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The University of Mississippi

HEALTHCARE CERTIFICATES OF NEED IN MISSISSIPPI: POLICY REVIEW
AND RECOMMENDATION

By

Aiden Seth Dickinson

A Thesis submitted to the faculty of The University of Mississippi in partial fulfillment of
the Requirements of the Sally McDonnell Barksdale Honors College.

Oxford

May 2018

Under the Direction of:

Advisor: Dr. Mark Chen

Reader: Dr. J.R. Love

Reader: Professor Jody Holland

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Dedication

I dedicate this thesis to those that I love, those that love me, and the Mississippi River.

To those that I love: thank you for allowing me to invest a part of my heart in you and for being those upon whom I rely.

To those that love me: thank you for investing a part of your heart in me and for giving me a reason to be held accountable so that I prove your investment to be worthwhile.

To the Mississippi River: thank you for starting out as a stream, allowing others to pour into you, growing over time, moving mountains, carving a new course, pushing toward the Gulf that you know you want, relenting for nothing, pouring over to nourish when necessary, controlling your own current, and rolling along no matter what gets in your way. Mighty River, may it forever be your song to Just Keep Rolling Along.

Acknowledgements

The research for and completion of this thesis would not have been possible without the Robert M. Hearin Support Foundation, McLean Institute for Public Service and Community Engagement, and the Catalyzing Entrepreneurship and Economic Development (CEED) Initiative. It was the nurturing support provided by these entities that allowed for the engaging of community partnerships that fully developed my appreciation for equitable accessibility to healthcare and furthered my zeal to take on the daunting task of an undergraduate thesis.

This work has been carefully guided by Dr. Mark Chen, Dr. J.R. Love, Dr. Jody Holland, and the faculties of the Trent Lott Leadership Institute and the Sally McDonnell Barksdale Honors College.

Without Dr. Bob Brown of the University of Mississippi, I would have had neither the academic fortitude to complete this work nor the breath in my lungs to have even tried. To teach is to give a lesson. To educate is to give a life, and Dr. Brown educated me in a way that kept me rolling along. Hi ho

Without the love and guidance of my loving family and friends, I would not be who I am, and I would be remiss to not acknowledge each of you.

Shepherd Center, I hope that I make you proud. I came in as a lost cause and left an invigorated scholar. Your purpose is to restore hope and rebuild lives. In me, you did just that.

Abstract

Healthcare Certificates of Need, often abbreviated as CON, are public policies implemented across America with many intentions but the primary purpose of engaging the healthcare marketplace in a way that allows for government regulation and monitoring. Over time, states have created their own types of certificate of need policies while others have abandoned these types of policies all together. Mississippi is a member of the former group that has crafted its own type of policies geared towards enabling Certificates of Need. As the healthcare marketplace shifts across America, this research delves into the certificate of need policies of states with healthcare outcomes like Mississippi's. but different in various policy aspects. Upon examination of these differences, this scholarship assesses Mississippi's specific policies and examines various case studies within the Magnolia State to determine whether or not these types of policies are appropriate for a state like Mississippi and, if not, what types of policies may be appropriate for changing the healthcare situation in various aspects. Supported by literature review, data analysis, case studies, and policy proposals, this scholarship aims to address healthcare Certificates of Need in Mississippi.

Table of Contents

Copyright Page	2
Dedication	3
Acknowledgements	4
Abstract	5
Table of Contents	6
List of Tables	7
Introduction	8
Intent	12
History	13
Specific Intentions of Certificates of Need as Public Policy	16
Positives	18
Negatives	18
Methodology and Analysis	19
Findings	39
Policy Recommendation	40
Repeal Mississippi’s Certificate of Need Laws	40
Create a Mississippi Health Planning Board	41
Enact market-friendly, patient-focused policies	42
Conclusion	45
References	48

List of Tables

- Table One** The Current Status of CON laws across America
- Table Two** The Bottom Eight States in American Health Care
- Table Three** Facilities, equipment and services covered under Tennessee’s CON law
- Table Four** Estimated changes in annual per capita healthcare spending patterns in Mississippi without CON
- Table Five** Estimated changes in access to healthcare facilities in Mississippi without CON policies in place
- Table Six** Estimated changes in Mississippi healthcare quality indicators
- Table Seven** Services, facilities, and equipment subject to CON review by the Mississippi Department of Health

Introduction

I will never forget looking out upon the Atlanta skyline as the sun began to set across the horizon. I would always roll my wheelchair to the guardrail on the top of the parking deck where my family and I would spend our evenings and look out on the golden landscape that never failed to remind me of just how far away from home I really was during those times. What I saw was not the transition to night in the backyards of rural Mississippi. What I saw was not the final rays of light whispering goodbye to the day through the columns of the Lyceum at the University of Mississippi. Yet, somehow, I was seeing the same sun cast its final beams on a world that held my new beginning. Even though I knew there was hope in my surroundings, I could not help but feel the absence of home in the sun's setting.

I would wake up every day of my freshman year at Ole Miss to the sunlight creeping across my eyelids. I practically leapt across campus, eager to meet new people, experience new things, and make every minute of sunlight count as I fell head over heels in love with my university, state, and world around me. As a self-professed citizen scholar and public policy student, I found it intellectually invigorating to be able to live life in a way that allowed me to connect people and policy, rhetoric and reality. My life was as golden as the many rays of sunlight I had soaked in up until the sun set for the day and life as I knew it on March 14, 2015.

It was a Saturday night like any other. I had no reason to be expectant, and I looked forward to returning to school from spring break the next morning. For me, all was well. Then, I got the headache. I had been working out and assumed I had overexerted myself. After all, I was a healthy eighteen-year-old that had not even put on

the notorious “freshman fifteen.” I thought little of it and went about the evening that very well should have been my last. As it were, my headache turned out to be caused by the formation of a brain aneurysm on a previously undiagnosed arteriovenous malformation, or AVM. My only real symptom that anything was wrong was the bone-chilling and life-altering experience of disaster—the aneurysm’s rupture and a subsequent hemorrhagic stroke. I remember the feeling. I remember the pain, and I remember the end, or at least what was diagnostically the end of life as I knew it but turned out to be the beginning of a better life than I ever could have imagined. It was the sunset of March 14th that gave me the sunrise of March 15th and lives with me until this very day.

I remember the moment I realized I was paralyzed. I felt the entrapment of my own body. It was that distinct feeling of internal condemnation, though, that led me to the external liberation that I found as soon as I realized that although I was trapped in my own body, I had a mind that was as free as ever. It was such a thought that guided me through each and every day leading up to my admission to Shepherd Center in Atlanta, Georgia, for intensive inpatient rehabilitation. My reprieve from the pain and frustration of grueling days of intensive therapy was the brief excursion to the top floor of the hospital’s parking deck where my family and I would watch the sunset. As aforementioned, I remember the insecurity of not being in my beloved Mississippi. I knew that Shepherd was the facility with the expertise to guide me to recovery, but I still hated that I was away from home. Even ore, I hated that progress in recovery did not come quickly. I never accepted the diagnosis that I would never walk again, and I did everything in my power to not be defined by the awful circumstances. I did not see the point in it all. *Why me?* Was a common question that I reckoned with throughout the

days. Then, one night, I got my answer. It was me because I could find a way to connect it to something else. As a citizen scholar that loved public policy, I am wired to find unique and often odd correlations between rhetoric and reality. One night, as I lay motionless in bed, I found my great correlation. To myself, I thought, ‘Seth, just as you are trapped in your own body, there are Mississippians whom are trapped in their circumstances, too. You’re here to fight free so that you can go back to help others fight free from whatever it is they might be trapped within, too.’ The thought shifted my entire perspective from one of a victim to one of a victor—a Mississippian with a mission. In a healthcare setting I found my purpose, and in healthcare policy I have found my passion.

On my last morning as a patient of Shepherd Center, I asked to visit the parking deck to watch the sunrise. For me, it was a poignant moment. During those trying moments of rehabilitation, I chose to change my perspective and resolve myself to making each opportunity count whether it be rehabilitation or research. Never again would I see the Sun fall on my surroundings and be discouraged. Now, I could see each new beginning in the world around me. Both within me and throughout me, there was a difference because on this final day I walked, not rolled, to the guardrail and saw the morning’s first light creep across a previously dark horizon.

When I returned to the University of Mississippi, the Sally McDonnell Barksdale Honors College, and Public Policy Leadership, I knew that I must find a way to bring together my passion for healthcare policy and my purpose of helping Mississippi. After all, I was fortunate. I had a family that was able to bear much of the cost of recovery and the flexibility to transition with me to Atlanta. The latter, I realized, was the most crucial factor in my recovery. I was privileged with having the access to the healthcare that I

need. My needs in recovery were unique and best met by a specialty hospital, but I still think that accessibility to healthcare facilities, regardless of need, is the most crucial factor in the ultimate well-being of an individual. Through research, I find that a crucial factor in healthcare accessibility through public policy is the presence or absence of policies requiring a “Certificate of Need” to create, expand, or acquire healthcare operations. For this research I will examine Certificate of Need Policies, their intent, their history, usage in modern policy, and standing effect in healthcare before focusing on Mississippi and nearby states’ CON policies, analyses thereof, and introduce a multi-step policy recommendation and conclusion.

Literature Review

In general, Certificate of Need (CON) laws or state programs represent a collage of regulatory programs that determine the availability of selected health care services. Thirty-six states in America have such laws or programs that are “designed to ensure access to health care services, maintain or improve quality, and control capital expenditures on health care services and facilities by limiting unnecessary health facility construction and checking the acquisition of major medical equipment” (Meesa 2012. p. 443). Under such laws, an entity must apply to a legally-designated state agency to prove that its plan for operation is in the best interest of not only the state but also the area in which it will operate. Primarily, the review and enforcement agencies of CON laws look to ensure that there is not an unnecessary duplication of services that may unnecessarily drain resources or create a toxic environment that runs contrary to the purposes of medicine. Generally, Certificate of Need laws act as a planning mechanism that allows

the government to have a certain level of control over healthcare services in what an economist might see as a “merit good.”

Blumstein and Sloan wrote that “In a nation whose institutions have relied on market mechanisms for making basic choices, governmental imposition of planning bears a burden of persuasion.” (pg. 3) In reasoning the persuasion, the authors provide two rationales for the need for government imposition in a market. First, the authors reason that government intervention traditionally follows some type of market failure while the second rationale follows the idea of healthcare being a merit good wherein a certain level of equity must be present to promote a sustainable, competitive market, meaning that if healthcare is a commodity in the American model then it is the responsibility of the government to become involved in the regulation of such commerce so that there is not too great of an inequity that results in a market failure that would not only have human condition costs but also financial. (Blumstein and Sloan.1978). With a theoretical rationale for such policies understood it is possible to more closely examine specific intentions of CON laws and regulations.

Intent

Simply put, the Intent of Certificate of Need laws can be broken down into six components that will later be analyzed individually. The components are: ensure an adequate Supply of health resources, increase the quality of care, ensure rural community access to care, ensure the provision of charity care to those unable to pay and for underserved communities, encourage the use of hospital substitutes, and contain the cost of care. Each of these six points of intent are interconnected but have notably different focuses. Generally, though, proponents of Certificate of Need policies state that with a

controlled healthcare landscape there is little room for the erosion of stability and the prevention of overgrowth. In a policy schematic, Certificate of Need policies intend to manage the convergence or avoidance of streams as understood by Kingdon's three stream policy window model.

In Kingdon's model, there are streams representing the problem, policy, and political facets involved in a matter possibly addressed by public policy (Kingdon. 1984). CON policies intend to avoid the political stream in an effort to prioritize a planned management approach to healthcare. This aim is achieved by selectively bringing together the problem stream of the need for adequate healthcare services and the policy stream involving the approval of targeted healthcare services through a bureaucratic measure that is selective and intended to be more manageable and equitable. This controlled stream intent of Certificate of Need laws is predicated upon the historical development of America's healthcare model.

History

The first federal law intended to address the types of issues addressed by Certificate of Need laws was the 1946 Hill-Burton Act. Specifically, the act was meant to control and increase the supply of the nation's medical facilities in a time where healthcare was largely a local matter. The legislation was brought forward as American soldiers returned from World War II and the American economy transitioned from a wartime complex into a domestic marketplace. With an economy that was considerably larger than before and a population boom in progress, national lawmakers saw Kingdon's streams growing into rivers and chose to act in a way that could control their convergence.

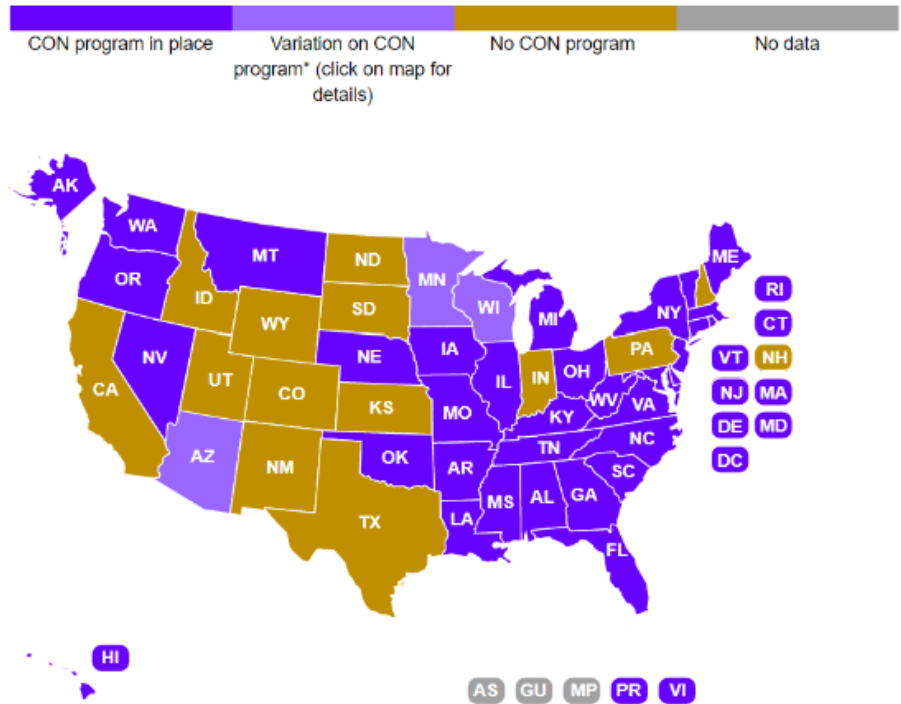
With the Passage of the National Health Planning and Resources Development Act of 1974, Congress firmly affixed itself to the theoretical policy idea that government should be involved in healthcare market regulation and legally reified the concept that healthcare should be handled with regional impacts in mind and therefore shifted healthcare to a regional and state level than solely a local matter. Before the Act, many states had created Health Systems Agencies (HSAs) to loosely monitor the delivery of healthcare in areas, but the new law provided for HSAs to be succeeded by Comprehensive Health Planning Agencies (CHPAs) to widen the focus of healthcare delivery in a way that reified the principle that healthcare was a good made available rather than a service provided. “Unlike the predecessor agencies, CHPAs are expected to take the initiative in determining health care needs of the region. The health providers in turn will be called upon to respond to the CHPAs long and short range plans by proposing programs to meet those objectives.” (Hyman, ix) The act additionally withheld funds from states that failed to enact CON laws by 1980 and required that healthcare providers desiring to open a healthcare facility to prove to the regulatory body that the community potentially serviced needs the services proposed to be rendered.

Historically, though, the State of New York had enacted the first CON law in 1964 prior to the 1974 federal law by granting its state government power to determine whether there was a need for any new hospital or nursing home before it was approved for construction and by the early 1980s every state except Louisiana had enacted CON-type laws (Mitchell. 2017). “In 1986, though, as evidence mounted that CON laws were failing to achieve their stated goals Congress repealed the federal act, eliminating federal incentives for states to maintain their CON programs. Since then, 15 states have done

away with their CON regulations. A majority of states still maintain CON programs, however, and vestiges of the National Health Planning and Resources Development Act can be seen in the justifications that state legislatures offer in support of these regulations” (Mitchell. 2017)

According to the National Conference of State Legislatures, 14 states have discontinued their CON programs. New Hampshire was the most recent repeal, effective 2016; 34 states currently retain some form of CON program. Puerto Rico, the US Virgin Islands and the District of Columbia also have CON programs; and 3 states have variations. **Table One.** below, illustrates the current status of CON laws across America.

Table One



Specific Intents of Certificates of Need as Public Policy

As mentioned earlier in this scholarship, CON policies are centered around six primary intentions that operate independently of one another and are tailored in such a way that necessitates the exploration of each in an examination of the policy framework. The first of these intents is to ensure an adequate Supply of Health Resources by carefully managing the placement of health services in a way that does not saturate the supply market in one area while depleting service opportunities in another. In close relation to the first, the second specific intent of the policy is to ensure rural community access to care by ensuring that health services are appropriated in a way that is equitable to less-populated areas as opposed to healthcare providers only focusing on ready-to-serve population markets. Increase the quality of care is the third intention of Certificate of Need policies and is predicated on the idea that a controlled entrance and allowance into a particular market will ensure that healthcare providers are giving the highest quality of care in order to remain worthy of its operation certificate. The fourth intention of ensuring the provision of charity care to those unable to pay and for underserved communities is based on the idea that healthcare providers will give due diligence to providing community service through care as a mechanism to prove its “worth” and “need” in the area that its certificate mandates. Encourage the use of hospital substitutes is the fifth intention of Certificate of Need policies and is built on the premise that healthcare providers will provide alternative methods of medical care such as telehealth centers or mobile clinics as in the case of the University of Mississippi Medical Center

that was recently designated “National Telehealth Center of Excellence” (Clarion Ledger 2017) that are cheaper to operate than traditional healthcare structures and therefore more profitable for the holder of the provider and the area it serves under its certificate. The final intention to contain the cost of care summarizes each of the five other intentions and again assumes that healthcare is a merit good that can be capitalized upon by a provider while remaining accessible and affordable. By containing the cost of care through monitoring by the certificate-granting authority, the containing of costs is assumed to be inevitable and holds the provider responsible for doing so under the risk of having its certificate revoked in most cases.

Policy in Effect

As a policy in effect, “two major arguments are espoused in employing certificate of need regulation to control hospital costs. Although they are based on somewhat different conceptions of the notion of “unnecessary” investment, both implicate uncontrolled expansion in rising hospital costs” (Salkever and Bice pg. 11). “One equates “unnecessary” with excess capacity as evidenced by low occupancy rates or idle equipment and services. As hospitals are fully utilized, excess capacity translates into higher costs.” (Salkever and Bice pg. 13). “In this context, the Institute of Medicine reported that the nation has a significant surplus of hospital beds and recommended a reduction from the current stock of 4.4 bed per 1,000 persons to 4.0 per 1,000 persons.” (Institute of Medicine. 1976)

Positives

Through the analysis of various certificate of need laws across the nation, I have determined numerous factors that lend credence to the positive impacts of such policies. Primarily, CON laws treat healthcare services in theory as not a typical product but rather as a good that should be carefully monitored. Further, specific services offered by a provider are categorized and taken into account individually rather than just as “healthcare-in-whole,” meaning that specialized services can be seen as individual agents and therefore targeted to an area. Additionally, The American Health Planning Association (AHPA) argues that CON programs limit health-care spending. CON programs can distribute care to areas that may be overlooked by new medical centers. Finally, I posit that CON policies, in theory, prioritize government involvement in healthcare and therefore make public health a priority.

Negatives

Through equal analysis, I have determined several factors that I determine to be negative factors to Certificate of Need policies in effect. Primarily, I believe that CON policies restrict competition in healthcare marketplaces and limit the opportunity for growth and innovation of services that may best fit an area. I also determined that CON implementation programs are susceptible to outside influencers and render monopolies in healthcare inevitable. Additionally, I struggle to find a reasonable justification for allowing a loosely or not-at-all monitored board of individuals to have the authority over a citizen’s access to affordable, equitable healthcare services.

Methodology and Analysis

To analyze the impact that Certificate of Need laws and regulations have on Mississippi, I first set out to determine the nation's overall healthcare landscape. Through research, I was able to follow along as data collection and policy analysis firm McKinsey & Company collected data that was then analyzed and studied by U.S. News and World Report. As it were, my search for comprehensive data was fulfilled when the final report entitled "Best States 2018" was released on February 27, 2018. The full report ranks all fifty states in seventy-seven categories across eight metrics of Health Care, Education, Economy, Opportunity, Infrastructure, Crime & Corrections, Fiscal Stability, and Quality of Life. For the purposes of this scholarship, though, the data were considered only in the Health Care metric.

According to the study's methodology, "The states were ranked on health care using three broad benchmarks: Access to care, quality of care and the overall health of the population. This includes concerning measures such as the percentage of adults without health insurance and the percentage who have not had a routine checkup in the past year – including those who went without medical attention because of the cost. It includes positive measures such as the percentage of children receiving medical and dental care under Medicaid. It includes measures of preventable hospital admissions, readmissions within 30 days of discharge, nursing home quality ratings and numbers of seniors covered under high-quality Medicare Advantage plans. It involves general measures that correspond with good physical and mental health – rates of smoking, obesity and suicide, along with self-reported mental health. And it considers infant and overall mortality rates" (USNWR. 2018).

The first metric taken into account was “access to healthcare.” Specifically considered were child wellness visits, insurance enrollment, adult wellness visits, adult dental visits, child dental visits and health care affordability. The methodology reasoned that although many Americans have access to quality health care, others face barriers, such as lack of insurance or access to facilities that prevent them from receiving basic services. The lack of access to quality health care increases the financial and public health burden on state residents as individuals and as a population and consequently carried thirty-three percent of the metric’s weight. It was in this category that Mississippi ranked forty-ninth of the fifty states and managed to rank in the bottom fifty states in each sub-category except for adult wellness visits and child dental visits where the State ranked fourteenth and fifteenth, respectively.









The second metric considered by the study was “health care quality” that took into consideration the four sub-metrics of hospital readmissions, Medicare quality, nursing home quality, and preventable admissions. Despite the small number of measures, the methodological justification reasoned that “though this subcategory’s rankings are determined by only four metrics, they offer a broad and multifaceted outlook on the state of health care in the nation. Health care quality is intrinsically linked to health care accessibility, and it contributes heavily to a state's population health, the other two subcategories used to determine the Best States for health care” (2018). In each of the sub-metrics, Mississippi ranked within the bottom forty-five states and was considered the worst overall state in regard to health care quality.

The final thirty-three percent attributed to a state’s overall healthcare ranking was “public health. The study states that, “this subcategory evaluated six metrics: mortality

rate, suicide rate, smoking rate, mental health, infant mortality rate and adult obesity rate. The Centers for Disease Control and Prevention provided the data, which were collected between 2015 and 2016, for each of the public health metrics. A population’s overall health is a strong indicator of the quality of life in a given state, providing insight into access to nutrition, economic challenges and other barriers to health that may persist within a state” (2018). Within the sub-metrics, Mississippi ranked fiftieth in infant mortality rate and adult mortality rate, forty-ninth in obesity rate, forty-sixth in smoking rate, forty-fourth in mental health, and twelfth in suicide rate. Overall, it was determined that Mississippi ranked last among all states in public health.

With each of the three metrics taken into consideration, it was determined that Mississippi ranked fiftieth among the states in the aggregated health care metric. As I looked at the data, I noticed that every state bordering Mississippi also ranked within the bottom ten states as shown in **Table Two**.

Table Two

Health Care Rank	State	Health Care Access	Health Care Quality	Public Health
#43	 Tennessee	35	40	43
#44	 West Virginia	12	47	49
#45	 Kentucky	14	49	46
#46	 Alabama	41	39	47
#47	 Louisiana	37	48	44
#48	 Oklahoma	47	42	45
#49	 Arkansas	38	46	48
#50	 Mississippi	49	50	50

As I looked at the geographic relationship between the states in Table Two, I was quick to think of the sociological influencers that contribute to the diminished success of states in the American Southeast; however, despite being true, it is not the purpose of this scholarship to delve into sociological implications. Instead, I chose to focus on the factor that I believe to be the most significant influencer of healthcare in a state: the presence of certificate of Need laws and regulations.

To conduct comparative research, I visited each state's certifying entity's website and explored the bureaucratic processes involved in obtaining a certificate of need or CON-type clearance. As a part of my research methodology, I observed requirements, specifications, and limitations put on the petitioning entity, including, but not limited to, waiting period, application fee, length of application, and noteworthy excerpts from application processes. It is my hope that this scholarship may be built upon and advanced through continued research and shifts in policy. I am aware that my methodology comes from the perspective of a scholar seeking a bachelor's degree and that legal intricacies are based upon a bachelor's degree-level of public policy and are not meant to be judicial in nature. As a result of limited legal knowledge, CON-type laws for the state of Louisiana are not taken into consideration due to the state's use of a Napoleonic legal structure with which the researcher is not familiar.

I began my research with the state with the higher ranking in healthcare, Tennessee. On the state's Department of Health website, www.tn.gov/health, the state clearly stated the intentions of its certificate of need law by writing, "A Certificate of need (CON) is a permit for the establishment or modification of a health care institution,

facility, or service at a designated location. Tennessee’s CON program seeks to deliver improvement in access, quality and cost savings through orderly growth management of the state’s health care system. The Division of Health Planning is charged with setting the standards and criteria for granting a CON in the State Health Plan. The Health Services Development Agency (HSDA) decides whether to grant or deny a CON using the standards and criteria” (State of Tennessee). Tennessee also explicitly listed the types of healthcare facilities, equipment and services covered under Tennessee’s CON law.

Table Three lists these institutions, equipment, and services.

Table Three

Burn Unit	Neonatal Intensive Care Unit
Open Heart Surgery	Organ Transplantation
Cardiac Catheterization	Linear Accelerator
Positron Emission Tomography	Linear Accelerator
Hospice	Psychiatric
Opiate Addiction Treatment provided through a nonresidential substation-based treatment center for opiate addiction	Initiation of service: Magnetic Resonance Imaging in a county with a population in excess of 250,000 – for pediatric patients only
Increasing the number of machines or Initiation of service: Magnetic Resonance Imaging in a county with a population of 250,000 or less – for any patients	Satellite Emergency Department
Nursing Home	Recuperation Center
Hospital	Ambulatory Surgical Treatment Center
Mental Health Hospital	Intellectual Disability
Home Care	Outpatient Diagnostic

Rehabilitation	Residential Hospice
Opiate Addiction treatment	Beds may be increased by 10% of licensed beds in a specific bed category without a CON once every three years

Upon review of the “standards and criteria” the HSDA requires of applicants, I discovered a meeting agenda from the most recent convening of the Health Planning Board. Upon review of the minutes and exploration of prior meetings’ minutes, I discovered that Tennessee reviews CON applicants on a case-by-case basis and employs different standards and criteria that are relevant to the area and the specific application by the petitioning entity. On each agenda was a note from general counsel that usually stated the legal framework involved and the various compliance requirements that must be met. If an entity met the requirements, then it was recommended for approval. If there were discrepancies or ambiguities with a petitioner’s case the General Counsel would work with the petitioner for clarification. After clarity was found, Counsel would recommend the Petitioner’s case to be considered rather than issuing a denial. Simply put, my research determined that Tennessee handled its CON applicants on a case-by-case basis.

Next, I reviewed the forty-sixth ranking state’s CON website to continue my research, Alabama. On Alabama’s State Health Planning and Development Agency (SHPDA)’s website, I discovered the agency’s CON mission statement that stated the mission as being: “To ensure that quality health care facilities, services, and equipment are available and accessible to the citizens of Alabama in a manner which assures continuity of care at a reasonable cost” (State of Alabama). As I explored the policies

within Alabama's Certificate of Need application process, I noted that the fee to apply was \$22,703. I thought that this figure was high but also noted that the funds would be refunded to the petitioner if the certificate was granted. Additionally, I examined the entirety of Alabama's application. The package was only sixteen pages and allowed for all filings to be done online if necessary. This was a stark contrast to Mississippi's one hundred-plus application that required monthly updates and could not be resubmitted if denied even in part.

As I prepared to research Arkansas' Certificate of Need policies, I expected to find many similarities to Mississippi's CON policies. After all, Arkansas ranked only one place above Mississippi. Like the other sites, the stated purpose of the Arkansas Health Services Permit Agency was listed as being "to ensure appropriate distribution of health care providers through the regulation of new services, protection of quality care and negotiation of competing interests so that community needs are appropriately met without unnecessary duplication and expense" (State of Arkansas). Interestingly, though, Certificates of Need are called Permits of Approval (POA) in Arkansas but serve the same function. Unique to Arkansas was the presence of three added purposes to Arkansas' POA approval process. "Evaluating the availability and adequacy of health facilities and health services as they relate to long term care facilities and home health care service agencies in Arkansas, designating those areas of the state, and specifying categories of health services which are underserved or overserved, and exempt certain underserved areas or categories of service from the permit of approval process, and developing policies and adopt criteria for the review of applications and issuing of permits of approval" were the three added benchmarks that an entity must reach in order

to be approved. Comparatively, the POA requirements that a petitioner must reach were similar to those of both Tennessee and Alabama. A significant difference, however, was the three-thousand-dollar application fee that a petitioner must pay for each and every proposal sent to the review board. The greatest difference between Arkansas and the other states was Arkansas' requirement that a separate POA must be filed for each different service rendered, even if it is performed by the same entity. Additionally, unlike the other states, there was no reapplication of the same petition even after recommendations were made. If the petition was denied, the applicant must wait for a period of no less than six months and then pay the fee or fees again to begin the process anew.

An analysis of Mississippi's Certificate of Need policy was based on a data-driven metric from aggregated data collected by the Mercatus Center. The analysis was split into sections on spending, access, and quality. On spending, it was noted that CON laws are associated with higher healthcare spending per capita and higher physician spending per capita, especially in Mississippi's case. **Table Four** shows the estimated changes in annual per capita healthcare spending patterns in Mississippi without CON.

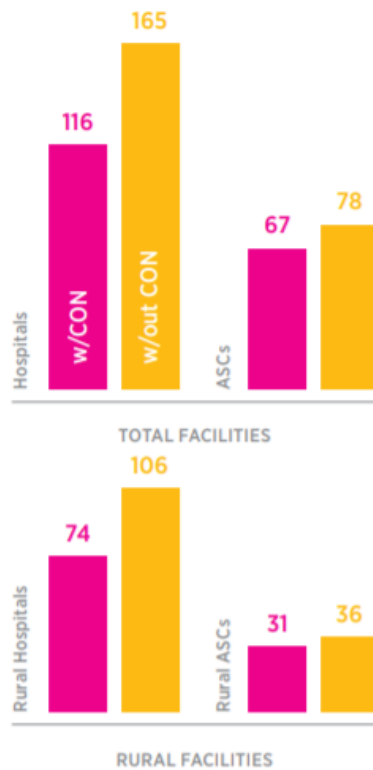
Table Four



In access, “Comparing rural areas in CON states with rural areas in non-CON states, research finds that the presence of a CON program is associated with fewer rural hospitals. A subset of CON states specifically regulating the entry of ambulatory surgical centers (ASCs), which provide healthcare services and compete with traditional hospitals. These states have fewer rural ASCs.” (Mercatus. 2017)

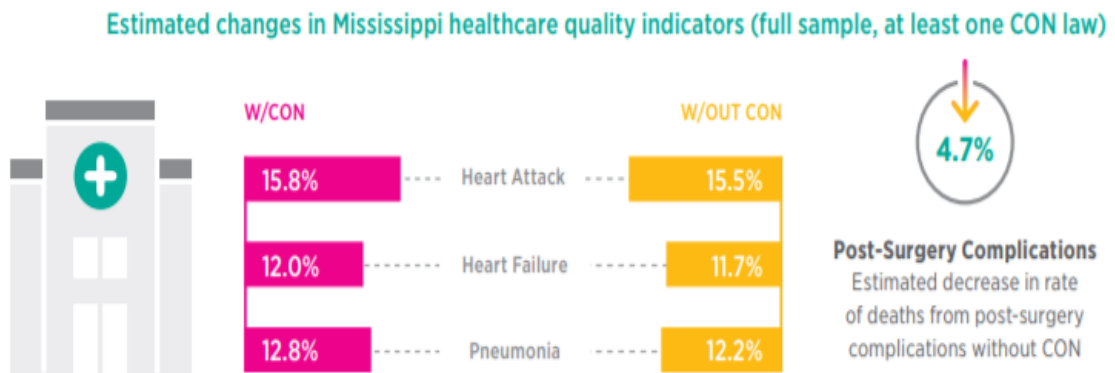
Table Five shows the estimated changes in access to healthcare facilities in Mississippi without CON policies in place with a special focus of the change in rural areas.

Table Five **Estimated changes in access to healthcare facilities in Mississippi without CON**



In quality, “Supporters of CON suggest that these regulations positively impact healthcare quality, but research finds that the quality of hospital care in CON states is not systematically higher than the quality in non-CON states. In fact, mortality rates for pneumonia, heart failure, and heart attacks, as well as patient deaths from serious complications after surgery, are statistically significantly higher in hospitals in states with at least one CON regulation. **Table Six** depicts Estimated changes in Mississippi healthcare quality indicators.

Table Six



The Case of Mississippi’s CON Policies

Since 1986 when the Mississippi Department of Health began administering the Certificate of Need program, it has reviewed more than 1,400 applications corresponding to \$5 billion in capital expenditures, showing that there has been significant money spent over time under the CON system in the Magnolia State, but it is noted that Mississippi is one of the most restrictive CON processes in the nation. **Table Seven** lists the Services, facilities, and equipment subject to CON review by the Mississippi Department of Health. It should be noted that Mississippi is one of thirty-two states with four or more CON restrictions.

Table Seven.

Acute Hospital Beds	Ambulatory Surgical Centers (ASCs)	Cardiac Catheterization
Gamma Knives	Home Health	Intermediate Care Facilities for those with Disabilities
Long-Term Acute Care	MRI Scanners	Mobile Medical Imaging
Nursing Home/ Care Beds	Open-Heart Surgery	PET scanners
Psychiatric Services	Radiation Therapy	Rehabilitation
Renal Care/Dialysis	Substance/Drug Abuse	Swing Beds

To acquire a CON for one or more of the nineteen listed services, facilities, or equipment, a petitioner must complete a one hundred and two-page application for each point and abide within the guidelines listed below by the Mississippi Department of Health:

“Section 41-7-171 et seq., Mississippi Code of 1972 Annotated, as amended, established the Mississippi Department of Health (Department) as the sole and official agency of the State of Mississippi to administer and supervise all state health planning and development responsibilities of the State of Mississippi. The intention of health planning and health regulatory activities is to prevent unnecessary duplication of health resources; provide cost containment, improve the health of Mississippi residents; and increase the accessibility, acceptability, continuity and quality of health services. The regulatory mechanism to achieve these results is the Certificate of Need (CON). A CON must be obtained from the Department before undertaking any of the activities described in Section 41-7-191 (1) without obtaining a Certificate of Need (CON) from the Department. No final arrangement or commitment for financing such activity may be made by any person unless a CON for such arrangement or commitment has been issued by the Department. The Department will only issue a CON for new institutional health services and other proposals which are determined to be needed pursuant to statutory requirements. Only those proposals granted a CON may be developed or offered within the State of Mississippi. Only the Department, acting in response to an application for a certificate of need, or in response to a decision of a court of competent jurisdiction, may cause a CON to be issued, denied, or withdrawn or may determine that CON review is not required. In carrying out these responsibilities, the Department shall make decisions

to issue or withdraw a CON by conducting the review of each application in accordance with the adopted procedures, standards, and criteria. No CON shall be issued unless the action proposed in the application for such Certificate has been reviewed for consistency with the specifications and criteria established by the Department and substantially complies with the projection of need as reported in the State Health Plan which is in effect at the time the application is received by the Department. The Department will disapprove a CON application if the applicant fails to provide or confirm that the applicant shall provide a reasonable amount of indigent care or has admission policies which deny access to care by indigent patients. (2) The Department will disapprove a CON application if approval of the request would have significant adverse effect on the ability of an existing facility or service to provide Medicaid/indigent care. The State Health Officer shall determine whether the amount of indigent care provided or to be offered is "reasonable." The Department has determined that a reasonable amount of indigent care is an amount which is comparable to the amount of such care offered by other providers of the requested service within the same, or proximate, geographic area. The Department shall adopt and revise as necessary criteria and review procedures for CON applications. Before review of new institutional health services or other proposals requiring a CON, the Department shall disseminate to all health care facilities and health maintenance organizations within the State and shall publish in The Clarion-Ledger (Jackson, Mississippi) and other newspapers deemed appropriate a description of the scope of coverage of the State Department of Health's Certificate of Need Program. Whenever the scope of such coverage is revised, the State Department of Health shall disseminate and publish a revised description in like manner. Certificates of Need shall

be issued by the State Health Officer based upon those criteria and standards established and lawfully adopted. Appropriate mechanisms for providing affected persons an opportunity for a formal hearing on matters to be considered by the State Department of Health have been developed. No CON shall be granted or denied until affected parties have been accorded such right to a formal hearing. A CON is not transferable from one person or entity to another except with the approval of the Department. A CON shall be valid for a designated period of not more than one year from the effective date. The Department may extend the CON for a period not to exceed six months in those cases where the applicant shows to the satisfaction of the State Department of Health that a good faith effort has been made toward completion of the project. All approved projects will be monitored by Department staff to assure compliance with stated policies, standards (including Life Safety, Construction, and Licensure), and approved costs. Recipients of Certificates of Need are required to make written progress reports of their projects at least every six months and at completion.” (Mississippi Department of Health)

Simply put, Mississippi’s process of reviewing Certificates of Need require an intensive effort on the part of the petitioner and are underscored by time and intensive scrutiny from the State of Department of Health. Such a high threshold on so many areas for review make Mississippi’s CON law one of the toughest in the nation. The high number of CON-required services is high but not unheard of by a national standard. Upon review, I discovered that Mississippi is one of thirty-two states that has four or more CON restrictions.

The policy is certainly not ignored in the state, though, as a recent debate roared through the Mississippi legislature. During the formulation of this thesis, the debate was reaching its fever-pitch. Anna Wolfe of the Clarion Ledger wrote on September 10, 2017 that “A national push to eliminate certain health care regulations has made its way to Mississippi, where free-market philosophy often influences policy decisions.” Health care providers looking to expand some services are required to receive a "certificate of need" from the state Department of Health. The certificates ensure facilities and services are added to communities that can support them, but one lawmaker thinks the requirement gives large health systems an advantage. "Basically, a certificate of need is a monopoly certificate," said Rep. Robert Foster, R-Hernando. "It gives you a monopoly for a certain service." The House Public Health and Human Services Committee will meet to discuss the certificate of need process and possible changes.” (Wolfe. 2017)

"By reviewing proposals for the location and scope of new health facilities or expansions of current facilities, the Certificate of Need process helps ensure that the quality of available care remains high while preserving health care access to as much of the state as possible," reads a recent newsletter from the Mississippi Health Department. In Mississippi, the process requires an applicant to show the service 1) is needed 2) does not duplicate an existing service and 3) does not discourage access to care by a patient who cannot afford to pay for it. The argument has been that health care entities like hospitals like to locate in good-income areas since they might make more money and draw paying patients away from smaller hospitals that have no way to balance the care or level of care offered to Medicaid and Medicare recipients and the uninsured.

“Representative Foster wants the state to stop requiring physicians to get the certificate of need certificate to perform procedures, buy new equipment or open certain outpatient surgery centers. A bill he wrote to accomplish this, HB 48, died in committee during the 2016 legislative session. The physicians in question, Foster noted, already must be licensed. "They should not have to get permission from the state to perform that service they have a license for," Foster said. "The problem is they cannot get a CON to do what they're trained to do. They can't open their own private practice. They have no option but to work for one of the corporate medical companies in our state." During the certificate application process, other providers, including large corporations, have the opportunity to challenge the justification for the additional service. "The big corporate health care providers will argue at CON hearings, 'If you allow this small clinic to do these services or buy these machines, it's going to affect our profit so much that it will bankrupt our hospital and we'll close and then you won't have a hospital,'" Foster said. Foster said the process can get expensive for the applicant to make its case against the challenger. "They should not have to go fight a legal battle with a major corporation just to buy an updated or new type of machine," Foster said. "We need more health care and need the cost to go down, and the only way to do that is to have competition." (Wolfe)

Questions about the effectiveness of the certificate are not new but had been overshadowed in recent years by debate over the Affordable Care Act. "If it looks like a number of states are reevaluating their CON laws right now, that's because they feel their hands are tied on doing much else, such as making major adjustments to coverage mandates or other insurance regulations," said Jameson Taylor, Mississippi Center for Public Policy vice president for policy. (2017)

Considering attempts in the last year to repeal the Affordable Care Act, eliminating certificates of need could create "additional instability in the market," said Richard Roberson, vice president of policy and state advocacy for the Mississippi Hospital Association, "which is a huge concern for hospitals and other providers as well."

The Mercatus Center at George Mason University, a think-tank focused on free-market research, estimates based on national data that eliminating certificate of need requirements could reduce health care spending in Mississippi by \$208 per patient per year. The data is tempered by the fact that in Mississippi, just 5 percent of certificate of need applications are denied, whereas other states have much higher denial rates. Matt Mitchell, Mercatus researcher and director of its Project for the Study of American Capitalism, notes the possibility of providers opting to forgo expansions altogether to avoid the cost and hassle of justifying the need for services. "How many people just don't even ask for it because they know it's a daunting process?" Mitchell asked." (Mercatus 2017). Research indicates rural areas in states with certificate of need requirements have fewer hospitals than those without and estimates that doing away with the regulation could increase the number of rural hospitals in Mississippi from 74 to 106 (Mercatus).

In 2017, Mississippi received seven applications for certificates of need from the following facilities: Forrest County General Hospital (two requested), Bedford Care Center, Renal Care Group Meridian, Renal Care Group Senatobia, Fresenius Kidney Care Southwest Jackson, Fresenius Medical Care South Mississippi Kidney Center.

On September 12, 2017, Anna Wolfe again contributed to the Clarion Ledger regarding Mississippi's Certificate of Need debate in a story that I believe provides context to this scholarship and should be included. Wolfe wrote:

In a three-hour-long public health committee hearing Monday, lawmakers sought to answer the question: Can health care operate in a free market?

The Legislature is considering changes to laws that require health care providers to receive a "certificate of need" from the state to buy certain equipment or offer certain services.

The certificate is designed in part to prevent health systems from over expanding and passing along the costs of expensive and underutilized equipment to patients.

Medical professionals, lobbyists and free-market economists packed the Capitol committee room Monday as lawmakers argued the benefit of more competition in health care.

"The logic of free market, it just doesn't exist in health care. It just doesn't," said Dr. John Fitzpatrick, Hattiesburg Clinic's board chairman.

Rep. Robert Foster, R-Hernando, one of the Legislature's staunchest opponents of certificate of need laws, retorted: "You're trying to say health costs are fixed; that you have no control over what your payment is or what your reimbursement is from Medicaid ... It's directly related to the fact that we do not have competition."

In unison, health professionals across the room shook their heads, including State Health Officer Mary Carrier.

"Repeal of the certificate of need would remove an important planning tool from the health care economy. Absent regulation, economic Darwinism would unleash a torrent of free market forces risking the equilibrium of supply and demand. We would see,

unquestionably, an increase in the cost to Medicaid," said Mississippi Healthcare Association's attorney John Maxey. "There is little dispute unrestrained investment in high cost health care facilities would concentrate in population centers, leaving rural consumers to struggle for ready access to health care services."

Sen. Brice Wiggins, R-Pascagoula, pushed back, pointing out that the state's Medicaid budget has ballooned in the last decade to over \$1 billion.

If certificate of need laws were designed to regulate costs, "apparently the CON is not working," Wiggins said.

"I can't accept that statement," Maxey said.

Some of the lawmakers' skepticism comes from the fact that existing providers — hospitals, clinics, nursing homes — could lose patients if other providers were able to locate near them.

"Is it not true you have a direct stake in keeping the status quo because y'all have monopolies in these industries?" Foster asked Maxey.

"I'm just a dumb farmer. I'm not a Phi Beta Kappa from a Harvard or Yale or some other fancy college, but I understand basic economics. I'm a business man. If one guy is the only guy in town selling, it's going to be really expensive. And he doesn't want anybody else to come in town so he's going to come up before us and give us all types of information saying the sky's going to fall, poor people aren't going to have access to care ... if you do away with us having the ability to have a monopoly. Well, that doesn't make any sense."

Matt Mitchell, senior researcher for the free-market focused research group Mercatus Center, provided recent data to the committee comparing states with certificates of need laws to those without.

Mitchell said that in general, states with certificate of need requirements have fewer hospitals, therefore a lack of access, and higher costs for individuals services than states without.

"It's possible CONs could restrict total spending but only doing so by denying access to services," Mitchell said.

Rep. Jarvis Dortch, D-Jackson, compared an unrestricted health care system to retail in Jackson, which is migrating more and more to surrounding counties Madison and Rankin where the tax base is greater.

"The CON is supposed to bridge that gap so hospitals aren't just placed in more affluent areas," Dortch said.

Currier noted the evidence and arguments on both sides of the issue, saying, "It just depends on how you look at it."

While Richi Lesley, Fresenius Medical Care market development director, presented to legislators, the fact that Mississippi appears at the bottom of nearly every health-related ranking hung in the air.

Centers for Medicare and Medicaid Services rates Fresenius' dialysis centers significantly higher quality than surrounding states, including states without certificates of need, Lesley stated, which "attests that what Mississippi is doing works."

"Y'all claim your CMS ratings are so great and they're better than all these other states that have no CONs," Foster said. "I don't care anything about your CMS ratings; the only thing that matters to me is that they all have healthier people in their states than we do. Every one of them. We're 50th — 50th — in health in the entire country."

■ Story by Anna Wolfe, September 10, 2017

As a note, the Mississippi Legislature did not address the public policy debate surrounding the 2018 Legislative session.

Findings

It was at this point in my research, review, and reflection of Certificate of Need policies, especially with the narrowed focus on Mississippi's Certificate of Need policies that I concluded that CON policies are not suitable for the State of Mississippi. With Mississippi's current system in place, many Mississippians are left underserved or not served at all by healthcare providers. Mississippi, as a whole, ranks lowly on each of the metrics assessed in the methodology of this research and has failed to address the situation entirely, as illustrated through Wolfe's covering of the policy debate and the inaction by the Mississippi Legislature during the most recent legislative session. I find that the implementation of policies that have failed Mississippians and the inaction of State leaders to address them leads the finding of this academic endeavor to be a multi-leveled policy approach to better the healthcare situation in Mississippi.

Policy Recommendation

With all data considered and policy implications assessed, I shift the intent of this scholarship to recommend a multi-stage change of policy within the State of Mississippi regarding Certificates of Need and medical planning within the state. In total, I recommend a three-part proposal that I hope to be further studied, revised if necessary, and applied. The three components of the proposal are as follows: Repeal Mississippi's Certificate of Need Laws Create a Mississippi Health Planning Board, Repeal Mississippi's Certificate of Need Laws, and enact market-friendly, patient-focused policies.

Repeal Mississippi's Certificate of Need Laws

Since the federal decision to revoke the need for Certificate of Need Laws provided by the 1974 National Health Planning and Resources Development Act, I feel as though many states have kept CON-type laws in place not only out of convenience but also because they worked for states that do not have the paltry economic conditions of Mississippi. As covered in the Analysis section of this research, states that can afford healthcare are more apt to be serviced with healthcare. Even the initial barrier to the free market will not deter corporations from making the adjustments necessary to enter into a market where the merit good of healthcare can be profitable. For Mississippi, though, there is less incentive to enter a place that is mired in poverty. By requiring so much of a healthcare entity, there is less appeal to take any chance to enter into the Mississippi market. On such a note, I believe that the first step in Mississippi healthcare reform should be the repeal of Mississippi's Certificate of Need law. Mississippi would not be the only state to do this for the reasons I have cited within this section. "The Nebraska

legislature, bowing to intense lobbying by hospitals and the health insurance industry, has effectively repealed the state's 19-year-old certificate of need (CON) law governing the sale of non-profit hospitals to for-profit hospitals. The public disclosure law, which was passed in 1996, was also targeted by anti-government regulation politicians who were rallied by the lieutenant governor. The new law repeals the CON process for new acquisitions, new services, equipment purchases, miscellaneous capital costs and assisted living beds.” (Scott. 1997) Especially in a state with such high levels of Medicare and Medicaid enrollees, I believe that the repeal of the CON protocols is vital to the security and start of reform in Mississippi.

Create a Mississippi Health Planning Board

With the burdensome certificate of need regulations gone, I propose that one positive attribute of the law remains, the concept of organized, statewide healthcare planning. Comprised of nine members from healthcare, law, business, and the Department of Health, the Mississippi Health Planning Board would be tasked with conducting reviews of the best available data to determine the type of healthcare policies the state should implement that would best serve the state as a whole while also targeting high-need areas with the state’s attention and the power to offer incentives, such as tax breaks, to entities that enter into an area that has been determined needy by the state Health Planning Board. The board would not have the power to restrict the entrance to a market by a healthcare company but would have the power to deter any state health grants from being received by a healthcare provider. Additionally, this board would be tasked with monitoring the price of services rendered to ensure that there was a well-regulated but, free, market for healthcare in Mississippi. Three appointees would be

nominated by the Governor, three by the Insurance Commissioner, and the final three by the Attorney General. Members of this committee would serve a term of two fiscal years and only one of the three appointments, determined by the Governor, would be allowed to serve for a consecutive term. The other two appointees would roll from the board and rendered ineligible to serve for three fiscal years.

Enact market-friendly, patient-focused policies

After the repeal of Mississippi's Certificate of Need law and the creation of the Mississippi Health Planning Board, the continuation of healthcare reform in Mississippi would then fall to the legislature, state agencies, and healthcare agencies. Sensible free-market policies would not only attract investment in the state but also render services to the people of the areas that were previously left behind by market barriers. The legislature should act to make Mississippi compliant with national health standards and accept the expansion money offered under the Affordable Care Act. According to Julie Steenhuisen of Reuters, if the expansion is approved, a sum of around 426 million dollars would become available to ensure more Mississippians.

With more Mississippians ensured, private health entities would have a greater incentive to enter the Mississippi market, knowing that more individuals would be eligible to pay or have their services paid for. Greatest of all, though, would be the burden falling upon the healthcare agencies to improve the quality of service in a more competitive environment where the free market is at play but the state, through the Health Planning Board, provides planned guidance and effective oversight so that there are effective and efficient services rendered.

An example of private management successfully changing the course of a health system is found in Sunflower County, Mississippi. Tammy Luhby wrote A Story for CNN on the success story by sharing the following:

“Just over a decade ago, North Sunflower Medical Center was on the verge of collapse. It had few patients and even less cash – only enough to operate for eight hours. Hospital administrators met every afternoon to see if they’d be able to open the doors the next day. The staff had to cover the lab equipment when it rained because the roof leaked. Nurses would clock out early and then stay to finish their shifts.

“They figured a piece of a paycheck was better than no paycheck,” Sandra Britt, the assistant to the administrator, said of those dark days in the early 2000s.

Fast-forward to today, the hospital is thriving even as many rural hospitals struggle to stay open and serve their communities. Its staff has more than tripled, as has the size of its health clinic. Patients come from miles away to get basic care or see a growing number of specialists.

“Whenever me and my family get sick, we come here,” said area resident Dexter Nailer, singing the hospital’s jingle, “Take me to Ruleville,” while helping his mother after her colonoscopy. “They really take care of you.”

North Sunflower is succeeding at a time when many rural hospitals in the US are struggling to survive. It serves as a lifeline in a county where nearly 40% of residents are living in poverty and in a state with some of the highest levels of obesity, diabetes and deaths from cardiovascular disease in the nation, and it has helped keep the tiny town of Ruleville afloat. It opened eye and dental clinics, a gift shop, a diagnostic center and a

hospice in downtown stores, many of which had been vacant and in disrepair. The 25-bed hospital also sponsors fundraisers for the local high school sports teams and supports area colleges and events, including the Great Ruleville Roast & Run in late September.

More than 80 rural hospitals have shut their doors since the beginning of 2010. Five of these hospitals have been in Mississippi, landing the state in the Top 5 in the nation for closures.

Many rural hospitals can no longer do all this. More than 80 have shut their doors since the beginning of 2010. Five of these hospitals have been in Mississippi, landing the state in the Top 5 in the nation for closures.

Far from the divisive health care debate in Washington, the challenges facing rural hospitals stem largely from having to care for patients who are older, sicker and poorer than those in urban and suburban areas. These facilities depend mostly on Medicare and Medicaid for reimbursement, and the government usually pays lower rates than private insurers.

Nearly half of rural hospitals lose money, according to the Sheps Center for Health Services Research at the University of North Carolina.

North Sunflower isn't immune to the problems plaguing its peers. Its costs are going up at a time when its reimbursements aren't. Medicare, Medicaid and private insurers are cutting their payments and taking longer to send the checks. After years of growth, it may have to rethink some of the services it offers.

"It's a daily struggle and it's getting harder," said Billy Marlow, North Sunflower's executive director who engineered the turnaround. "They'll do everything they can not to

pay.” (Luhby. 2017) Yet, with these three policy proposals adopted, hospitals such as North Sunflower could continue their mission to improve healthcare in Mississippi. Now, though, they would not be fighting the battle alone.

- Story from Tammy Luhby

Conclusion

Watching the sun set on the Georgia landscape profoundly changed me. After watching the sun rise on my last day at Shepherd Center, the poignancy was not lost on me as I returned to my studies and responsibilities as a citizen-scholar at the Sally McDonnell Barksdale Honors College. My first day back as a student, I experienced the sunrise of a new opportunity. That opportunity, I knew, was to use the circumstances of my life to better the lives of those around me, especially in my beloved Mississippi home.

Through my experience, I found that I am able to relate to other individuals in various circumstances and that healthcare is a policy aspect that impacts each of us. I remember being in group therapy sessions where those around me talked about the issues that mattered most to them. In those conversations, we never spoke about whether or not we would walk again, go to the bathroom alone again, or even feed ourselves again. Instead, the conversations seemed to always drift back toward our respective homes. While we were all thankful to be in a place that provided nurturing care, it still was not home. There was no way to bloom in recovery where we were planted. Instead, our circumstances uprooted us and set us down in a completely different place.

As my roots took hold and I recovered, my life began to grow again. I fought, and I hoped. After all, the only things I really had were effort and hope. Thankfully, in

that soil, my new tree of life grew. Eventually, my tree bore fruit. The fruit it bore was my new reality, and I am determined to make it count. Now, with the seed of that fruit, I have planted a new life back in Mississippi. My roots have grown in the fertile soil of my life at the University of Mississippi, and I have determined to grow for myself and others a harvest that will nourish all Mississippians. In the light of the sunrise, I have nurtured and produced this thesis as the final fruition of my scholastic endeavors at the University of Mississippi. Now, as the sun sets on my career as an undergraduate Rebel, my only hope is that this fruit will produce a seed that may be planted somewhere else, take root, and nourish Mississippians for years to come.

While I am fortunate that I was able to go elsewhere to have my healthcare circumstances addressed, I strongly believe that all Mississippians should have the access to healthcare where they are and as they are. By eliminating certificate of need requirements in the State of Mississippi and implementing the policies proposed, I feel as though more Mississippians will be able to remain rooted in our home and the sun over the Mississippi sky will nourish those that bask in its rays, take root in its soil, grow in its landscape, provide shade for those whom need it, and bear fruit for the state for years to come.

During my second summer back after rehabilitation, I worked with two other university students on behalf of the McLean Institute for Public Service and Community Engagement's Catalyzing Entrepreneurship and Economic Development (CEED Initiative) in Vardaman, Mississippi to create a sustainable, effective Entrepreneurial Learning Center (ELC) for the local youth to come and learn about health and wellness, planning, and critical thinking. Our focuses resonated with me as I was able to see young

minds become engaged with their health and physical and emotional wellbeing just as I found myself doing in light of my experiences. I was particularly pleased to engage with young minds in critical thinking exercises as we discussed ways to reconsider circumstances in a way to shift perspectives and carry on no matter the situation.

Such an endeavor to transform Mississippi through policy is the conclusion of this thesis and the beginning of whatever journey comes next in my academic career. The sun sets just as the pages of this thesis come to a close, I implore you, the reader, to never stop seeking a tomorrow through another work, vision, or piece of scholarship. I ask you to Keep on the Sunny Side and always Just Keep Rolling Along.

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