MISSISSIPPI STATE DEPARTMENT OF HEALTH

A New Vision for the Mississippi State Health Plan

Executive Summary

INTRODUCTION

In 2023, the Mississippi Department of Health engaged Health Management Associates (HMA) to conduct research, analyze data, and gather opinions to establish a new vision for the State Health Plan. According to the Department, "*The State Health Plan establishes criteria and standards for health-related activities which require Certificate of Need review in an effort to meet the priority health needs identified by the Department of Health.*"

HMA collected information from a diverse set of stakeholders from a public opinion survey and key informant interviews. HMA analyzed publicly available data on the number of providers and beds in the health system and used that data to project the need for services and facilities. HMA also compared Mississippi regulations and statutes with other peer states that have a similar State Health Plan.

After gathering and analyzing all these data and information sources, key themes were identified about how the State Health Plan could be envisioned for the future. These key themes are related to the State Health Plan as well as the data, information, and processes that HMA used to produce the document.

Thirty-nine percent of key informants interviewed said the Certificate of Need program should be modified. Sixteen percent said it should be eliminated, and 6% said it should be kept as is.

THE MISSISSIPPI STATE HEALTH PLAN

The Mississippi State Health Plan (the Plan) describes the overall health of Mississippians, the current structure of the health system, and the health system's projected needs. The Mississippi State Department of Health, Division of Health Planning and Resource Development, publishes and updates the Plan as state code requires.[1] The plan was last updated in 2022.

The executive and legislative branches, private providers, research centers, academic institutions, and other stakeholders in Mississippi use the State Health Plan to understand the health system and how it could be improved. Though the State Health Plan is a valuable tool for health planners and policymakers, the Department of Health recognizes that revisions are needed to make it more accurate and meaningful.

The Mississippi State Health Plan is a valuable document for health planners, policymakers, facilities, providers, and the public. As described in state code, the Mississippi Department of Health is responsible for producing and updating the State Health Plan. The Plan is organized into seven chapters. Chapter 1 describes the legal authority for the plan, Certificate of Need (CON) policies, and provides population projections and numbers of current licensed providers by provider type. Chapters 2 to 7 describe facilities and services that are covered by the State's CON program. These facilities and services include:

- Acute care hospitals
- Long-term care in nursing homes and intermediate care facilities
- Behavioral health residential and inpatient services
- Perinatal care
- Comprehensive medical rehabilitation services
- Other health care services, such as home health, ambulatory surgical centers, and end-stage renal disease services

[1] Sections 41-7-173(s) and 41-7-185(g)

CERTIFICATE OF NEED

Certificate of Need (CON) programs were introduced in the United States in the 1970s under a federal requirement. Generally, certificates of need are required to build, expand, sell, or acquire healthcare facilities or service providers within a state. The governing body of a state's Certificate of Need program has the authority to control the supply of facilities and services with the goal of having neither a surplus nor a shortage of healthcare services. Since the federal requirement was lifted in 1986, 15 states have eliminated their Certificate of Need programs entirely, leaving 35 states with more limited programs. Across those 35 states, programs vary widely in terms of the following:

- Which agency/body completes the reviews, such as the state or an independent body
- Services or facilities covered by the program
- Criteria for approval, which is typically focused on need, costs, impact on population, and sustainability
- Application and approval processes
- Fees and other funds used to support the program
- Capital thresholds

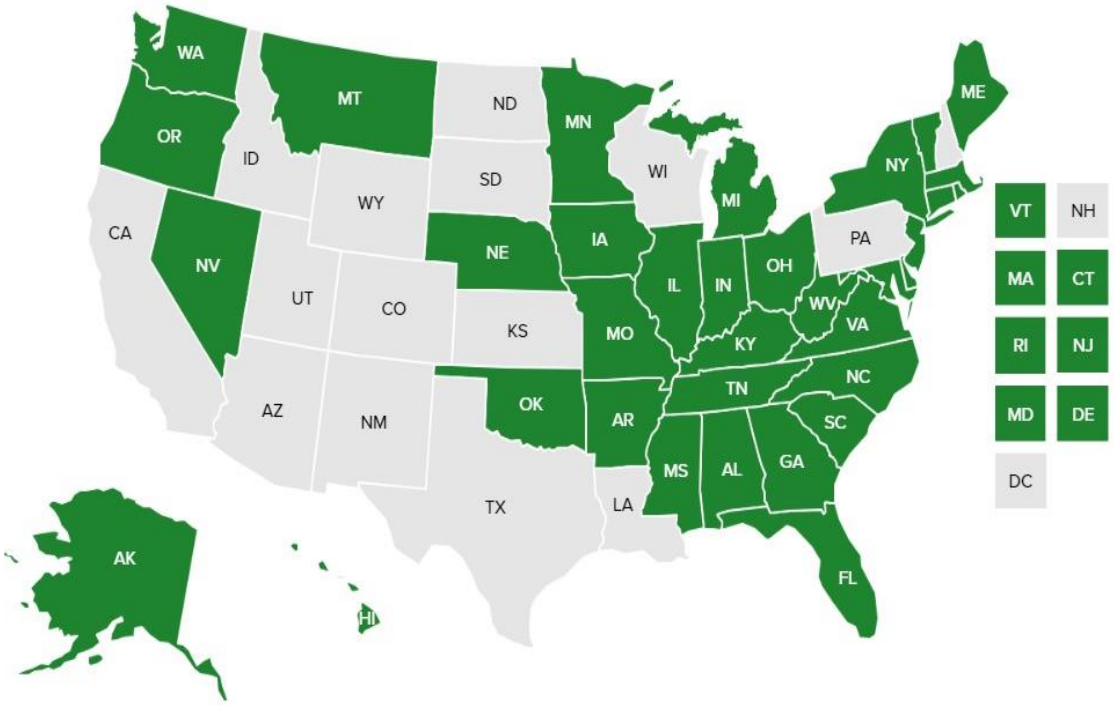

Figure 1: States Nationwide with a CON Program (as of 2020)

Certificate of Need: Disparate Views

The value of Certificate of Need programs has been heavily debated since their introduction. Generally, policymakers have held one of the following three perspectives on the effects of Certificate of Need programs based on their economic philosophy.

1. *Certificate of Need programs are valuable because* they control healthcare costs by reducing unnecessary supply of healthcare facilities and services. Adherents to this viewpoint argue that Certificate of Need programs prevent a surplus supply, which would result in a deadweight loss for society. Other Certificate of Need advocates argue that c Certificate of Need application processes can benefit projects with a demonstrated community value and under-resourced communities.

2. *Certificate of Need programs have a negative economic impact* because they restrict supply and, therefore, competition. Opponents of Certificate of Need programs lead to a shortage of supply, which allows an incumbent to maintain control over the marketplace, set prices, and raise overall costs. Other negative impacts, they say, are related to the administrative costs of Certificate of Need program that states and applicants incur.

3. *Certificate of Need programs have a neutral effect on healthcare outcomes.* Under this hypothesis and with all other variables held constant, outcomes in states with and without Certificate of Need programs differ in statistically insignificant ways.

HMA reviewed approximately 45 peer-reviewed publications and found no overwhelming evidence to favor any of the three hypotheses.

Certificate of Need Approvals

Once a provider submits a Certificate of Need application to the state, the review process begins. Review processes include confirmation that all required documents and materials are included, analyses of the application, including any utilization and financial data, determination of whether the need criteria are met, and a recommendation for approval or disapproval. Providers may contest disapprovals and may request a hearing. The state health officer has the final say regarding whether to approve or disapprove an application, and the final decision is posted on the state's website.

In 2016 − 2023, the Mississippi Department of Health reviewed 10 − 18 Certificate of Need applications annually. Most of the submitted and approved applications were for hospital clinics and services,[2] skilled nursing facilities,[3] and End-Stage Renal Disease (ESRD) services. The average approval rate was 95 percent across this period.

Table 1: MSDOH CON Applications and Approvals

Year	Number of Applications	Number of Approvals	Number of Denials or Withdrawn or Open	Approval Rate
2016	17	16	1	94%
2017	15	15	0	100%
2018	16	15	1	94%
2019	11	11	0	100%
2020	10	10	0	100%
2021	12	10	2	83%
2022	18	17	1	94%
2023	11	8	3	TBD

The MSDH's CON average approval rate was 95% across this period.

[2] Hospital application approvals were not for building a new hospital, but mainly for adding service lines, beds, or equipment.

[3] Mississippi has had a moratorium on nursing facilities since 1990 with one exception for one year. The moratorium is for construction of new facilities, conversions from hospital beds to nursing home beds, and expansion of beds.

HMA STUDY: APPROACH

HMA conducted a study to establish a new vision for the State Health Plan. The study had three major components:

1. **Information Gathering:** Public opinion survey and key informant interviews.

The first component of the study entailed gathering quantitative and qualitative data and information to understand stakeholder perspectives regarding the State Health Plan. This part of the analysis included:

- Conducting a web-based public opinion survey via the Department of Health's website from October 26 to November 30, 2023. The survey asked for feedback on the most important health issues and needs in the state and the strengths and weakness of the Certificate of Need program. Respondents who were unfamiliar with the Certificate of Need process could skip those items on the survey. In total, 90 people completed the questionnaire.
- HMA conducted 31 key informant interviews with stakeholders, such as Department of Health leadership, Board of Health members, and representatives of other state agencies, think tanks and academic institutions, trade associations, civic organizations, and legal firms.

2. **Data Analysis:** Analysis of public data to determine social vulnerability index by county**.**

The second component of the study was an analysis of publicly available data to inform what could be included in the State Health Plan to describe the health of Mississippians and the state's healthcare system.

This part of the analysis involved: Analyzing and stratifying the number of providers and beds based on the social vulnerability index, which allows for a comparison of providers and beds by counties with the highest and lowest levels of vulnerability. Vulnerability is informed by factors such as socioeconomic status, household composition and disability, minority status and language, and available housing and transportation.

3. **Regulatory Comparison:** Comparison of regulatory impact across peer states.

The third component of the study involved comparing the regulatory framework of Certificate of Need programs across a group of peer states. The selected peer states included Arkansas, Alabama, Georgia, Louisiana, and Tennessee. Within the timeframe of the project, HMA was able to complete interviews with licensure and CON staff from four of the states—all but Tennessee. The information gathered for each state included:

- Capital expenditure threshold
- Facilities that require a CON
- Services or activities that require a CON
- Services or activities that are exempt from Certificate of Need
- Criteria for review
- Oversight body
- Filing fee amount
- Funding sources to support the Certificate of Need program
- Process of application, approval, and making decisions public
- State has a health plan

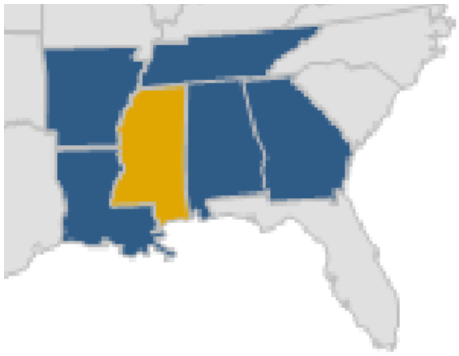

Figure 2: Selected Peer States

HMA STUDY: RESULTS

1. **Information Gathering:** Public opinion survey and key informant interviews.

The first component of the study was to gather quantitative and qualitative data and information to understand what stakeholders think about the State Health Plan. Results from the key informant interviews indicate that:

- Strengths of the Certificate of Need program are that it limits profiteering and oversupply, ensures more equitable distribution of services, and the process is agnostic to lobbying.
- Weaknesses of the Certificate of Need program are the data used are outdated and unreliable, the formulas need to be revised, and it does not account enough for performance or quality.
- Strengths of the Mississippi healthcare system are systems of care, reaction to crises, interagency relationships, and good providers and facilities (i.e., home health, safety net providers).
- Weaknesses of the Mississippi health system are payment rates, workforce, distribution of services across the state, lack of a single healthcare authority, and reduced rural services.
- Respondents noted a number of specific policies that would address weaknesses of the Mississippi health system. Respondents offered policies they would like to see enacted to improve the health system (Figure 3).

INTERVIEW RESPONDENT

"How can you plan if everyone is not reporting the same data and its three years old?"

Figure 3: Interview Respondent Recommendations for the Mississippi Health System

Results from the public opinion surveys indicate that:

There were 90 completed surveys, 48 respondents answered yes that they or their organization used the State Health Plan or engaged in the CON process.

Out of the individuals that were either *very familiar or somewhat familiar* with the state health plan, respondents were asked if they thought components should be changed. A score of 5 means the component should not be changed or improved; a score of 1 means the content needs to be completely rewritten.

Table 2: Survey Respondent Recommendations for the Mississippi State Health Plan

Element of the State Health Plan	Average Score
Types of Health Services Included	2.44
Actual Data Collected and Presented	3.04
Projected Data	2.68
Need Criteria	2.40
Formulas used to calculate the need criteria	2.44

Respondents were asked to rank the top five most useful informational or data elements for decisionmakers to include within the new State Health Plan. The results below show the ranking of each informational or data element from all 90 completed surveys.

Table 3: Ranking of Useful Information or Data Element

Informational or Data Element	Number of Responses
Maps or graphics to show how resources are allocated across the state	43
Public health data on overall health status of Mississippians	39
Focus on priority areas like maternal mortality and behavioral health	33
Information on gaps in services	32
Cost data from health care providers	30

Informational or Data Element	Number of Responses
Information across age span	30
Quality of care data	29
Clinical data from health care providers	28
Health disparities	28
Information by disease state	28
Health care workforce data	24
Non-health factors	24
Data on access or health care deserts	21
Information on utilization of services	21
Rural health data	20
Survey data from end users	12
Information on location and size of health care facilities	8
Health of immigrants and new Americans	3

Respondents provided de-identified demographic information. The majority of respondents were 31 to 49 years old, Caucasian, have a master's degree, live in the Capital/River region, and work in Health Care or Social Assistance.

2. **Data Analysis:** Analysis of public data to determine social vulnerability index by county.

The second component of the study involved analyzing publicly available data to inform what could be included in the State Health Plan to describe the health of Mississippians and the health system. The types of data analyses conducted are described below.

- Analysis of the number of approved Certificate of Need applications by county and stratified by life expectancy. Figure 4 shows that the dark blue counties have high life expectancy and a high number of Certificate of Need approvals. The colorless counties have low life expectancy rates and a low number of Certificate of Need approvals. Mississippi has more colorless than blue counties.
- Analyzing the number of Certificate of Need approved applications by county and stratified by the total population growth rate. Figure 6 shows that the dark blue counties have a high

number of Certificate of Need approvals and a positive or less negative growth rate. The colorless counties have a low number of Certificate of Need approvals and a lower population growth rate.

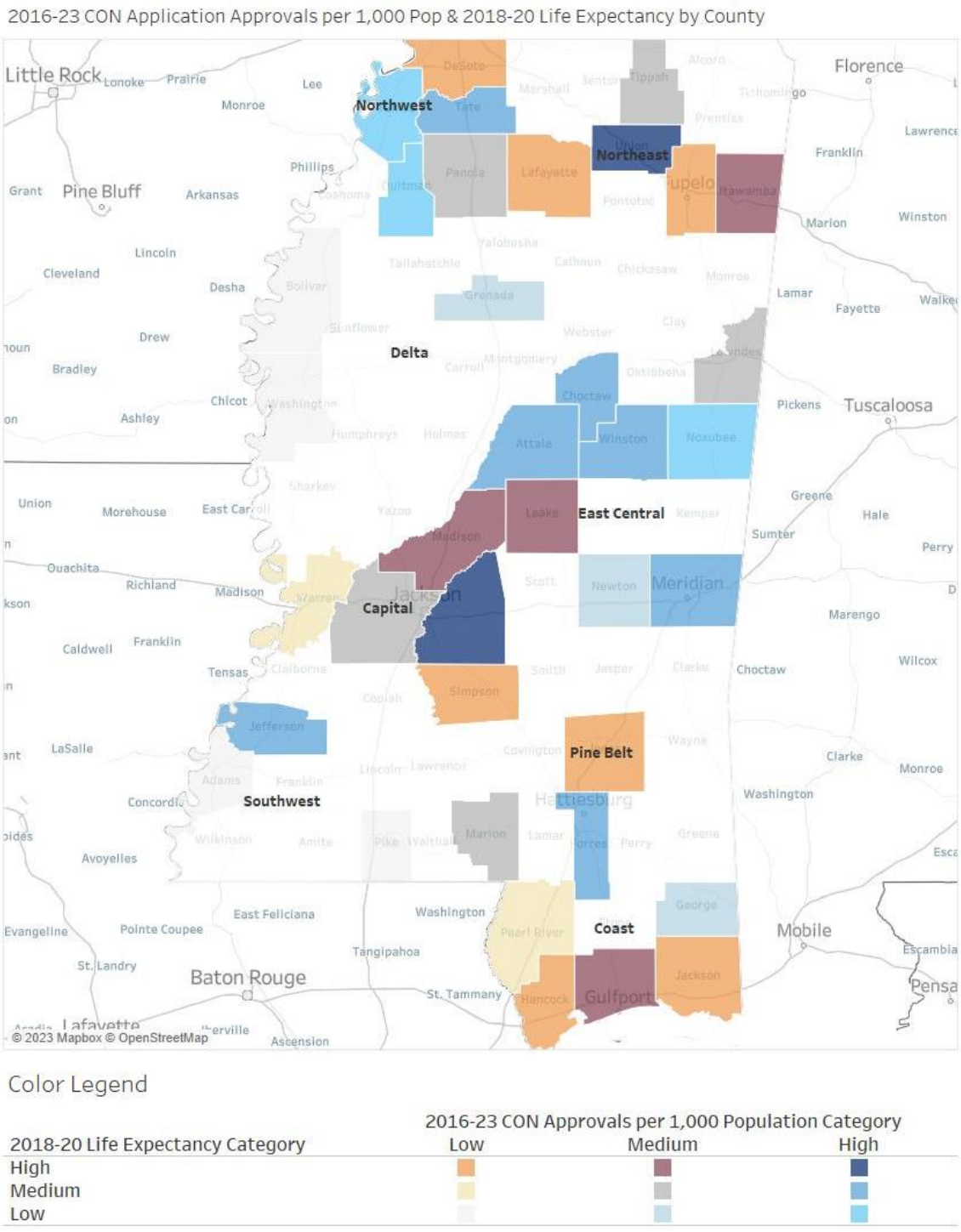

Figure 4: Comparison of CON Approvals with Life Expectancy

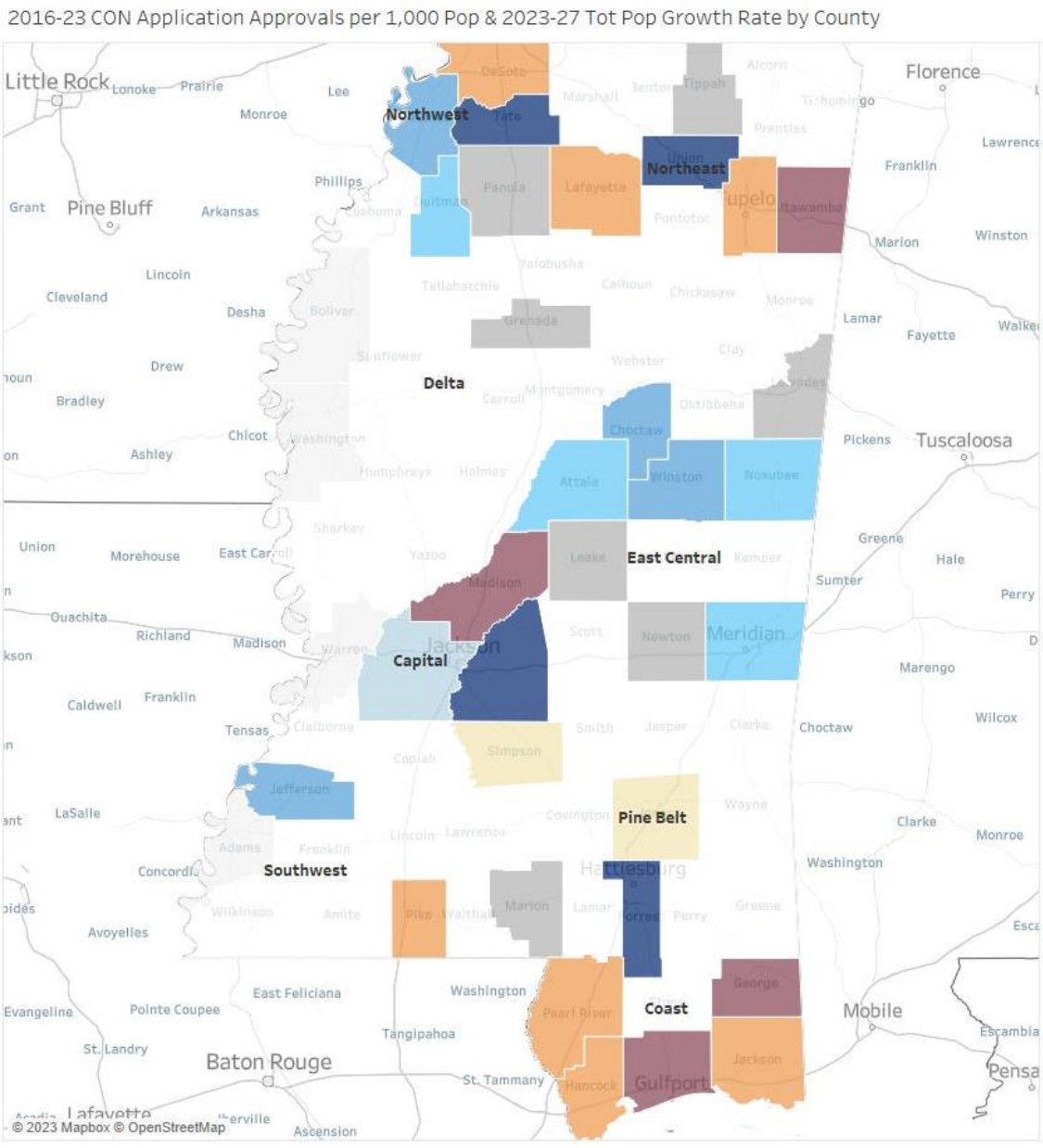

Figure 5: Comparison of CON Approvals with Total Population Growth

3. **Regulatory Comparison:** Comparison of regulatory impact across peer states.

The third component of the study was a comparison of the regulatory framework of Certificate of Need programs across a group of peer states. Results from the comparison are highlighted in the table below.

Table 4: CON State Comparisons

CON State Comparisons		
	Mississippi	**Key Differences in Peer States**
Capital expenditure threshold	$1.5M for equipment $5M for clinical $10M non-clinical	Three states have no threshold. Georgia has a $10M threshold regardless of type of application.
Facilities that require a CON	Hospitals, long-term care hospitals, rehabilitation, home health, ESRD	Arkansas and Louisiana do not require for hospitals. Facilities covered by other states, but not in Mississippi are hospice and adult/pediatric day centers.
Services or activities that are exempt from Certificate of Need	Exemption of facilities owned by the state	Alabama has exemptions when a facility's occupancy rate is 95% or more for preceding 24-month period. Louisiana has an exemption for a facility that needs to be replaced because of fire. Tennessee has an exemption for counties that are economically distressed and have no hospital.
Publish application decisions	Approvals posted on website	Alabama, Arkansas, Louisiana, and Tennessee do not publish approvals/denials online.
Funding sources to support the CON program	Only application fees	Arkansas, Louisiana, and Tennessee all receive general funds as well as application fees.
Formulas	Primarily based on populations ratios and applied to population projections supplied by academia	Alabama uses a utilization model instead of a population-based model. Arkansas sets population levels (i.e., over or under 50,000) for the number of services allowed.

CROSS-CUTTING THEMES

The final step in this analysis was to triangulate the results across the three areas of study as well as the background information and evidence to identify key themes.

Separate the State Health Plan into Two Documents

Stakeholders widely recognize the need to describe the CON program and the Mississippi healthcare system. However, doing this in two separate documents would be more efficient, meaningful, and useful.

Chapter 1 of the present State Health Plan could be moved into a separate document that could be expanded to include more accurate and useful information and data. Examples of information that were mentioned that should be included in this more comprehensive document includes costs, quality, access to care, and the identification and discussion of priority areas and populations. Respondents wanted this comprehensive document to include metrics, historical data, trends, and recognition of best practices where available. Along with publicly available, relevant, accurate and regularly updated data, Respondents also recommend Chapter 1 be informed by a comprehensive landscape assessment of available services as well as unmet service needs, especially by priority populations.

Such a document could be used to inform collaborative policymaking and planning. It was noted that no single state agency or entity is identifying cross-agency solutions to position Mississippi to best meet the healthcare needs of its citizens in the future. Several state agencies play leading roles in shaping the Mississippi healthcare system, sometimes leading to a piecemeal approach to problem solving based on each entity's unique mission and strategy.

A single healthcare taskforce or authority could gather data and information, interpret the results, present information to policymakers and the public, and identify policies that agencies could collaboratively work to implement. For example, efforts on maternal and infant health were discussed several times as an opportunity to bring together siloed groups and focus on a singular topic, using data-informed decisions to drive resource allocation and better outcomes.

Tennessee has an excellent standalone state health plan. It describes priorities and includes dashboards and maps to show gaps and hotspots, which helps build consensus in decision making about resource allocation. Tennessee's plan is streamlined to 24 pages and lists agreed upon priorities, legislation enacted to support those priorities, and other programs or initiatives state agencies are undertaking to support the priorities. The plan is updated annually as required by statute.

A separate, comprehensive document that is updated routinely would allow for the sharing of best practices and description of trends that need to be accounted for in resource allocation. For example, significant shifts are occurring in healthcare, moving from institutional or facility-based services to home and community-based services. Services that were traditionally delivered in hospitals are now being delivered in same-day surgery centers and outpatient clinics. Length of stay in acute care settings has decreased over time. These trends have resulted in a large number of unoccupied acute care beds in Mississippi and consequently profit margins that are lower than the national average.

Nursing facilities also are experiencing this trend with decreased occupancy rates and efforts to build out more home and community-based care. This trend was exacerbated by the COVID-19 pandemic. Mississippi has a moratorium on nursing facility beds, but a collaborative approach could be used to identify ways to address excess capacity in the system.

A separate document could also address workforce development, which interviewees described as critical to maintaining the healthcare system. Tracking the number of licensed providers by county allows for comparisons against population projections or national benchmarks. This information can help inform solutions that range from loan repayment, increased reimbursement rates, childcare, and higher education offerings.

Use Certificate of Need Application Data to Inform Changes

More respondents noted that some changes needed to be made to the CON program rather than calling for its elimination. A review of the CON applications from the past seven years shows that fewer applications are filed annually in Mississippi than in peer states. Respondents noted that this discrepancy may be because organizations avoid submitting applications that might be rejected.

Others noted the high cost of submitting an application related to legal fees and gathering all the required information and data. CON application data show that organizations with the highest number of applications were hospitals, ESRD services, ambulatory surgical centers, and major medical equipment suppliers. Hospitals typically sought to add clinic services, major medical equipment, and certain beds such as inpatient psychiatric care. For the most part, applicants are not requesting to build facilities, and the nursing facility moratorium has halted applications for that purpose. Applications indicate that the most meaningful part of the CON program centers on equipment and services that are shifting from the inpatient to outpatient setting.

Revise Abeyance Regulations

Abeyance is used to store beds temporarily with the intent to perhaps use them at a later date. In Mississippi, this practice has unintended consequences that are affecting the healthcare system. Bed owners may lease these beds at a price they determine to keep beds in the system. Abeyance drives up prices, creates a secondary market, and might even change the original type of bed that was licensed.

Other states have a different approach to abeyance. One state allows facilities to place beds into abeyance for five years with an assigned market price. Each year, for five years, the bed loses value. At the end of five years the bed is worth $0 and is removed from the total count of licensed beds, thus ratcheting down the beds under a moratorium. Mississippi could consider this framework which incentivizes the seller to sell the bed as

early as possible. It also reduces the overall bed count in the state and pushes occupancy rates down to more accurate numbers. The current abeyance system has a dampening effect on the healthcare system, as it skews the total number of beds and their value.

Redistribute Services and Beds

The analysis of CON applications in comparison with life expectancy and population levels shows a maldistribution of services and facilities in Mississippi. People who live in the delta and other rural areas are experiencing a significant lack of access to facilities and services. Most CON applications have been concentrated in a few areas of the state, including Hinds County. Application results suggest that even though the demand for healthcare services is high in the state, few organizations are willing to build facilities or provide services, possibly because the start-up costs are too high, and organizations are concerned about the return on their investment. This concern is understandable, given that several of the areas identified are economically distressed, have high poverty levels, and access to care is limited.

Other states have used a variety of policies to incentivize organizations to redistribute services, including loosening regulations, increasing reimbursement, subsidizing costs through mechanisms like grants or tax breaks, or entering into public-private partnerships. One or all of these options might need to be employed to incentivize organizations to provide more services in these distressed areas. For example, Tennessee has chosen to exempt economically distressed areas from CON requirements.

Consider New Models to Drive Better Organization of the Health System

Organizing the healthcare system into hubs and spokes would also help to alleviate the need for redistribution of facilities and services. For example, all areas of the state should have reasonable access to primary care, dental, and behavioral health services. These services could be provided in homes and community settings and focus on prevention and management of chronic conditions. Transportation, telehealth, hospitals without walls, community health workers, doulas, community paramedics, and remote patient monitoring are all ways to connect the hubs and spokes to increase access to care. Regional hubs could have infrastructure with higher levels of care such as inpatient psychiatric services, residential treatment facilities, specialty services, major medical equipment, and acute care.

Finally, a few areas of the state would have the highest level of services such as trauma care, children's hospital, burn care, etc. Behavioral health and maternity care are both areas where the hub and spoke model has been implemented in other states. Hub and spoke models would allow the state to reorganize its healthcare system for greater efficiency and cost-effectiveness; however, without a state healthcare authority or similar body, it will be difficult to improve care coordination.

Improve Data Accuracy

All peer states separate licensure and CON data. Mississippi's State Health Plan is informed by licensure data, even though the purposes of the licensure data are not aligned with CON

requirements. For example, licensure is focused on the total number of beds, not necessarily the type of beds. Type of beds has little effect on CON program applications. Both programs would benefit from knowing whether the reported beds are staffed.

Peer states use different approaches to collecting and updating data. In one state, after the initial information is collected in the CON application, data on the use of services or the number of available beds is updated. The form is one page, and the results are made public online annually. Collecting and updating data creates an additional administrative burden for both healthcare organizations and the state. Though respondents noted that the data are inaccurate and unavailable, they were less likely to recognize there was less recognition that this could be solved by requiring interim data that could be collected from organizations.

Increase Accountability and Transparency

Once Certificate of Need applications are approved in Mississippi, the state should follow up to determine whether the expectations outlined in the application can be achieved realistically. For example, applications that describe the value that the project brings to the community should be reevaluated. Licensure could be a tool to ensure organizations adhere to the commitments they made to the state. A random sample of applications could be reviewed each year, with the goal of reviewing all within a five-year period.

Consider Exemptions

Beyond economically distressed areas, the literature review and the peer state comparisons noted CON exemptions in other states. Areas where Mississippi is significantly behind national benchmarks should be considered for exemptions, such as behavioral health and substance use disorder (SUD) services and facilities such as Psychiatric Residential Treatment Facilities. For example, respondents noted a need for more psychiatric care beds in the state as well as SUD beds. The state could also consider expanding access to maternal and infant care services.

Modify Criteria

The Department of Health could propose some modifications to the Board of Health that could be made without legislative action. Examples include a comprehensive review of the formulas and need criteria, proposing more streamlined ways for applicants to navigate the process and ways the state makes decisions. Process redesign and a revision of criteria might make the process more equitable to organizations that lack the resources to gather the data, prepare the analysis, and afford legal representation to submit or defend an application.

Ensure Adequate and Equitable Financing for Certificate of Need

Mississippi relies only on application fees to fund its CON program. Peer states had more staff, general funds from the legislature, and more applications per year. Adequate funding of the program

could mean increasing funds or decreasing the services and facilities under CON review. In additions, Mississippi imposes costs on the applicant, and other states require applicants to reveal the total spending on the program. Collecting this information could help to determine if economically disadvantaged areas should be exempt from the process or costs subsidized so that they have equal consideration. This could be in the form of a grants program to offset costs to facilities that cannot cover legal fees both for applications and hearings that are focused on appeals.

Revise Formulas

Mississippi should review the criteria and formula in the State Health Plan report. The order of revision could be triangulated to the actual application data, meaning preference should be given to the areas where the most applications are submitted. Peer states have less complicated and more transparent formulas that are published and even have attached Excel templates and are based on criteria that extend beyond on population needs. The state could consider revising the formulas in the four most common areas of application. This process would require a data analyst or statistician. Application approval ratings that are in the high 90 percent also might infer that the formulas may not be as meaningful as possible. Respondents noted that organizations would not submit an application if they believed it would be rejected, but also said opposition tactics could be just as useful to reduce the state's control of supply.

NEXT STEPS

The Mississippi State Health Plan can evolve into a series of documents that are used by different people in a meaningful way. The Plan could be used to drive changes in the health system infrastructure, develop workforce policies, and target populations and areas of the greatest need. By using accurate data, the state can make more timely decisions on how to allocate resources and best practices to scale and scope. Finally, the State Health Plan is a valuable document to describe the Certificate of Need process and its projected needs. Given that the CON data show that resource allocation might be misaligned with need, the state should consider simplifying and adapting other states' approaches.

"If the CON is done correctly, it should direct services to areas where they are most needed. Right now, the SHP is strictly CON focused. If it were all encompassing maybe it could inform better decisions."

- *Respondent, Key Information Interviews.*