They contend that because the regulations will result in fewer providers, each provider will tend to perform more services and this, in turn, will increase their competence. There are two problems with this argument. First, in the volume–quality relationship, causality may run in the opposite direction. That is, high-quality providers may attract more business, and that is why we see a positive correlation between volume and quality in some fields. Second—and more fundamentally—barriers to competition tend to undermine quality, not enhance it (Beaulieu et al. 2020; Jayadevappa et al. 2023).

[3] See, e.g., Joskow (1980), Ashby (1984), and Anderson and Kass (1986).

[4] Stigler (1971), Green and Nader (1973), and Peltzman (1976).

§ 701, 100 Stat. 3799 1986). Since then, several states have either pared their programs back or eliminated them altogether.

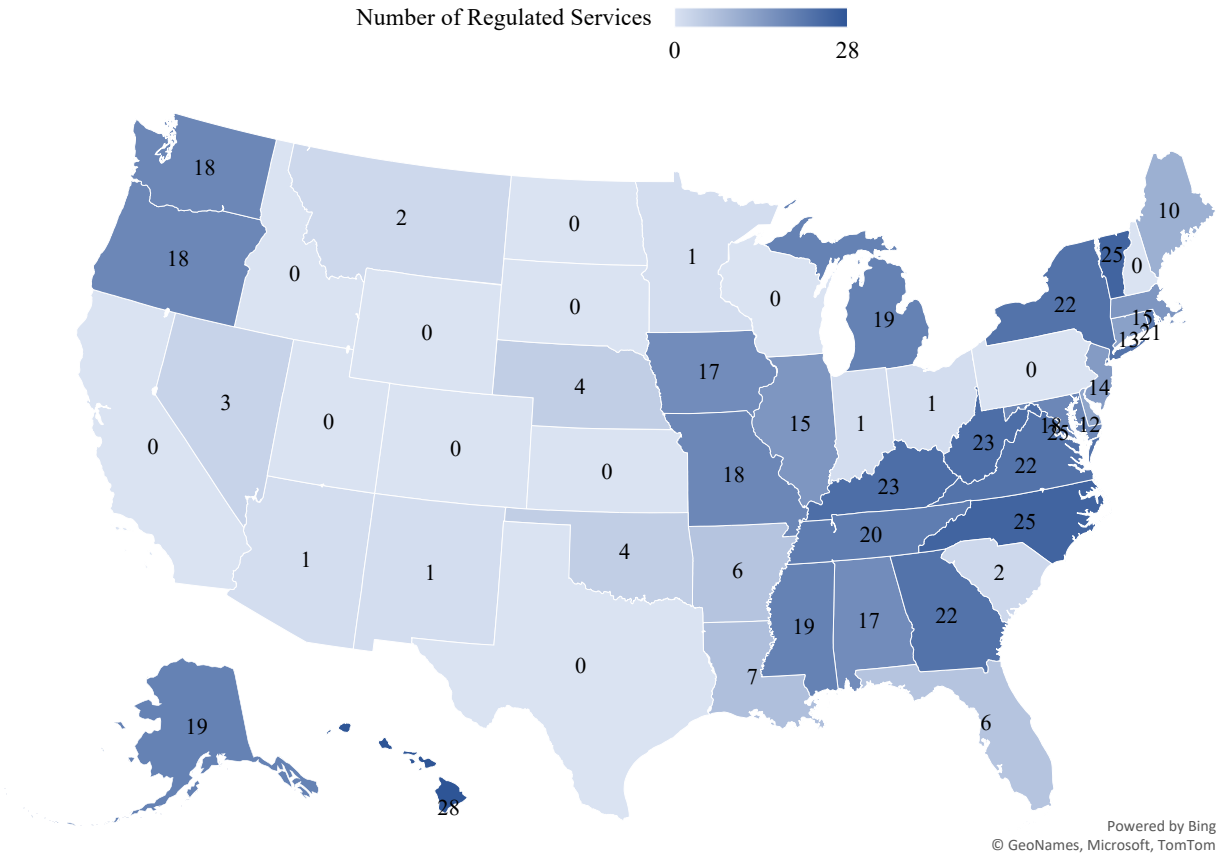
B. Regulated Services

Because of this unique legislative history, CON programs vary significantly across time and geographical location. Today, 39 states and the District of Columbia require a CON for at least one health care service or technology (see Figure 1).[5] In many of these states, the CON regime is quite limited. In Arizona, Minnesota, and New Mexico, for example, CONs are required only for ambulance services. In Indiana and Ohio, CONs are required only for nursing homes (South Carolina will soon join this list).[6] Hawaii, which requires a CON for 28 services and technologies, regulates more activities than any other state.

[5] The number of states with CON programs varies depending on whether states with ambulance-service CONs are counted. Such CONs are often excluded because they appear in transportation statutes rather than health care statutes and because they have received relatively little academic attention.

[6] In 2023, South Carolina eliminated the CON requirement for all services except hospital and nursing-home services. The requirement for hospitals will be phased out over three years, although it will not be enforced in counties that currently lack hospitals.

Figure 1: Number of Health Care Services in Which a CON is Required



Source: Mitchell, Philpot, and McBirney (2021), updated to reflect recent legislative changes.

Table 1 lists the services and technologies to which CON requirements most commonly apply. The most common CON requirements are for nursing-home beds (found in 34 states, including DC), psychiatric services (31 states), new hospitals (29 states), and intermediate-care facilities for those with intellectual disabilities (28 states). The least common CONs are for ultrasounds (two states) and subacute services (regulated only by Illinois).

Table 1: Regulated Services

Service or Technology	States with CON Requirements
Nursing-Home Beds/Long-Term-Care Beds	34
Psychiatric Services	31
New Hospitals or Hospital-Sized Investments	29
Intermediate-Care Facilities for Individuals with Intellectual Disabilities	28
Hospital Beds (Acute, General, Med-Surg, etc.)	27
Ambulatory Surgical Centers	25
Cardiac Catheterization	25
Long-Term Acute Care	25
Rehabilitation	24
Substance/Drug Use	24
Open-Heart Surgery	22
Radiation Therapy	21
MRI Scanners	20
PET Scanners	19
Home Health Agencies	17
Neonatal Intensive Care	18
Organ Transplants	18
Hospice	16
Obstetrics Services	16
CT Scanners	15
Linear Accelerator Radiology	15
Mobile Hi Technology (CT, MRI, PET, etc.)	15
Renal Failure/Dialysis	13
Burn Care	11
Swing Beds	11
Assisted Living and Residential Care Facilities	10
Gamma Knives	9
Lithotripsy	9
Ground Ambulance	8
Air Ambulance	6
Ultrasound	2
Subacute Services	1

Source: Mitchell, Philpot, and McBirney (2021), updated to reflect recent legislative changes.

C. Application Costs

CON-application fees vary widely. Arizona, for example, charges a flat fee of $100, whereas Maine charges a flat fee of $250,000 (Cavanaugh et al. 2020, 4). Many states charge fees that vary in proportion to proposed capital expenditures. Hawaii, for example, charges a fee equal to

0.001% of the cost of the project; this percentage applies to the first $1 million of the project, and the state charges an additional 0.0005% for any costs above this amount (Cavanaugh et al. 2020, 49). In many cases, however, compliance and opportunity costs are far more significant than fees. Although there is no systematic data on compliance costs, it is clear that providers can spend months or even years preparing applications and that they may employ boutique consulting firms to help them navigate the process. Beyond these direct costs, providers lose the opportunity to provide services and generate revenue. This lost revenue can amount to tens or even hundreds of thousands of dollars in opportunity costs (Hoover 2012). There is no systematic data on approval rates across all states, but one analysis found that approval rates range from 51% (Virginia) and 57% (Georgia) to 77% (Michigan) (Stratmann and Monaghan 2017).

D. The Challenge of Assessing Need

Unlike regulations that attempt to weed out underqualified providers, such as licensure, need review is not designed primarily to assess a provider's qualifications, safety record, or fitness. Instead, CON review is designed to assess the degree to which the community "needs" the service in question. In most other markets, need is assessed by the entrepreneur, based on his or her expectation of profitability. There is a strong case to be made that need review is unnecessary; because providers are risking either their own capital or capital they have promised to repay, they have a strong incentive to carefully weigh the venture's financial viability. Need is typically assessed by market exchange; the best way to assess whether a product or service will create value in excess of its cost is to subject it to a market test. Whether a product or service is truly needed can be known only through the discovery process of market exchange—mediated

by the signals of prices, profit, and loss—and only by subjecting the product or service to the discipline of dynamic market competition (Kirzner 1997; Hayek 2002).

Regulatory need review attempts to substitute bureaucratic planning for the market test. However, regulators face three fundamental challenges in assessing need:

1. Need is subjective; it depends on the individually defined value that each consumer believes he or she will obtain from a service. A service that caters to the tastes and values of an ethnic or religious minority, for example, may create a great deal of value for members of that group but very little value for members of other groups.[7]
2. Need is local; it depends on the tastes, preferences, and opportunities of local consumers as well as the preferences, technologies, and costs (including opportunity costs) of local suppliers.
3. Need changes; most people were unaware that they needed electricity, penicillin, or the Internet before these things were invented. Indeed, research suggests that when health care providers can change their services without the requirement of proving need to a regulator, they are more likely to adapt to changing circumstances, technologies, and desires.[8]

E. Anticompetitive Aspects of Needs Assessment

Whereas other regulations are designed to address market imperfections such as asymmetric information or externalities, CON review *introduces* a market imperfection by limiting

[7] New York regulators initially denied a CON to an all-female Hassidic Jewish ambulance service, failing to appreciate that the service catered to the unique needs of this community. Similarly, Kentucky regulators denied a CON to a pair of Nepali immigrants who wanted to start a home health service that catered to the cultural and linguistic needs of their community. (Kessler 2020; Dipendra Tiwari, Kishor Sapkota, and Grace Home Care, Inc., v. Eric Friedlander, and Adam Mather 2022)

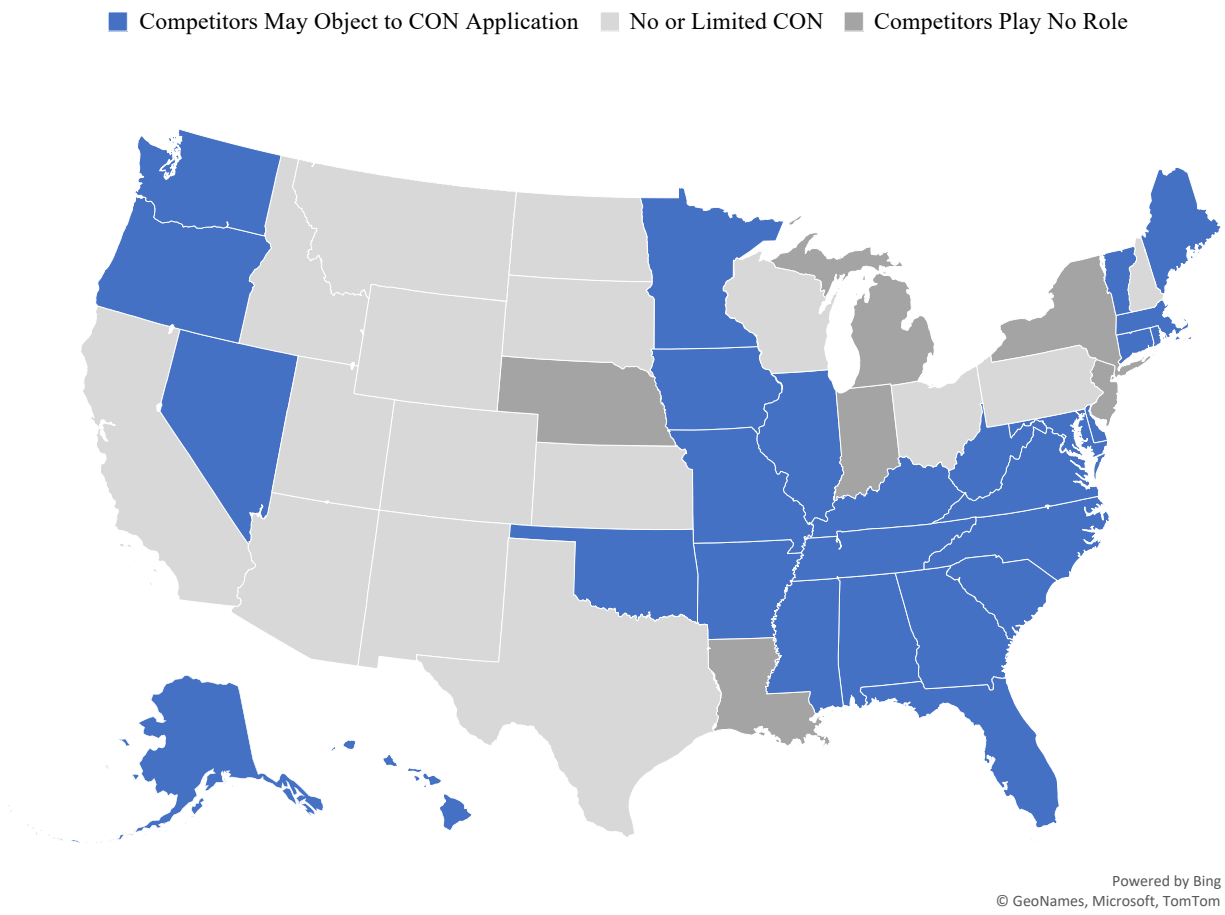
[8] "Hospitals located in states with stronger Certificate of Need laws are significantly less likely to convert [to offer other types of services] (8 percent less likely)." (D'Aunno, Succi, and Alexander 2000).

competition and—in extreme cases—creating local monopolies. Need assessment has several anticompetitive aspects:

1. Need assessment limits supply. As economists Jon Ford and David Kasserman explained nearly three decades ago, "The economic effect [of a CON] is to shift the supply curve of the affected service back to the left," and "the effect of such supply shifts is to raise . . . [the] equilibrium price" (Ford and Kaserman 1993, 783–84).
2. Decision-makers often have conflicts of interest. In many states, the decision to grant a CON is made by a board whose members are appointed by the governor (as discussed below, Mississippi does not have a CON board). Employees of incumbent providers are typically allowed to serve on this board, earning CON regulations the moniker "competitor's vetoes" (Sandefur 2015; Ohlhausen and Luib 2015). Even when the decision is made by an agency rather than a board, agency staff are likely to have been drawn from the industry itself because only industry insiders will have the knowledge and interest required for such positions (Dal Bó 2006).
3. In all but six CON states, incumbent providers are allowed to participate in the CON process and object to applications from would-be competitors (Figure 2). Opposition can trigger an expensive and time-consuming process featuring hearings that are similar to legal proceedings. Often, incumbents drop their objections after the applicant agrees not to encroach on the territory of the incumbent, a type of territorial collusion that would be a per se violation of the Sherman Antitrust Act if it were not facilitated by the state (Hovenkamp and Areeda 2020; see Chapter 20, Section 7, "Naked Market Division Agreements").

4. Even when potential competitors do not object to an application, statutory language and regulatory guidelines essentially ensure local health care monopolies. This occurs because the statutory language requires regulators to deny a CON if they believe the new service will "duplicate"—that is, compete with—an existing service.
5. Regulatory formulas used to assess need discourage competition. The formulas require regulators to account for the utilization of current health care services when assessing whether a new service is needed. For example, regulators survey incumbent hospitals regarding how many of their beds are currently being utilized. If the share of beds being used is low enough, regulators conclude that no new beds are needed and reject any new applications. Incumbent providers are thus incentivized to keep a certain share of their beds unoccupied; doing so will virtually ensure the rejection of CON applications from would-be competitors.

Figure 2. The Role of Competitors



3. Mississippi's CON Laws

A. The Goals of Mississippi's CON Program

According to regulatory guidelines issued by Mississippi's Office of Health Policy and Planning, "The intention of health planning and health regulatory activities is to prevent unnecessary duplication of health resources; provide cost containment, improve the health of Mississippi residents; and increase the accessibility, acceptability, continuity and quality of health services." ("CON Review Manual," n.d., 1). According to these guidelines, regulators aim to assess the needs of "all residents of the area—in particular low income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups, and the elderly" ("CON Review Manual," n.d., 50).

B. Mississippi Services Requiring a CON

Mississippi's CON program is more comprehensive than those of most other states. As Table 2 shows, the state requires a CON for 19 services and technologies. A CON is also required when a provider wishes to make certain capital expenditures. They must obtain a CON for the purchase of any medical equipment costing $1.5 million or more, any clinical services expected to cost $5 million or more, and any nonmedical health services expected to cost $10 million or more ("CON Review Manual," n.d., 8–9). Providers are also required to obtain CONs when they wish to relocate services by a distance greater than one mile or when a new owner wishes to acquire an existing facility ("CON Review Manual," n.d.).

Despite the aim of cost containment, the state requires a CON for low-cost modes of care, such as ambulatory surgical centers, home-health services, and swing beds. It also requires

CONs for services that are unlikely to be overprescribed, such as pediatric skilled nursing facilities, radiation therapy, renal-failure/dialysis care, and substance-use care. Finally, despite the goal of ensuring access for vulnerable and/or underserved populations, the state requires CONs for services that cater to several vulnerable populations, including intermediate-care facilities for those with intellectual disabilities, nursing-home services, psychiatric-care services, and substance-use services.

Table 2: Health Care Services Requiring a CON in Mississippi

Ambulatory Surgical Centers
Cardiac Catheterization
Gamma Knives
Hospital Beds (Acute, General, Med-Surg, etc.)
Invasive Diagnostic Services (e.g., Angiography)*
Long-Term Acute Care
MRI Scanners
Mobile Hi Technology (CT, MRI, PET, etc.)
New Hospitals or Hospital-Sized Investments
Nursing-Home Beds/Long-Term-Care Beds
Open-Heart Surgery
Pediatric Skilled Nursing Facilities*
PET Scanners
Psychiatric Services
Radiation Therapy
Rehabilitation
Renal Failure/Dialysis
Substance/Drug Use
Swing Beds

*Mitchell, Philpot, and McBirney's (2021) assessment did not include these services, so they are not counted in other states in the map shown in Figure 1.

Sources: Mitchell, Philpot, and McBirney (2021), Cavanaugh et al (2020), and Mississippi State Department of Health (2022).

C. *Mississippi's CON-Application Process*

In Mississippi, CON decisions are made by the State Health Officer, and his or her decisions are informed by professional staff analysis. The State Health Officer is appointed by the State Health Board, an 11-person body whose members are selected by the governor and serve staggered terms. CON applicants are required to pay a processing fee equal to one-half of one percent of the project's proposed capital expenditure. The fee can be no less than $5,000 and no more than $25,000 (Miss. Code Ann. § 41-7-188).

Before applying for a CON, an applicant may pay a $2,500 fee to request a "determination of reviewability," which provides the Department's opinion about whether a CON is needed. Once an applicant has requested such a determination, the Department publishes a notice on its website that the request has been made (giving potential competitors time to prepare an objection), and the Department is required to respond to the request within 45 calendar days (Miss. Code Ann. § 25-43-2.103).

Would-be competitors are allowed to object to an applicant's CON request. They may submit written comments opposing the application, request a hearing on the application, and appeal the final decision. If a hearing is requested, objectors are allowed to question the applicant and argue the case for denial (Miss. Code Ann. § 41-7-197(2)).

In evaluating an application, the Department considers 16 factors (Table 3).

Table 3: Factors Considered by the Department's CON-Application Assessment

1	State Health Plan	The proposal must demonstrate substantial compliance with the "State Health Plan," an annual publication of the State Board of Health that projects need across all CON-regulated areas of care.
2	Provider's Long Range Plan	Any long-range plans of the applicant.

3	Availability of Alternatives	The availability of less costly or more effective alternative services.
4	Economic Viability of the Project	The economic viability of the project with considerations of feasible charges and utilization rates. If the project's capital expenditures are equal to or greater than $2 million, the applicant must submit a financial-feasibility study prepared by an accountant.
5	Need for the Project	Need for the project. Regulators consider (1) the degree to which "low income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups, and the elderly . . . are likely to have access to those services" ("CON Review Manual," n.d., 50); (2) in the case of service providers requesting relocation, the needs of the community they are currently serving; (3) "the current and projected utilization of like facilities or services within the proposed service area" ("CON Review Manual," n.d., 50); (4) "the probable effect of the proposed facility or service on existing facilities providing similar services to those proposed" ("CON Review Manual," n.d., 50); and (5) any "significant opposition to the proposal . . . expressed in writing or at a public hearing" ("CON Review Manual," n.d., 51).
6	Access to the Facility or Service	The degree to which the service will increase access to care for medically underserved populations.
7	Information Requirements	The applicant's willingness to record and maintain records about utilization data; demographic data of patients; costs and charges per patient day and per procedure; and any charity care offered.
8	Relationships with Existing Health Care Systems	The provider's relationship with existing health care systems.
9	Availability of Resources	The availability of resources (both human and financial).
10	Relationship to Ancillary or Support Services	The provider's relationship to ancillary or support services.
11	Effect on Training Programs	The proposal's effect on health-professional training programs.

12	Access to the Facility for Training Programs	The degree to which health-professional schools in the area will be able to access the services for training purposes.
13	Special Needs of Entities That Serve People outside the Area	The special needs of entities that provide services to those who do not reside in the area.
14	Construction Costs	The construction costs of the project.
15	Competing Applications	In the case of "competing applications," "determination will be made that the entity approved is the most appropriate applicant for providing the proposed health care facility or service" ("CON Review Manual," n.d., 54).
16	Quality of Care When There Is Already an Existing Service	"In the case of existing services or facilities, the quality of care provided by those facilities in the past" ("CON Review Manual," n.d., 55).

Unless a hearing is requested, the Department is required to issue its recommendation within 45 calendar days of the application filing (or within 15 days of the receipt of any additional information). The state health officer is then required to issue his or her decision within 90 days of the application filing (Miss. Code Ann. § 41-7-197).

4. How CON Laws Affect Spending, Access, and Quality

The advocates of CON programs (typically, the representatives of large hospital systems) often characterize CON repeal as risky, dangerous, or fraught with unforeseeable consequences. They often point to the stated rationales of CON regulation and claim that if the regulatory regime were reformed or repealed, access will decline, spending will rise, and quality will suffer.

These concerns are unfounded. Over 100 million Americans—nearly a third of the population—live in states without CON laws in health care. Four in ten Americans live in states with limited CON regimes that apply to only one or two services, such as ambulance services or nursing homes. Economists, health researchers, and other social scientists have spent decades studying these regimes, comparing outcomes in CON and non-CON states and assessing changes in outcomes in those states that have either reformed or entirely eliminated their CON programs. The evidence from this research overwhelmingly suggests that CON regulations do not work as advertised.

To date, 118 peer-reviewed academic studies have assessed the effects of CON. Because most of these studies have assessed CON programs across multiple dimensions (e.g., cost and access), there have been over 400 empirical assessments of the regulations. These assessments typically include hundreds or thousands of observations, spanning most if not all states and covering several years if not decades. The studies have employed multivariable-regression analyses, which allow them to control for potentially confounding factors, such as local economic or demographic characteristics that might affect outcomes.

Fortunately, policymakers who wish to understand the effects of CON laws can avail themselves of a surfeit of evidence. Few regulations have been so well studied. Moreover, the

evidence is quite clear: CON laws are associated with higher spending (Ho and Ku-Goto 2013; Bailey 2016, 2019), reduced access (Stratmann and Russ 2014; Myers and Sheehan 2020; Mitchell and Stratmann 2022), and diminished quality of care (Ghosh, Roy Choudhury, and Plemmons 2020; Chiu 2021; Stratmann 2022). CON laws are also associated with worse outcomes for underserved populations (DeLia et al. 2009; Stratmann and Koopman 2016). None of this evidence, however, should be surprising. Standard microeconomic models suggest that supply restrictions with anticompetitive features such as this are likely to shift supply inward, raise per-unit costs, diminish access to care, and undermine quality of care. For Mississippi policymakers who wish to act on this information, the next section offers a menu of options for reform.

5. What to Do

A. The First and Best Option: Full Repeal

The first and best option for addressing Mississippi's CON program would be to simply repeal the sections of the law that authorize it: Miss. Code Ann. § 41-7-171 through Miss. Code Ann. § 41-7-209.

With full repeal, Mississippians can expect to spend less per procedure and less per patient. For example, reimbursements for coronary artery bypass grafts fell by 9% in Pennsylvania and 3% in Ohio following CON repeal (Ho and Ku-Goto 2013). Compared with hospital charges in CON states, those in non-CON states are 5.5% lower five years after repeal (Bailey 2016). Medicare reimbursements for total knee arthroplasty are 5%–10% lower in non-CON states than in CON states (Browne et al. 2018). Spinal-surgery reimbursements fall faster (by about 11% per year) in non-CON states than in CON states (Ziino, Bala, and Cheng 2020). The costs of total knee and total shoulder arthroplasty are lower in non-CON than in CON states (Schultz, Shi, and Lee 2021). Non-CON states have lower hospital expenditures per admission (Rivers, Fottler, and Frimpong 2010), slower growth in Medicare and Medicaid expenditures on nursing-home care (Rahman et al. 2016), and 4% lower real per capita health care expenditures (Bailey 2019).

With full repeal, Mississippians could also expect greater access to care. If the trends in other states held in Mississippi, they could expect to be served by about 30% more hospitals and 14% more ambulatory surgical centers (Stratmann and Koopman 2016). They could expect to find more hospitals offering coronary artery bypass graft surgery (Vaughan Sarrazin, Bayman, and Cram 2010), cardiac revascularization (Popescu, Vaughan-Sarrazin, and Rosenthal 2006; Li and Dor 2015), and coronary angiographies (Cantor et al. 2009; DeLia et al. 2009). They could

expect to see more hospitals per cancer incident (Short, Aloia, and Ho 2008), more medical imaging services (Stratmann and Russ 2014; Horwitz and Polsky 2015; Perry 2017; Baker and Stratmann 2021), and more neonatal intensive care units as well as more beds in each unit (Lorch, Maheshwari, and Even-Shoshan 2012). In the absence of CON laws, Mississippians could expect to encounter shorter wait times for admittance, examination, pain-medication administration, and discharge (Myers and Sheehan 2020). Finally, during the next pandemic or emergency, their hospitals would be less likely to run out of beds (Mitchell and Stratmann 2022).

With full repeal, Mississippians could also expect to enjoy higher-quality care. For example, compared with patients in CON states, those in non-CON states experience better outcomes along eight dimensions of quality, including lower mortality rates among surgical inpatients with serious treatable complications, lower mortality rates for heart attack, heart failure, and pneumonia, and higher patient ratings (Stratmann 2022). During the Covid pandemic, patients in non-CON states had lower levels of mortality from natural death, septicemia, diabetes, chronic lower respiratory disease, influenza or pneumonia, and Alzheimer's (Ghosh, Roy Choudhury, and Plemmons 2020).

Compared to home-health patients in CON states, those in non-CON states experience higher levels of functional improvement for bathing, ambulating, transferring to beds, managing oral medication, and managing pain, as well as lower ER and acute-care admissions (Wu et al. 2019). Knee-arthroscopy patients in non-CON states experience fewer ER visits within 30 days of their procedures and fewer infections within six months of their procedures (Cancienne et al. 2020). Patients going into surgery in non-CON states are more likely to be operated on by high-quality surgeons (Cutler, Huckman, and Kolstad 2010). Home-health-agency patients in non-CON states can expect their agencies to receive higher ratings from the Centers for Medicare and Medicaid

(Ohsfeldt and Li 2018). Finally, nursing-home patients in non-CON states are less likely to be physically restrained (Zinn 1994).

Among Mississippi's populations, its vulnerable and underserved patients are the most likely to benefit from full CON repeal. In a Mississippi without CON, those struggling with substance-use disorders would be more likely to find the help they need (Noh and Brown 2018), and they would be more likely to find substance-use-treatment facilities that accept private insurance (Bailey, Lu, and Vogt 2022). In the absence of CON, Mississippians seeking psychiatric care could expect to find more treatment options and more facilities that accept Medicare (Bailey and Lewin 2021).

In a Mississippi without CON, the state's safety-net hospitals could expect to earn higher margins, making it easier for them to care for the state's lowest-income patients (Dobson et al. 2007). In the absence of CON, the state's cancer and Medicare patients would be less likely to be crowded out (Perry 2017). The state's African American population would be more likely to receive potentially life-saving screenings (Cantor et al. 2009; DeLia et al. 2009).

The state's rural community also stands to gain. In a Mississippi without CON, rural patients could expect to be served by 30% more rural hospitals and 13% more rural ambulatory surgical centers (Stratmann and Koopman 2016). Rural hospitals would be more likely to adapt to changing needs (D'Aunno, Succi, and Alexander 2000). Rural patients could expect to travel shorter distances for hospice care (Carlson et al. 2010) and for CABG, and they would be less likely to leave the state to obtain care (Baker and Stratmann 2021).

B. Phased Repeal

The first states to eliminate their CON laws did so immediately. Some, like Colorado, acted before the federal government by passing legislation that would automatically end their programs in the event that the federal inducement was eliminated (Colo. Rev. Stat. § 25-3-521 (1982)). More recently, however, states have chosen to phase out their CON programs over time. In 2019, for example, Florida immediately eliminated several CON requirements but repealed hospital CONs two years later. This approach was also used in South Carolina in 2023.

One benefit of phased repeal is that it allows providers who recently made expensive investments to adjust to the new regulatory regime. For example, a provider who has recently purchased an expensive piece of imaging equipment may have made the investment with the expectation that CON laws would continue to be enforced. Lawmakers might consider immediately eliminating CONs for services with minimal capital requirements, such as psychiatric care, but phasing out CONs for more capital-intensive services over a number of years.

C. Eliminating CONs That Disproportionately Harm Vulnerable Populations

Another option for reform would be to eliminate CONs that disproportionately limit care for vulnerable and underserved populations (the list of services associated with such CONs can be found in Miss. Code Ann. § 41-7-191). For example, the state might consider eliminating the CON requirement for pediatric skilled nursing facilities, the CON for psychiatric services, or the CON for substance-use-treatment facilities. In doing so, the state would join reformers such as North Carolina, which recently eliminated its CON requirements for chemical-dependency treatment and psychiatric services (N.C. Gen. Stat. § 131E-176).

D. Eliminating CONs for Low-Cost Alternatives to Care

Given the stated purpose of encouraging low-cost alternatives to care, Mississippi might also consider eliminating CONs that limit the provision of low-cost modes of care. Prime candidates in this category include ambulatory surgical centers,[9] home-health agencies, pediatric skilled nursing facilities, psychiatric services, substance-use-treatment facilities, and intermediate-care facilities.

E. Eliminating CONs for Procedures That Are Unlikely to Be Overprescribed

CON regulations were originally conceived to stop providers from overprescribing expensive and/or unnecessary procedures. Thus, another option for repeal is to eliminate CONs that limit the supply of services that are unlikely to be overprescribed. Good candidates in this category include the CONs for pediatric skilled nursing facilities, home-health care, radiation therapy, renal-failure and dialysis clinics, and substance-use-treatment facilities.

F. Raising Thresholds

A simple and easy way to exempt more procedures from CON review would be to raise the thresholds that trigger a CON and require that these thresholds automatically adjust to inflation (these thresholds are defined in Miss. Code Ann. § 41-7-173). So, for example, the threshold for the purchase of medical equipment might be raised from $1.5 million to $3 or $4 million (in Illinois, for example, the threshold for such purchases is over $3.5 million and it is annually updated to account for inflation (Cavanaugh et al. 2020, 57)).

[9] Ironically, the National Health Planning and Resources Development Act specifically adduced encouragement of ambulatory care as a rationale for CON regulations.

G. Altering the Standards for Assessing Need

Miss. Code Ann. § 41-7-187 empowers the Department to set its own standards and criteria for CON review, and Table 3 lists the Department-established criteria that are currently in use. Several of these standards might be altered. For example, the state should not assess need using "the current and projected utilization of like facilities or services within the proposed service area" ("CON Review Manual," n.d., 50). As explained above, this standard incentivizes current providers to keep a certain share of their facilities underutilized because underutilization increases the odds that a new CON request will be rejected. Nor should regulators consider "the probable effect of the proposed facility or service on existing facilities providing similar services to those proposed," because that would bias the process against competition. Nor should they take account of "significant opposition to the proposal . . . expressed in writing or at a public hearing" if it comes from a would-be competitor. Finally, the Department's manual should not state that "the intention of health planning and health regulatory activities is to prevent unnecessary duplication of health resources," because this would imply that the intention is to ensure a monopoly on provision of care ("CON Review Manual," n.d., 1).

H. Ending the Competitor's Veto

The most controversial aspects of CON review are its anticompetitive features. As discussed above, incumbent providers are allowed to take part in the CON-review process. They may object to an applicant's CON request, submit written comments opposing the application, request a hearing on the application, and appeal the final decision. If a hearing is requested, they are allowed to question the applicant and argue the case for denial (Miss. Code Ann. § 41-7-197(2)).

Taken together, these attributes of the process amount to a "competitor's veto" (Sandefur 2015; Ohlhausen and Luib 2015). Moreover, from the perspective of public welfare, none of them are justified. Six CON states forbid competitors from taking part in the CON-evaluation process, and Mississippi lawmakers who wish to strip the process of its most anticompetitive features could make Mississippi the seventh state to do so.[10]

I. Lowering the Costs of Compliance

Another way to ease the burden of CON is to lower its compliance costs. Direct costs could be reduced by lowering the fees the state charges applicants, and indirect costs could be decreased by reducing the paperwork burden of the process. This could be accomplished by radically reducing the number of factors considered by the Department, listed in Table 3.

J. A Duty to Follow Up on Denied Applications

Whenever a regulation restricts the supply of a service, it is difficult to know what might have been the case in the absence of the restriction. One way the Department can better understand the effects of its decision on an application is to follow up with applicants whose CONs have been denied. The Department might ask such applicants to estimate the forgone provision of services or to report any difficulties in providing care they have encountered as a result of the denial.

K. Increasing Transparency

Finally, lawmakers could pave the way for future reforms by increasing the system's transparency. The Department currently reports the status of CON applications by posting

[10] The other states are Indiana, Louisiana, Michigan, Nebraska, New Jersey, and New York. For more details, see Cavanaugh et al. (2020, 4, 61, 75, 89, 117, 131).

weekly CON reports on its website. The reports, however, are organized by week instead of by application, so anyone interested in understanding the fate of all the applications submitted over the course of a given year must download and read 52 reports, cross-checking the names of projects across all of them. A more transparent way to report this information would be organize the reports by project. In addition, the Department should publish not only the staff's recommendations but the State Health Officer's final decision, which is currently communicated only to the applicant. Better yet, the Department could be required to track certain statistics and report them to the public on a regular basis. It would be especially helpful to know the following:

1. The percentage of applications that are opposed by competitors
2. The percentage of applications that are approved by the Department
3. The percentage of approved applications as well as the percentage of such applications opposed by competitors and the percentage unopposed by competitors
4. The average length of time the Department takes to make a decision on an application as well as the average length of time the Department takes for opposed and unopposed applications

The state might also consider surveying applicants to gather information that would help the public understand the costs of the regulations. For example, applicants could be asked to estimate the amount of time and money the application process has cost them and/or the number of patients they have been unable to treat while awaiting CON approval. It is difficult to know how many providers have never applied for CONs because they are discouraged by the direct and indirect costs of the process.

6. Conclusion

Mississippi policymakers who wish to increase access to lower-cost and higher-quality care should consider repealing the state's CON laws. As a guide, they can look to the experiences of the one-in-three Americans who live in states with no CON laws in health care. These experiences have been documented in 118 peer-reviewed studies that collectively contain over 400 separate empirical assessments. An overwhelming majority of these tests associate CON regulations with detrimental outcomes, such as higher costs, diminished access, lower quality of care, and more limited services for underserved populations.

Mississippi's policymakers can also look to other states for guidance on how to reform its CON program. This paper presents several options, ranging from full repeal to increased transparency.

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