Health Services Planning
Certificate of Need Regulation
Mississippi

American Health Planning Association
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Acknowledgements

This report presents an assessment of selected aspects of Mississippi's Certificate of Need (CON) program. The study is responsive to the legislative mandate outlined in House Bill1221 (2006). Mississippi CON program coverage and operations are examined in the context of regulatory practices and trends nationally and in the light of evolving health care industry and market conditions.

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Executive Summary

Mississippi is one of the 25 states that have continuously maintained a certificate of need (CON) program for nearly three decades. The number and array of facilities, services, and equipment subject to review are comparable with the majority of states that have CON regulation.

Surveys and interviews of key stakeholders reveal a comparatively high level of support for the Mississippi program. Aspects of the program, and how it is implemented, give rise to a number of specific concerns. There is substantial agreement, however, that planning and CON regulation are beneficial, especially in helping ensure the economic stability of essential community hospital and long-term nursing care services.

Modest in size, and with limited resources, the program has a dedicated, public-spirited staff. Among the program's strengths are its commitment to maintaining a current, up-to-date state health plan and an efficient, user friendly website that makes basic planning and CON information available in a timely manner. The state health plan is more current than comparable plans in many other states.

Current review procedures, processes and timelines compare favorably with those in the majority of state CON programs. The average review periods for standard and expedited reviews are reasonable, and are comparable with, or shorter than, those reported in most other states. Although concern has been expressed about the number of administrative and judicial appeals in recent years, the percentage of applications in these categories is not significantly higher than in most other states and is lower than in some.

Several distinct features limit the regulatory scope and reach of the program. These include a high medical equipment review threshold, an unusually broad single specialty surgery center exemption, and a unique provision that permits conversion of regulated mobile services to fixed site services outside of CON review. These provisions, and the way they are implemented, make the Mississippi CON program unique. No other CON program contains all three features. They introduce a degree of uncertainty in planning, give rise to questions about fairness and equitable treatment of those subject to regulation, and are likely to be increasingly problematic for the long-term stability and viability of community hospitals.

There is no compelling evidence that the program is "broken" or needs to be "fixed". There are, however, a number of administrative, planning, and policy changes that should be considered as possible ways to improve program efficiency, effectiveness, and fairness. Consideration should be given to the following:

Policy Considerations

Several policy changes are needed to restore, or otherwise ensure, basic fairness and equity among CON applicants and existing service providers. Most of these changes would require legislation. They would also help maintain confidence in the program.

1. ***Regulation of Medical Office Buildings:*** The current practice of reviewing capital expenditures for some medical office buildings, depending on where they are located and on who controls them, is not equitable. These projects and expenditures should be treated equally regardless of setting. There is little argument that the law should be expanded to cover all medical office buildings. Consequently, consideration should be given to exempting medical office buildings from CON review. Services and equipment subject to CON regulation that may be offered or placed in medical office buildings should continue to be regulated in that setting.

2. ***Medical Equipment Capital Expenditure Threshold:*** The current medical equipment capital expenditure review threshold is higher than that of most states. This, and the permutations associated with the implementation of the threshold, creates disincentives for efficient program operations, permits "gaming" of the review process, and does not treat all service providers equally. Consideration should be given to eliminating the medical equipment capital expenditure review threshold, exempting all equipment replacement projects from review, and requiring the review of all new services and all expansions (equipment additions) of covered services and medical equipment. This pattern of coverage would be more easily understood and administered, would establish a "level playing field," and would be equitable to affected parties.

3. ***Conversion of Mobile Services to Fixed Services:*** The current practice of permitting existing mobile service sites to convert to fixed service sites outside of CON review is problematic. It generates considerable uncertainty and instability, making effective planning for the affected services unusually difficult. It also raises fairness and equity concerns. Consideration should be given to interpreting the conversion of a mobile service to a fixed site service as the establishment of a new service requiring review and CON approval.

4. ***Paper Hospital Beds:*** Currently, licensed hospital beds can be taken out of service and "banked" indefinitely. Consideration should be given to adopting the practice of a number of states where surplus beds (and health care facilities) are removed permanently from the licensure rolls if they are not actively used to provide patient care during the previous year (12 months). This would be consistent with the provision that a facility that has closed a medical service for 12 months must obtain a certificate of need to reopen that service.

5. ***Single Specialty Surgery Centers:*** Exclusion of single specialty surgery centers from review is one of the more striking features of the Mississippi CON program.

Mississippi is one of four CON states that have such exemptions. The Mississippi exemption arguably is the most inequitable. Consideration should be given to establishing a level playing field by requiring CON review of the establishment and expansion of all surgery centers that seek licensure and Medicare certification.

6. ***Conditioning CON Approvals:*** Most state CON programs permit conditional approval of applications. Under existing rules, Mississippi CON applications may be approved or disapproved as submitted, or approved "by modification, by reduction only". This limitation reduces the flexibility of the CON program. States that permit conditional approval use conditions to achieve a number of health policy goals and objectives, often to assure equitable access to care. Conditional approvals might prove equally useful in Mississippi. Permitting conditional approval also might reduce the number of appeals of CON decisions. Consideration should be given to permitting approval of CON applications with conditions.

7. ***Facility Capital Expenditure Review Threshold:*** The current facility capital expenditure review threshold is $2.0 million. This is the national median among state CON programs with expenditure thresholds. Given the rapid increase in construction costs recently, and significantly higher financing costs, consideration should be given to indexing the health facility expenditure threshold, or to establishing a higher threshold for non-clinical services.

8. ***Patient-Level Health Data System:*** Mississippi and Idaho are the only states that do not have, or are not developing, a statewide patient-level hospital discharge database. There are many indications of the need for such data. Comprehensive patient level data are needed to permit the better informed and more precise planning that is required to improve CON regulation, particularly in ensuring fairness and equity among service providers. Consideration should be given to working with the Mississippi Hospital Association to establish a comprehensive all payer patient-level hospital discharge data system as soon as possible.

9. ***Nursing Home Moratorium:*** The moratorium on nursing home development has been in place for nearly two decades. It should be replaced with a restructured prospective planning process. The redesigned planning process should be built around a call or request for applications feature that permits better control of the number of beds that may be authorized during any given period. It should incorporate use rate trends, occupancy levels, and Medicaid program use and budget considerations. This approach has worked well elsewhere and should be examined to determine how the underlying principles might best be applied in Mississippi

10. ***Planning District Configurations:*** Planning districts of varying number and size are used in health services planning and CON regulation. There have been specific proposals to change the boundaries of some of these districts. More data than is now available, particularly service-specific patient origin and destination data, are needed to assess reliably the relative value and usefulness of different district configurations. The existing boundaries, which now have little material effect on CON decisions, should be maintained unchanged until these data are obtained and analyzed.

Administrative and Procedural Considerations

1. ***Batch Processing and Letter of Intent Requirement***: The quarterly batch processing cycle, under which applications for any service may be filed four times annually, should be changed to an annual or semiannual cycle with staggered filing dates for defined service categories. This arrangement would promote competitive review of like proposals. The letter of intent filing requirement should be retained, incorporated in the restructured batch processing cycle, and enforced consistently.

2. ***Expedited Review***: Consideration should be given to expanding the number and type of applications that qualify for expedited review. Applications proposing only non-clinical capital expenditures of more than $2.0 million, now subject to the standard review process, should be considered for expedited review. These include proposals to develop parking structures, construct administrative (non-clinical) space, and upgrade data systems.

3. ***Capital and Operating Leases***: There is concern that some applicants may portray capital leases as less costly annual operating leases and, thereby, avoid CON review of some projects. Consideration should be given to developing and applying rigorously and consistently a set of rules that define clearly what constitutes lease expenses and under what set of circumstances those costs must be capitalized over the expected useful life of the project.

State Health Plan

Many aspects of the Mississippi State Health Plan are commendable. It ranks high among comparable state plans in terms of its currency and clarity. The plan compares favorably with most other state health plans (including state medical facility plans) in being updated annually and made available to interested and affected parties. It is also superior to many in inviting public and interested party participation early in the development process. It is relied on heavily in the review of CON applications.

Its strengths notwithstanding, there are a number of areas where changes in the plan might encourage better institutional and community planning by providers of health services and would facilitate more effective or more equitable CON regulation. The changes that should be considered are delineated in Section III.

Study Question Summary Responses

1. Can review periods (including appeals) be reduced without compromising fairness?

Response: Recent and current average review periods are reasonable. They are generally consistent with, or shorter than, review periods found elsewhere. The Mississippi CON program contains a number of procedural and public interest safeguards that extent the average review period. There is no compelling reason to arbitrarily reduce review periods, or circumscribe procedural safeguards (e.g., appeal rights), in order to reduce the average lengths of CON reviews.

Findings: Average review periods have increased over the last decade. Nevertheless, the average review period in Mississippi compares favorably with those in most other states, including "peer" states with comparable CON programs. The increase in the length of the average review period appears to result from the reduction in the scope of the program over the last decade, principally from elimination of less controversial and complex projects from review and raising both the facility and the medical equipment capital expenditure review thresholds. These changes result in large and more complex projects being a larger percentage of the residual pool of projects considered. The residual pool of projects also contains those more likely to generate opposition and subsequent requests for public hearing.

Notwithstanding the procedural safeguards, average (and median) review periods for CON applications are reasonable. In general, decisions on applications that are not delayed by public hearings are rendered within 135 days, within 90 days of the publication of the departmental staff analysis of the project. Decisions on about three-fourths of all applications are published within 135 days. Nearly all of those with review periods of 135 days or longer are delayed by requests for public hearings. The average (and median) review period compares favorably with other CON programs with a similar scope of coverage. It would be difficult to reduce the average review period without changing the procedural safeguards (e.g., limiting the right of appeal) that are now a part of the program.

Virtually all interest and affected parties would like shorter review periods, but few would like to see appeal rights or other procedural safeguards circumscribed. Due process, equitable treatment, and transparency are essential aspects of any credible regulatory program. These aspects of the program should not be sacrificed in order to reduce review periods.

2. Can additional "non-substantive" transactions be exempted from CON review?

Response: Because of the reduction in the scope of the Mississippi CON program over the last two decades, most "non-substantive" projects have already been exempted from review, as have a number of projects that are considered "substantive" in many states. Consequently, there are few, if any, non-substantive projects remaining to exclude from coverage.

Although they are not considered non-substantive, two categories of projects that might be exempted for other reasons are end-stage renal disease services and hospital affiliated medical office buildings.

Findings: Mississippi's CON program is not overly regulatory or burdensome. Program changes over the last two decades have reduced the number and array of services, facilities, and medical equipment subject to review. Review caseloads now average about 50 applications a year. Compared with programs that regulate both acute care and long-term care services, and with neighboring and peer states, the scope and reach of the Mississippi program are limited.

Three notable features limit the effective scope of the program. The first is the relatively high medical equipment capital expenditure review threshold. Only six states have a higher threshold. The comparatively high equipment review threshold means that, though nominally subject to review, many equipment transactions are not reviewed.

The unusually broad exemption for single specialty surgery centers from review also limits scope of the program. Nationally, twenty-seven state CON programs cover ambulatory surgery centers. Only four (Georgia, Maryland, Mississippi, and Washington) exempt single specialty centers from review. The Mississippi exemption is the broadest of the four. It has no size (number of operating rooms), capital expenditure, or other limitation. As implemented, the exception also opens the door to the conversion of single specialty surgery centers to multi-specialty centers without CON review.

The third feature of the Mississippi CON program that limits its reach is the unique provision that exempts the conversion of mobile services to fixed site services from review, provided the project does not have some other feature that triggers review. This provision eliminates review of a substantial number of medical equipment projects.

No other state CON program has all three of these features. The principal questions raised by an examination of the scope of the Mississippi CON program relate to whether, as implemented, the focus of the program is too narrow rather than whether it is overly regulatory.

3. Can additional transactions be handled as expedited reviews?

Response: Currently, a number of non-clinical proposals that entail capital expenditures of more than $2.0 million are subject to the standard review process. These include

proposals to develop parking facilities, construct administrative (non-clinical) space, and upgrade data systems. The nature of these projects, especially the economic incentives inherent in them, makes them good candidates for expedited review.

If not exempted from review, most proposals to construct medical office buildings could also be handled under the expedited review process.

Findings: Current review policies and practices provide for an expedited review process for less substantive projects. Projects that qualify for expedited review include cost overruns, changes in ownership, service and facility relocations, and changes that may be necessary to comply with licensure standards and building codes. The current policy is to render decisions on these applications in 90 days or less. In most instances, this goal is met.

Consideration might be given to changing the basic nature of expedited review. Currently, expedited review of projects in Mississippi means only that review on such projects begins before the formal quarterly batch cycle initiation date. It does not mean necessarily that the actual review process is abbreviated, that application filing and data requirements are reduced, or that other aspects of the review process are minimized. A true expedited review process, which reduces filing requirements and focuses review narrowly on specific key questions and issues could prove useful. Projects that logically would qualify for less intensive review include the non-clinical capital expenditure proposals mentioned above, as well as projects that involve replacement of obsolete physical plant or equipment. Amending the CON law, or changing regulations, to create this category of review and limiting the opportunity to intervene in the expedited review process might be necessary to assure that the expedited process works as planned.

4. Are population projections reliable and used appropriately?

Response: Virtually all CON programs rely on official state population estimates and projections. The Mississippi program uses population data published by the Center for Policy Research and Planning, a component of the Mississippi Institutions of Higher Learning (IHL). The current plan is based on the IHL's projections for the year 2010. It contains population estimates and projections by county for 2010.

There is no evidence of strong concern or dissatisfaction with the population data used in the state health plan or in CON reviews. The principal limitation in planning and analysis relates to lack of a patient-level health service and facility (inpatient and outpatient) use data, not to inaccurate or inappropriate population data.

Findings: There is no evidence of strong or widespread dissatisfaction with the population data used in the state health plan or in CON regulation. The program relies on the data developed by the Center for Policy Research and Planning, a component of the Mississippi Institutions of Higher Learning (IHL). The current state health plan is based on the IHL's projections for the year 2010. Population growth and change in Mississippi

has been comparatively low. Although there is considerable variation within the state, this overall pattern is not expected to change soon.

Those surveyed and interviewed expressed confidence in state demographic data and acknowledge that the State Health Plan, which is updated annually, contains the most recent official IHL population estimates and projections. In addition, as is the case in other states, the Mississippi CON program is sufficiently flexible to permit applicants to cite other population sources and data if they believe it materially supports their application and arguments. In addition to the IHL estimates and projections, a number of applicants use Claritas population estimates and projections and data from other sources in their applications. These data and the calculations based on them are given their proper weight.

Examination of the state health plan, and staff reports on specific CON applications, indicate that the major analytical limitation is the absence of service-specific use rates and trends. This arises not from weak or inaccurate population data, but from the lack of patient-level hospital discharge and outpatient use data. Mississippi is one of only two states that does not have, or is not developing, a comprehensive all payer patient level discharge data system. These data are needed to permit more accurate and meaningful use of population estimates and projections.

5. **Is appropriate consideration given to how residents choose health care services?**

Response: The current state health plan does not address directly the question of how residents choose a source of care. Neither does it consider the resulting medical trade patterns and primary service areas. The lack of comprehensive patient-level use and patient origin data, particularly for acute care services (inpatient and outpatient), makes it difficult to document geographic and service specific use rates and medical trade patterns.

Department staff tries to compensate for the lack of planning data by conducting periodic (quarterly) samples of hospital discharges. A quarterly sample of a limited number of data elements (between one-third and one-half of those collected in many state patient-level data systems) is available. These data are useful, but do not provide adequate information to perform reliable small area analyses. This effort is commendable, but compensatory.

Findings: Patient origin and medical market data are limited. Mississippi is one of only two states that do not have patient-level hospital discharge data systems. There are many indications of the need for such data. The data are needed to permit the better informed and more precise planning that is required to improve CON regulation, particularly in ensuring fairness and equity among service providers.

Consideration should be given to working with the Mississippi Hospital Association to establish a comprehensive all payer patient-level hospital discharge data system as soon as possible. Any system developed should include the collection of outpatient data for

hospitals and all other freestanding services and facilities subject to CON regulation. Data collection should not be limited to hospital services alone.

6. **Does the state health plan give adequate and appropriate consideration to interstate migration for services subject to CON regulation?**

Response: The current state health plan does not address directly the question of interstate migration for health care services. Again, the lack of comprehensive patient-level use and patient origin data, particularly for acute care hospital services, makes it difficult to document medical trade patterns the primary service areas of health care facilities.

Findings: Patient origin and medical market data are limited. Department staff tries to compensate for the lack of data by conducting periodic (quarterly) samples of hospital discharges. This effort is commendable, but it is time consuming and inadequate to meet planning and CON regulation needs. Given the lack of comprehensive patient origin and destination data for Mississippi facilities, and only limited information of the use of health care facilities in other states by Mississippians, the state health plan does not take migration for care into account in planning for the development of institutional health care services.

The hospital use data that are available from neighboring states indicates that net migration between Mississippi and three neighboring states, Alabama, Arkansas, and Louisiana, is not substantial. About 1,800 Mississippi residents use Alabama hospitals each year and several hundred Alabama residents use Mississippi hospitals. Net migration is not significant. Patient origin data are not available to assess the flow of hospital patients between Mississippi and Arkansas and Louisiana, but all indications are that patient flow in both directions is low and that net migration is not significant for planning purposes.

There is substantial migration to Memphis, Tennessee hospitals by residents of North Mississippi. Excluding those using Veterans Administration hospitals, more than 18,500 Mississippians used western Tennessee hospitals in 2005. Virtually all of these hospitals are in the Memphis metropolitan area. More than half of those using Memphis area hospitals came from four counties (Desoto, Marshall, Tunica and Panola), with 75% (6,983 of 9,344 discharges) coming from Desoto County. The northern Mississippi migration pattern is essentially one way. Comparatively few Tennessee residents use Mississippi hospitals.

It should be stressed that this does not mean that an additional hospital or substantial numbers of additional hospital beds, beyond those that have already been authorized, are needed in one or more of the northern Mississippi counties to meet this need. As has been the case in other metropolitan areas, this pattern will change gradually as those moving into the rapidly growing areas loosen ties to Memphis and reorient to their new communities.

With the exception of travel to Memphis hospitals, net migration for care to neighboring states for care is not significant. A patient-level hospital discharge data system is needed to make these data describing the geographic use patterns and medical trade patterns routinely available within Mississippi and available for exchange with neighboring states.

7. Do the current planning district configurations affect disproportionately or negatively the treatment accorded to health service and facility projects subject to CON review?

Response: The geographic areas (planning districts) now delineated in the state health plan and used in CON review are based on traditional planning principles and considerations. They were not arbitrarily drawn and are not inherently illogical or biased against any community or service provider. It is noteworthy that the acute care districts are generally consistent with the Mississippi hospital referral regions and service areas service areas identified by Dartmouth Medical School researchers in their analysis of Medicare hospital discharge data.

Given the large surplus of hospital capacity, and the long-standing moratorium on nursing home development, the planning districts currently have only limited application in CON review. There is little reason to change the districts until comprehensive patient level discharge become available and is assessed to determine the most appropriate configurations based on local use rates and medical trade patterns.

Findings: The planning areas now in use are variations, in most cases aggregations, of the nine public health districts established by the Mississippi Department of Health (MDH) in 1980. It established these districts to provide a regional structure to facilitate management of the public health programs and services for which the Department is responsible. The Board of Health subsequently modified the public health district structure to form the existing acute care and long-term care districts.

Cursory examination of the GHSA districts may suggest a haphazard, or even arbitrary demarcation, but that is not the case. Comparison of the GHSA districts indicates that an effort has been made to reflect general development and medical trade patterns. It appears that the boundaries were drawn to reflect established medical trade patterns. When established, they were county groupings wherein the large majority (>90%) of residents obtain hospital services.

The boundaries chosen for the acute and long-term care planning districts reflect many of the principles normally associated with health services planning. Though not homogenous or equal in all respects, the effort to establish roughly equivalent districts that reflect population distribution, transportation routes, general development patterns, and medical trade patterns is evident. Although the size and population density of the districts vary greatly, relative (proportional) distribution of the state's population among both the acute care and the long-term care planning districts has remained stable since 1980. This is likely to remain the case for the next decade or more.

Any change to the current planning district boundaries should be based on an analysis of operational data and a showing that the proposed reconfiguration would be likely to result in more precise and accurate need assessments that would be conducive to more effective planning and regulation. There is a need for more complete patient level hospital discharge data that would permit reliable service-specific use rates to be calculated, patient origin and destination patterns documented, and medical markets and trade patterns defined. Less extensive, but reliable patient origin and destination data are needed for long-term care services. Any significant change in planning boundaries should await the collection and analysis of these data.

8. Are the service-specific review criteria, standards, and formulas specified in the sate health plan appropriate and equitable?

Response: Most of the service-specific review criteria, standards, and formulas presented in the state health plan and used in CON review are similar to those used in peer state CON programs. The deficiencies identified are that there is little distinction between optimal and minimum use, inconsistent delineation of service planning horizon, little reference to service volume quality standards, lack of consideration of technological advances, and some service volume standards are lower than those in many states. The other principal concern is that the hospital and nursing home bed formulas, as now structured, over estimate (project) bed need demand.

Findings: Service-specific findings are discussed in Section III, pages 56-63. They are summarized in Section IV, pages 65-69.

9. What are the effects, if any, of the large surplus of licensed hospital beds on the validity and credibility of the state health plan and its use in CON review?

Response: The enduring large hospital bed surplus, both actual licensed capacity and previously licensed beds that may be brought back into service outside of CON review, make rational planning for acute care capacity difficult. Current practices contribute to uncertainty and market instability. They also undermine confidence in the program.

Findings: The large surplus of licensed acute care beds results from structural changes in the health care delivery system. Decreases in inpatient demand, resulting largely from the shift to outpatient care where appropriate, have not be accompanied by equivalent reductions in licensed inpatient capacity. There is little likelihood that most of surplus hospital beds that now exists will be brought back into service.

Licensed hospital beds can be taken out of service and "banked" indefinitely. Hospitals that have been closed for up to five years may be reopened without undergoing CON review, provided the reopening does not otherwise trigger CON review. With thousands of surplus acute care beds statewide, these circumstances create market uncertainty and instability, and make realistic planning all but impossible. There is some evidence of an emerging "market" for selling and leasing unlicensed and unused beds. None of these considerations are conducive to effective planning or equitable regulation.

Consideration should be given to adopting the practice of a number of states where surplus beds (and health care facilities) are removed permanently from the licensure rolls if they are not actively used to provide patient care during the previous year (12 months). This would be consistent with Mississippi's provision that a facility that has closed a medical service for 12 months must obtain a certificate of need to reopen that service.

House Bill 1221 (2006), Section 2

SECTION 2. The State Board of Health shall, not later than October 15, 2006, develop and make a report to the Chairmen of the Public Health and Welfare Committees of the Senate and House of Representatives, the Lieutenant Governor, the Speaker of the House of Representatives and the Governor, including any recommended legislation, on the following policies and procedures relating to the State Health Plan and the Health Care Facility Certificate of Need Law:

(a) Review the procedures under which health care facility certificates of need are requested and issued or denied. Make reasonable recommendations

(i) to reduce the time periods required for certificate of need review and appeal there from without compromising the fairness of the decision;

(ii) to exempt additional non-substantive transactions by health care facilities from the certificate of need requirement; and

(iii) to authorize additional transactions by health care facilities which may receive an expedited review.

(b) Verify the fairness of how the annual State Health Plan considers changing population projections and how residents choose health care services.

(c) Verify the fairness of how the annual State Health Plan considers that residents travel to neighboring states to receive health care services.

(D) Verify the fairness of the different planning districts applicable to each type of health care certificate of need activity by a facility. For example, General Hospital Service Areas compared to Long-Term Care Planning Districts, compared to Ambulatory Surgical Planning Areas, compared to Home Health Agency Planning Areas, compared to Perinatal Planning Areas, compared to Adolescent and Adult Psychiatric Facility Planning Areas, etc.

(e) Verify the fairness and appropriateness of the formulas used to determine the need for health care services under the certificate of need law.

(f) Review the existence of licensed beds listed in the Directory of Licensed Health Care Facilities which are unused and available for transfer to another facility or location under the certificate of need process, and the effect of these unused beds on the State Health Plan.

I
Background and Context

A. Introduction

Certificate of need (CON) regulation is a form of state-sponsored planning used to guide the development of needed health care services. It requires state approval before health service providers may establish or expand certain health care services and facilities or acquire certain major medical equipment.

States began experimenting with health services planning and CON regulation in the 1960s. They used it as a tool to improve access to care, to constrain burgeoning health care facility investment and costs, and to otherwise provide guidance and direction to an undisciplined, rapidly growing health care system. More than a dozen states established CON programs in the decade between 1964 and 1973.[1]

Taking notice of this trend among the states, and of the need to address the increasingly problematic health care issues states were confronting, Congress passed the National Health Planning and Resources Development Act (NHPRDA) in 1974. NHPRDA required state planning and CON programs as a condition of State participation in federal public health service grants and contracts, effectively mandating state CON programs nationwide. NHPRDA required that state programs meet a common minimum set of planning procedures and standards. By the late 1970s, nearly all states established CON programs that were generally consistent with NHPRDA requirements. [2]

Mississippi established its planning program by Executive Order, pursuant to the federal requirement that states have such programs in place by 1979. The state legislature enacted certificate of need (CON) legislation [Miss. Code Sec. 41-7-191] in 1979. Mississippi was the 44th state to establish a CON program. The program operated in accordance with federal guidelines from 1979 until 1986, when the federal requirement that states maintain planning and CON programs was lifted.

With the demise of the federal planning and CON program requirements, responsibility for the Mississippi program shifted from the health planning commission mandated under the federal program to the Mississippi State Board of Health and the State Health Department. Program operations have evolved over the last two decades in response to local experience, interaction with health service providers, legislative mandates, and the changing needs and circumstances of Mississippians.

The program has received considerable legislative attention in recent years. During the last four legislative sessions (2003 - 2006), for example, about seventy-five separate CON bills (along with more than 20 companion bills) have been introduced. Nearly all died in committee in the house of origin after referral to the appropriations committee.

Only four of these bills passed: one in 2003, two in 2004, and one in 2006. The bill passed in 2003, which permitted health care facilities to re-license beds that had been removed from the licensure rolls without CON review, was vetoed. So only three of the bills introduced became law.

The more significant recent changes in the program came earlier this year with the passage of House Bill 1221. The principal changes authorized include:

- Removal of lithotripsy from CON review;
- Requiring CON approval to reopen a formerly licensed health care facility closed for 60 months or more;
- Exempting replacement or relocation of critical access hospitals from CON coverage;
- Extending to one mile the distance health services may be moved (relocated) and remain exempt from CON review; and
- Authorizing the issuance of certificates of need for several long-term care projects that would not be approvable under the existing State Health Plan.

These changes became effective March 29, 2006. A subsequent Attorney General opinion makes clear that any facility closed for 60 months or more must obtain CON approval before reopening or otherwise making use of previously licensed acute care beds.[3]

The bills that died in committee, or otherwise did not become law, ran the gamut of CON issues debated in many state legislatures. They ranged from extending CON coverage to services not regulated (e.g., hospice services) to repeal of the authorizing legislation. Most dealt with three topics:

- Exempting selected projects from CON coverage;
- Exempting selected projects from the nursing home and home health services moratoria; and
- Authorizing the development of competing acute care services, including a full-service community hospital, in DeSoto County.

Other notable issues raised include the realignment of hospital planning districts, raising the health care facility capital expenditure review threshold, and relaxing CON coverage of ambulatory surgery centers.

At least two of the bills that died in committee in recent years called for studies of aspects of the CON program. Section 2 of HB 1221 (2006) directs the Mississippi Department of Health to undertake a multifaceted study of the program.[4] The study called

for requires the Mississippi Department of Health to address many of the questions raised in the legislature during the last five years.

B. Purpose

The Mississippi Department of Health (MDH) commissioned this study as part of its assessment of the program. The study protocol calls for an examination of elements of the program and of the use of the State Health Plan in CON program operations. The underlying purpose is to ensure that program operations are as fair, efficient, and effective as possible, and that the planning and analysis undertaken in support of CON regulation reflect shifting demographic and medical trade patterns, technological change, best practices, and structural changes in the delivery of health care services.

The focus is on planning and review practices and processes, not on the intrinsic merits of health services planning or certificate of need regulation as a health policy tool.

C. Methods and Data

Much of the data and information used in this report necessarily comes from primary sources. Sources, methods, and data relied upon most heavily include:

- Baseline CON program information collected from state programs nationwide;
- Planning documents and CON review criteria and standards for Mississippi and selected comparable (peer) states;
- Mississippi Health Department health facility survey data files for the period 1996 through 2006;
- Interviews and surveys of Mississippi planning and CON staff, health service providers, policymakers, and other affected and interested parties;
- Mississippi CON application and report files for the period 1997 through 2006;
- Hospital patient origin data for Mississippi and neighboring states; and
- Recent studies and reports that address the question of the role and value of health services planning and regulation.

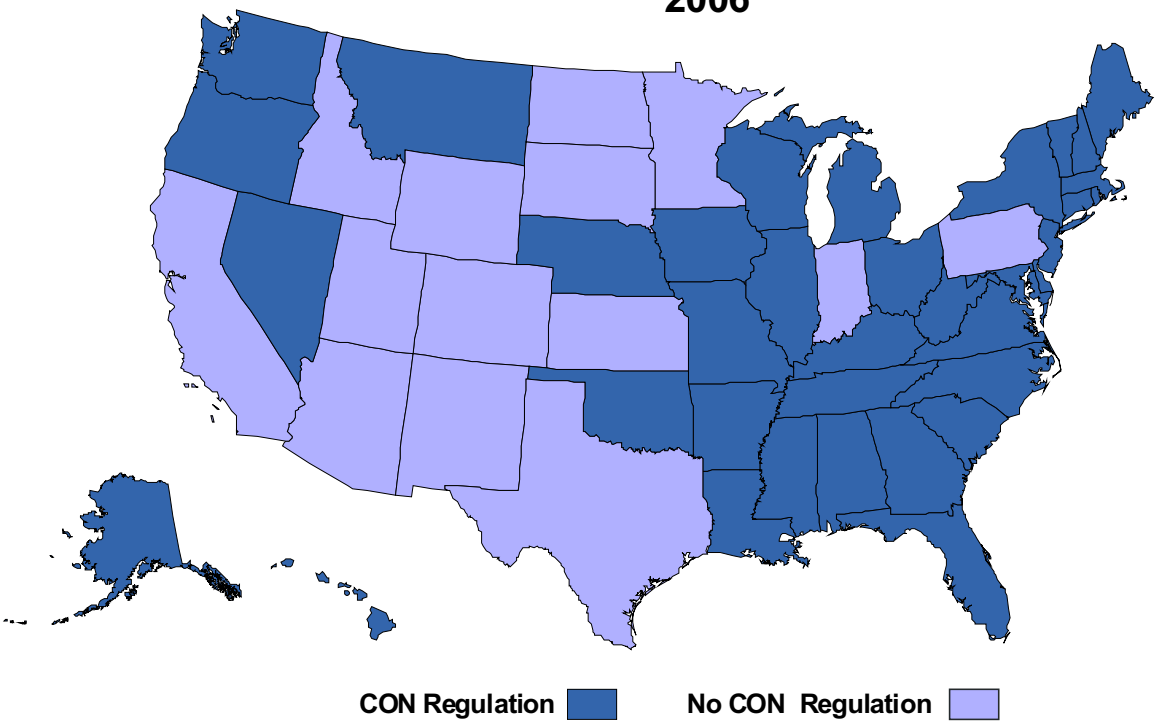
This approach, and these data, make it possible to construct a picture of the current state of CON regulation in Mississippi and nationwide. Appendix A contains a summary of interested party survey responses.

D. Environment and Trends

A majority of the states that now maintain CON programs established them in the 1970s. Most began with programs of similar regulatory scope and reach. The 1974 federal statute (National Health Planning and Resources Development Act, PL 93-641) requiring states to establish planning and CON programs was patterned after state programs established during the previous decade. The planning activities and the minimum scope of CON regulation required were based largely on the experience in states where programs evolved between 1964 and 1973.

Whatever their intrinsic merits, federal planning and CON regulation requirements were controversial from the beginning. Concerted efforts to remove the federal mandate began before P.L. 93-641 could be fully implemented. Consequently, the federal requirement that states maintain CON programs as a condition of state participation in certain public health programs was lifted in 1986. Subsequently, thirteen states dropped regulation in the 1980s. During the next decade, two of those states reestablished regulation and three others terminated their programs. Chart 1 shows the history and timelines of CON regulation by state over the last four decades. Currently, fourteen states do not have CON programs (Map 1).

Map 1
State CON Regulation
2006



No state has eliminated or established a CON program in nearly a decade, but nearly all of the 37 jurisdictions[5] that have retained CON programs have narrowed their focus, reducing either the scope or intensity of regulation. The services and facilities regulated under these programs vary considerably from state to state (Chart 2). Most of the changes in the scope of regulation occurred in the mid-1980s. Changes were more sweeping in the western half of the U. S. than elsewhere. In general, program modifications came later and have been less sweeping in the east and south. Nearly all states in the south and northeast have retained CON programs in some form.

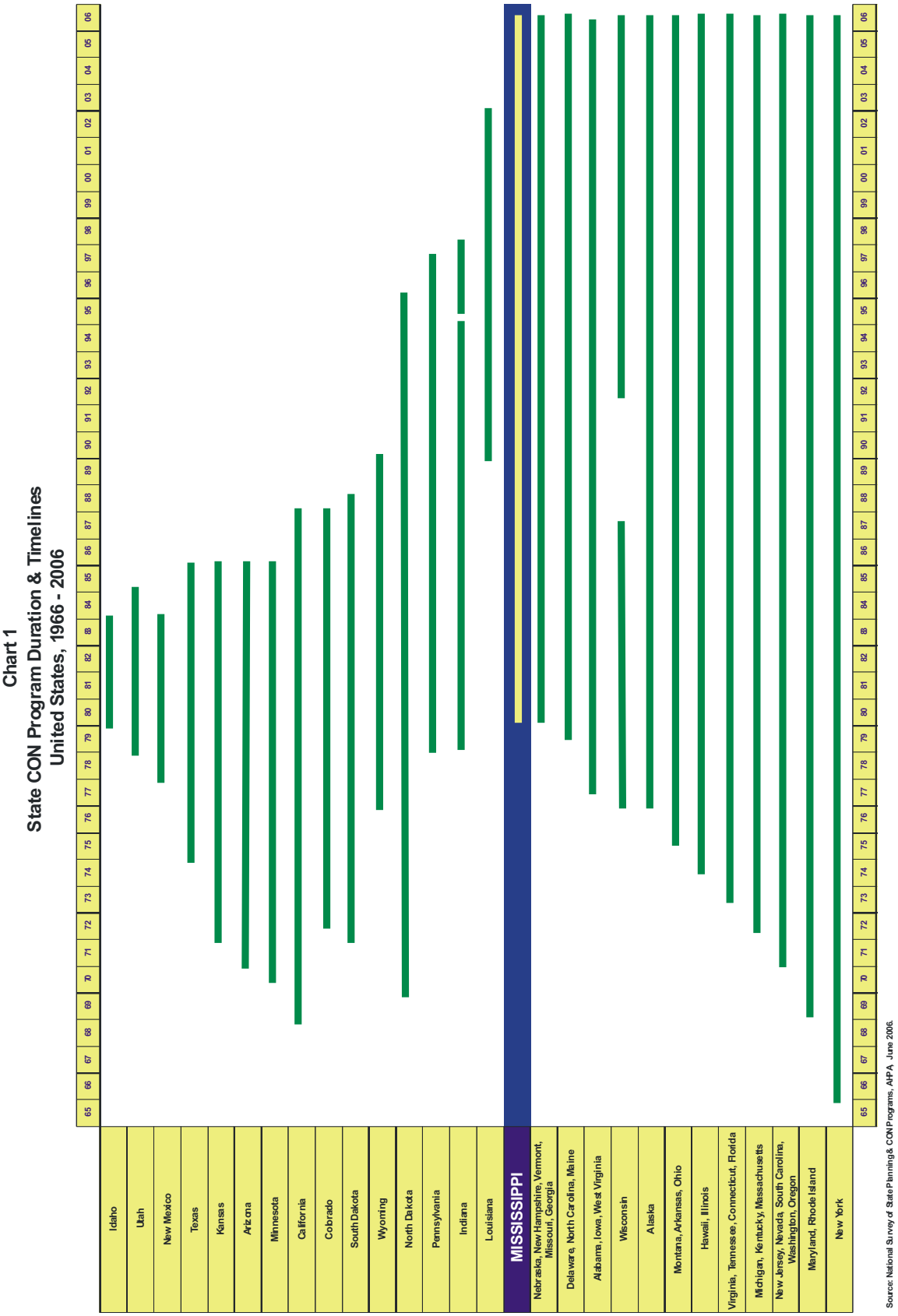


Chart 1
State CON Program Duration & Timelines
United States, 1966 - 2006
65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 00 01 02 03 04 05 06
Idaho
Utah
New Mexico
Texas
Kansas
Arizona
Minnesota
California
Colorado
South Dakota
Wyoming
North Dakota
Pennsylvania
Indiana
Louisiana
MISSISSIPPI
Nebraska, New Hampshire, Vermont, Missouri, Georgia
Delaware, North Carolina, Maine
Alabama, Iowa, West Virginia
Wisconsin
Alaska
Montana, Arkansas, Ohio
Hawaii, Illinois
Virginia, Tennessee, Connecticut, Florida
Michigan, Kentucky, Massachusetts
New Jersey, Nevada, South Carolina, Washington, Oregon
Maryland, Rhode Island
New York
Source: National Survey of State Planning & CON Programs, AHPA June 2006.

States maintain CON programs to achieve a number of health policy goals. These goals differ somewhat from state to state, and from one health service to another, but all CON regulation and related planning are intended to compensate for observed or presumed medical care market deficiencies. Historically, the overriding consideration has been to promote access, ensure quality, and help control costs by limiting market entry to those facilities and services that are found to be needed, appropriately sponsored, and designed to promote quality and equitable access to care. Each state CON program implicitly incorporates these principles by predicating certification on the basis of community or public "need".

CON regulation, and the planning that underlies it, remain a matter of considerable debate, academically and in state legislatures. Although the value and effectiveness of CON regulation in helping control costs remains debatable, there is a growing body of evidence that suggests planning and CON regulation are useful in promoting quality, improving access to care, and helping maintain the economic stability and viability of essential community hospitals and the services they are uniquely situated to provide. These considerations, and the need to control state health care spending, notably Medicaid spending for nursing homes and other long-term care services, form the basis of support for CON programs in most states.

II

Mississippi CON Program Operations

A. Distinctive Aspects of the Program

Mississippi regulates 17 of the approximately 30 services, facility and equipment categories covered by state CON programs nationwide**.** The number and type of services regulated by each state are shown in Chart 2. Chart 2 also identifies, where applicable, the CON capital expenditure review thresholds for facility, equipment and new service capital expenditures.

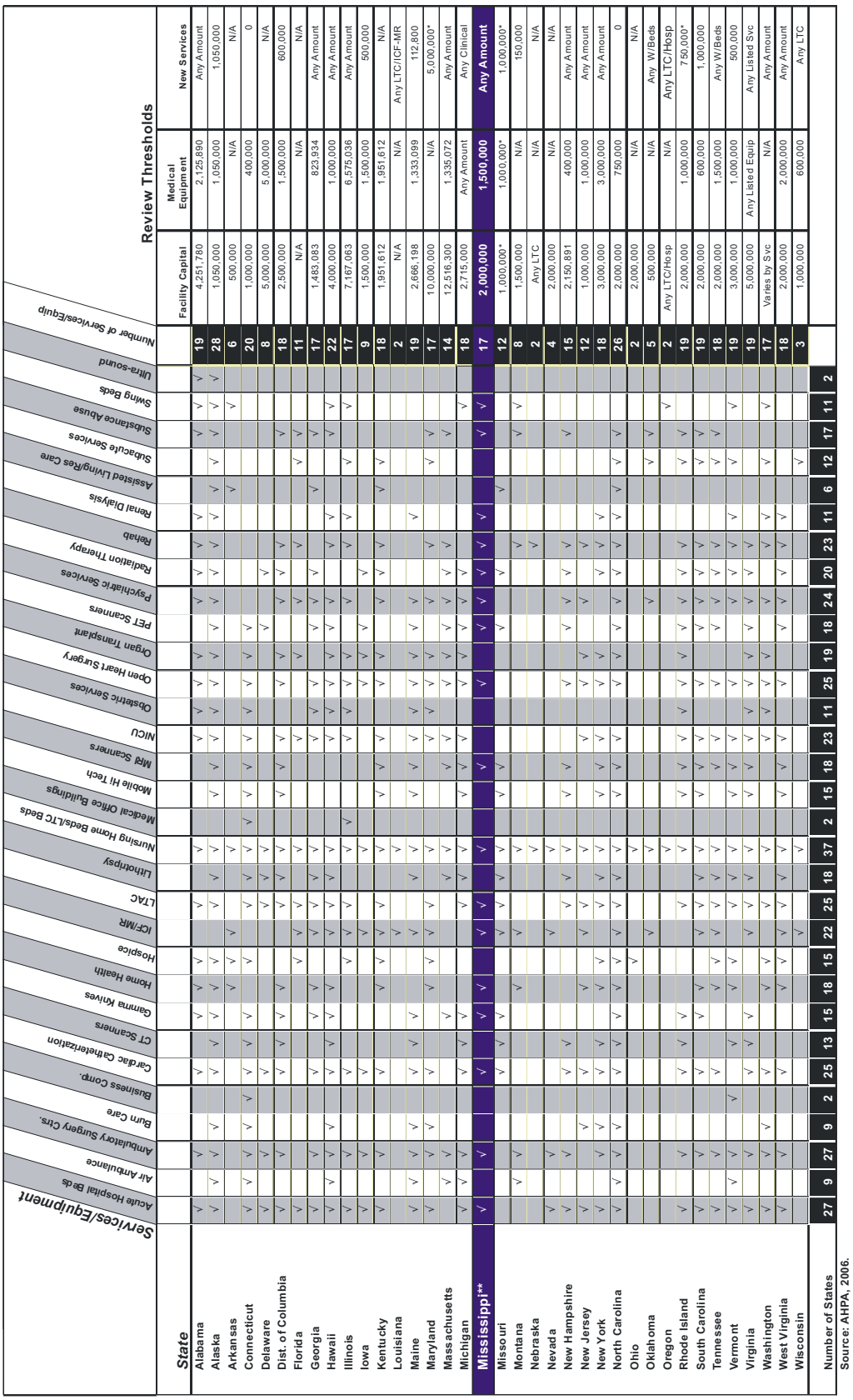
Nominally, the Mississippi CON program covers both a number and an array of services that are comparable to those of most other states that regulate acute care services under CON. The program potentially covers about two-thirds of the services and facilities subject to CON regulation in other states with CON programs that cover both acute care and long-term care services (Chart 2). The health facility capital expenditure review threshold is now $2.0 million, the national median (Chart 3).[6] The medical equipment capital expenditure review threshold is $1.5 million. It is significantly higher than the national median (Chart 4). Neither threshold is indexed.

Several features limit the regulatory reach of Mississippi's CON program. The first is the relatively high medical equipment capital expenditure review threshold. Only six states have a higher threshold. The comparatively high equipment review threshold means that, though nominally subject to review, many equipment transactions are not reviewed.

Another feature that limits the scope of Mississippi's CON program is the exemption of single specialty surgery centers from review. Nationally, twenty-seven state CON programs cover ambulatory surgery centers. Only four (Georgia, Maryland, Mississippi, and Washington) exempt single specialty centers from review. The Mississippi exemption is the broadest of the four. It has no size (number of operating rooms), capital expenditure, or other limitation. As implemented, the exception also opens the door to the conversion of single specialty surgery centers to multi-specialty centers without CON review.

The third feature of the Mississippi CON program that limits its reach is the unique provision that exempts the conversion of mobile services to fixed site services from review, provided the project does not have some other feature that triggers review. This provision eliminates review of a substantial number of medical equipment projects.

Chart 2
Certificate of Need Coverage Summary
By State, 2005

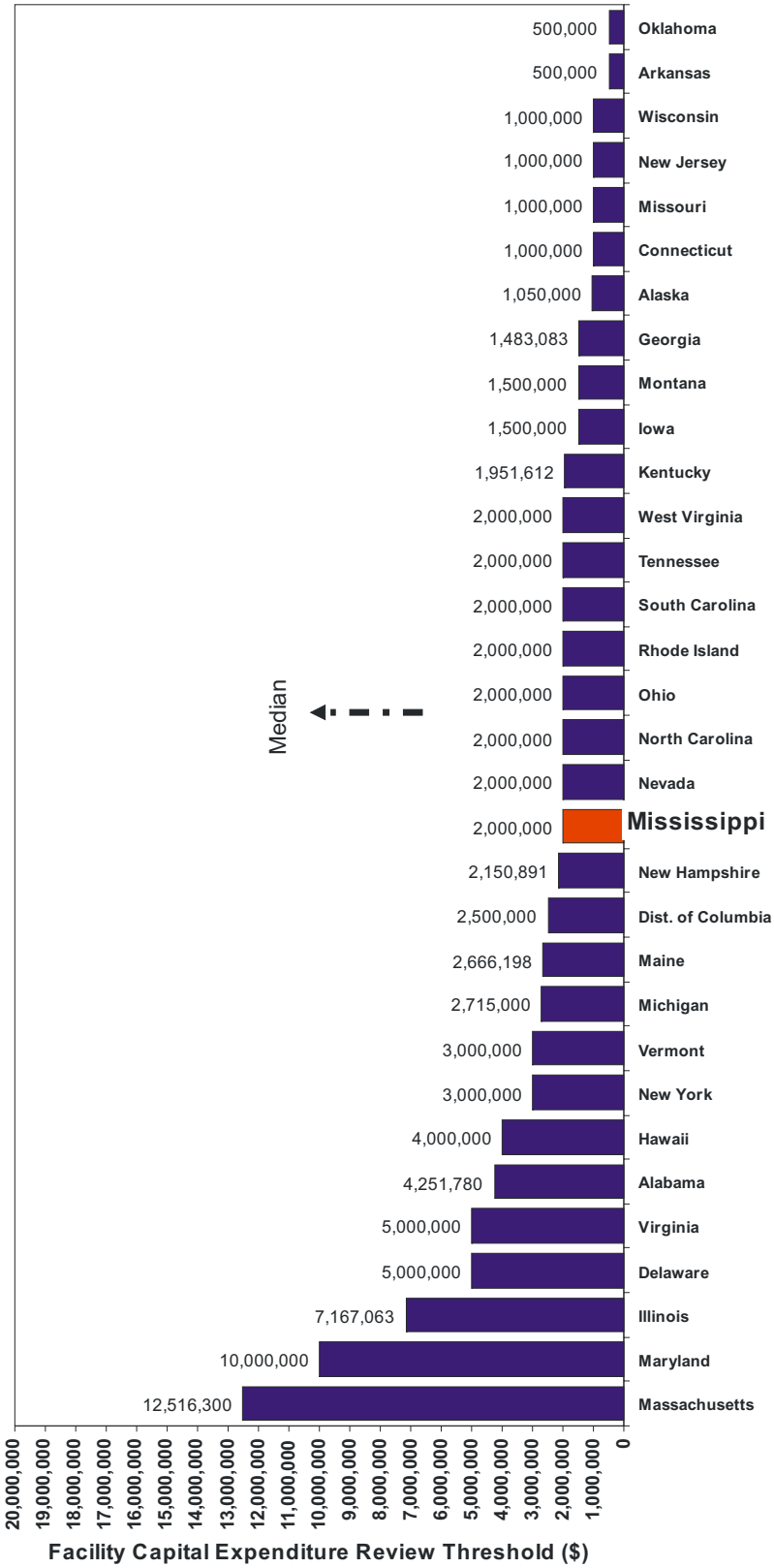


State	Acute Hospital Beds	Air Ambulance	Ambulatory Surgery Ctrs.	Burn Care	Business Comp.	Cardiac Catheterization	CT Scanners	Gamma Knives	Home Health	Hospice	ICF/MR	LTAC	Lithotripsy	Nursing Home Beds/LTC Beds	Medical Office Buildings	Mobile Hi Tech	MRI Scanners	NICU	Obstetric Services	Open Heart Surgery	Organ Transplant	PET Scanners	Psychiatric Services	Radiation Therapy	Rehab	Renal Dialysis	Assisted Living/Res Care	Subacute Services	Substance Abuse	Swing Beds	Ultra-sound	Number of Services/Equip	Review Thresholds: Facility Capital	Review Thresholds: Medical Equipment	Review Thresholds: New Services
Alabama	√		√		√		√	√	√	√		√		√				√	√	√			√	√	√			√	√	√	**19**	4,251,780	2,125,890	Any Amount
Alaska	√	√		√		√		√	√			√		√		√	√	√	√	√		√	√	√	√		√	√	√	√	**28**	1,050,000	1,050,000	1,050,000
Arkansas							√		√	√	√			√												√						**6**	500,000	N/A	N/A
Connecticut	√	√	√	√	√	√		√	√			√	√	√	√	√	√	√	√	√	√	√	√	√	√						**20**	1,000,000	400,000	0
Delaware	√		√		√		√			√	√	√		√						√			√								**8**	5,000,000	5,000,000	N/A
Dist. of Columbia	√		√		√		√		√			√		√		√	√	√	√	√		√	√	√	√		√				**18**	2,500,000	1,500,000	600,000
Florida	√								√			√		√				√		√		√	√	√	√		√				**11**	N/A	N/A	N/A
Georgia	√		√		√		√		√			√	√	√				√	√	√		√	√	√	√	√					**17**	1,483,083	823,934	Any Amount
Hawaii	√	√	√	√	√		√		√			√	√	√				√	√	√		√	√	√	√		√	√			**22**	4,000,000	1,000,000	Any Amount
Illinois	√		√							√	√	√		√	√			√	√	√		√	√	√	√	√			√		**17**	7,167,063	6,575,036	Any Amount
Iowa	√		√									√	√	√				√	√	√			√	√	√				√		**9**	1,500,000	1,500,000	500,000
Kentucky	√		√						√	√		√		√	√		√	√	√	√		√	√	√	√		√				**18**	1,951,612	1,951,612	N/A
Louisiana	√								√			√		√				√					√	√		√						**11**	N/A	N/A	Any LTC/ICF-MR
Maine		√	√		√	√	√			√			√	√	√	√	√		√	√	√				√						**2**	2,666,198	1,333,099	112,800
Maryland	√	√		√	√			√	√	√		√		√			√	√	√	√	√	√	√	√		√	√	√			**19**	10,000,000	N/A	5,000,000*
Massachusetts	√		√		√		√			√		√		√	√	√	√	√	√	√	√		√	√		√	√				**17**	12,516,300	1,335,072	Any Amount
Michigan	√	√	√		√	√			√	√		√	√	√	√	√	√	√	√	√	√	√	√	√				√			**14**	2,715,000	Any Amount	Any Clinical
Mississippi	√		√		√	√			√	√	√	√	√	√		√	√	√		√	√	√	√	√	√		√	√			**18**	**2,000,000**	**1,500,000**	**Any Amount**
Missouri		√			√						√	√	√	√	√				√				√								**17**	1,000,000*	1,000,000*	1,000,000*
Montana		√							√					√										√			√				**12**	1,500,000	N/A	150,000
Nebraska														√										√			√				**8**	Any LTC	N/A	N/A
Nevada	√		√								√			√														√			**2**	2,000,000	N/A	N/A
New Hampshire	√		√		√							√	√	√		√	√		√	√		√	√				√				**4**	2,150,891	400,000	Any Amount
New Jersey	√				√				√		√	√		√			√		√	√		√		√							**15**	1,000,000	1,000,000	Any Amount
New York	√		√		√		√		√	√	√	√		√	√	√	√		√	√		√	√	√	√						**12**	3,000,000	3,000,000	Any Amount
North Carolina	√	√	√		√		√		√	√	√	√		√	√	√	√		√	√		√	√	√	√		√				**18**	2,000,000	750,000	0
Ohio										√																					**26**	2,000,000	N/A	N/A
Oklahoma											√			√														√	√			**2**	500,000	N/A	Any W/Beds
Oregon												√		√														√	√			**5**	Any LTC/Hosp	N/A	Any LTC/Hosp
Rhode Island	√		√		√		√							√		√	√		√	√		√	√				√				**2**	2,000,000	1,000,000	750,000*
South Carolina	√				√				√		√	√	√	√	√	√	√		√	√		√	√	√	√		√	√			**19**	2,000,000	600,000	1,000,000
Tennessee	√		√		√				√	√	√	√	√	√	√	√	√		√	√		√	√	√	√		√	√			**19**	2,000,000	1,500,000	Any W/Beds
Vermont	√	√	√			√			√	√		√	√	√	√	√	√		√	√		√	√	√	√		√		√		**18**	3,000,000	1,000,000	500,000
Virginia	√		√		√	√			√	√	√	√	√	√	√	√	√		√	√		√	√	√	√		√		√		**19**	5,000,000	Any Listed Equip	Any Listed Svc
Washington	√		√		√				√	√	√	√	√	√	√	√	√		√	√		√	√	√	√		√		√		**19**	Varies by Svc	N/A	Any Amount
West Virginia	√				√				√	√	√	√	√	√	√	√	√		√	√		√	√	√	√		√		√		**17**	2,000,000	2,000,000	Any Amount
Wisconsin	√		√						√	√	√	√	√	√	√	√	√		√	√		√	√	√	√		√		√		**18**	1,000,000	600,000	Any LTC
Number of States	**27**	**9**	**27**	**9**	**2**	**25**	**13**	**15**	**15**	**18**	**15**	**22**	**25**	**18**	**37**	**2**	**15**	**18**	**23**	**11**	**25**	**19**	**18**	**24**	**20**	**23**	**11**	**6**	**12**	**17**	**11**	**2**			

Source: AHPA, 2006.
* For selected services.
**Medical office buildings and CT scannners may be subject to CON regulation in some atypical circumstances.

Chart 3
State Certificate of Need Program
Facility Capital Expenditure Review Thresholds
2005

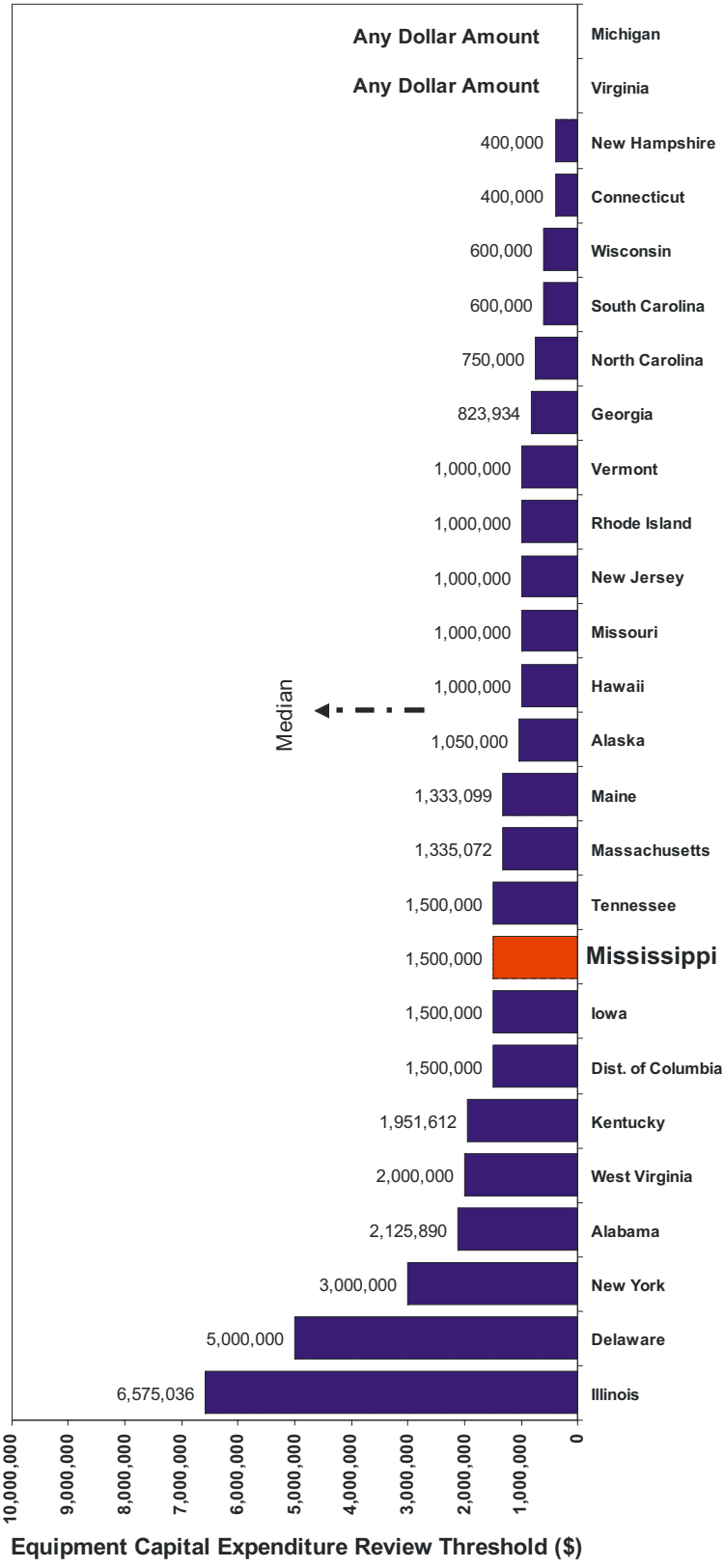
(Mode = $2,000,000)



Source: National Survey of State Planning & CON Programs, AHPA, June 2006.

Chart 4
State Certificate of Need Program
Equipment Capital Expenditure Review Thresholds
2005

(Mode = $1,000,000)



Source: National Survey of State Planning & CON Programs, AHPA, June 2006.

These three provisions, and the way they are implemented, give the Mississippi CON program a distinctive character. No other CON program contains all three features. In combination, they introduce a substantial degree of uncertainty in planning, give rise to questions about fairness and equitable treatment of those subject to regulation, and are likely to be increasingly problematic in their effect on the stability and viability of essential community hospitals.

B. Review Process and Procedures

State law designates the Mississippi Department of Health as the state agency responsible for all state health planning and development activities. Among other things, these activities include:

- Inventorying health facilities and services;
- Identifying priority health needs;
- Establishing criteria and standards for CON review;
- Preparing a draft state health plan for consideration by the State Board of Health; and
- Conducting CON reviews.

The stated goals of health planning and CON regulation in Mississippi are to improve the health of residents, enhance access to care, assure quality, prevent unnecessary duplication of resources, and promote cost containment.

In fulfilling these responsibilities, and working toward these goals, the Department maintains a staff of eight and an annual operating budget of about $500,000 dedicated to planning and CON regulation.[7] Current program objectives are to:

- Collect the statistical and programmatic information needed to develop the *FY 2007 State Health Plan*;
- Conduct timely reviews of certificate of need (CON) applications for health care services, facilities, and equipment as provided by Section 41-7-191 of the *Mississippi Code*;
- Issue 90% of CON declaratory rulings (review determinations) within 10 business days of receipt of complete requests;
- Publish staff analyses of CON applications within 45 days of receipt of a complete application;
- Publish a timely (within five days) electronic weekly report on CON activities; and
- Publish State Health Officer final CON orders within ten days of decisions.

Agency records show that, except for CON applications that entail public hearings, these objectives are being met.

Mississippi CON review procedures and processes are well documented and generally consistent with those found elsewhere. The Department publishes a CON Manual, which

was updated earlier this year. The manual is a detailed guide to the CON application and review process. There is substantial evidence that, in most respects, staff follows closely the procedures, processes, and other dictates outlined in the manual. As provided in law, and reflected in the CON manual and elsewhere, the review process is well defined, open, and contains strong procedural safeguards.

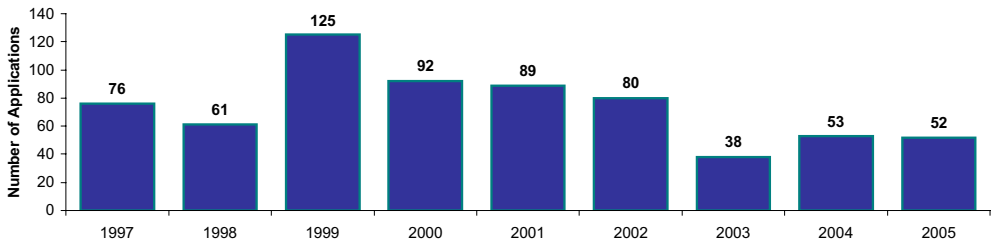
The review manual, review schedules, a detailed outline of the standard review process, required notices, published staff reports, and CON decisions are posted on the Department website.[8] The array of CON program and operational information available online is more extensive than in many other states. The website is kept current and is comparatively user friendly.

C. Review Volume and Trends

> *Legislative changes, legal rulings, and evolving practices have combined to reduce the number of CON applications reviewed each year by more than half over the last two decades. The program now issues far more declaratory rulings, usually certifying that CON review is not required for a contemplated project, than CON decisions. Under current coverage and practices, the number of CON applications reviewed is likely to average about 50 per year over the next several years.*

Changes in CON regulation in Mississippi over the last two decades have paralleled the national trend toward less comprehensive and less intense coverage. Agency records show that about 1,600 CON applications have been reviewed since 1986, an average of about 80 per year. With reductions in the number of services subject to review, imposition of higher medical facility and medical equipment capital expenditure review thresholds, and expansion of exemptions, the number of applications reviewed each year has decreased by more than half over the last two decades. This has occurred despite the increase in capital spending and the growth in both the size and complexity of the health care system.[9] The average annual review caseload during the last decade (1997-2006)

Figure 1
Mississippi CON Applications
Total Applications
1997 - 2005

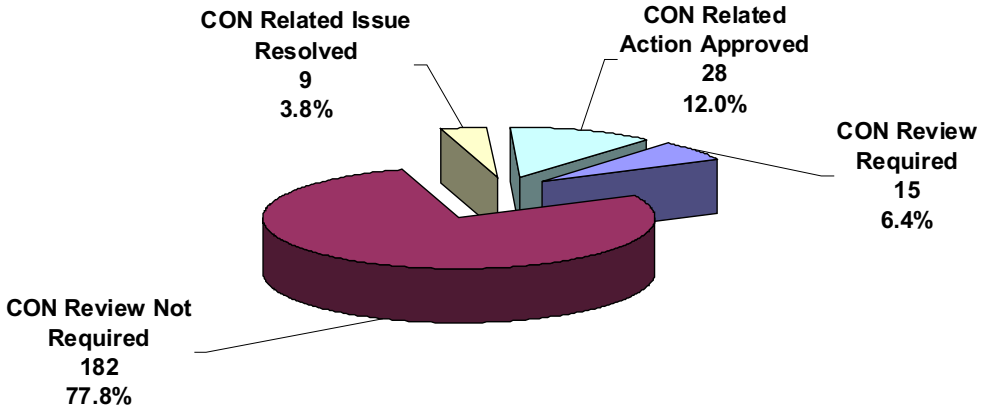


Source: Mississippi CON Applications, 1997 - 2006, Mississippi Department of Health, 2006.

was about 68 per year. The majority of these applications were reviewed between 1999 and 2002, when more than 150 nursing home applications were filed in response to the moratoria exemptions granted by the state legislature in 1999 (Figure 1). The average annual caseload over the last five years has been about 60 applications per year. About 50 applications were reviewed in both 2004 and 2005. This pattern appears to be holding in 2006.

In addition to the CON applications reviewed, the program issues scores of related review determinations and other findings each year. Over the last five years, the program has issued an average of more than 100 review determination rulings annually.[10] The large majority of these rulings certify that action and capital expenditures contemplated by health service providers do not require CON review and approval. Over the last 18 months, for example, the program issued 234 review determinations. As shown in Figure 2, only fifteen (6.4%) of the projects contemplated were found to require CON review.

Figure 2
Mississippi CON Program
Declaratory Rulings by Disposition
January 1, 2005 - June 30, 2006



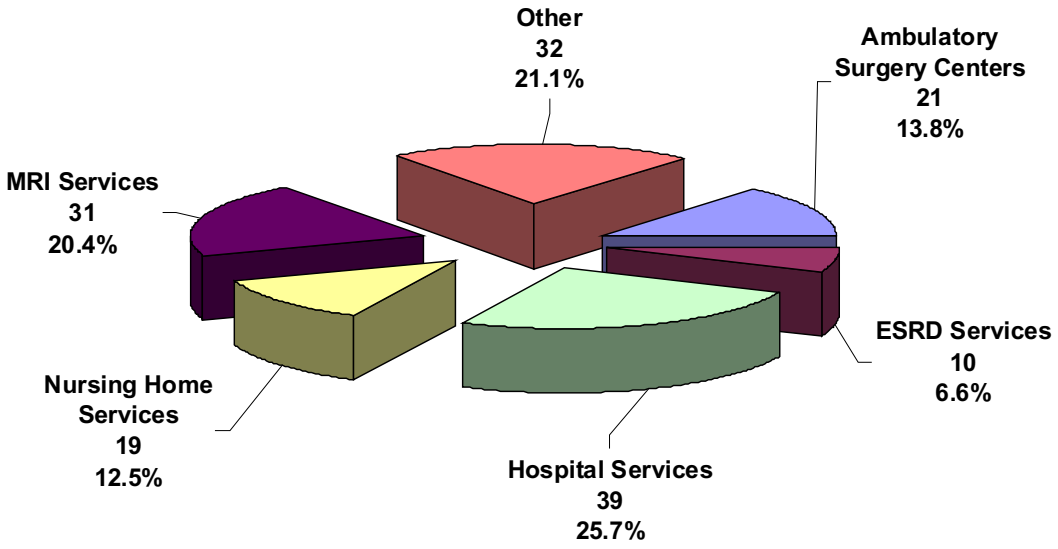
Source: CON Program Records, Mississippi DOH, 2006.

Nearly one-fourth of the determinations requested involved proposed changes in ownership, and more than 6% involved the de-licensing of hospital or nursing home beds. The remainder (78%) involved activities and expenditures that under other circumstances (e.g., less generous exemption provisions or a lower facility or medical equipment capital expenditure review threshold) would require CON review.

Figure 3 shows review determination rulings by service category during the last year and a half. About half dealt with hospital and nursing home projects, the next largest groups involved major medical equipment, largely MRI services and equipment, followed by ambulatory surgery center and renal dialysis projects. Many, if not most, of these requests relate to the atypical review posture of the CON program with regard to single

special surgery centers, major medical equipment review thresholds, and the conversion of mobile service sites to fixed service sites.

Figure 3
Mississippi CON Program
Review Determinations by Service
January 1, 2005 - June 30, 2006



Source: CON Program Records, Mississippi DOH, 2006.

Unless capital expenditure review thresholds or service coverage are changed, it is unlikely that the number of CON applications is likely to average more than 50 per year over the next several years.

D. Batch Processing

> *Mississippi CON review procedures now employ a limited form of batch processing. Restructuring the process could prove useful in reviewing larger numbers of similar projects competitively and in encouraging the filing of more complete and more accurate applications.*

Mississippi CON applications may be filed in any one of four quarterly review cycles. Applications deemed complete are accepted for review on January 1, April 1, July 1, and October 1 each year. The stated purpose of this schedule is "to allow all applications of similar types, facilities, or equipment affecting the same health planning area to be reviewed in relation to each other four times per year."[11] Some applications filed in advance of the quarterly filing dates, often those that are likely to qualify for expedited review, are accepted and review initiated before the filing deadline.

This is a form of batch processing, but is limited in that it does not assure that similar projects will be reviewed and compared competitively. Most state CON programs contain provisions for the concurrent review of certain applications based on selected criteria.

This grouping, or "batching," is done because there can be distinct advantages in evaluating on a "competitive" basis proposals to meet the public's need for health services and facilities sharing common or similar characteristics. Batching of similar applications for review is a preferred approach if resource allocation is to be done on the basis of the relative merits of proposals or of the providers submitting them. Properly used, batching should promote the consideration of alternatives and allow greater exercise of choice by the regulatory authority, particularly when there is a need or desire to expand the type or array of services offered.

Batching can also be used to manage the CON review workload, although there are limitations to the efficiencies that can be achieved by any given batching scheme or protocol. Batched cycles, by their very nature, result in substantial workload variation. This potential management problem is offset, however, by the high degree of administrative control that such schemes make possible. Given the commonality of the issues and data being examined, resources can be used comparatively efficiently under most batching schemes. The knowledge and experience gained in the review of one application are usually transferable to similar proposals.

More than two-thirds of state CON programs, 25 of 37 programs, report that they use batch processing protocols and schemes of some type. Most of those that do not have relatively small application volumes that make batch processing of proposals, and competitive review itself, of limited value.

Of the states with batching protocols, slightly more than half incorporate a "letter of intent" notification filing in their CON application filing procedure. Prospective CON applicants are required to file a notice of their intention, or "letter of intent," to file a CON proposal with program officials, usually at least thirty days before the application itself is filed. The notice is formally posted, and otherwise widely distributed to interested and potentially affected parties. Parties with similar plans or interests, as well as those who may be materially affected by the applicant's proposal, are alerted to the pending application. This process affords them a minimum period of time to take any action they deem to be in their best interest or in the public interest. Such action may include the filing of a competing CON application that will be reviewed concurrently with any others filed during that review cycle.

CON applications may be batched for competitive review on a number of bases. The most common characteristic or criterion used is the type of service proposed. Under these batching arrangements, proposals for identical or similar services, facilities or equipment are grouped for competitive review. Other criteria used to group applications include the geographic area of the proposal, the cost of the project, and the determination, based on established criteria such as the applicant's existing or proposed service area or any special population that would be served, that the proposal is competitive with other applications that have been filed.

Some states (e.g., New Jersey and Virginia) use highly structured batch processing schemes for selected services. They typically incorporate variants of the "request for

proposals" process that is used widely to obtain competitive bids for a range of products and services. Properly planned and administered, this protocol can be effective in stimulating and "managing" competition in the development and provision of certain health care services.

Changing the quarterly batch processing cycle, under which applications for any service may be filed four times annually, to an annual or semiannual cycle with staggered filing dates for defined service categories would facilitate competitive review of like proposals. It has the potential of stimulating competing proposals for needed services, encouraging applicants to file more complete and accurate operational data, and permitting more efficient use of staff time.

E. Letter of Intent

> *Consistent enforcement of the requirement that CON applicants provide notice of their intention and plans by filing a "letter of intent" before the application is filed would improve the transparency of program operations, assure equal treatment of all interested parties, and promote beneficial competition among service providers.*

Mississippi CON procedures require that applicants file a letter of intent before filing an application. There is broad agreement that the requirement is not uniformly honored and is not enforced consistently. Substantial numbers of applications are filed without notice. They are accepted, provided the application is complete and the applicant met the filing deadline. The letter of intent requirement helps ensure the regulatory process is transparent and more equitable to all parties. It is designed to:

- Encourage regulatory transparency,
- Assure fair and equal treatment of those regulated under CON,
- Promote competition among health service providers subject to regulation, and
- Permit more efficient and effective management of the CON program and related planning activities.

Some states require that notices be filed only with state CON program officials. Some require that notification go directly to interested parties, as well as to appropriate state officials. Currently, CON applicants are required to notify the Department of their plans. The Department, in turn, notifies other interested parties and the general public. Consideration should be given to requiring applicants to notify directly—as they notice the Department—other service providers in the area they plan to serve of their intention. The Department would remain responsible for notifying the general public and responding to interested parties inquiries.

Typically, letters of intent are not more than a single page containing only information that identifies the legal name of the potential applicant, describes the nature of the capital expenditure proposed, e.g., the service, facility, or medical equipment to be developed or

acquired, and specifies the date (or CON review cycle) the application is to be filed. States with CON application fees usually do not assess a fee to file a letter of intent. Fees usually are not assessed until the application is filed and accepted for review. Consequently, in most states, letters of intent may be filed and withdrawn or allowed to expire without charge.

Batch processing and letter of intent notification are useful regulatory tools. They are mutually reinforcing and should be considered complementary. Consideration should be given to restructuring the existing batch processing protocols to permit competitive review of similar applications.

F. Review Tracks and Periods

Average CON review periods (average number of days per review) have increased over the last decade. This pattern is not unexpected, given the changes on coverage. Larger and more complex projects now constitute a larger percentage of the applications filed and ultimately reviewed. Residual projects also are the type of projects that are more likely to generate opposition and requests for public hearings.

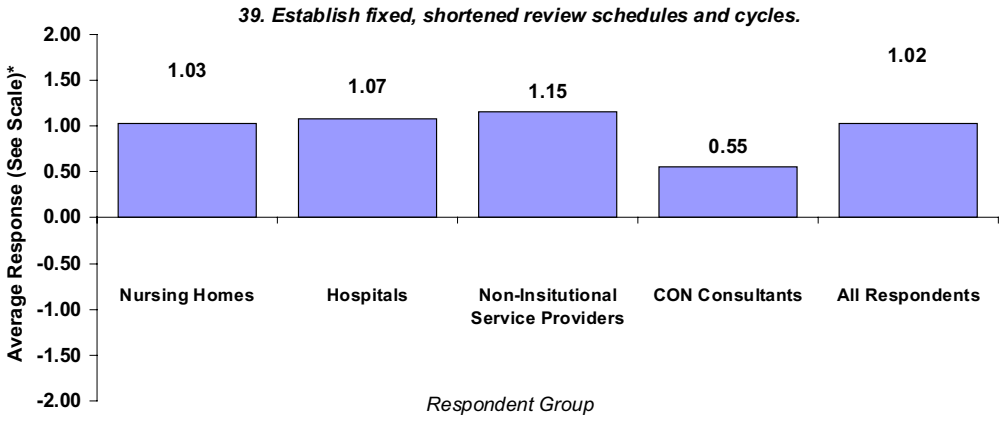
Recent and current review periods are reasonable for the program structure and processes in place. Nevertheless, consideration should be given to expanding the number and type of applications that qualify for expedited review and to changing the nature of the expedited review process.

The review structure and process now in place contemplates two review tracks, a standard cycle of approximately 135 days and a shorter, expedited review track of no more than 90 days. The Department's stated goal is render all CON decisions within 90 days of publication of the staff analysis of the application.[12] The review period may be extended if the State Health Officer determines that it is necessary to defer consideration of the proposal, or if the applicant or an affected party requests a public hearing. If the review period is not extended, CON applicants may seek redress in Chancery Court to compel a timely decision.[13] These nominal review periods compare favorably with those of other states with similar CON coverage.

As in most states, there is strong support for shorter review cycles among all of those involved in, or subject to, the CON review. Nearly all of the key stakeholders contacted would like to see shorter review cycles (Chart 5). There is, however, a strong belief that shorter review cycles should not be established at the expense of the existing due process provisions built into the review schedule, or if the changes made would introduce greater inequality by not treating all service providers equitably. There appears to be little support, for example, to limit or circumscribe the ability of interested parties to request and compel public hearings.

Agency records indicate that, although the Department has not consistently met its goals, average and median review periods are comparatively short. Between 1997 and 2005, about 20% of all applications were handled in 90 days or less. Nearly all of these qualified for expedited review. The review period for more than half (51%) of the applications reviewed was between 90 and 135 days, so nearly three-fourths of all

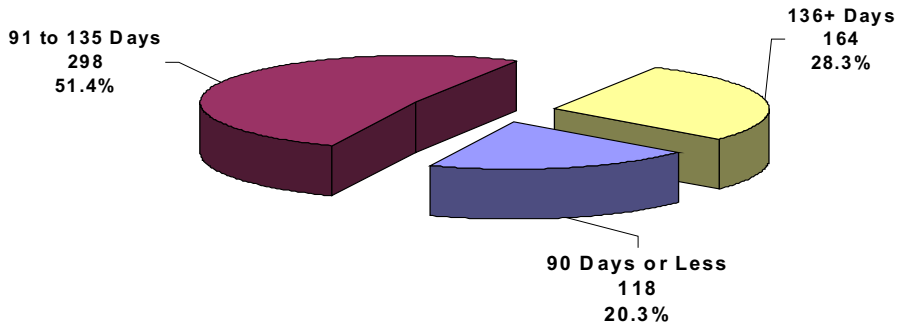
Chart 5
Mississippi CON Survey Responses
Average Response by Respondent Group



* Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.
Source: AHPA Survey, July, 2006.
Note: Total number of responses may vary by question because not all respondents answered all questions.

projects were handled in 135 days or less (Figure 4). Approximately 28% of the applications had review periods of more than 135 days. The majority of these were delayed by public hearings. During the decade between 1995 and 2004, for example, interested parties requested hearings on approximately 125 applications. This represented

Figure 4
Mississippi CON Applications
Distribution of Total Applications by Length of Review Process
Average Time in Days
1997 - 2005



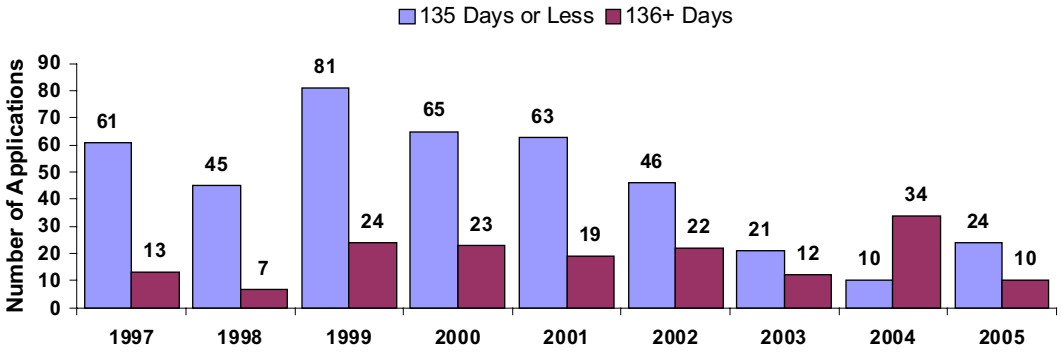
Source: Mississippi CON Applications, 1997 - 2006, Mississippi Department of Health, 2006.

about 22% of the total applications reviewed. Most of the hearing requests, about 61%, were subsequently withdrawn. Data are not available to permit a precise calculation of the number of days that hearings and appeals add to the average length to the review period. The data do indicate, however, that, excluding applications that are subject to appeal, the average review time for standard review is less than the 135-day objective.[14]

These review periods are reasonable for the program structure and processes in place. The Mississippi CON program contains a number of due process features (e.g., a broad definition of affected party, direct state notification by letter of interested parties, a broad *ex parte* contact provision) that necessarily affect the length of the review process. These provisions are laudable. Changing them could raise questions of fairness and equity. Even with these features, the average elapsed time from application submission to State Health Officer decision—which includes review for completeness, written notice to interested parties, applicant submission of additional information, staff review of the application, administrative hearing [optional], and issuance of a decision by the State Health Officer—compares favorably with the average review periods reported by other state CON programs.

It is noteworthy that the average review time has increased over the last decade as the number of applications reviewed each year has decreased (Chart 6). This pattern is not unexpected. It appears to mirror changes in coverage, especially the exemption of some services from review (e.g., CT scanners) and raising the capital expenditure review

Chart 6
Mississippi CON Applications
Distribution of Total Applications by Length of Review Process
Average Time in Days
1997 - 2005



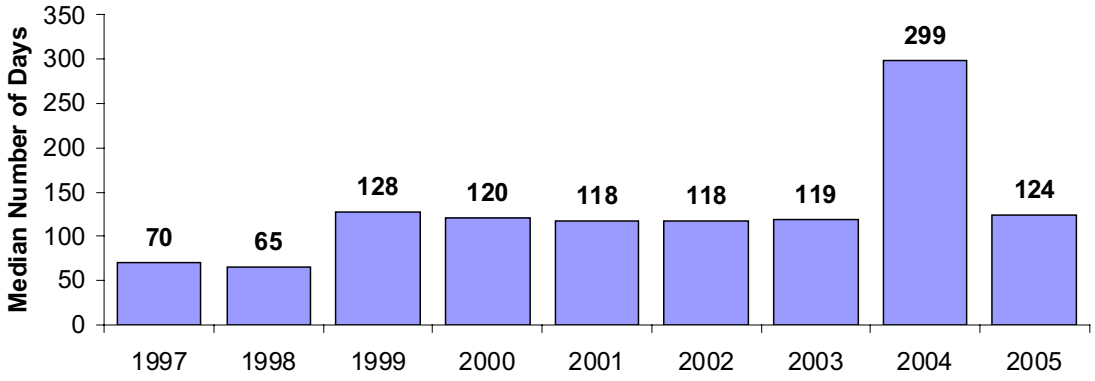
Source: Mississippi CON Applications, 1997 - 2006, Mississippi Department of Health, 2006.

thresholds. Many of the projects no longer subject to review as a result of these changes were among the less substantial proposals submitted. Larger and more complex projects now constitute a larger percentage of the applications filed and ultimately reviewed. In addition, the residual projects also are the type of projects that are more likely to generate

opposition and requests for public hearings. As depicted in Chart 7, the median number of days for processing CON applications increased in 1999 and, with the exception of 2004 when there were a number of lengthy hearings and appeals, has been approximately 120 days over the last seven years.

Proposals that typically qualify for expedited review include, cost overruns, changes in ownership, service and facility relocations, and projects undertaken to comply with licensure standards, building codes, and payer requirements. The program objective is to handle these proposals in 90 days or less. As with the standard review process, the nominal expedited review period compares favorably with the review periods in states that incorporate a similar review track in the CON review process.[15]

Chart 7
Mississippi CON Applications
Median Number of Days for Processing Applications
1997 - 2005



Source: Mississippi CON Applications, 1997 - 2006, Mississippi Department of Health, 2006.

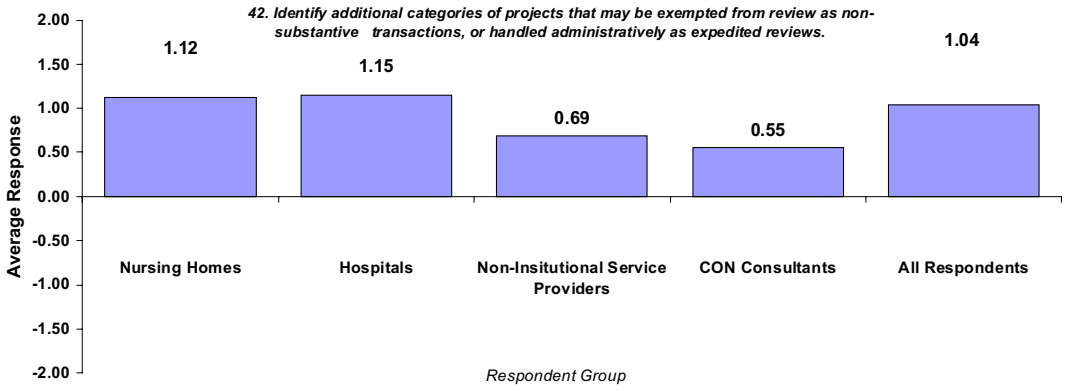
Given the provisions of the Mississippi CON review process (e.g., the broad definition of affected party, and the changes in coverage and review thresholds), the only practical opportunity to decrease average review times would be either to lower the review capital expenditure thresholds or to adopt a much broader definition of projects that qualify for expedited review. The latter is likely to prove more productive than the former, and to be less problematic in terms of provider equity. The principal options include reviewing non-clinical projects on an expedited basis and lowering the facility capital expenditure review threshold to $1.0 million or less, thereby recapturing many of the comparatively minor projects eliminated from review when the threshold was raised. Based on the number, types, and capital expenditure levels of the projects filed over the last few years, these changes, though substantial, probably would not produce a substantial reduction in the average review period. These changes may be desirable for other reasons, but they are not needed to reduce, or otherwise correct, an overly lengthy or unduly burdensome review process. Moreover, as discussed elsewhere, some of the benefit that would be derived

from these changes could be achieved by eliminating CON coverage of medical office buildings, which appears to be warranted for other reasons.

It appears that the only practical, equitable, and non-disruptive way to reduce average review times would be to expand the categories of projects that quality for expedited review. Currently, a number of non-clinical proposals that entail capital expenditures of more than $2.0 million are subject to the standard review process. These include proposals to develop parking facilities, construct administrative (non-clinical) space, and upgrade data systems. The nature of these projects, especially the economic incentives inherent in them, makes them good candidates for expedited review. If not exempted from review, most proposals to construct medical office buildings could also be handled administratively. Consideration should be given to expanding the number and type of applications that qualify for expedited review.

There is broad support among those knowledgeable about and affected by the CON program to expand the number and type of projects that qualify for expedited review, provided this can be done without sacrificing due process or compromising fairness (Chart 8). This view is particularly strong among hospital and nursing home officials.

Chart 8
Mississippi CON Survey Responses
Average Response by Respondent Group



* Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.
Source: AHPA Survey, July, 2006.
Note: Total number of responses may vary by question because not all respondents answered all questions.

Consideration might also be given to changing the basic nature of expedited review. Currently, expedited review of projects in Mississippi means only that such projects are reviewed outside of the quarterly batch cycles. It does not mean necessarily that the actual review process is abbreviated, that application filing and data requirements are reduced, or that other aspects of the review process are minimized. A true expedited review process, which reduces filing requirements and focuses review narrowly on specific key questions and issues could prove useful. Projects that logically would qualify for less intensive review include the non-clinical capital expenditure proposals mentioned

above, as well as projects that involve replacement of obsolete physical plant or equipment. Amending the CON law, or changing regulations, if possible, to create this category of review and limiting the opportunity of others to intervene in the expedited review process might be necessary to assure that the expedited process works as planned.

G. Review Thresholds

> *The CON program employs two capital expenditure review thresholds: a health facility threshold ($2.0 million) and a medical equipment threshold ($1.5 million). Both thresholds were raised during the last decade, consistently maintaining levels at or above the levels found in most states. Neither is indexed or distinguishes between clinical and non-clinical projects.*
>
> *The high medical equipment threshold is problematic. Consideration should be given to eliminating the medical equipment capital expenditure review threshold. With the exception of proposals to replace existing equipment, all equipment acquisitions—establishing new services and expanding existing services—should be subject to review. This coverage arrangement would be more easily understood and administered, would establish a "level playing field," and would be more equitable to all parties and interests. Equipment replacement should remain exempt from review.*

State CON capital expenditure review thresholds vary widely. Some states review certain categories of services, regardless of their capital or annual operating costs. Those that set expenditure review thresholds usually distinguish between new services, medical equipment, and health facility development, renovation, and expansion. Nationally, review thresholds for renovation, expansion and development of health care facilities range from $0.5 million to more than $12.0 million (Chart 2).

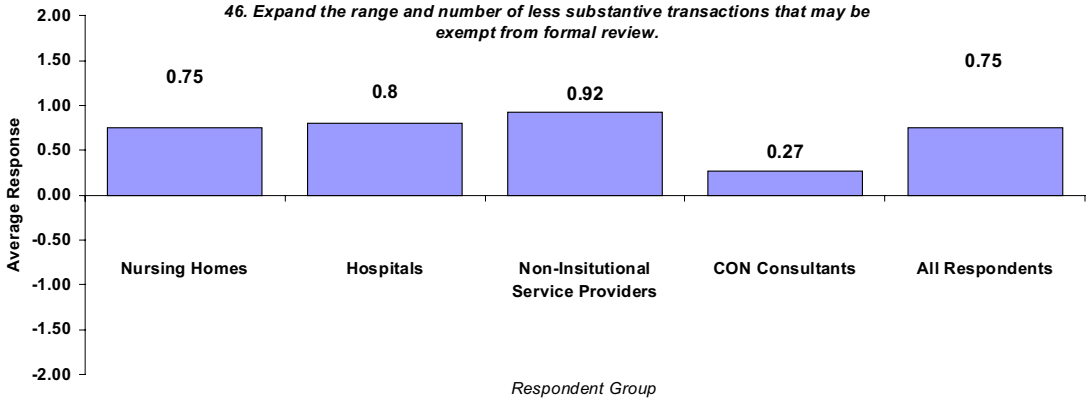
Mississippi's CON program has two capital expenditure review thresholds: $2.0 million for medical facility projects and $1.5 million for medical equipment subject to review. The health care facility threshold, now at $2.0 million, is at the national median. The medical equipment threshold, currently at $1.5 million, is well above the national median. Neither is indexed. Mississippi increased both thresholds during the last decade, consistently maintaining levels at or above the levels found in most states (Chart 3 and Chart 4).

The facility capital expenditure may be made by or on behalf of a health care facility. A CON is required regardless of whether there is an expansion or other significant change in services, or whether the expenditure is for clinical or non-clinical purposes. As in many other states, there is no meaningful distinction between clinical and non-clinical services and expenditures or between those that incorporate potentially disruptive economic incentives and health system implications and those that would affect only the applicant organization or entity.

There are a number of costly equipment purchases by hospitals (e.g., laboratory testing systems and information system hardware and software) that are not regulated by most CON programs. Generally, expenditures of this type are for equipment and services that support hospital operations rather than for use directly in providing care. Beyond the economic incentives inherent in these projects, the institution and circumstance specific nature of these proposals makes evaluation of them under ordinary CON review criteria and standards difficult.

If expansion of capacity, quantitatively or functionally, is the focus of a capital project, the financial interests of the facility may differ from that of the health care system and the community it serves. If no expansion in capacity is involved, the incentives for the facility are likely to encourage frugality and limit the expenditure. If the expenditure will not attract additional patients, and the revenues that go with those patients, the incentives

Chart 9
Mississippi CON Survey Responses
Average Response by Respondent Group



* Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.
Source: AHPA Survey, July, 2006.
Note: Total number of responses may vary by question because not all respondents answered all questions.

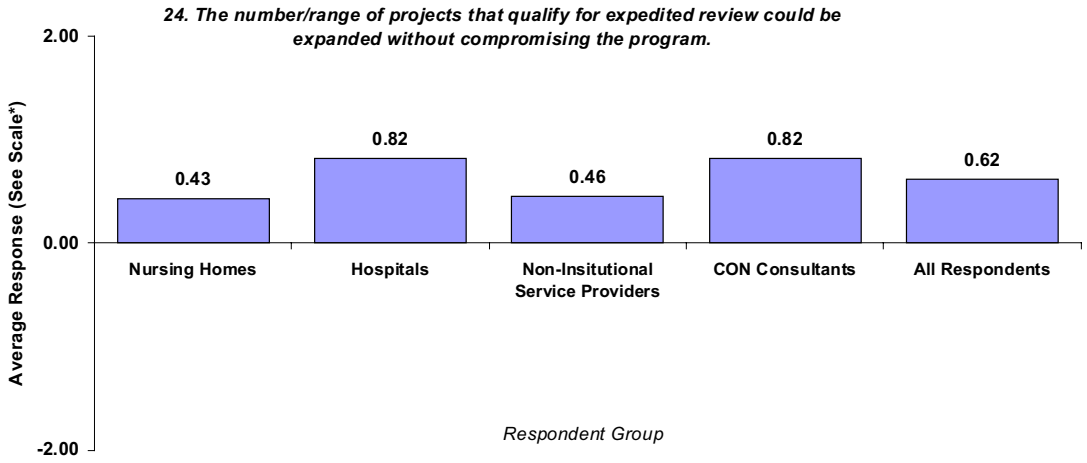
for the applicant are more likely to coincide with the interests of the health care system and the public. Of course, some capital outlays that do not expand capacity are designed not to address significant structural or operational problems but rather to improve appearances that can help attract patients away from other facilities.

Because all health facility capital expenditures get built into the base that is, indirectly, used to determine reimbursement, and because most such expenditures are incurred to expand capacity, there is a public purpose in continuing to control most of the large capital expenditures now subject to CON regulation. Recognizing, however, that incentives for facilities to incur expenditures for some projects do not conflict with health care system stability and the public interest, it is reasonable to consider increasing the capital expenditure threshold for some types of projects. Consideration could be given to having a higher threshold for expenditures that do not involve clinical space or service.

An increase, for example, from $2,000,000 to $5,000,000 might be considered for non-clinical capital outlays, given that many projects that fall within this range do not affect the health care system or the community negatively.

As noted already, there is broad support for expanding the expedited review track. There is also general support of exempting some less substantive projects from review, provided this can be done without compromising the public interest or fairness for all service providers (Chart 9). As indicated in (Chart 10), there is broad and substantial belief that this can be done without weakening, or otherwise compromising, the program.

Chart 10
Mississippi CON Survey Responses
Average Response by Respondent Group



* Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.
Source: AHPA Survey, July, 2006.
Note: Total number of responses may vary by question because not all respondents answered all questions.

Alternatively, these non-clinical services could be exempted from review. A blanket exemption carries the inherent risk of not disclosing for public review and consideration those very large capital outlays that represent investments and strategies to capture patients from existing services. Unchecked, projects in this category could contribute to segmentation of the market, reducing access to care for some, and would be potentially disruptive and system destabilizing.

There is little agreement among those interviewed and surveyed on raising either capital expenditure review threshold (Table A-1, Question 38, Appendix A).

CON regulation of major medical equipment in most states focuses on six services: cardiac catheterization, lithotripsy, CT scanning, MRI scanning, PET scanning, and radiation therapy (Chart 2). Mississippi regulates four of these services: cardiac catheterization, MRI scanning, PET scanning, and radiation therapy. CT scanning and lithotripsy were subject to review at one time but have been dropped from coverage.

There are strong reasons for regulating these services and the equipment used in providing them. All four of the services (and equipment) covered are costly and usually highly profitable. They also are services that can, and increasingly are, provided outside of community hospitals. Diagnostic imaging, radiation therapy, and cardiac catheterization are among the more profitable hospital services. In many facilities the operating returns from these services represents more than 100% of the hospital's annual operating margin. With some of the services, average program volumes, which are more likely to be higher under planning and CON regulation, are linked to superior treatment outcomes.

Profitable outpatient services (procedure based services) are attractive to many parties. Without planning controls, many new services would be developed, costs per patient would increase (adding to total expenditures), and the profitability of existing providers, particularly small community hospitals, would be substantially affected. In many communities the stability of essential community hospitals depends on their maintaining a substantial share of this market and the revenue stream associated with it.

Although there is value in regulating these services, the current review process does not treat all service providers the same. In the words of many service providers and other interested parties, there is no "level playing field" in the regulation of the four major medical equipment categories now subject to review. Inequities have arisen in recent years as a result of legal opinions, judicial rulings, legislative changes, and MDH interpretations of these holdings.

Currently, a party proposing to establish a new service subject to review with equipment costing less than $1,500,000 must get CON approval. An existing service provider, however, can expand capacity by adding the same piece of equipment outside of CON review.[16] In a region or community where there is need for additional capacity, it may be preferable, for geographic access or other reasons, to establish a new service rather than to expand an existing facility. The proposed new service, however, cannot be reviewed competitively and may be denied approval because the expansion of the existing service can be initiated while the proposed new service is under review. The lack of a level playing field creates inequity.

Related inequities permit the system to be "gamed". Replacement medical equipment is not subject to review. Nominally, a provider wishing to add a state-of-the-art MRI system, which can cost $3.0 million or more, would require CON approval to do so because the cost exceeds the capital expenditure review threshold. The applicant can avoid review, however, by "replacing" its existing unit with the sophisticated expensive MRI system and "adding" an MRI scanner costing less than $1,500,000, then replacing that unit whenever the service provider wishes with a more expensive unit.

Even if the system is not gamed as described above, it is otherwise problematic in that under current market conditions, it provides an incentive to purchase cheaper, and perhaps less clinically useful or reliable, equipment to get under the $1.5 million

threshold when expanding. A program established to promote quality should not contain structural incentives for purchasing less effective equipment than might be appropriate.

States institute capital expenditure review thresholds for medical equipment to try to moderate or otherwise tailor the review process to local circumstances. The intent is to avoid unduly burdensome regulation, not to open inadvertently disruptive and potentially destabilizing loopholes that penalize some established services, especially essential community hospitals.

Permutations associated with the current medical equipment capital expenditure review threshold, individually and collectively, create disincentives for efficient program operations, permit "gaming" of the review process, and do not treat all service providers fairly. Consideration should be given to eliminating the medical equipment capital expenditure review threshold. With the exception of proposals to replace existing equipment, all equipment acquisitions—establishing new services and expanding existing services—should be subject to review. This coverage arrangement would be more easily understood and administered, would establish a "level playing field," and would be more equitable to all parties and interests. Equipment replacement should remain exempt from review.

H. Service Coverage

Changes in program coverage and operations over the last decade and a half have resulted in a less effective and less equitable review process. Consideration should be given to several changes that, collectively, would increase fairness among interested and affected parties, make the review process more effective, and protect the public interest. These include:

- *Eliminate medical office buildings from CON review;*
- *Require CON review for the conversion of mobile services to fixed cited services;*
- *Eliminate the single specialty surgery ambulatory surgery center exemption from CON review;*
- *Require CON review for the establishment and expansion of all licensed and Medicare certified surgery facilities services;*
- *Replace the moratorium on nursing home development and expansion with a structured planning process incorporating the "request for proposals" principle; and*
- *Eliminate the opening of previously licensed hospital beds outside of CON review and approval.*

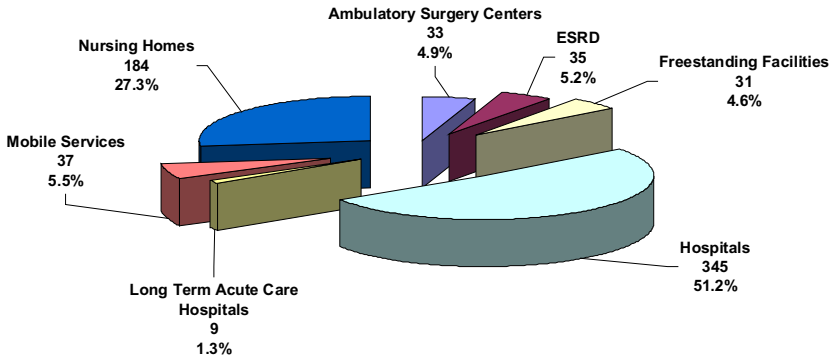
Section 41-7-191 of the Mississippi Code requires the Mississippi Department of Health to maintain a statewide CON program. The statue provides that CON approval from the Department is required before any party:

- Establishes a new health care facility;
- Relocates a health care facility;
- Increases the bed capacity of a health care facility;
- Acquires or relocates major medical equipment with a capital cost of $1.5 million or more;
- Changes ownership of a covered health care service or facility without proper notice to the Department; or
- Undertakes a health care facility capital expenditure of $2.0 million or more.

In a number of respects the Mississippi CON program is similar to the programs found in other states that regulate acute care services. The number and array of services regulated is not greatly dissimilar. Currently, Mississippi covers 17 of the 30 most commonly regulated service, facility, and equipment categories (Chart 2).

Two services covered in Mississippi that are regulated less frequently elsewhere are renal dialysis and hospital swing beds. Only eleven of the thirty-seven states with CON programs cover ESRD facilities. Eleven states also regulate hospital swing beds. Only seven states regulate both services.[17] These services would be the stronger candidates for exemption from review were the scope of coverage to be reduced. Over the last decade about 5% of the applications reviewed have been for ESRD services (Figure 5). Most of those applications were handled between 1997 and 2001, with relatively few ESRD recent filings during the last five years.

Figure 5
Mississippi CON Applications
Percent Distribution of Applications by Type of Service
1997 - 2005



Source: Mississippi CON Applications, 1997 - 2006, Mississippi Department of Health, 2006.

Services not covered in Mississippi that are regulated in large numbers of other states include CT scanning, hospice, lithotripsy, neonatal intensive care, and organ transplantation. Except for CT scanning, most states that regulate acute care services, include these services in their coverage. In terms of the number and array of services, facilities, and major medical equipment subject to CON controls, the scope and reach of

Mississippi's CON program are less comprehensive than is found in most states that regulate acute care services.

In analyzing CON program coverage and discussing program operations with interested and affected parties, two issues stand out:

- Consistency of the program's coverage and operations with evolving medical technology, medical market economics, reimbursement levels, and best planning and regulatory practices; and

- Public and service provider equity, often expressed as a concern about the absence of a "level playing field."

When considering possible changes in CON program coverage and related operations, it is useful to assess options with these issues and concerns in mind.

1. Medical Economics and Markets

Although the U. S. health care system is the most market oriented in the world, most medical care in not delivered in an environment that conforms with classic economic theory or principles. This is uniformly true of the services subject to CON review in Mississippi. Policies favoring "consumer-directed" and "consumer-driven" health care notwithstanding, this is not likely to change soon. The more important economic and market factors to be considered in setting or assessing CON coverage patterns and practices include:

- The individual receiving care usually has little knowledge of actual costs, usually pays little of the cost of care directly, and has only a limited role in whether and where care is provided;

- Society expects medical care providers, particularly hospitals, to treat persons needing care regardless of the individual's ability to cover the cost of care or whether third party reimbursement, including Medicaid payments, fully covers the cost of care. Facilities must, in effect, engage in cross-subsidization, covering losses for services to those unable to pay with profits or net revenues from "profitable services";

- Cross-subsidization is accepted as appropriate and desirable, with medical care facilities expected to provide services on which they lose money, making up those losses with profits or net revenues from other services;

- For services covered by private or public insurance, the amount paid to providers of care usually is set by the third-party payers rather than the operator of the service;

- Both public and private insurers set their reimbursement rates based on estimates of average costs, a form of indirect collective cost-based reimbursement that has replaced facility specific cost-based payment, so that costs are passed through to businesses, individuals, and governments; and

- Experience has shown that medical care demand is not independent of supply, with use rates for services (use per person or population group) increasing when supply increases.

Some general economic principles do apply to the medical care field. There are, for example, economies of scale, with higher volume providers generally having lower unit costs. Higher volume providers also generally have better quality, with facilities performing more procedures usually having lower morbidity and mortality rates.

Hospitals often lose money on a number of essential services, such as emergency department care. The losses may occur because reimbursement levels are low, relative to operating costs, or because substantial proportions of patients in those services are uninsured or covered by a program, such as Medicaid, whose payments may not cover the full cost of care.

Hospitals offset those losses with gains on other services. The gains from those services are a result of reimbursement being significantly greater than the costs of providing services. Such profitable services also may be ones not highly used by uninsured individuals. For several years, diagnostic imaging (particularly MRI and, to a lesser extent, CT procedures) and ambulatory surgery have been profitable services that have provided the revenue to enable hospitals to absorb losses incurred in providing other needed services.

With diagnostic imaging and other procedure oriented services being unusually profitable, it is not surprising that others—individual physicians, medical groups, and entrepreneurs—wish to offer them. If enough of the more profitable diagnostic imaging and ambulatory surgery patients are shifted from hospitals to freestanding settings, the financial health and viability of community hospitals can be jeopardized. The economics, financial incentives, and potential effects of service delivery patterns within the system should be taken into effect when considering possible CON program changes.

Unfortunately, “cherry picking” is inherent in market economics and, hence, is necessarily a planning and operational consideration in medical care. There often is an unending line of those who wish to offer the more profitable services. There is no similar queue of persons wishing to offer the unprofitable but needed services.

Equity and fairness in all respects is, or should be, a cardinal principle in CON regulation. The integrity, and ultimately the acceptability of the program depends on the perception that its structure and processes do not contain undue bias and that all affected parties are treated equitably. This concern with fairness is often translated into the sports metaphor of whether there is a “level playing field” for all parties or contenders.

Nearly all affected parties support the Mississippi CON program. There is a strong body of opinion that the program serves Mississippi and Mississippians reasonably well. There is, however, a broad and growing sense that the regulatory playing field has become increasingly tilted against community hospitals and the essential services they provide. Indications that there is not a level playing field include circumstances where:

- A project to be developed by one party is subject to CON review but the same or a similar project from another party does not require review;
- A less expensive (often less capable) piece of equipment is exempt from review but a more advanced piece of the same equipment that can provide greater clinical benefit for some patients requires CON approval;
- A party seeking to establish a service with a unit of fixed medical equipment must obtain CON authorization, but another provider who currently has mobile service of any type or degree does not need CON approval to acquire the same fixed service and equipment;
- A service provider can add capacity without CON approval and, thereby, affect the need for a proposed new service that does require CON authorization; and
- An existing provider, proposing to add capacity, is judged by one standard whereas an applicant for a new service, proposing the same capacity change, is judged under a different standard.

The inequities in the system affect not only the opportunities for some applicants to gain approval of a project. More importantly they can also affect the medical care that is available to residents of Mississippi, the costs that are incurred and passed on to patients and insurers, the accessibility of some services and, at least potentially, quality of some services.

2. Medical Office Buildings

Mississippi's CON program requires review of hospital proposals to develop a medical office building on campus, if project costs exceed $2.0 million. It does not require CON authorization for any other entity proposing to construct a medical office building in any other location.

Hospitals recognize certain benefits to having a medical office building on campus. In markets where there are multiple hospitals, physicians with offices on site are more likely to hospitalize patients at the adjacent hospital. In all situations, physicians in an office building on campus are more likely to use ancillary outpatient services at the hospital and less likely to refer patients elsewhere or to develop their own services. The use of a given hospital for inpatient care provides a competitive advantage for that hospital.

The use of existing hospital outpatient services often coincides with the public interest. Because of economies of scale, unit costs for services at the hospital may be reduced. In addition, the patients referred by private physicians, being more likely to have insurance, can increase the proportion of total charges paid to that hospital. That improves the economic performance for those services, reducing the need to obtain higher payments elsewhere. There can, therefore, be significant financial benefits to having a medical office building on the campus of a hospital.

The negative effects of hospital campus medical office buildings are limited and usually are not systemic; they are seldom disruptive to the health care system. Owners and potential developers of other office buildings are affected. Medical office buildings on a hospital campus may not produce the property tax revenues that another medical office building would. Those two factors, however, do not increase costs for the health care system and are not likely to affect decisions about whether to issue a CON.

Requiring a CON for a medical office building if it is on a hospital campus but not requiring a CON approval for the same expenditure to construct a medical office building elsewhere is not equitable. To be fair, the program would cover the expenditure regardless of setting or not require review for any setting. No one argues that the law should be expanded to cover all medical office buildings. A level playing field, therefore, can be achieved only by exempting medical office buildings on campus from review. There appears to be broad support for exempting projects such as this from review (Chart 9).

From a health system perspective, a medical office building on a hospital campus has no identifiable negative effect and can produce cost benefits. Consideration, therefore, could be given to exempting medical office buildings from CON review regardless of the capital expenditure for such buildings.

3. Conversion From Mobile to Fixed Unit Service

A unique feature of the Mississippi CON program is the provision that exempts conversion of mobile services to fixed site services, provided the project does not have some other feature that requires review. Under this provision an entity that cannot justify a fixed MRI, for example, can submit an application that proposes use of a mobile MRI. The period of service can be as little as one morning or one day a week. Once approval of a service site is secured, however, that provider can replace its use of the mobile service with a fixed MRI. This is usually done with notice to the Mississippi Health Department (MDH) in the form of a request for a declaratory ruling from the CON program that the change is not subject to review. As discussed elsewhere, MSDH handles a large number of declaratory rulings, a large percentage of which are for MRI and other mobile services.

This creates a substantial loophole; one that is potentially destabilizing. In an area that could justify one MRI, five parties, each with few patients, could agree to share a mobile system that would operate one day per week at each site. The five parties could each subsequently acquire a fixed MRI, resulting in the addition of five new MRIs, each in a

separate program, in an area that needs only one. In another location, an applicant for a fixed MRI in that planning district could be denied for lack of need while another party with just 25 percent of the total patients of the first applicant could be approved for a mobile service, only to then convert it to a fixed MRI.

The practice of permitting existing mobile service sites to convert to fixed service sites outside of CON review is problematic, and is not limited to MRI or other diagnostic imaging services. This provision eliminates review of a substantial number of medical equipment projects. It also generates considerable uncertainty and instability. In addition, it raises fairness and equity considerations.

Consideration should be given to interpreting the conversion of a mobile service to a fixed site service as the establishment of a new service requiring review and CON approval or, if necessary, seeking legislative change.

4. MRI Services

Under current payment arrangements, MRI is a very profitable service. Reimbursement rates were set years ago when procedures times were long and volumes usually modest. Now procedures are much shorter in duration and MRI scanners can routinely perform 5,000 to 6,000 procedures per year where there is sufficient demand. The operator's cost per procedure has decreased, but reimbursement rates have not changed much. As a result, profits can be substantial.

Not surprisingly, many are interested in providing the service. If a CON were not required for establishing an MRI service, numerous new MRIs would be acquired. Among the effects of that would be the following:

- The average number of procedures per MRI would decrease, resulting in increases in expenses per procedure;

- The total number of procedures provided to Mississippi residents would increase, as establishing new services leads to increased use, resulting in increased costs and reimbursement; and

- Hospital finances would be negatively affected as physicians who now refer patients to hospitals for MRI scans would provide them in their offices or refer them to freestanding outpatient settings.

There is significant value in maintaining CON coverage of MRI. If there is to be equity—a level playing field—acquisition of all MRI equipment, new services and equipment additions to existing services, should be subject to CON review. Equipment replacement should remain exempt from review.

5. PET Imaging Services

PET scanning is a relatively new diagnostic imaging service. The planning and CON review issues regarding PET are similar to those for MRI. PET scanners, now being superseded by PET-CT scanners, are expensive, with current unit costs of between $2.0 and $3.0 million. Several years ago, PET scanning was used for cardiac studies, but it now is used largely for cancer patients. Just as happened earlier with both CT and MRI scanning, use of PET scanning is increasing substantially and technologic developments have rapidly decreased procedures times and increased the effective capacity of scanners.

Currently, state-of-the-art PET-CT scanners can accommodate three patients per hour (20 minutes per patient). Equipment under development is expected to handle four patients an hour. In some high volume settings, fixed units now are scanning as many as 6,000 patients a year, eight times the volume standard in the Mississippi State Health Plan. At current reimbursement rates of at least $2,000 per procedure, PET has become highly profitable for operators who can achieve efficient use of the equipment.

Mississippi has a comparatively large number of PET services, the large majority of which are part-time mobile services. There are more than 25 authorized service sites. Currently, seven are fixed site services. Most service sites have low use. In 2004 only about 5,200 PET procedures were reported statewide. Several of the mobile service sites report service volumes comparable with, or higher than, some of the existing fixed site services. Unless CON review requirements are changed to require approval of conversions from mobile service sites to fixed site service, a number of facilities are likely to replace their mobile services with fixed units at low use levels. That would increase expenditures and could undermine the viability of some mobile PET services, jeopardizing availability of that service at certain hospitals. There should be one, equitable review standard for all of those establishing or expanding mobile and fixed services.

Consideration should be given to leveling the playing field by requiring CON review convert from a mobile service to a fixed PET or PET-CT service. This would promote equity and provide protection against unnecessary expenditures.

6. Radiation Therapy

Under normal operating circumstances, cancer treatment also generates significant profits, particularly if it is outpatient treatment and the provider is focused on privately insured and Medicare patients. Some states where a CON is not required for radiation therapy have had numerous freestanding radiation therapy services developed. As a result, community hospitals have lost significant numbers of the more profitable outpatients while still providing inpatient care and limited outpatient treatments, particularly to the uninsured and Medicaid recipients. A similar experience would be likely in Mississippi if there were not CON coverage of radiation therapy.

No change in coverage appears to be desired or warranted.

7. Cardiac Catheterization

Cardiac catheterization and open-heart surgery provide clear evidence of the cost and quality issues that are fundamental to CON planning and regulation. Cardiac catheterization unit costs (cost per procedure) are lower in facilities performing large numbers of catheterizations. More importantly, mortality rates for both catheterizations and open-heart surgery procedures have been shown to be significantly lower in high volume programs. Studies document that open-heart surgery mortality rates, in aggregate, are lower in states with CON coverage of open-heart surgery than in other states.

Mississippi needs fewer rather than more cardiac catheterization and open-heart surgery programs. Several of the existing programs operate at less than the modest use levels specified in the Mississippi State Health Plan. If there were no CON coverage, there would be an even larger number of programs. It is likely these new programs would be duplicative and not properly located. The result could be higher unit costs and less than optimal quality.

No change in coverage appears to be desired or warranted.

8. CT Scanning

CT scanning is not subject to CON review in Mississippi. Coverage was dropped a number of years ago at a time when the cost of CT scanners was coming down and computed tomography was becoming a more common and widespread service. In the last few years, however, some state-of-the-art CT scanners require CON review because they are above the $1.5 million medical capital expenditure review threshold. Advanced high-speed CT scanners now have capital costs comparable to those of MRI and PET scanners: $2,000,000 to $3,000,000. Some states that eliminated regulation of CT capital expenditures are considering reinstating coverage. After removing CT scanning and other major medical equipment from CON regulation in 1989, Virginia resumed regulation of all of these services and equipment in the 1990s. West Virginia recently reinstated CON regulation of CT scanners because of the higher costs and expanding use.

Although the number of CT scans performed is greater than MRI or PET scans, the economic and service delivery issues regarding CT scanners are otherwise similar to those surrounding MRI and PET scanning. It would be reasonable, therefore, to consider reinstating CON coverage of CT services on the same basis that MRI and PET services are subject to review. If the $1.5 million medical equipment capital expenditure review threshold were to be replaced by coverage of any new service or expansion for covered services, there would be a rationale for including CT scanning as a covered service. Otherwise, the $3,000,000 state-of-the-art CT scanners would not be subject to any public scrutiny or review.

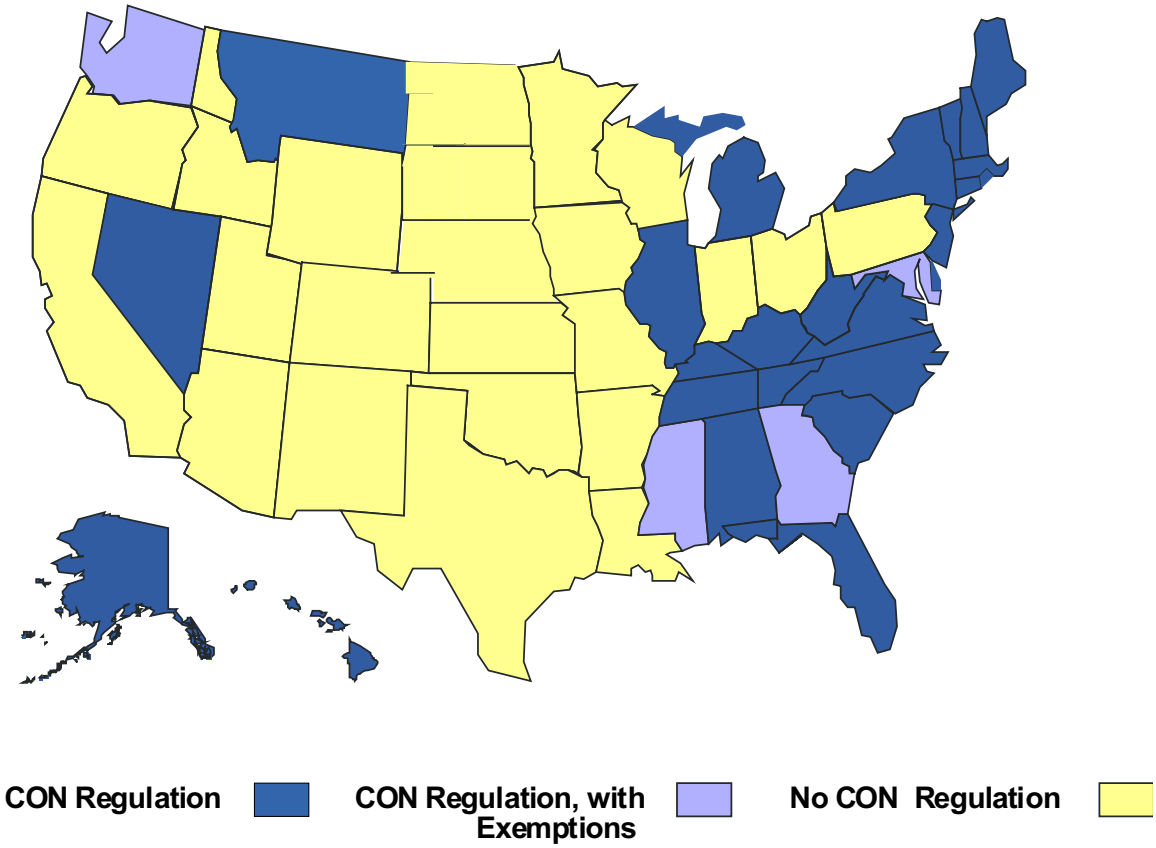
9. Surgical Services

Ambulatory surgery rivals high-end diagnostic imaging services for profitability. There

are, therefore, strong economic incentives for developing new services. The motivation is enhanced because surgeons, who often have ownership interests in freestanding ambulatory surgery centers, direct patients and decide where they receive surgery.

One of the more striking examples of the lack of a level CON playing field in Mississippi is the exclusion of single specialty surgery centers from coverage. Nationally, twenty-seven state CON programs cover ambulatory surgery centers. Only four (Georgia, Maryland, Mississippi, and Washington) exempt single specialty centers from review (Map 2). The Mississippi exemption is the broadest of the four. It has no size (number of operating rooms) or capital expenditure limitation. The other three states with single special surgery center exemptions limit the exemption either in terms of the number of operating rooms that may be maintained or in terms of the amount of the capital expenditure that may be incurred.

Map 2
CON Regulation of Surgery Services
2006



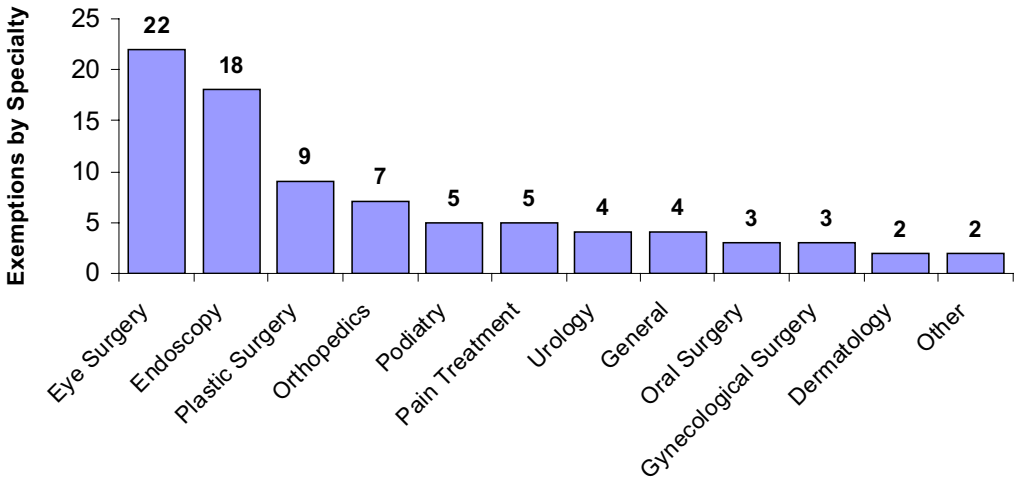
In addition to not having these limitations, the Mississippi exemption is compounded by the reigning interpretation of how exempt single specialty centers may conduct their day-to-day business operations. Single specialty centers are exempt from CON review

because they are considered to be physician offices rather than medical care facilities. This interpretation is based on the belief and assumption that exempt centers would provide only one type of surgery, that associated with the specialty of the surgeon or surgical group granted the exemption. In the main, this may be the case, but there is no assurance that single specialty centers do not evolve into multi-specialty centers, which nominally are subject to CON review.[18]

In setting the limitations on single specialty surgery center operations, MDH applies a Medicare program policy dating from 1994 that permits Medicare payments for surgeries provided under "one day lease" arrangements in certified centers.[19] Application of this principle in combination with the single specialty center exemption means that there is no prohibition against exempt single specialty centers in Mississippi leasing space to any number of unaffiliated surgeons, surgical groups, or entrepreneurs. The only limitation is that different surgical groups may not use the facility concurrently. Thus, there is no assurance, or effective requirement, that single specialty centers do not become, in effect, multi-specialty centers. An ophthalmology center, for example, is free to lease its operating rooms, of which there can be any number, to other surgical specialties on any day of the week.

The current array of surgical services in Mississippi illustrates the results of this atypical regulatory landscape. Single specialty exemptions have been granted to 84 centers over the last decade. More than a dozen surgical specialties are represented among these centers. Nominally, nearly half of the exemptions were granted to ophthalmologists and gastroenterologists (Chart 11).

Chart 11
Mississippi CON Program
Single Specialty Ambulatory Surgery Facility Exemptions
Exemptions by Specialty
1997 - 2006



Source: CON Program Records, Mississippi DOH, 2006.

The 84 exempt centers is more than three times the number of freestanding multi-specialty surgery centers. The combination of competing freestanding multi-specialty centers and the exempt single specialty centers appears to be having a marked effect on community hospitals. Over the last decade, Mississippi community hospitals have steadily lost market share to competing outpatient surgery centers. Although surgical demand has continued to grow statewide, total surgical volumes at community hospitals have decreased since 1999. All net growth in surgical demand during the last seven years has gone to non-hospital services. Community hospitals continue to lose market share. This pattern, which would be troublesome in any state or community, is more problematic in states such as Mississippi where the average hospital size is comparatively small and the average hospital daily census is comparatively low. The loss of market share equates to less efficient, if not less effective, service delivery.

Beyond market share considerations, there are other consequences to having a plethora of single specialty surgery centers. They include:

- Community hospitals lose profitable patients to surgery centers but must continue to serve less profitable inpatients, those with more complex needs, the uninsured, and Medicaid patients;

- Some patients whose surgery previously was done in physician offices are now done in single specialty surgery centers, with higher charges and reimbursement for the same procedures;

- There may be more surgeries performed than necessary; and

- There is not the same oversight found in most hospitals and large surgery centers, resulting in greater risk of quality problems.

Another issue regarding CON coverage of surgery services concerns the lack of effective control of surgery capacity in all settings. Those wishing to establish a multi-specialty surgery center must get CON approval, demonstrating need for additional capacity. Existing providers, both hospitals and ambulatory surgical centers, however, can expand capacity by adding rooms without going through the CON process, thereby eliminating any regional need for the capacity the applicant for the new surgery center proposes. CON coverage of increases in the number of operating rooms is necessary if equity and fairness are to be assured.

10. Hospice Services

Home health services are subject to CON review. Hospice care is not. Most hospice care is provided in the home, a form of home health care provided by staff trained to work with the terminally ill and their families. Inpatient care, when needed, usually is provided at existing hospitals or nursing homes with which hospice organizations have contracts. There are many similarities between home health and hospice care, but they are treated differently under the CON program.

There appears to be strong support, at least within the home health industry, for continuing CON coverage of home health. There is some concern, however, about the large number of hospice organizations that have been created, some of which reportedly are operating inefficiently. Given the similarities between home health and hospice service providers, it would be reasonable to consider treating the two similarly under the CON program.

11. Personal Care Homes

Nursing home services and facilities are subject to CON review. Personal care homes are not. All states with CON programs require approval for nursing home beds. Some also require CON approval for personal care homes or comparable assisted living facilities. Nursing homes and personal care homes provide different levels of care. Nationally, however, the differences are becoming less pronounced as many personal care homes are caring for people who previously would have been served in nursing homes.

The ability to pay for care also can be a determinant of whether someone is in a personal care home or nursing home. Some persons remain in a personal care home until their resources are depleted to the point that they no longer can pay the cost of care. At that point, they are transferred to nursing homes as a Medicaid eligible patient. Often the principal difference in these circumstances is as much financial as clinical. This pattern results in nursing home patients being disproportionately Medicaid patients, affecting both the financial status of nursing homes and state Medicaid budgets.

The numbers of patients and beds in nursing homes have been relatively stable in recent years, nationally and in Mississippi. Nationally, however, the numbers of assisted living facilities and beds have increased substantially. As care distinctions blur and as financial circumstances affect where a person is placed, MDH should monitor developments to determine whether CON coverage to assisted living facilities should be considered.

12. Moratoria and Legislative Exemptions

There are long standing legislatively mandated moratoria on nursing home and home health service development in Mississippi. The nursing home moratorium has been in place for more than a decade. What began as a near term response to help control the growth in Medicaid spending has evolved into a continuing substitute planning process supervised by the legislature. Nursing home development is managed through periodic special legislation that authorizes specific projects. In 1999, the legislature authorized additional nursing home beds in twenty-six counties. Hundreds of additional beds have been added in this way. This necessarily adds a political dimension that is problematic for effective planning and regulation. It invites extension of the principle to other regulated services.

This arrangement may have been necessary when first adopted. Given the projected need for more than 4,000 additional nursing home beds statewide delineated in the State Health Plan, direct legislative control may continue to be necessary until more

appropriate and realistic estimates and projections of need can be developed through the regular planning process. It is evident, however, that the current arrangement is not conducive to effective planning and is not sustainable indefinitely. Beyond the inherent complications and inequities it presents for nursing home and related long-term care service development, these anomalous circumstances undermine the credibility of the planning process and the CON program.

Through the laws adopted, legislatures set policy and establish the principles that are to be followed in implementing that policy and those principles equitably. When there is special legislation providing exceptions or directing decisions for a specific project or area, the process of a legislative body establishing policy and an administrative body implementing that policy equitably breaks down. Over the last decade, there have been numerous pieces of such special legislation adopted, as well as many others proposed but not adopted.

In the past three legislative sessions, for example, 26 bills (excluding duplicate "companion" bills introduced in both the House and Senate) have been introduced to direct a CON decision for a specific circumstance or situation. These bills have covered a wide range of projects, including new hospitals, psychiatric beds, nursing homes, home health agencies, radiation therapy, magnetic resonance imaging (MRI), and intermediate care facilities for the mentally retarded. Most of these were not enacted, but the environment and atmosphere they reflect remains strong.

If the law is not being implemented as the legislature directs, it can amend the law so that all comparable situations are addressed rather than targeting legislation to a specific situation or project. One of the problems of making administrative decisions by legislative action is that it is likely to be inherently inequitable. Another problem is that adoption of one piece of special legislation virtually assures the filing of others.

Ultimately, the solution lies in lifting the moratorium on nursing home development. Consideration should be given to replacing it with a more reliable prospective planning process. The process should incorporate a call or request for applications feature that permits better control of the number of beds that may be authorized during any given period. It should take into account nursing home use rates and trends, occupancy levels, and Medicaid program use and budget considerations. This approach has worked well elsewhere and should be examined to determine how it might best be applied successfully in Mississippi.

It would be better to have the legislature periodically review the CON law and the plans adopted to implement it, rather than rely on special legislation addressing specific situations that gain legislative attention. Legislative restraint on specific projects is desirable. The development of a better, economically sustainable, and politically palatable planning process is needed to make that possible.

13. Hospital Beds

There are far more hospital beds than are needed in Mississippi. In recent years, the average occupancy rate of licensed beds statewide has been less than 50 percent. The Mississippi State Health Plan indicates that hospitals with more than 50 beds can operate efficiently at 70 to 80 percent occupancy. Larger hospitals are expected to operate at the upper end of that range. Each of the seven general hospital service area districts has at least 50 percent more beds than are needed.

This surplus has not been caused by approval of substantial numbers of additional hospitals or hospital beds through the CON program. Most of the excess capacity was developed decades ago. The surplus is a function of the substantial reduction in inpatient hospital use over the last twenty-five years. Much care has been shifted to outpatient settings, and lengths of stay have dropped for those who are hospitalized. As a result, far fewer beds are needed than two decades ago.

Hospital size and distribution reflect, and are affected by, the rural nature of much of Mississippi. About two-thirds (54 of 82) of Mississippi counties have populations of less than 30,000. Unless they are regional centers serving more than one county, any hospital in these counties is likely to have limited services and limited use. As hospital use has shifted from the inpatient to the outpatient setting over the last quarter century, the population needed to support an acute care hospital has increased steadily. Eight counties have no hospital. In half of these counties, the only hospital closed during this period.

Mississippi's CON and licensure programs are atypical in that they permit unneeded hospital beds to be "banked indefinitely". Beds that are not needed to meet current or near-term demand may be taken removed from the licensure rolls but retained as part of the official bed complement. These "unlicensed" beds may be brought back into service without CON approval. In most states, hospital beds removed from the licensure rolls are no longer considered to be part of the official bed complement and must be reauthorized before they can be reopened or replaced. In many states hospital beds not used within a specified period of time, usually 12 months, are stricken from the licensure rolls and cannot be reopened and "re-licensed" without State approval.

The more distinctive, and problematic, "unlicensed" beds are those formerly located in hospitals that have closed. There are 15 hospitals in this category. (There was a 16th hospital, but it reopened with 3 beds in late 2005.) The 15 hospitals had a total of 409 beds before closing. Eleven of the 15 closed hospitals were in counties where there is another hospital. House Bill 1221 (2006) addressed this situation in a limited way. It provides that CON approval is now required to reopen a formerly licensed hospital closed for 60 months or more. It does not address closures of less than five years. The potential for closed hospitals and unused hospital beds to be reopened outside the CON process creates uncertainty as to the actual supply of hospital beds and a degree of instability for those providers that continue to serve communities (and planning districts) where the closures occurred.

There are modest numbers of beds in two other categories of unlicensed beds. There are 111 de-licensed beds in existing hospitals. With the exception of 6 beds at Delta Regional Medical Center, all are in counties with populations of less than 30,000 and only modest, if any, growth. With the exception of Delta Regional Medical Center, no hospital with de-licensed beds is using as much as one-third of its licensed capacity. It is likely that few, if any, of the unlicensed beds will be reopened.

MDH also reports 342 beds as authorized but not yet licensed. Most of those, however, are in three locations: 140 beds being added at Baptist Memorial Hospital in Desoto County, 60 beds legislatively authorized to be transferred from a defunct hospital to a nearby hospital (Tri-Lakes Medical Center) with an occupancy rate of less than 40 percent, and 37 beds previously licensed at Greene County Hospital, which reopened with 3 beds late last year.

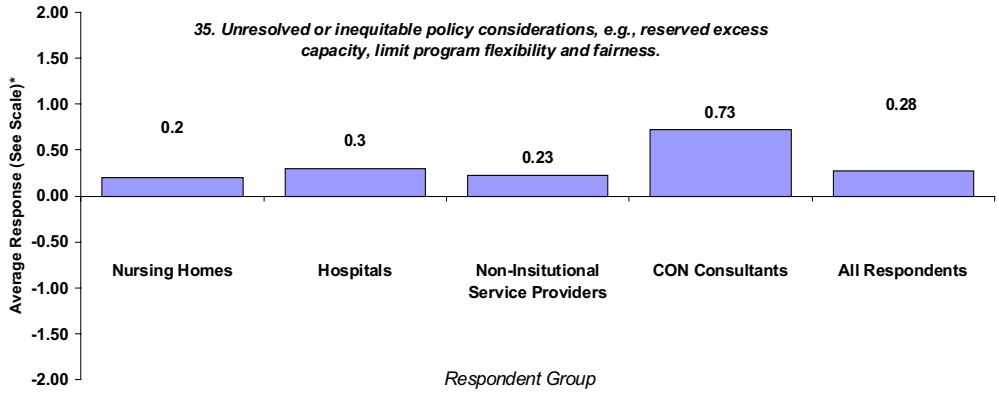
The remaining 105 beds are groups of between 1 and 25 beds located at 10 different facilities. Each of these 10 facilities have less than 50 percent occupancy and only two fill more than about one-third of their licensed beds. Some of these hospitals do not operate all of their licensed beds. Few of the unused (non-operational or unlicensed) beds in these 10 hospitals are likely to be opened. Some of the facilities are critical access hospitals that are limited to operating no more than 25 beds. They, of course, should be permitted to operate as many beds as are necessary and can be used.

Retention of these unlicensed beds in the inventory has not created a significant planning problem because Mississippi has such a large surplus of hospital beds that there is no planning region, and few communities, that need additional beds. Eliminating these beds from the inventory would not change that situation. Moreover, these beds are not in medical service areas where occupancy rates are high. Although there may be a need periodically for additional beds in a few high growth areas such as Desoto County, there is not a general need for additional inpatient hospital capacity in any region.

Because Mississippi has a large surplus of hospital beds and because it is likely that few, if any, of the previously licensed beds would ever open, the current environment should be conducive to considering requiring a CON to add to the number of licensed beds in any hospital. This would extend the principle inherent in the change in HB 1221 requiring CON approval to reopen a hospital closed for 60 months or more. Although the practical effects of such a requirement are limited now (few, if any, beds would open without this provision), it would provide clarity, equity, and a greater sense of system stability. It also could prove beneficial should a region experience growth that led to a need for additional beds in the future. Those involved in, and affected by, the CON program see the hospital bed situation as an anomalous situation that does not present a major near term problem, but one that should be resolved to improve the planning process and to make regulation more rational, predictable and acceptable (Chart 12).

The general, statewide surplus of acute care hospital beds will not change soon. Mississippi has relatively high inpatient use rates. Population growth, aging, and related demographic changes are not likely to increase inpatient demand statewide. Use rates in

Chart 12
Mississippi CON Survey Responses
Average Response by Respondent Group



*** Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.**
Source: AHPA Survey, July, 2006.
Note: Total number of responses may vary by question because not all respondents answered all questions.

high growth areas are likely to decrease somewhat as younger and more affluent residents move into those areas. The questions of how to reduce unneeded capacity and permit development of any additional capacity needed in high growth areas needs to be addressed directly through more precise (i.e., targeted, service area) and effective planning. Acute care bed planning methods and standards are discussed below in Section III.

III

Mississippi State Health Plan

A. Overview

Many aspects and elements of the Mississippi State Health Plan are commendable. It ranks high among comparable state plans in terms of its currency, its comprehensiveness, and its utility in CON review. It compares favorably with nearly all other state health plans, especially those plans that have evolved into more narrowly focused medical facility plans, in being updated annually and made available directly and online to interested and affected parties. The process used in developing the plan, which invites public and interested party participation early in the process, is superior to the procedures and processes used in many states.

The structure, organization, and contents of the plan are designed to facilitate its use in reviewing CON applications. It identifies both the general review criteria and the service-specific criteria and standards that are to be used in assessing CON applications and informing staff recommendations and state health officer decisions on them. The plan makes clear that the service specific review standard, where available, take precedence over the general review criteria. The general criteria, which are delineated in the *Mississippi Certificate of Need Review Manual*, are referenced, but not listed in the plan. The plan indicates that where service-specific review criteria have not been published, "the application will be reviewed using the general CON review criteria and standards presented in the *Mississippi Certificate of Need Review Manual* and all adopted rules, procedures, and plans of the Mississippi Department of Health."[20] The plan indicates that, in applying both the general and the service-specific review criteria and standards, primary consideration will be given to cost containment and the unnecessary duplication of services and facilities. Interviews with key stakeholders suggest that program staff focus on avoiding the unnecessary duplication of resources as the principal means of containing costs.

Each service-specific set of review criteria and standards identifies the planning district (i.e., the geographic area) that is to be used in assessing the need for additional capacity, the need methodology and formulae to be applied, the population estimates and projections to be used, and any legislative mandates or other policy considerations that may be applicable. Maps of the planning districts, inventories of existing service capacity, and projected capacity needs are presented where they are available and applicable. Taken collectively, these data and information and the discussion accompanying it permits potential CON applicants to determine quickly whether a contemplated proposal is consistent with the plan and is likely to be approved.

CON program staff appears to rely heavily on the state health plan in its evaluation of applications. Published staff reports routinely cite consistency or inconsistency with the applicable review criteria as the basis for recommendations. The citations are often not accompanied by supporting analysis or explanation. Potential applicants are encouraged to apply plans criteria and standards to their proposals to determine whether they are likely to be received favorably.

B. Population and Planning Districts

Planning for health and related social services requires geographic and demographic frames of reference. Whether identified quantitatively, or incorporated implicitly without direct acknowledgement, the population to be served must be identified if a project is to be rationally planned, budgeted, and its results assessed. In most circumstances, the greater the specificity with which the market to be served can be defined geographically and demographically, the greater the potential for success.

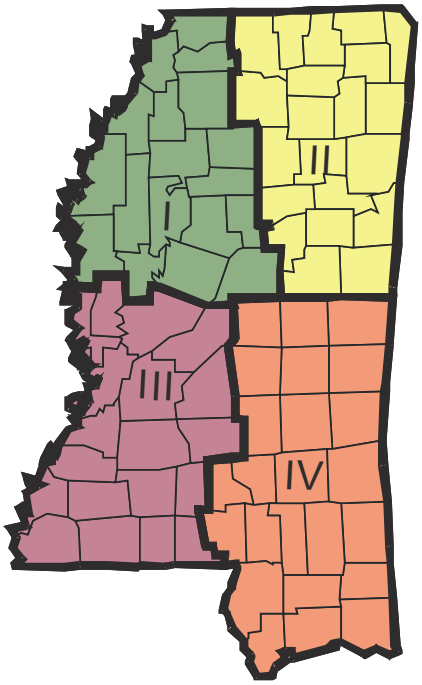
This requirement places a premium on identifying, and where possible quantifying, medical markets and trade patterns, the geography and population served by existing services and facilities, and the potential service areas and populations to be served by proposed services and facilities. State planning and CON programs commonly do this by specifying the official state population estimates and projections to be used, and by dividing the state into designated geographic planning areas. They also often incorporate "service area" principles and formulae in the criteria and standards used to assess capital expenditure proposals.

Mississippi adheres to these practices to the extent that data permit. As noted in the Mississippi State Health Plan, and in other regulations and documents, population estimates and projections used in planning and related CON regulation are those published by Center for Policy Research and Planning, a component of the Mississippi Institutions of Higher Learning (IHL).[21] The current plan is based on the IHL's projections for the year 2010. It contains population estimates and projections by county for 2010.

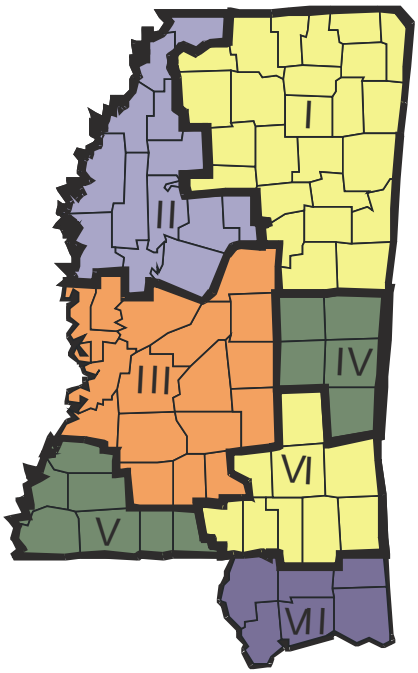
The plan also delineates the geographic areas to be used as the primary planning units. The planning districts specified are aggregations of contiguous counties, including the cities and towns within those boundaries. They range from single (i.e., statewide) regions for some services to as many as nine regions for others. The acute care hospital service area configuration, the one that comes into play most often in CON review, has seven planning districts. The long-term care (e.g., nursing home) configuration, the second most frequently used configuration in CON review, contains four districts**.** Map 3 contains maps depicting the designated planning regions by type of service for the four most frequently used planning districts.

Map 3
Mississippi Planning Areas

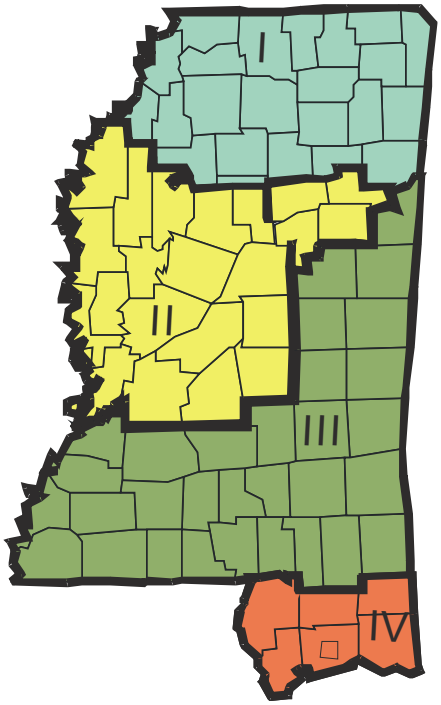
Mississippi Long Term Care Service Areas



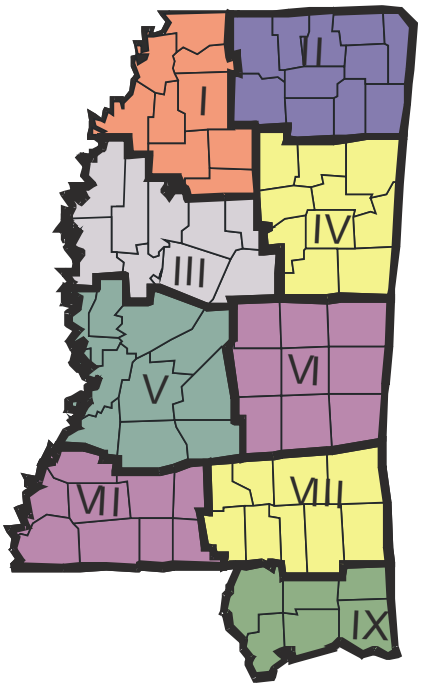
Mississippi General Hospital Service Areas



Mississippi Mentally Retarded/
Developmentally Disabled Planning Areas



Mississippi Perinatal Service Areas



The number, variation, and use of designated planning districts in the state health plan and in CON reviews raise questions about their relevance, utility, and fairness. These concerns have increased in recent years as population growth in northern Mississippi has called into question the underlying logic of the acute care and long term care districts. Dissatisfaction with what some believe to be deficiencies in the general hospital service area configuration has led to at least one legislative proposal to alter the configuration by creating a distinct 8th district from contiguous counties now assigned to planning districts one and two.[22] The bill did not pass, but the questions raised by the proposal remain.

States vary considerably in their approach to defining and designating planning areas. Most first established regional health planning service areas under provisions of the National Health Planning and Resources Development Act of 1974. More than 200 such regions were designated nationwide by 1979.[23] These planning areas incorporated a number of features believed to be important in promoting effective planning and CON regulation. These factors include:

- Minimum population size (between 500,000 and 1,000,000 persons under NHPRDA);
- Geographic cohesion (i.e., contiguous whole political jurisdictions);
- Accommodation of major geographic barriers;
- Recognition of importance of "regionalizing" some health services;
- Consistency with major transportation and development patterns; and
- Compatibility with identified medical trade patterns and markets.

A number of states (e.g., Florida, Georgia, North Carolina and Virginia), continue to use these health service areas as basic planning regions.[24] With the repeal of NHPRDA, and the closure of most regional health planning agencies, many states modified their approach to regional planning. They shifted from the health service areas designated under NHPRDA to more conventional geographic entities, usually counties or previously established multipurpose planning districts and regions. Alabama, Kentucky and Tennessee, for example, shifted to individual counties, and selected aggregations of contiguous counties, as the basic geographic planning areas.[25] South Carolina adopted revised planning regions with a modified distribution of counties within them.[26] Nearly all states continue the inherently strong orientation toward counties as the underlying and collateral planning unit. Where data permit, most also use calculated institutional and program service areas based on local service-specific use rates and service delivery patterns.

Current planning district boundaries in Mississippi were made subsequent to the repeal of NHPRDA, but are not otherwise linked to federal health service area designations.[27] The planning areas now in use are variations, in most cases aggregations, of the nine public health districts established by the Mississippi Department of Health (MDH) in 1980. It established these districts to provide a regional structure to facilitate management of the public health programs and services for which the Department is responsible. The Mississippi Heath Care Commission, the designated state health planning authority under

NHPRDA, adopted the public health regions as its official sub-state planning regions in 1984.

With the demise of the federal planning program, the Mississippi Health Care Commission was disestablished in 1986 and its functions and responsibilities transferred to MDH.[28] Designed to facilitate management of public health programs and service delivery, the nine public health districts were not necessarily logical regional entities congruent with the planning and regulation of acute care hospital or long-term nursing care services. The Board of Health subsequently modified the public health district structure to form the existing acute care and long-term care districts.

The boundaries chosen for the acute and long-term care planning districts reflect many of the principles normally associated with health services planning. Though not homogenous or equal in all respects, the effort to establish roughly equivalent districts that reflect population distribution, transportation routes, general development patterns, and medical trade patterns is evident. Although the size and population density of the districts vary greatly, relative (proportional) distribution of the state's population among the seven the general hospital service areas (GHSA) has remained stable since 1980 (Table 2). Assuming expected recovery from Hurricane Katrina, this is likely to remain the case for the next decade or more.

Table 2
Mississippi Population Distribution
General Hospital Service Areas (GHSA)
1980 - 2010

GHSA	Year							
	1980		1990		2000		2010*	
1	601,723	23.9%	617,083	24.0%	680,187	23.9%	694,660	23.3%
2	385,014	15.3%	368,820	14.3%	403,767	14.2%	432,041	14.5%
3	648,540	25.7%	673,311	26.2%	741,267	26.0%	775,939	26.1%
4	159,830	6.3%	153,852	6.0%	157,091	5.5%	157,892	5.3%
5	117,029	4.6%	121,089	4.7%	130,535	4.6%	127,375	4.3%
6	249,477	9.9%	260,556	10.1%	286,436	10.1%	307,681	10.3%
7	359,025	14.2%	378,505	14.7%	445,375	15.6%	479,962	16.1%
State Total	***2,520,638***	***100.0%***	***2,573,216***	***100.0%***	***2,846,658***	***99.9%***	***2,975,550***	***100.0%***

Source: U. S. Bureau of the Census, Population Division, *Population of Counties by Decennial Census: 1900 to 1990,* Compiled by Richard L. Forstall, 2006; Mississippi Population Projections for 2005, 2010, and 2015, Center for Policy Research and Planning, Mississippi Institutions of Higher Learning; *Mississipi State Health Plan,2007* (Draft), 2006. *Projected.

Cursory examination of the GHSA districts may suggest a haphazard, or even arbitrary demarcation, but that is not the case. Comparison of the GHSA districts indicates that an effort has been made to reflect general development and medical trade patterns. It appears that the boundaries were drawn to reflect established medical trade patterns. When established, they were county groupings wherein the large majority (>90%) of residents obtain hospital services. Recent hospital patient origin studies conducted by MDH staff shows that in only five of the state's 82 counties do majorities of the residents use hospitals in other GHSAs. All five of these jurisdictions are boundary counties where

there is substantial migration into the adjacent county for services.[29] All of these counties are rural, with an estimated combined population of 91,868 in 2005. Collectively, they are expected to grow to 98,771 (7.5%) by 2010.

Changes to the GHSA boundaries to reflect these patterns would require moving Tate County from GHSA 1 to GHSA 2, Holmes County from GHSA 2 to GHSA 3, and Jefferson Davis County and Smith County from GHSA 3 to GHSA 6, and Stone County from GHSA 7 to GHSA 6. The net effect of these changes would be an increase in the size and population of GHSA 6. This may be desirable for a number of reasons, but there would be little practical effect on current planning practice or on prospective CON decisions. The state, and all redrawn GHSAs would still have far more acute care hospital beds than needed, or permissible under the State Health Plan. These changes would not affect materially need assessments for other regulated acute care services.

Mississippi has four standard metropolitan statistical areas (SMSA) within its boundaries. Four counties in the northwest are part of the Memphis, Tennessee SMSA. Three of the seven GHSAs are formed around these metropolitan areas. Two of the SMSAs, Gulfport-Biloxi (Hancock, Harrison and Stone Counties) and Pascagoula (Jackson and George Counties) are located in GHSA 7. GHSA 6 is constructed around the Hattiesburg SMSA (Forrest, Lamar and Perry Counties), and the Jackson SMSA (Copiah, Hinds, Madison, Rankin, and Simpson Counties) is the center of GHSA 3. Although they do not qualify as SMSAs, two the other four GHSAs have sizable cities at their core. The GHSA districts are the prescribed planning unit for all acute care serviced subject to CON review. Given current population distribution and medical trade patterns, they are reasonable configurations.

Table 3
Mississippi Population Distribution
Long Term Care Planning Districts (LTCPD)
1990 - 2010

			Year			
LTCPD	1990		2000		2010*	
1	472,317	18.4%	519,386	18.2%	552,379	18.6%
2	532,067	20.7%	584,299	20.5%	593,980	20.0%
3	704,497	27.4%	772,634	27.1%	803,746	27.0%
4	864,335	33.6%	968,409	34.0%	1,025,445	34.5%
State Total	***2,573,216***	***100.0%***	***2846728***	***99.9%***	***2,975,550***	***100.0%***

Source: U. S. Bureau of the Census, Population Division, *Population of Counties by Decennial Census: 1900 to 1990,* Compiled by Richard L. Forstall, 2006; Mississippi Population Projections for 2005, 2010, and 2015, Center for Policy Research and Planning, Mississippi Institutions of Higher Learning; *Mississippi State Health Plan, 2007* (Draft), 2006. *Projected

A similar pattern holds for the four long-term care planning districts (LTCPDs). The current arrangement essentially divides the state into quadrants that are much more equally balanced than the GHSA districts in terms of geography, and population size and distribution (Map 3). As shown in Table 3 and Table 4, the ratios of total population, elderly population, and licensed nursing home beds are generally proportionally distributed among the four planning regions.

The current long-term care planning districts have been in place for about a decade. A special long-term task force drew them (proposed their adoption), based on established nursing home use and referral patterns. The relatively large size and small number of districts established, combined with a comparatively large and widely distributed elderly population, results in more regional uniformity than with acute care services.

Because of the long standing moratorium on nursing home development and expansion, the number, size, and configuration of the LTCPDs have little practical influence in long-term care planning and CON regulation. Under the current formula used to estimate need, all districts show large numbers of additional nursing beds needed, with total projected need of nearly 8,400 more statewide. This is nearly 50% more than the current licensed bed complement (17,710 beds) and, given use levels and trends elsewhere, calls into question the reliability of the planning methods used to project bed need. There are legislative moratoria on development of most long-term care services subject to CON review. Currently, there are moratoria on nursing home beds, home health services, and ICF/MR facilities. In the case of nursing homes, the state legislature has effectively controlled the number and location of nursing homes for nearly two decades.

Table 4
Mississippi Elderly Population & Nursing Home Bed Distribution
Long Term Care Planning Districts (LTCPD)
2006

LTCPD	*Population, 65 Years +*		*Licensed Beds*	
1	78,137	17.3%	3,344	18.6%
2	96,463	21.3%	4,026	22.4%
3	116,638	25.8%	4,676	26.0%
4	160,814	35.6%	5,929	33.0%
State Total	***452,052***	***100.0%***	***17,975***	***100.0%***

Source: Mississippi State Health Plan, FY 2006, Mississippi Department of Health, 2006.

Although Mississippi has a number of service-specific planning district configurations, there is little or no evidence that the boundary variations are problematic in terms of

health services planning or effective CON regulation. In the instance of long-term care, district considerations seldom come into play. In the case of acute care, there is more than adequate capacity for nearly all covered services in all districts. District limitations come into effect, as they are intended, when the ultimate justification of a CON proposal depends on local considerations overriding regional considerations. Although there may be strong disagreements on a small number of applications, interviews and surveys of an array of knowledgeable and interested parties revealed little difference of opinion and a general acceptance of the current boundaries (Table A-1, Question 26, Appendix A).

The most notable recent proposal to change the planning district boundaries arose out of the desire to permit the development of an additional acute care hospital in north Mississippi. Some believe an additional hospital is needed there to serve the growing population in the area and to provide competition to the principal existing service provider.

This four county area is the most rapidly growing part of the state and, because of its comparative affluence and other positive demographic characteristics, is an unusually attractive market. The counties in question are now located in two acute care planning districts, GHSA 1 and GHSA 2. House Bill 195 (2006) would have required MDH to change the GHSA boundaries to "include Desoto, Tunica, Tate and Marshall Counties together in the same General Hospital Service Area."[30] Although this requirement could have been met, had the bill passed, by redrawing GHSAs one and two to place all four counties in one district, that would not have achieved the intended objective. Because of the large numbers of surplus acute care beds in both districts, relocating the counties in either GHSA would not result in a projected need for additional hospital beds. The objective of HB 195 could be met only by creating a separate, presumably the eighth, GHSA containing only Desoto, Tate, Tunica and Marshall Counties. Even this redesign could prove problematic, depending on the need projection formulae used, the planning horizon chosen and on how interstate travel for hospital care is considered.

A number of changes could be made to one or more of the planning districts to make them more symmetrical geographically, more evenly balanced demographically, or more responsive to near terms system perturbations and associated political concerns. The near term benefit would be likely to be offset by unintended consequences and longer-term problems.

Elimination of some, or all, of the service-specific planning districts requirements in the State Health Plan may be seen as the practical response to dissatisfaction with the existing configurations. This is the approach taken in a substantial number of states since the repeal of federal health planning requirements. This step necessarily entails greater reliance on the primary service area or the County as the geographic frame of reference for planning and CON regulation. Reliance on program or facility primary service areas, in turn, places a premium on reliable patient discharge data. Some of these data are now available in limited form. A quarterly sample of a limited number of data elements (between one-third and one-half of those collected in many state patient-level data systems) is available. These data are useful, but do not provide adequate information to

perform reliable small area analyses. Without a functioning comprehensive patient-level discharge system, eliminating planning districts and relying solely on counties and service area analyses would prove problematic. Larger number of districts may be warranted, but they need to be determined based on the analysis of discrete small demographic and health service use data.

Any change to the current planning district boundaries should be based on an analysis of operational data and a showing that the proposed reconfiguration would be likely to result in more precise and accurate need assessments that would be conducive to more effective planning and regulation. There is a need for more complete patient level hospital discharge data that would permit reliable service-specific use rates to be calculated, patient origin and destination patterns documented, and medical markets and trade patterns defined.[31] Less extensive, but reliable patient origin and destination data are needed for long-term care services. Any significant change in planning boundaries should await the collection and analysis of these data.

There is no evidence of strong or widespread dissatisfaction with the population data used in the State Health Plan or in CON regulation. As is the case in virtually all CON programs, MDH relies on official state population estimates and projections. As shown in Table 5, population growth and change in Mississippi has been comparatively low. Although there is considerable variation within the state, this overall pattern is not expected to change soon.

Those surveyed and interviewed expressed confidence in state demographic data and acknowledge that the State Health Plan, which is updated annually, contains the most recent official IHL population estimates and projections. In addition, as is the case in other states, the Mississippi CON program is sufficiently flexible to permit applicants to cite other population sources and data if they believe it materially supports their application and arguments. In addition to the IHL estimates and projections, a number of applicants use Claritas population estimates and projections and data from other sources in their applications. These data and the calculations based on them are given their proper weight.

The principal limitation with regard to population in the State Health Plan is the absence of service-specific use rates and trends. This limitation arises not from population data limitations but from the lack of patient-level hospital discharge data. Mississippi is one of only two states (Idaho is the other) that does not have, or is not developing, a comprehensive all payer patient level discharge data system (Table A-2, Appendix A). These data would permit more accurate and meaningful use of population estimates and projections.

The other significant data related limitation in the plan is the lack of reliable data on interstate migration for care by Mississippi residents. Given the lack of comprehensive patient origin and destination for Mississippi facilities and only limited information of the

Table 5
Mississippi
Population Distribution and Change by County
1980 - 2010

Jurisdiction	Year 1980	1990	2000	2001	2002	2003	2010	% Change 1980-2003	% Change 1990-2003	% Change 2000-2010
Mississippi	2,520,638	2,573,216	2,844,658	2,857,577	2,866,349	2,880,793	2,975,550	14.3%	12.0%	4.6%
Adams County	26,316	29,819	34,340	33,820	33,479	33,183	30,497	26.1%	11.3%	-11.2%
Alcorn County	33,036	31,722	34,558	34,711	34,789	34,888	34,983	5.6%	10.0%	1.2%
Amite County	13,369	13,328	13,599	13,530	13,518	13,550	13,303	1.4%	1.7%	-2.2%
Attala County	19,865	18,481	19,661	19,736	19,688	19,672	19,658	-1.0%	6.4%	0.0%
Benton County	8,153	8,046	8,026	7,931	7,867	7,823	7,545	-4.0%	-2.8%	-6.0%
Bolivar County	45,965	41,875	40,633	40,291	39,483	39,300	38,216	-14.5%	-6.1%	-5.9%
Calhoun County	15,664	14,908	15,069	14,981	14,885	14,872	13,843	-5.1%	-0.2%	-8.1%
Carroll County	9,776	9,237	10,769	10,700	10,598	10,572	10,704	8.1%	14.5%	-0.6%
Chickasaw County	17,853	18,085	19,440	19,476	19,336	19,252	17,862	7.8%	6.5%	-8.1%
Choctaw County	8,996	9,071	9,758	9,640	9,713	9,682	9,810	7.6%	6.7%	0.5%
Claiborne County	12,279	11,370	11,831	11,770	11,646	11,449	12,263	-6.8%	0.7%	3.7%
Clarke County	16,945	17,313	17,955	17,835	17,825	17,693	17,089	4.4%	2.2%	-4.8%
Clay County	21,082	21,120	21,979	21,856	21,873	21,511	21,266	2.0%	1.9%	-3.2%
Coahoma County	36,918	31,665	30,622	30,250	29,926	29,482	28,977	-20.1%	-6.9%	-5.4%
Copiah County	26,503	27,592	28,757	28,872	28,794	29,039	30,466	9.6%	5.2%	5.9%
Covington County	15,927	16,527	19,407	19,529	19,753	20,138	20,566	26.4%	21.8%	6.0%
DeSoto County	53,930	67,910	107,199	113,390	118,664	124,447	148,614	130.8%	83.3%	38.6%
Forrest County	66,018	68,314	72,604	73,093	73,380	74,205	78,869	12.4%	8.6%	8.6%
Franklin County	8,208	8,377	8,448	8,397	8,289	8,338	8,460	1.6%	-0.5%	0.1%
George County	15,297	16,673	19,144	19,523	20,040	20,511	21,572	34.1%	23.0%	12.7%
Greene County	9,827	10,220	13,299	13,233	13,232	13,324	15,573	35.6%	30.4%	17.1%
Grenada County	21,043	21,555	23,263	23,032	22,955	22,777	23,157	8.2%	5.7%	-0.5%
Hancock County	24,537	31,760	42,967	43,948	44,629	45,222	49,548	84.3%	42.4%	15.3%
Harrison County	157,665	165,365	189,601	189,545	190,094	189,461	197,103	20.2%	14.6%	4.0%
Hinds County	250,998	254,441	250,800	249,670	248,896	248,807	238,871	-0.9%	-2.2%	-4.8%
Holmes County	22,970	21,604	21,609	21,608	21,488	21,262	20,866	-7.4%	-1.6%	-3.4%
Humphreys County	13,931	12,134	11,206	11,012	10,785	10,683	11,529	-23.3%	-12.0%	2.9%
Issaquena County	2,513	1,909	2,274	2,196	2,129	2,058	2,463	-18.1%	7.8%	8.3%
Itawamba County	20,518	20,017	22,770	22,925	22,969	23,183	24,059	13.0%	15.8%	5.7%
Jackson County	118,015	115,243	131,420	132,914	132,949	133,616	140,832	13.2%	15.9%	7.2%
Jasper County	17,265	17,114	18,149	18,289	18,253	18,161	18,659	5.2%	6.1%	2.8%
Jefferson County	9,181	8,653	9,740	9,692	9,692	9,511	9,299	3.6%	9.9%	-4.5%
Jefferson Davis County	13,846	14,051	13,962	13,720	13,567	13,386	13,529	-3.3%	-4.7%	-3.1%
Jones County	61,912	62,031	64,958	64,945	65,066	65,221	67,024	5.3%	5.1%	3.2%
Kemper County	21,867	15,893	10,453	10,660	10,521	10,466	11,033	-52.1%	-34.1%	5.5%
Lafayette County	31,030	31,826	38,744	38,878	39,177	40,124	42,892	29.3%	26.1%	10.7%
Lamar County	23,821	30,424	39,070	40,165	41,147	41,917	46,891	76.0%	37.8%	20.0%
Lauderdale County	77,285	75,555	78,161	77,582	77,634	77,746	77,055	0.6%	2.9%	-1.4%
Lawrence County	12,518	12,458	13,258	13,390	13,420	13,484	13,936	7.7%	8.2%	5.1%
Leake County	18,790	18,436	20,940	21,462	21,716	22,057	21,942	17.4%	19.6%	4.8%
Lee County	57,061	65,581	75,755	76,723	76,993	77,646	77,577	36.1%	18.4%	2.4%
Leflore County	41,525	37,341	37,947	37,245	36,756	36,346	35,522	-12.5%	-2.7%	-6.4%
Lincoln County	30,174	30,278	33,166	33,353	33,559	33,556	34,904	11.2%	10.8%	5.2%
Lowndes County	57,304	59,308	61,586	61,065	60,894	60,569	59,163	5.7%	2.1%	-3.9%
Madison County	41,613	53,794	74,674	76,492	77,855	79,804	89,684	91.8%	48.4%	20.1%
Marion County	25,708	25,544	25,595	25,300	25,230	25,254	25,514	-1.8%	-1.1%	-0.3%
Marshall County	29,296	30,361	34,993	34,993	35,230	35,543	37,129	21.3%	17.1%	6.1%
Monroe County	36,404	36,582	38,014	38,125	37,884	37,913	37,752	4.1%	3.6%	-0.7%
Montgomery County	13,366	12,388	12,189	12,104	11,949	11,895	11,606	-11.0%	-4.0%	-4.8%
Neshoba County	23,789	24,800	28,684	28,514	28,769	29,190	30,429	22.7%	17.7%	6.1%
Newton County	19,944	20,291	21,838	21,961	21,906	22,084	22,286	10.7%	8.8%	2.1%
Noxubee County	13,212	12,604	12,548	12,498	12,381	12,281	11,536	-7.0%	-2.6%	-8.1%
Oktibbeha County	36,018	38,375	42,902	42,510	41,925	41,528	44,922	15.3%	8.2%	4.7%
Panola County	28,164	29,996	34,274	34,592	34,910	35,125	36,606	24.7%	17.1%	6.8%
Pearl River County	33,795	38,714	48,621	49,611	50,403	50,900	55,302	50.6%	31.5%	13.7%
Perry County	9,864	10,865	12,138	12,213	12,259	12,232	13,060	24.0%	12.6%	7.6%
Pike County	36,173	36,882	38,940	38,886	38,936	39,027	40,619	7.9%	5.8%	4.3%
Pontotoc County	20,918	22,237	26,726	27,055	27,127	27,694	29,345	32.4%	24.5%	9.8%
Prentiss County	24,025	23,278	25,556	25,447	25,576	25,632	27,069	6.7%	10.1%	5.9%
Quitman County	12,636	10,490	10,117	10,016	9,965	9,706	10,395	-23.2%	-7.5%	2.7%
Rankin County	69,427	87,161	115,327	118,990	121,624	124,867	142,629	79.9%	43.3%	23.7%
Scott County	24,556	24,137	28,423	28,494	28,285	28,519	28,936	16.1%	18.2%	1.8%
Sharkey County	7,964	7,066	6,580	6,374	6,304	6,215	5,828	-22.0%	-12.0%	-11.4%
Simpson County	23,441	23,953	27,639	27,445	27,718	27,584	28,834	17.7%	15.2%	4.3%
Smith County	15,077	14,798	16,182	16,117	15,960	15,856	15,503	5.2%	7.1%	-4.2%
Stone County	9,716	10,750	13,622	14,141	14,116	14,264	15,605	46.8%	32.7%	14.6%
Sunflower County	34,844	32,867	34,369	34,190	33,852	33,590	33,626	-3.6%	2.2%	-2.2%
Tallahatchie County	17,157	15,210	14,903	14,690	14,502	14,384	14,058	-16.2%	-5.4%	-5.7%
Tate County	20,119	21,432	25,370	25,531	25,598	25,877	27,973	28.6%	20.7%	10.3%
Tippah County	18,739	19,523	20,826	20,900	20,961	20,998	21,502	12.1%	7.6%	3.2%
Tishomingo County	18,434	17,683	19,163	19,012	19,085	19,013	18,934	3.1%	7.5%	-1.2%
Tunica County	9,652	8,164	9,227	9,369	9,696	10,002	10,304	3.6%	22.5%	11.7%
Union County	21,741	22,085	25,362	25,765	25,874	26,128	27,130	20.2%	18.3%	7.0%
Walthall County	13,761	14,352	15,156	15,260	15,120	15,205	14,944	10.5%	5.9%	-1.4%
Warren County	51,627	47,880	49,644	49,324	49,156	49,005	47,428	-5.1%	2.3%	-4.5%
Washington County	72,344	67,935	62,977	61,966	61,057	60,164	57,624	-16.8%	-11.4%	-8.5%
Wayne County	19,135	19,517	21,216	21,197	21,201	21,176	21,525	10.7%	8.5%	1.5%
Webster County	10,300	10,222	10,294	10,322	10,279	10,146	9,833	-1.5%	-0.7%	-4.5%
Wilkinson County	10,021	9,678	10,312	10,269	10,293	10,314	10,253	2.9%	6.6%	-0.6%
Winston County	19,474	19,433	20,160	20,096	19,983	19,917	19,828	2.3%	2.5%	-1.6%
Yalobusha County	13,139	12,033	13,051	13,312	13,304	13,327	12,944	1.4%	10.8%	-0.8%
Yazoo County	27,349	25,506	28,149	27,913	28,009	28,244	29,065	3.3%	10.7%	3.3%

Source: U. S. Bureau of the Census, Population Division, Population of Counties by Decennial Census : 1900 to 1990,Compiled by Richard L. Forstall, 2006;
Mississippi Population Projections for 2005, 2010, and 2015, Center for Policy Research and Plannin g, Mississippi Institutions of Higher Learning, March 2002;
Mississipi State Health Plan, 2007 (Draft), September 2006.

use of health care facilities in other states by Mississippians, the State Health Plan does not take migration for care into account in planning for the development of institutional health care services.

C. Best Practices

Planning is a dynamic process, and planning for the rapidly changing health services and facilities covered by most CON programs especially so. Planning practices and the review criteria and standards used should reflect, and to the extent possible incorporate, best practices. This requires being attentive to technological advances, research findings, demographic changes, shifting economic incentives, as well as to significant changes in the organization and delivery of health care and planning and quality standards.

There are a number of areas and topics where different approaches or changes in planning techniques might encourage better institutional and community planning by service providers. This, in turn, should facilitate more effective and more equitable CON regulation. Some of the changes that should be considered are discussed below.

1. Distinguish Between Urban and Rural Areas

Mississippi is highly diverse. It is large geographically, with four metropolitan areas within its borders and several counties within the Memphis, Tennessee metropolitan area. Nevertheless, more than 60% of Mississippi residents live in rural areas. Only about one-third of the population lives in communities with populations of 10,000 or more. This population distribution pattern presents a number of planning and service development limitations that CON regulation should take into account.

Low population density necessarily means that most health care services are likely to be smaller in size and scale and to serve a larger geographic area. Larger service areas are necessary to generate sufficient demand to support basic operations. There are substantial economies of scale in many health care services. Smaller scale operations are likely to be less efficient than large-scale operations. There are likely to be more mobile services in low-density areas than in urban areas. Under normal operations, these services and facilities are likely to have lower volumes than urban services.

Given these considerations, and the desire to encourage efficient operations in all settings, it often is appropriate to have higher service volume standards in urban areas than in rural areas. If the lower rural "optimal" operating levels are assumed to be norm in urban areas, efficient services are penalized. If they operate at the higher efficiency levels that are routinely attainable, the lower planning standards, in effect, invite competitors to come in. Under these circumstances, efficient operators are encouraged to add capacity earlier than necessary in order to protect their markets.

Given Mississippi's population distribution and service use patterns, where data permit, it may be useful to distinguish between urban and rural use rates, service delivery patterns, and trends. Effective planning and fair regulation may require different urban and rural

service volume thresholds for some services. Diagnostic imaging services subject to CON review, MRI and PET imaging for example, fall into this category. Under selected circumstances, different service volume standards for radiation therapy services too may be appropriate.

2. Identify Optimal Operations

Medical technology has advanced rapidly during the last two decades. Improvements continue, particularly in diagnostic imaging and procedure based therapies. With improvements in technology, clinical applications of CT, MRI and PET imaging, cardiac catheterization, and radiation therapy have expanded. In most communities, demand for these services has grown accordingly, with demand for diagnostic imaging growing at double digit rates for several years in many areas.

All of these technologies entail the use of expensive equipment and computer software. Cost containment involves ensuring efficient use of this equipment, combined with the controlled diffusion (managed introduction and expansion) of these services as demand grows. Ensuring efficient use requires acknowledging the unstated distinction often made between service volume standards and system or equipment capacity. One of the more striking and useful aspects of technological change has been the dramatic increase in equipment and system capability and throughput. Average scan (procedure) times for CT, MRI, and PET-CT scanners, for example, have fallen dramatically over the last decade and are continuing to decrease. In some cases, the actual scan time has decreased to the point that it is a relatively small part of the overall procedure time. State-of-the-art CT and MRI scanner operating capacity has more than doubled over the last decade and is continuing to increase. PET-CT scan times too have decreased sharply and are expected to continue to decrease.

Diagnostic imaging is not the only service category benefiting from technological change. Advances in radiation therapy have improved its utility, and reduced both treatment planning and average procedure times. Radiation therapy technology continues to advance. The changes underway are likely to increase new patient caseloads somewhat, but may well reduce both the total number of treatments and the average treatment time, effectively increasing capacity and throughput.

Technological advances are also altering the mix of procedures used to diagnose and treat some clinical problems. Improvements in the set of technologies used to perform cardiac catheterization have resulted in a rapid increase in the number of therapeutic procedures. This is expected to continue, limiting the growth in both diagnostic procedures and open-heart surgery procedures. In addition, there are indications that recent advances in CT and MRI scanning may permit the substitution of noninvasive scans for some of the more costly and risky invasive procedures.

There is inherent tension between the desire to permit rapid diffusion new technologies and efficient use of the services that rely on them. This nearly always results in establishing planning standards that are substantially lower than either system capacity or

"optimal" use under specified circumstances. It is a truism that planning standards set as minimum performance levels, in practice, soon are treated as maximum standards. Operating levels adopted to indicate points and circumstances where adding capacity may be considered, under the pressures of day-to-day operations, quickly become accepted as "optimal" levels at which additional capacity should be authorized.

Currently, the Mississippi state health plan contains a number of planning standards that were established as minimum use levels but have evolved into maximum standards when used in CON analyses. There is little, if any, discussion of the nominal capabilities or capacities of regulated equipment. There are occasional references to "optimal" use levels for some equipment. MRI planning standards, for example, stipulate that 1,700 procedures is the minimum standard and that 2,500 procedures is the "optimal" caseload. There is no consideration of system capacity or throughput.

Whatever the merit of the 1,700 procedures planning standard, 2,500 MRI procedures per scanner per year, is not optimal use in most circumstances. Some MRI services in Mississippi and many, if not most, services elsewhere have much higher use. The underlying logic of the planning standards established and the rationale for how they are to be applied would be better understood if they were placed in context by a focused discussion of the underlying technology, its capabilities, and nominal capacity. Where planning standards are substantially below nominal capacity, the reasons for the standard should be stated.

3. Migration for Care

Comprehensive historical discharge data are not available to permit an accurate analysis of interstate travel for care. Migration for care is an important consideration in evaluating health service needs in the rapidly growing four county area of northern Mississippi that is part of the Memphis, Tennessee metropolitan area. The hospital use data that are available from neighboring states indicates that net migration between Mississippi and three neighboring states, Alabama, Arkansas, and Louisiana, is not substantial. About 1,800 Mississippi residents use Alabama hospitals each year and several hundred Alabama residents use Mississippi hospitals. Net migration is not significant. Moreover, it is evident that most of those who use Alabama hospitals do so because of convenience, and probably physician choice, rather than being forced to do so because of a lack of nearby Mississippi facilities. More than one-half come from three counties (George, Jackson, Harrison). Nearby Alabama hospitals are as convenient, or in some cases more so, than Mississippi facilities in Jackson and Harrison counties or in Hattiesburg. Patient origin data are not available to assess the flow of hospital patients between Mississippi and Arkansas and Louisiana, but all indications are that patient flow in both directions is low and that net migration is not significant for planning purposes.

There is substantial migration to Memphis, Tennessee hospitals by residents of North Mississippi. Excluding those using Veterans Administration hospitals, more than 18,500 Mississippians used western Tennessee hospitals in 2005. Virtually all of these hospitals are in the Memphis metropolitan area. More than half of those using Memphis area

hospitals came from four counties (Desoto, Marshall, Tunica and Panola), with 75% (6,983 of 9,344 discharges) coming from Desoto County. The northern Mississippi migration pattern is essentially one way. Comparatively few Tennessee residents use Mississippi hospitals.

The medical trade pattern in the Memphis area is not atypical. It can be found in many metropolitan areas nationally, particularly those with rapidly growing suburban communities. Assuming net migration of 17,000 cases a year and an average length of stay of five days, this represents and acute care average daily inpatient hospital census of about 233 patients. An average daily census of this magnitude would generate an acute care bed need of about 290 beds, assuming they were located in one hospital.

It should be stressed that this does not mean that an additional hospital or substantial numbers of additional hospital beds, beyond those that have already been authorized, are needed in one or more of the northern Mississippi counties to meet this need. As has been the case in other metropolitan areas, this pattern will change gradually as those moving into the rapidly growing areas loosen ties to Memphis and reorient to their new community.

The principal planning task in these situations is to calibrate health facility infrastructure with development and population growth, not try to anticipate it. Rapid development and population growth nearly always brings demographic and other market changes. It is highly likely, for example, that those moving into the communities bordering Memphis will have substantially lower inpatient hospital use rates than elsewhere in Mississippi. Combined with the ongoing shift to outpatient care, in lieu of inpatient services, this suggests that careful planning is needed to avoid duplicative and wasteful spending for inpatient facilities and services that will not be needed.

An all payer patient-level hospital discharge data system is needed to permit the geographic and service-specific planning that is needed to determine how best to meet the needs of these growing communities. The current state health plan does not address these questions directly. Reliable, comprehensive data are needed to permit future editions to address such questions.

D. Review Criteria and Standards

The Mississippi State Health Plan contains service specific review criteria and standards for most of the services and facilities subject to CON review. These standards are used in combination with, and in the context of, the general review principles and criteria published in the Mississippi CON Manual. As provided by statute and regulation, MDH staff relies heavily on the state health plan in evaluating CON applications and formulating recommendations to the State Health Officer. Most of those interviewed and surveyed see the state health plan as a useful guide to institutional health services planning and development.

To remain relevant and useful, CON review criteria and standards must evolve to reflect technological advances, health system changes, and evolving health services delivery practices. Standards should be examined periodically to ensure that they incorporate best practices and are consonant with research showing links between program volume and treatment outcome.

In general, the service-specific review criteria and standards in the Mississippi state health plan are comparable with those found in neighboring and other "peer" states. The comments offered below are based on a service-by-service comparison of the Mississippi standards with those of eight states: Alabama, Georgia, Kentucky, Maryland, North Carolina, South Carolina, Tennessee, and Virginia. Chart 13 shows the array of services subject to CON review in those states and the review thresholds they currently have in place.

1. Acute Care Hospitals, Hospital Beds

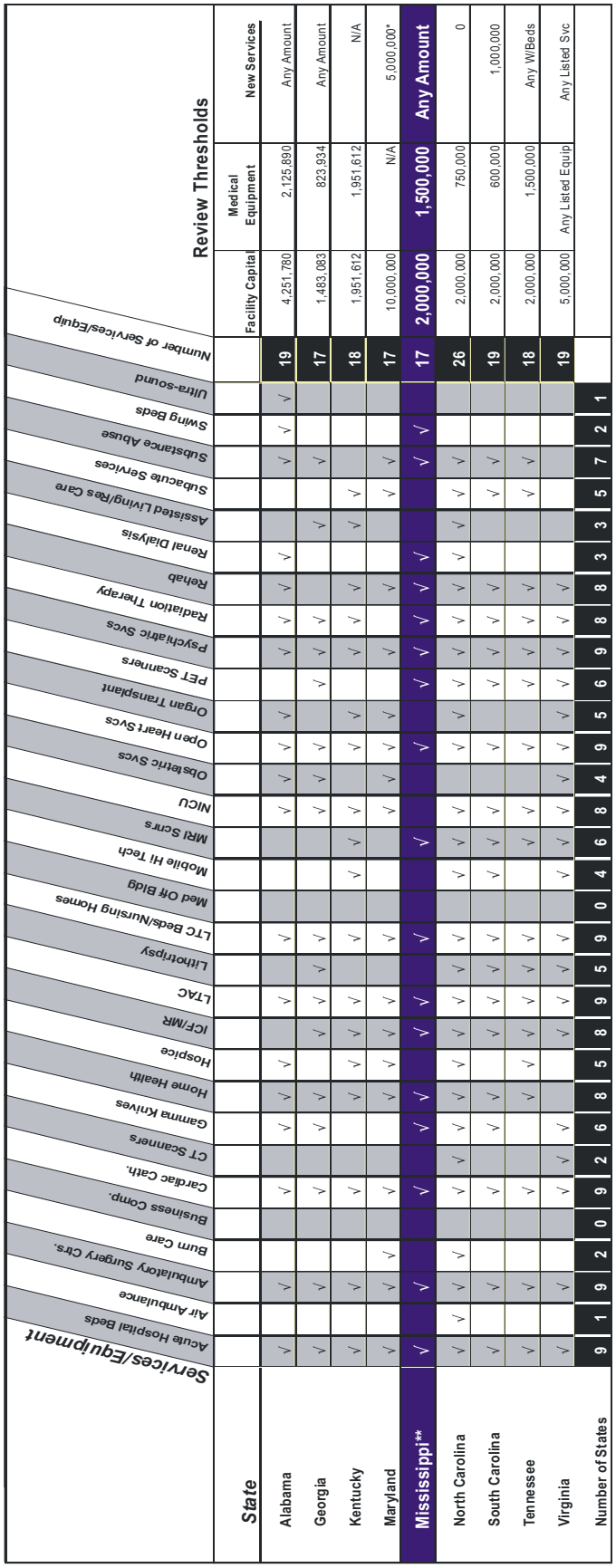
Unlike most other states, Mississippi uses different methods to determine hospital bed need in counties that do not have hospitals and those that now have hospitals. Counties without hospitals are permitted to establish facilities with 1.78 beds per 1,000 persons residing in the county, up to a maximum of 100 beds initially. Nine of Mississippi's 82 counties do not have hospitals. There must be a demonstrated need for at least 100 beds for a new hospital to be authorized.

The formula used to project need in counties with hospitals is probabilistic. It contains a "confidence factor" of 2.57. The formula is applied to each hospital (i.e., the entire hospital) individually, not to the planning district or to defined services. This formula is intended to give a projected bed need sufficiently large to ensure that there is a probability that the hospital will have an empty bed, and therefore able to accommodate a patient, 99% of the time. This is a high confidence factor that, if applied, in normal markets and circumstances would result in authorization of substantially more hospital beds than would be used efficiently.

Other than the understandable desire to permit the development community hospitals in counties without hospitals, neither of these methods is optimal. Many planning and CON programs have dropped probability formulas in favor of service-specific use rate trends and other indicators of likely future need and demand. This approach requires more comprehensive patient level data than is now available in Mississippi.

The planning horizon—the year, or interval, for which the need projection is developed—is not stated explicitly in the plan. It is implicit in the method used in counties without hospitals as the formula incorporates population data for the year 2010. This is not indicated for counties with hospitals. It is unclear whether 2010 or another year is the target projection year for these counties.

Chart 13
Certificate of Need Coverage Summary
Mississippi - Comparison States
2005



State	Acute Hospital Beds	Air Ambulance	Ambulatory Surgery Ctrs.	Burn Care	Business Comp.	Cardiac Cath.	CT Scanners	Gamma Knives	Home Health	Hospice	ICF/MR	LTAC	Lithotripsy	LTC Beds/Nursing Homes	Med Off Bldg	Mobile Hi Tech	MRI Scnrs	NICU	Obstetric Svcs	Open Heart Svcs	Organ Transplant	PET Scanners	Psychiatric Svcs	Radiation Therapy	Rehab	Renal Dialysis	Assisted Living/Res Care	Subacute Services	Substance Abuse	Swing Beds	Ultra-sound	Number of Services/Equip	Review Thresholds: Facility Capital	Review Thresholds: Medical Equipment	Review Thresholds: New Services
	√																																		
Alabama	√	√	√		√	√		√	√	√		√		√				√	√	√	√		√	√	√			√	√	√	19	4,251,780	2,125,890	Any Amount
Georgia	√	√			√			√	√		√	√	√	√				√	√		√	√	√	√		√		√			17	1,483,083	823,934	Any Amount
Kentucky	√	√			√				√	√	√	√		√	√		√	√	√	√		√	√	√		√					18	1,951,612	1,951,612	N/A
Maryland	√	√	√		√				√	√	√	√		√				√	√			√		√		√	√	√			17	10,000,000	N/A	5,000,000*
Mississippi**	√	√			√	√		√	√		√	√		√			√		√	√	√	√	√	√			√	√			17	2,000,000	1,500,000	Any Amount
North Carolina	√	√	√		√	√		√	√	√	√	√	√	√			√	√	√	√	√	√	√	√	√	√	√				26	2,000,000	750,000	0
South Carolina	√	√	√		√	√		√	√	√	√	√	√	√	√		√	√	√	√	√	√	√	√		√	√	√				19	2,000,000	600,000	1,000,000
Tennessee	√	√	√		√	√		√	√	√	√	√	√	√			√	√	√	√	√	√	√	√		√	√	√				18	2,000,000	1,500,000	Any W/Beds
Virginia	√	√	√		√	√		√	√	√	√	√	√	√	√		√	√	√	√	√	√	√	√		√	√	√				19	5,000,000	Any Listed Equip	Any Listed Svc
Number of States	9	1	9	2	0	9	2	6	8	5	8	9	5	9	0	4	6	8	4	9	5	6	9	8	8	3	3	5	7	2	1				

Source: AHPA, 2006.
* For selected services.
**Medical office buildings and CT scannners may be subject to CON regulation in some atypical circumstances.

Routine use of acute care hospitals is not random, so probability models are not be best approach to projecting bed need in most circumstances. Given the large number of surplus hospital beds throughout the state (with the possible exception of a couple of counties in the north), the formulas now used do not present practical problems, and they are not likely to become problematic soon. Nevertheless, the acute care bed planning methodology should be changed as soon as the data needed to do so are available.

Consideration should be given to working with the state hospital association to develop a data reporting system that could be used to develop a more appropriate and more flexible planning model for acute care beds. A service specific model that incorporates age-adjusted use rates and primary service area concepts and principles is recommended.

2. Nursing Homes, Nursing Home Beds.

There has been a moratorium on nursing home development since 1990. On occasion, the legislature has authorized the development additional nursing homes and the expansion of nursing homes as exceptions to the moratorium. Consequently, the planning methodology prescribed in the state health plan is used largely to identify the number and location of beds that would be likely to be approved if there were no moratorium. In aggregate, the FY 2007 draft state health plan indicates that 8,388 additional nursing home beds are needed statewide. This represents an increase of nearly 50% in the current licensed bed complement.

Given that the need methodology has not been meaningfully tested in years, and the trend toward substantially lower age-adjusted long-term care use rates elsewhere, it is likely that actual use of the current review criteria and standards would lead to the authorization for substantially more nursing home beds than are needed. There can be no real test of the methodology as long as the moratorium is in place. The moratorium is not likely to be lifted as long as there is an indication that the number of licensed nursing home beds would increase by nearly 50%. The state Medicaid budget could accommodate this increase in demand only with great difficulty.

Consideration should be given to replacing the moratorium with a restructured, prospective planning process. The process should be built around a call or request for applications feature that permits better control of the number of beds that may be authorized during any given period. It should incorporate use rate trends, occupancy levels, and Medicaid program use and budget considerations. This approach has worked well elsewhere. It should be examined to determine how the principles might best be applied in Mississippi.

3. Surgery Capacity, Ambulatory Surgery Centers

The state health plan does not contain review criteria and standards for the addition of surgery capacity (operating rooms) to existing surgery services. There are criteria and standards for the establishment of ambulatory surgery centers, but they apply only to multi-specialty centers. Single specialty surgery centers are exempt from CON review.

The service volume standards prescribed for multi-specialty surgery centers appear to be internally inconsistent. Minimum capacity is defined as 1,000 surgeries per operating room per year, but "optimal" capacity is defined as 800 surgeries per operating room per The "1,000 surgeries" standard (or higher) is appropriate standard for multi-specialty surgery centers.

Given the lack of control of surgery capacity in all settings, other than in the establishment of multi-specialty ambulatory surgery centers, the rationale for the service volume standards is illusive. Existing providers, both hospitals and ambulatory surgical centers can expand capacity by adding rooms without going through the CON process, thereby eliminating any regional need for the capacity the applicant for the new surgery center proposes. CON coverage of increases in the number of operating rooms is necessary if equity is to be assured.

Consideration should be given to establishing a level playing field by requiring CON review of the establishment and expansion of all surgery centers that seek licensure and Medicare certification.

4. Therapeutic Radiation

The review criteria and standards used to assess proposals to develop and expand radiation therapy services are similar to those used in most other states. The service volume standards, 320 new cancer cases and 8,000 radiation therapy treatments per year, incorporated in the need projection method are reasonable and comparable to those in place elsewhere. The principal difference in the Mississippi methodology and the methods used in most peer states is the inclusion of a population ratio factor (one therapeutic radiation therapy unit per 148,148 persons). The way this factor is derived and applied is not problematic.

As in the peer CON states, the principal weakness of the state health plan is the lack of attention to the emergence of stereotactic radiosurgery (SRS) technology. The state health plan discusses gamma knife technology and equipment, but does not address SRS in the form of cyber knife systems and linear accelerator based SRS systems (e.g., Varian's Trilogy system). It is likely that many, if not most, CON proposals to add radiation therapy services and equipment over the next several years will propose either cyber knife or linear accelerator based SRS technology. Methods for assessing the need for these technologies and services should be developed as soon as possible.

The criteria and standards used to assess applications for new gamma knife services are appropriate and reasonable. The policy statement provision that would permit consideration of expanding an existing service at the 200 patients a year threshold does not appear to be warranted. It appears to conflict with the 475 patients standard presented in the principal need criterion. These differences should be reconciled. Consideration should be given to increasing the threshold level to the need criterion threshold.

5. MRI Services and Equipment

Mississippi MRI service review criteria and standards include a comparatively complex DRG-based need estimation methodology. The underlying intent of this approach, to base capacity on evidence of clinical need is laudable, but it is difficult to see how this method could be applied accurately in practice. Most other states do not try to achieve this level of clinical precision. Moreover, were it achievable, the ultimate utility of this level of precision is obviated by reliance on affidavits in projecting the likely use of mobile services and by the ability of part-time mobile services to convert full-time fix service sites without CON approval. Consideration should be given to eliminating the "DRG disease classification system" component of the need determination methodology.

Compared with the review standards used in most peer states, the service volume standard, 1,700 procedures per year, is low. This is less than 50% of standard operating capacity for state-of-the-art MRI equipment. Many MRI services, in Mississippi and elsewhere, routinely provide more than 4,000 procedures (scans) per MRI system annually. Consideration should be given to increasing the minimum service volume standard statewide, or to developing separate standards for rural and metropolitan area services.

As discussed above, the comparatively high medical equipment review threshold ($1.5 million), and the ability of mobile services to convert to full-time fix site services outside of CON review, are inequitable and make effective planning and regulation problematic. Consideration should be given to eliminating both of these factors.

6. PET Scanning

PET scanning criteria and standards prescribed in the state health plan are comparable to those in place in peer CON states. The service volume standards, 750 procedures per year to establish a service and 1,500 procedures a year to expand a service, are less than one-third the capacity of state-of-the-art PET (or PET-CT) scanner. The nature, history, and the evolving clinical profile of PET scanning are such that none of the planning standards in peer states related meaningfully to capacity. No change in the service volume standard is recommended.

Given the pattern of PET service development in Mississippi, the collateral standard of a minimum population of 300,000 per PET system does not appear to be relevant or provide useful planning guidance. Consideration should be given to eliminating or modifying this criterion.

Mississippi has more than 25 authorized PET service sites. Most are mobile sites with comparatively low use, but several of the mobile service sites report service volumes comparable with or higher than some of the existing fixed site services. Unless CON review requirements are changed to require approval of conversions from mobile service sites to fixed site service, a number of service providers are likely to replace their mobile services with fixed units at low use levels.

As discussed above, the comparatively high medical equipment review threshold ($1.5 million), and the ability of mobile services to convert to full-time fix site services outside of CON review, are inequitable and make effective planning and regulation problematic. Consideration should be given to eliminating both of these factors.

7. Cardiac Catheterization and Open Heart Surgery

The planning criteria and standards in place for cardiac catheterization and open-heart surgery are comparatively low, but consistent with minimum professional standards. Most peer states do not specify a minimum population service base. But given the demography of Mississippi, there are circumstances where the 100,000 population requirement could have applicability and utility.

A number of catheterization and surgery programs have very low service volumes. Given the well-established connection between service volume and treatment outcome for both catheterization and cardiac surgery, consideration should be given to raising the service volume thresholds to levels that have been shown to minimize morbidity and mortality, and phasing out surgical programs with fewer than 100 cases per year.

At a minimum, a cardiovascular services reporting system should be established to permit reporting of facility and practitioner case volumes and treatment outcomes. There are successful reporting systems in a number of states that have proven valuable in identifying and correcting problems. They can serve as useful models of how to proceed.

8. *ESRD Services*

Only two of the peer state CON programs (Alabama and North Carolina) cover end-stage renal dialysis (ESRD) services. Mississippi review criteria and standards are comparable with those in these states and with the criteria and standards of the other states that regulate ESRD facilities.

As discussed above, given the nature of ESRD services and the role the federal Medicare programs plays in limiting capacity and paying for kidney dialysis and transplantation, consideration could be given to eliminating ESRD services from CON regulation.

If CON coverage is maintained, no change in the existing review criteria and standards is recommended.

9. Long-Term Acute Care Hospitals

Many states do not have separate review criteria and standards for long-term acute care hospitals. They usually rely on acute care hospital planning standards and Medicare program requirements in assessing CON proposals to establish long-term acute care hospitals. Comprehensive patient level data are need to permit an accurate determination of the number and type of patients with average lengths of hospital stays that may appropriately be served in long-term acute care hospitals.

Mississippi's review criteria and standards are comparable to those in place in peer CON states where there are standards. No change is recommended until more precise and complete patient level discharge data are available.

IV

Summary Conclusions, Findings, and Recommendations

A. Conclusions

Mississippi's certificate of need program is similar in many respects to those that are maintained by the thirty other states that regulate both long-term and acute care health care services. But over the last three decades, the program has taken on a character that distinguishes it from all other CON programs. Comparison of the program's structure and operations with those of eight peer programs shows that three atypical features limit the regulatory scope and reach of the program.

These features include a high medical equipment review threshold, an unusually broad single specialty surgery center exemption, and a unique provision that permits conversion of mobile services to fixed site services without CON review. These provisions, and the way they are implemented, make the Mississippi CON program unique. No other CON program contains all three features. They introduce a degree of uncertainty in planning, give rise to questions about fairness and equitable treatment of those subject to regulation, and could prove increasingly problematic in their effect on the long-term stability and viability of community hospitals.

Consideration should be given to changing these aspects of the program, to restore and maintain fair and equitable treatment for all affected parties. Many, if not most, of these changes would require legislative action. Several of the changes suggested are needed to return to, or otherwise ensure, basic fairness and equity among potential CON applicants and existing service providers. They would also help safeguard the public interest and the integrity of the program.

Surveys and interviews of key stakeholders reveal a comparatively high level of support for the Mississippi program. Aspects of the program, and how it is implemented, give rise to a number of specific concerns. There is substantial agreement, however, that planning and CON regulation are beneficial. Most of those contacted support retention of the program to help ensure the economic stability of essential community hospital and long-term nursing care services.

Many aspects and elements of the Mississippi State Health Plan are commendable. It ranks high among comparable state plans in terms of its currency, its comprehensiveness, and its utility in CON review. It compares favorably with nearly all other state health plans, especially those plans that have evolved into more narrowly focused medical facility plans, in being updated annually and made available directly and online to interested and affected parties. The process used in developing the plan, which invites

public and interested party participation early in the process, is superior to the procedures and processes used in many states.

The program has a dedicated, public-spirited staff. Among the program's strengths are its commitment to maintaining a current, up-to-date state health plan and an efficient, user friendly website that makes basic planning and CON information available in a timely manner. The state health plan is notably more current and more comprehensive than comparable plans in many states.

There is no compelling evidence that the program is "broken" or needs to be "fixed". There are, however, a number of administrative, planning, and policy changes that should be considered as possible ways to improve program efficiency, effectiveness, and fairness.

B. Findings

1. Mississippi's CON program is not overly regulatory or burdensome. Program changes over the last two decades have reduced the number and array of services, facilities, and medical equipment subject to review. Compared with programs that regulate both acute care and long-term care services, and with neighboring and peer states, the scope and reach of the Mississippi program are limited.

2. Several features give the Mississippi program a distinct, if not unique, character. These include an exceptionally broad single specialty surgery center exemption, a high medical equipment capital expenditure review threshold, and a unique provision that permits mobile outpatient services to convert to fixed service sites with dedicated equipment without CON review. These distinctive aspects of the program, in combination and as implemented, make predictable and equitable planning difficult.

3. The number and array of CON applications subject to review has decreased by more than half over the last two decades, as CON coverage has been eliminated for some services and as both the health facility and the medical equipment capital expenditure review thresholds have been raised. Review caseloads now average about 50 applications a year. Absent major changes in coverage, and the indexation of the review thresholds, the current number and array of projects reviewed each year is not likely to change significantly.

4. Mississippi's program contains procedural safeguards that are commendable, but may increase somewhat the average review period for CON applications. These include a broad definition of interested (or affected) party that, compared with definitions in a number of states, icreases the number of parties that may gain standing and request public hearings. Similarly, *ex parte* contact rules are stronger than in many states, limiting or delaying discussions between applicants, interested parties and program staff for a substantial part

of the review cycle. Although these aspects of the program may increase somewhat average review periods, they are otherwise commendable and have the support of most of those likely to be affected.

5. Notwithstanding the procedural safeguards, average (and median) review periods for CON applications are reasonable. In general, decisions on applications that are not delayed by public hearings are rendered within 135 days, within 90 days of the publication of the departmental staff analysis of the project. Decisions on about three-fourths of all applications are published within 135 days. Nearly all of those with review periods of 135 days or longer are delayed by requests for public hearings. The average (and median) review period compares favorably with other CON programs with a similar scope of coverage. I would be difficult to reduce the average review period without changing the procedural safeguards (e.g., limiting the right of appeal) that are now a part of the program.

6. Average review periods have increased over the last decade. This increase is not unexpected. It is associated with, and reflects, the elimination of less controversial and complex projects from review and raising both the facility and the medical equipment capital expenditure review thresholds. These changes result in large and more complex projects being a larger percentage of the pool of projects considered. Notwithstanding this increase, the average review period in Mississippi compares favorably with those in peer states.

7. Review policies and practices provide for an expedited review process for less substantive projects. Projects that qualify for expedited review include cost overruns, changes in ownership, service and facility relocations, and changes necessary to comply with licensure standards and building codes. The current policy is to render decisions on these applications in 90 days or less. In most instances, this goal is met. As currently implemented, expedited review means only that such projects are reviewed outside of the quarterly batch cycles. It does not mean necessarily that the actual review process is abbreviated, that filing requirements are reduced, or that other aspects of the review process are minimized. Nor is a meaningful distinction made between clinical and non-clinical projects in determining whether a project qualifies for expedited review.

8. The current from of batch processing is based on quarterly application filing cycles. It does not ensure that similar projects are reviewed and compared competitively. Similarly, a related letter of intent notification requirement is not consistently enforced. In combination, these two features reduce somewhat the transparency of program operations and limit the ability to conduct concurrent and competitive analyses and reviews.

9. Mississippi uses capital expenditure thresholds to limit the scope of both facility and medical equipment reviews. The facility expenditure threshold is

now at the national median. The medical equipment is well above the national median. The medical equipment threshold, as implemented in connection with other provisions applied to mobile medical services, raises a number of planning problems.

10. The array of services covered is similar to that of most states that regulate acute care services. Mississippi regulates 17 of the 30 services that are subject to CON regulation in other states. The two services covered in Mississippi that are regulated less frequently elsewhere are renal dialysis and hospital swing beds. Services not regulated in Mississippi that are regulated in a number of other states include CT scanning, organ transplantation, and hospice facilities.

11. Conditional approval of CON applications in Mississippi is restricted, largely to projects that are reduced in size or scope. There is only limited flexibility to apply desirable collateral conditions or contingencies that might make an otherwise unacceptable project approvable.

12. The geographic areas (planning districts) now used in the Mississippi State Health Plan and in CON review are based on traditional planning principles and considerations. They were not arbitrarily drawn and are not inherently illogical. Given the large surplus of hospital capacity, and the long-standing moratorium on nursing home development, the planning districts currently have only limited application in CON review. The acute care districts are generally consistent with the Mississippi hospital referral regions and service areas service areas identified by Dartmouth Medical School researchers in their analysis of Medicare hospital discharge data.[32] There is little reason to change the districts until comprehensive patient level discharge data become available and is assessed to determine the most appropriate configurations based on local needs and circumstances.

13. Population data used in the state health plan and in CON analysis and review are not problematic. Planning and CON staff use official state population estimates, which are recognized and accepted by applicants and other interested parties. The principal population related limitation is the lack of comprehensive data on interstate travel and migration for care. With the exception of travel to Memphis, Tennessee, area hospitals, net migration to neighboring states for care is not significant. A patient-level hospital discharge data system is needed to make data describing geographic use patterns and medical trade patterns routinely available within Mississippi and available for exchange with neighboring states.

14. The Mississippi State Health Plan compares favorably with the plans in most states. Nevertheless, there are weaknesses and deficiencies that, if corrected, could make the plan more useful in CON review and in providing much needed guidance to existing and potential providers of health services.

These include:

a. The facility and bed need bed formulae used to estimate and project need for acute care beds is probabilistic in nature. It incorporates a very high "confidence factor" that, as applied, yields an overly high estimate of acute care bed need. If a probability method is to be used, either a low confidence factor constant should be used or the high constant now used (99% confidence level) should be applied to the service area rather than to each hospital in the area.
b. There is no consistent delineation of the planning horizon for the services, facilities, and equipment covered. The planning horizon is likely to be between 3 and 5 years for most services and equipment, and between 5 and 10 years for new acute care hospitals.
c. In a number of instances, technological advances that are likely to affect directly the nature of CON proposals submitted are not acknowledged or reflected in the plan. Examples include, the growing significance of primary (emergency or rescue) percutaneous coronary interventions (PCI) in cardiovascular services and stereotactic radiosurgery (SRS) in radiation therapy.
d. Optimal operations and service volumes often are not distinguished from minimum (or acceptable) operations and volumes. The absence of this distinction contributes to the evolution of minimum standards into optimal use levels in practice, which in turn may lead to the authorization of excess capacity.
e. In general, the service-specific program volume review standards are low and are not related to system or equipment capacity.
f. There are few references to, or consideration of, quality implications of low average program volumes for those services where a strong relationship between high volume and superior treatment outcomes has been demonstrated.
g. The distinction between services that should be planned and organized on a regional basis from those that are properly planned and organized on a local community basis often is not evident.

15. The principal concerns that arise from an assessment of program coverage and operations, and from the comments and criticism of key informants, include:

    a. Changes in program coverage, rules, and practices have

accumulated to the point that they result in less fairness and unequal treatment of CON applicants, and a "playing field" that increasingly is not "level";

b. The lack of comprehensive patient level data that are needed to permit more detailed and reliable analysis, planning, and CON review; and
c. The inconsistent recognition of technology and service delivery changes, and demonstrated best practices, in health plan development and CON review.

C. Recommendations

Batch Processing: Consideration should be given to changing the quarterly batch processing cycle, under which applications for any service may be filed four times annually, to an annual or semiannual cycle with staggered filing dates for defined service categories. This arrangement would promote competitive review of like proposals. It has the potential of stimulating competing proposals for needed services, encourages applicants to file more complete and accurate operational data, and permits more efficient use of staff time.

Current procedures require that applicants file a letter of intent before filing a CON application. The requirement is not uniformly honored and is not enforced. Substantial numbers of applications are filed without notice. They are accepted, provided the applicant meets the filing deadline. The letter of intent requirement helps ensure the regulatory process is more transparent and more equitable to all parties. The requirement can and should be enforced. It is particularly useful in association with batch processing of competing applications

Expedited Review: Consideration should be given to expanding the number and type of applications that qualify for expedited review. Currently, a number of non-clinical proposals that entail capital expenditures of more than $2.0 million are subject to the standard review process. These include proposals to develop parking structures, construct administrative (non-clinical) space, and upgrade data systems. The nature of these projects, especially the economic incentives inherent in them, makes them good candidates for expedited review.

Capital and Operating Leases: Although there are standard definitions of operating and capital leases, there are questions about consistency in applying tests to distinguish one from the other. There is concern that some applicants may portraying capital leases as less costly annual operating leases, thereby avoiding CON review of some projects that would be reviewed if properly presented as capital leases. Consideration should be given to developing and applying rigorously and consistently a clear set of rules that makes clear what constitutes lease expenses and under what set of circumstances those costs must be capitalized over the useful life of the project.

Analysis of CON Applications: Recently published evaluations of CON applications subject to standard review rely heavily on a narrow application of the applicable State Health Plan standard and on the data submitted by applicants, some of which is uncorroborated and of questionable reliability. Many reports would be strengthened by a stronger focus on economic and market trend analysis. This would be useful, particularly in assessing major health services proposals and in placing questionable proposals in context. It also would improve the standing and credibility of the program. A substantial limiting factor is the absence of a patient level hospital discharge data system that would permit in depth analysis of community need, medical markets and trade patterns, and use levels and trends.

Nursing Home Moratorium: There is a long-standing moratorium on nursing home development in Mississippi. As has occurred in many other states, what began as a near term response to help control the growth in Medicaid spending has evolved into a substitute planning process. Nursing home development is managed through periodic special legislation that authorizes specific projects. This arrangement is not conducive to effective planning and is not sustainable indefinitely. Beyond the inherent complications and inequities it presents for nursing home and related long-term care service development, these anomalous circumstances undermine the credibility of the planning process and the CON program.

Consideration should be given to replacing the moratorium with a reliable prospective planning process. The process should be built around a "call or request for applications" feature that permits better control of the number of beds that may be authorized during any given period. It should incorporate use rate trends, occupancy levels, and Medicaid program use and budget considerations. This approach has worked well elsewhere and should be examined to determine how the principles might best be applied in Mississippi.

Regulation of Medical Office Building Development: The current practice of reviewing expenditures for some medical office buildings, depending on where they are located and on who effectively controls them, does not present a level playing field. To be equitable, such expenditures should be treated equally regardless of setting. There is little argument that the law should be expanded to cover all medical office buildings. A level playing field, therefore, can be achieved only by exempting all medical office buildings from review. Consideration should be given to exempting medical office buildings from CON review.

Medical Equipment Capital Expenditure Threshold: The permutations associated with the current medical equipment capital expenditure review threshold creates disincentives for efficient and effective program operations, permits "gaming" of the review process, and does not treat all service providers fairly.

Consideration should be given to eliminating the medical equipment capital expenditure review threshold, exempting all equipment replacement projects from review, and requiring the review of all new services and all expansions (equipment additions) of covered services. This pattern of coverage would be more easily understood and

administered, would establish a "level playing field," and would be more equitable to all affected parties.

Conversion of Mobile Services to Fixed Services: The current practice of permitting existing mobile service sites to convert to fixed service sites outside of CON review is problematic. It generates considerable uncertainty and instability. It also raises fairness and equity considerations. Consideration should be given to interpreting the conversion of a mobile service to a fixed site service as the establishment of a new service requiring review and CON approval.

Paper ("Ghost") Hospital Beds: Currently, licensed hospital beds can be taken out of service and "banked" indefinitely. Hospitals that have been closed for up to five years may be reopened without undergoing CON review, provided the reopening does not otherwise trigger CON review. With thousands of surplus acute care beds statewide, these circumstances create market uncertainty and instability, and make realistic planning all but impossible. There is some evidence of an emerging "market" for selling and leasing unlicensed and unused beds. None of these considerations are conducive to effective planning or equitable regulation.

Consideration should be given to adopting the practice of a number of states where surplus beds (and health care facilities) are removed permanently from the licensure rolls if they are not actively used to provide patient care during the previous year (12 months). This would be consistent with Mississippi's provision that a facility that has closed a medical service for 12 months must obtain a certificate of need to reopen that service.

***Single Specialty Surgery Centers*:** Exclusion of single specialty surgery centers from review is one of the more striking features of the Mississippi CON program. Mississippi is one of four CON states that have such exemptions. Regardless of their size and cost, or their receipt of facility fees, these centers are considered to be private physician offices. Multi-specialty surgery centers are subject to CON review regardless of location, size, cost, or ownership. Under prevailing rules and interpretations, there is no effective prohibition against exempt single specialty centers becoming,in effect, multi-specialty centers. The only limitation is that they may not use the same space and personnel to serve more than one surgical specialty at a time.

Consideration should be given to establishing a level playing field by requiring CON review of the establishment and expansion of all surgery centers that seek licensure and/or Medicare certification.

Conditioning CON Approvals: Most state CON programs permit conditional approval of applications. Under existing rules, Mississippi CON applications may be approved or disapproved as submitted, or approved "by modification, by reduction only". This limitation reduces the flexibility of the CON program considerably. States that permit conditional approval use conditions to achieve a number of health policy goals and objectives, notably assuring equitable access to care. Conditional approvals might prove equally useful in Mississippi. Permitting conditional approval might also reduce the

number of appeals of CON decisions. Consideration should be given to permitting approval of CON applications with conditions.

Facility Capital Expenditure Review Threshold: The current facility capital expenditure review threshold is $2.0 million. This is the national median among state CON programs with expenditure thresholds. Given the rapid increase in construction costs recently, and significantly higher financing costs, consideration should be given to either raising or indexing the health facility expenditure threshold, or to establishing a higher threshold for non-clinical services.

Patient-Level Health Data System: Mississippi is one of only two states that do not have patient-level hospital discharge data systems. There are many indications of the need for such data. The data are needed to permit the better informed and more precise planning that is required to improve CON regulation, particularly in ensuring fairness and equity among service providers.

Consideration should be given to working with the Mississippi Hospital Association to establish a comprehensive all payer patient-level hospital discharge data system as soon as possible.

Planning District Configurations: Planning districts of varying number and size are used in health services planning and CON regulation. There have been specific proposals to change the boundaries of some of these districts. More discrete and comprehensive data than is now available, particularly service-specific patient origin and destination data, are needed to access reliably the relative value and usefulness of different district configurations. The existing boundaries should not be changed until these data are obtained and analyzed.

State Health Plan: Planning is a dynamic process, and health services planning especially so. There are a number of areas and topics where changes in the Mississippi state health plan might encourage better institutional and community planning by providers of health services and would facilitate more effective or more equitable CON regulation. Some of the changes that should be considered include:

- Acknowledge and account for interstate travel for certain health care services, e.g., acute care hospital services.
- Distinguish between urban and rural use rates, patterns, and trends where data permit.
- Acknowledge the effective capacity of major medical equipment subject to review, and distinguish between actual capacity and planning expectations and standards.
- Cite normative professional planning standards, especially those linked to favorable treatment outcomes, and raise planning standards to those levels where circumstances permit.
- Distinguish between services that should be planned for on a regional basis and those that are properly planned for considering largely local considerations.

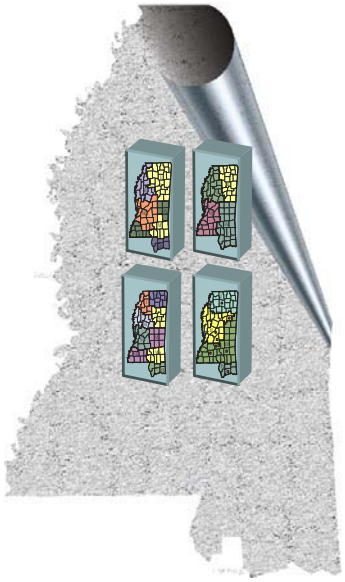
- Identify the planning horizon that is to be used for each service category.
- Cite, and where possible follow, best practices that have been identified or are in use elsewhere.
- Identify national and regional trends that may be used to place local use patterns and CON proposals in context.
- Incorporate up-to-date technological developments, and emerging practice patterns, in rapidly evolving medical services, e.g., SRS in radiation therapy and primary PCI in cardiovascular services.
- Incorporate recognized quality standards where there are accepted standards.
- Develop and apply community and regional service-specific use rates where data permit.

NOTES

[1] 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.
[2] J. Feder and W.J. Scanlon, 1980. "Regulating the Bed Supply in Nursing Homes." *Milbank Memorial Fund Quarterly* 58(1): 54-87
[3] See H. B. 1221 Opinion Letter: Jim Hood, Attorney General, State of Mississippi to Brian Amy, MD, State Health Officer, Mississippi Department of Health, July 10, 2006.
[4] See Appendix A for HB 1221 requirements.
[5] Thirty-six states and the District of Columbia; see Map 1.
[6] State CON capital expenditure review thresholds vary widely. Some states review certain categories of services, regardless of their capital or annual operating costs. Those that set expenditure review thresholds usually distinguish between new services, medical equipment, and health facility renovation, expansion and development. Nationally, review thresholds for renovation, expansion and development of health care facilities range from $0.5 million to more than $12.0 million. It should be noted, however, that many of the states with higher capital expenditure review thresholds review an enumerated list of services (e.g., CT scanners, MRI scanners, PET scanners, cardiac catheterization laboratories, linear accelerators) regardless of the capital cost.
[7] An initiative by the Department to increase CON fees in the summer of 2006 resulted in a legal opinion from the Attorney General that raising the current fee limit of $25,000 is not discretionary with the Department. Legislative action will be necessary to raise the fees and, presumably, increase the planning and CON program budget. See Attorney General opinion letter of September 8, 2006, regarding "Authority of MSDH to raise CON fees".
[8] *Certificate of Need Review Manual, May 13, 2000*, Mississippi State Department of Health; (Revised 2006.
[9] Services removed from CON coverage include CT scanning and lithotripsy.
[10] CON Declaratory Rulings Log, 2001 – 2006, Mississippi Department of Health, July 2006.
[11] *Certificate of Need Review Manual, May 13, 2000*, Mississippi State Department of Health, p. 28.
[12] The staff analysis is usually published in 45 days or less after receiving a complete application.
[13] Unlike some states, failure to render a timely decision may not be construed as approval of the application. *Certificate of Need Review Manual, May 13, 2000*, Mississippi State Department of Health.
[14] CON Application Hearing Log (Listing), Mississippi Department of Health, 2006.
[15] The terminology and nominal review periods vary from state to state. Some refer to non-substantive reviews, some administrative reviews, and some expedited reviews.
[16] Increasingly these providers are obtaining review determination rulings in these cases.
[17] See Chart 2.

[18] The current regulatory posture on surgery centers has been arrived at as a result of statutory language that can be interpreted as conflicting and the resulting legal opinions from the Mississippi Attorney General. See surgery center opinions dated March 22, 1994, January 9, 1996, and February 20, 2002. It is evident that the policy issues involved can be resolved only by the state legislature.
[19] "Clarification of CMS Payment Policies Regarding Ambulatory Surgery Centers (Note 23).
[20] *Mississippi State Health Plan, FY 2006*, p. VIII-12, Mississippi Department of Health, 2006.
[21] See *Mississippi State Health Plan, FY 2006*, p. I-3, Mississippi Department of Health, 2006. The estimates and projections currently in use may be found in *MISSISSIPPI, Population Projections for 2005, 20010 and 2015*, Mississippi Institutions of Higher Learning, March 2002.
[22] House Bill 195, Section 1(g), General Session, Mississippi House of Representatives, March 2006.
[23] See "Establishing Ambulatory Surgical Centers (ASC) Based on a One Day Lease," Office of Survey and Certification, HCFA, DHHS, July 7, 1994 and "Clarification of CMS Payment Policies Regarding Ambulatory Surgical Centers/Independent Diagnostic Testing Facilities Conducting Business from the Same Location," CMS, DHHS, June 12, 2003.
[24] See Virginia State Medical Facilities Plan, 2004.
[25] See *Alabama State Health Plan, 2004-2007*, Alabama State Health Coordinating Council, 2004 & 2006. Update to Kentucky State Health Plan, 2004-2006, Kentucky Cabinet for Health and Family Services, January 2006; Tennesse Guidelines for Growth: Criteria and Standards for CON, Tennessee Health Planning Commission, 2000.
[26] See *South Carolina Health Plan, 2004-2005*, South Carolina Department of Health and Environmental Control, 2005, p. II-2.
[27] Mississippi was a single (statewide) health service area state under NHPRDA, so there were no formally designated sub-state health services areas.
[28] See F. E. Thompson, Jr., MD, State Health Officer to John Turcotte, Director, Joint Commission on Performance Evaluation and Expenditure Review, November 14, 1995.
[29] See "Acute Care Hospital Utilization vs Current Districts and MDH Health Planning Data Collection." MDH Office of Health Policy and Planning, Sam Dawkins, Director, April 12, 2006.
[30] House Bill 195, Section 1(g), General Session, Mississippi House of Representatives, March 2006.
[31] CON program staff compensate for the lack of a comprehensive patient level discharge database by conducting quarterly sample surveys of hospital discharges. The surveys are limited in scope (fewer data elements than needed or desirable) and duration (two weeks each quarter). This effort recognizes the necessity and value of discharge data. CON program staff and Mississippi hospital officials should be commended for their efforts. The initiative should be expanded into a comprehensive effort covering all discharges as soon as possible
[32] John E. Wennberg, MD, MPH, *et. al*., *Dartmouth Atlas of Health Care*, The Center for the Evaluative Clinical Sciences, Dartmouth Medical School, American Hospital Publishing, 1996, pp. 15-20, 29.

Appendix A



House Bill 1221 (2006)
Section 2

SECTION 2. The State Board of Health shall, not later than October 15, 2006, develop and make a report to the Chairmen of the Public Health and Welfare Committees of the Senate and House of Representatives, the Lieutenant Governor, the Speaker of the House of Representatives and the Governor, including any recommended legislation, on the following policies and procedures relating to the State Health Plan and the Health Care Facility Certificate of Need Law:

(a) Review the procedures under which health care facility certificates of need are requested and issued or denied. Make reasonable recommendations

(i) to reduce the time periods required for certificate of need review and appeal there from without compromising the fairness of the decision;

(ii) to exempt additional non-substantive transactions by health care facilities from the certificate of need requirement; and

(iii) to authorize additional transactions by health care facilities which may receive an expedited review.

(b) Verify the fairness of how the annual State Health Plan considers changing population projections and how residents choose health care services.

(c) Verify the fairness of how the annual State Health Plan considers that residents travel to neighboring states to receive health care services.

(D) Verify the fairness of the different planning districts applicable to each type of health care certificate of need activity by a facility. For example, General Hospital Service Areas compared to Long-Term Care Planning Districts, compared to Ambulatory Surgical Planning Areas, compared to Home Health Agency Planning Areas, compared to Perinatal Planning Areas, compared to Adolescent and Adult Psychiatric Facility Planning Areas, etc.

(e) Verify the fairness and appropriateness of the formulas used to determine the need for health care services under the certificate of need law.

(f) Review the existence of licensed beds listed in the Directory of Licensed Health Care Facilities which are unused and available for transfer to another facility or location under the certificate of need process, and the effect of these unused beds on the State Health Plan.

Table A-2
State Patient Level Hospital Data Collection Programs
2005

	Authority		Collection Agency Type			
	Mandated Collection	Voluntary Collection	State Agency	Hospital Association	Other Private Organization	Notes
Jurisdiction						
Alabama						No Program
Alaska (2)		X		X		No Public Release
Arkansas (1)	X		X			
Arizona	X		X			
California (1)	X		X			
Colorado (2)		X		X		
Connecticut (4)	X		X			
Delaware (1)	X		X			
District of Columbia	X			X		
Florida (1)	X		X			
Georgia (3)	X			X		
Hawaii (2)		X			X	
Idaho						No Program
Illinois (4)	X		X			
Indiana (3)	X			X		Limited Public Release
Iowa (3)	X			X		Limited Public Release
Kansas (5)	X			X		
Kentucky (1)	X		X			
Louisiana (1)	X		X			
Maine (1)	X		X			Collects Payer Claims Data
Maryland (1)	X					Collects Outpatient Claims Data
Massachusetts (1)	X		X			
Michigan (2)		X		X		Limited Public Release
Minnesota (5)		X		X		Limited Public Release
Mississippi						No Program
Missouri (4)	X		X			Limited Public Release
Montana (2)		X		X		No Public Release
Nebraska (2)		X		X		
Nevada (1)	X		X			
New Hampshire (1)	X		X			
New Jersey (1)	X		X			
New Mexico (1)	X		X			
New York (1)	X		X			
North Carolina (3)	X			X		
North Dakota (1)	X		X			
Ohio (2)		X		X		No Public Release
Oklahoma (1)	X		X			
Oregon (1)	X		X			
Pennsylvania (1)	X		X			
Rhode Island (1)	X		X			
South Carolina (1)	X		X			
South Dakota (2)		X		X		
Tennessee (3)	X			X		
Texas (1)	X		X			
Utah (1)	X		X			
Vermont (4)	X		X			
Virginia (3)	X				X	Virginia Health Information
Washington (1)	X		X			
West Virginia (1)	X		X			
Wisconsin (3)	X			X		
Wyoming (2)		X		X		
Totals	***38***	***10***	***29***	***17***	***2***	

Source: National Association of Health Data Organizations (NAHDO), 2005. Information as of July 2005.

(1) Mandate: State agency or state-affiliated agency collects and distributes data under mandate.
(2) Voluntary: Hospital Association or other private agency collects data without state mandate, with voluntary participation by hospitals.
(3) State mandate with delegated authority to nonstate agency: State agency contracts with independent private agency to implement mandate.
(4) Two systems: Both the state and the hospital association collect hospital discharge data statewide.
(5) State mandate not implemented--hospital association collects membership data voluntarily.

Table A-1
Mississippi CON Survey Summary
Average Response by Respondent Group

	Respondent Group									
	Nursing Homes		Hospitals		Non-Institutional Service Providers		CON Consultants		All Respondents	
	Number	Average	Number	Average	Number	Average	Number	Average	Number	Average
Part 1: CON Program and Process										
1. CON program staff are courteous and professional in dealing with applicants and the public.	58	0.97	55	0.84	13	1.15	11	0.64	137	0.90
2. CON program staff are knowledgeable and responsive to inquiries and requests for help.	58	0.55	55	0.27	13	1.38	11	(0.46)	137	0.43
3. Technical assistance is readily available from CON program staff.	58	0.34	55	0.42	13	1.00	11	(0.18)	137	0.39
4. CON program staff are a frequent source of technical assistance.	58	0.13	55	0.20	13	0.92	11	(0.91)	137	0.15
5. Communications from and with CON program staff are timely and effective.	58	0.56	55	(0.02)	13	0.92	11	(0.36)	137	0.29
6. CON staff determinations of the eligibility of proposals for expedited reviews are reasonable and well understood by applicants.	55	0.12	55	0.55	13	0.69	11	(0.91)	134	0.26
7. Review criteria and standards are well known and understood by applicants.	58	(0.19)	53	0.55	13	0.23	11	(0.64)	135	0.10

Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.

Source: AHPA Survey, July 2006.
Number = Number of Persons Responding to question; Average = Mean value of all responses in the category.
Note: Total number of responses may vary by question because not all respondents answered all questions.

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	Nursing Homes		Hospitals		Non-Institutional Service Providers		CON Consultants		All Respondents	
	Number	Average	Number	Average	Number	Average	Number	Average	Number	Average
8. CON review processes and procedures are well known and understood by applicants.	57	(0.29)	55	0.60	13	0.69	11	(0.27)	136	0.16
9. The CON review process may be affected (e.g. speeded up) by calls to programs officials.	58	(0.22)	55	0.06	13	0.46	11	(0.82)	137	(0.09)
10. Applicants employing consultants receive better or more favorable treatment than those without consultants.	55	0.30	55	0.06	13	0.23	10	1.20	133	0.26
11. Applicants should retain consultants to ensure timely decisions on applications.	58	0.50	55	0.56	13	0.69	11	1.46	137	0.62
12. Recent legislative changes in the CON program have resulted in a more equitable/less burdensome review process.	58	(0.13)	53	(0.13)	13	(0.23)	11	(0.55)	135	(0.17)
13. Average or typical project review times (periods) are reasonable and acceptable.	58	(0.01)	55	0.38	13	0.00	11	(0.27)	137	0.12
14. Public notice of CON application filings, reviews, and hearings is adequate and reasonable.	58	1.01	55	0.64	13	0.69	11	(0.27)	137	0.73
15. Imposition of moratoria on certain services, e.g., home health, nursing home beds, are necessary and an appropriate response to market and service conditions.	58	0.48	55	0.38	13	0.54	11	1.18	137	0.50

Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.

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	Nursing Homes		Hospitals		Non-Institutional Service Providers		CON Consultants		All Respondents	
	Number	Average	Number	Average	Number	Average	Number	Average	Number	Average
16. Public participation and involvement in CON reviews and hearings is adequate.	58	0.29	55	0.62	13	0.23	11	0.55	137	0.43
17. Information requested in CON applications is appropriate and reasonable.	58	(0.01)	55	0.62	13	0.23	11	(0.91)	137	0.19
18. The program has the data resources required to assess the needs of the public.	58	0.27	55	0.11	13	0.23	11	(1.09)	137	0.09
19. The program uses needs assessment effectively to determine health service and facility requirements.	58	(0.29)	55	(0.04)	13	0.46	11	(0.91)	137	(0.16)
20. The service/major equipment need methodologies and formulae are appropriate and fair to all CON applicants.	52	0.07	55	(0.18)	13	0.46	11	(0.55)	131	(0.04)
21. Staff assessments of CON proposals are fair, and appropriately detailed and rigorous.	58	(0.22)	55	0.49	13	1.15	11	(2.00)	137	0.05
22. CON applications are batched (grouped) appropriately for competitive review where possible.	58	(0.06)	55	0.20	13	0.46	11	1.09	137	0.18
23. Current review criteria, standards and processes do not favour any class of service provider.	58	(0.44)	55	0.24	13	0.69	11	(0.55)	137	(0.07)

Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.

Source: AHPA Survey, July 2006.
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Respondent Group									
Number	*Average*	*Number*	*Average*	*Number*	*Average*	*Number*	*Average*	*Number*	*Average*
24. The number/range of projects that qualify for expedited review could be expanded without compromising the program.									
58	0.43	55	0.82	13	0.46	11	0.82	137	0.62
25. Population estimates/projections are reliable, adequate and are used appropriately and fairly.									
55	(0.12)	55	0.27	13	0.23	11	(0.82)	134	0.01
26. The service-specific geographic planning regions are appropriately configured and fair to all service providers.									
57	(0.01)	55	0.26	13	0.46	11	(0.55)	136	0.09
27. Assessments of CON applications incorporate best practices concepts and principles.									
52	(0.55)	55	0.18	13	0.46	11	(1.54)	131	(0.22)
28. The Mississippi State Health Plan is a reliable guide for use in CON reviews and decisions.									
58	(0.27)	53	0.57	13	0.46	11	0.00	135	0.14
29.Current CON review methods adequately take into account changing medical trade patterns.									
58	(0.39)	55	(0.33)	13	0.00	11	(1.36)	137	(0.40)
30. Staff assessments of CON proposals are responsive to technological developments and changes in medical practice.									
58	(0.39)	55	0.40	13	0.00	11	(0.82)	137	(0.07)
31. The program discourages many capital projects that would otherwise be undertaken.									
58	0.29	55	0.49	13	0.69	11	0.27	137	0.40

Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.

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Respondent Group									
Number	*Average*	*Number*	*Average*	*Number*	*Average*	*Number*	*Average*	*Number*	*Average*
32. CON review helps ensure that unnecessary expenditures (capital and operating expenses) by health care providers are not passed on to payers or to the general public.									
56	0.00	55	0.42	13	1.38	11	0.91	135	0.37
33. The CON program unfairly benefits existing hospitals by protecting their market dominance.									
58	0.36	55	(0.16)	13	0.69	11	0.82	137	0.21
34. The service-specific review criteria and standards used in CON reviews are credible and appropriate.									
58	(0.13)	55	(0.06)	13	0.54	11	(0.27)	137	(0.05)
35. Unresolved or inequitable policy considerations, e.g., reserved excess capacity, limit program flexibility and fairness.									
58	0.20	54	0.30	13	0.23	11	0.73	136	0.28
36. CON program actions and decisions have become more responsive to outside pressure and influence over the last decade.									
58	0.34	55	0.55	13	0.46	11	0.55	137	0.45
37. CON recommendations and decisions are generally consistent with the applicable statutory language and governing regulations.									
58	0.43	55	0.49	13	1.15	11	(1.36)	137	0.38
Part 2: Program Improvement									
38. Raise review expenditure thresholds to reduce the number of application filings.									
58	0.29	55	1.07	13	0.00	11	(0.27)	137	0.53

Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.

Source: AHPA Survey, July 2006.
Number = Number of Persons Responding to question; Average = Mean value of all responses in the category.
Note: Total number of responses may vary by question because not all respondents answered all questions.

Table A-1
Mississippi CON Survey Summary
Average Response by Respondent Group

Nursing Homes		Hospitals		Non-Institutional Service Providers		CON Consultants		All Respondents	
Respondent Group									
Number	*Average*	*Number*	*Average*	*Number*	*Average*	*Number*	*Average*	*Number*	*Average*
39. Establish fixed, shortened review schedules and cycles.									
58	1.03	54	1.07	13	1.15	11	0.55	136	1.02
40. Communicate more frequently and more directly with applicants.									
58	1.17	55	0.67	9	0.89	11	1.09	133	0.94
41. Identify a lead or key contact person for each application.									
58	0.19	51	(0.10)	13	0.23	11	(0.64)	133	0.01
42. Identify additional categories of projects that may exempted from review as non-substantive transactions, or handled administratively as expedited reviews or.									
58	1.12	55	1.15	13	0.69	11	0.55	137	1.04
43. Employ batched competitive review of all similar proposals in a service area.									
55	0.47	55	0.82	13	0.23	11	0.00	134	0.55
44. Provide better organized and more sophisticated technical assistance to applicants and other interested parties									
58	0.65	55	0.98	16	0.56	11	0.82	140	0.78
45. Institute a "request for applications" process to promote competitive filings and review.									
58	0.29	55	(0.40)	13	0.92	11	(0.27)	137	0.02
46. Expand the range and number of less substantive transactions that may be exempt from formal review.									
58	0.75	55	0.80	13	0.92	11	0.27	137	0.75

Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.

Source: AHPA Survey, July 2006.
Number = Number of Persons Responding to question; Average = Mean value of all responses in the category.
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Table A-1
Mississippi CON Survey Summary
Average Response by Respondent Group

	Respondent Group									
	Nursing Homes		Hospitals		Non-Institutional Service Providers		CON Consultants		All Respondents	
	Number	Average	Number	Average	Number	Average	Number	Average	Number	Average
Part 3: Future Policy Directions										
47. CON review requirements should be relaxed further to reduce regulatory burdens on affected parties.	58	(0.15)	55	(0.40)	13	(0.46)	11	0.27	137	(0.24)
48. CON coverage should be eliminated on certain types or categories of projects (e.g., home health, ambulatory surgery centers).	55	(0.74)	55	(1.13)	13	0.23	11	0.82	134	(0.67)
49. CON coverage and review thresholds have been relaxed too much; stricter review processes and thresholds should be used.	58	(0.37)	54	(0.22)	13	(0.46)	11	(1.09)	136	(0.38)
50. The CON program should emphasize population based needs assessment to control unnecessary proliferation of facilities and services.	58	0.65	55	0.84	13	0.92	11	0.00	137	0.70
51. Services developed outside of CON review and approval should be considered both in community needs assessments and in CON reviews.	58	0.20	55	0.33	13	0.23	11	(1.09)	137	0.15
52. The CON program should focus on quality assurance, financial feasibility, etc., and let the market place determine the supply and distribution of medical facilities and services.	58	0.06	55	(0.64)	13	0.00	11	0.00	137	(0.22)

Response Scale: (2) Strongly Agree; (1) Somewhat Agree; (0) Neither Agree or Disagree; (-1) Somewhat Disagree; (-2) Strongly Disagree.

Source: AHPA Survey, July 2006.
Number = Number of Persons Responding to question; Average = Mean value of all responses in the category.
Note: Total number of responses may vary by question because not all respondents answered all questions.