CONVICTING CON

DeCONstruction

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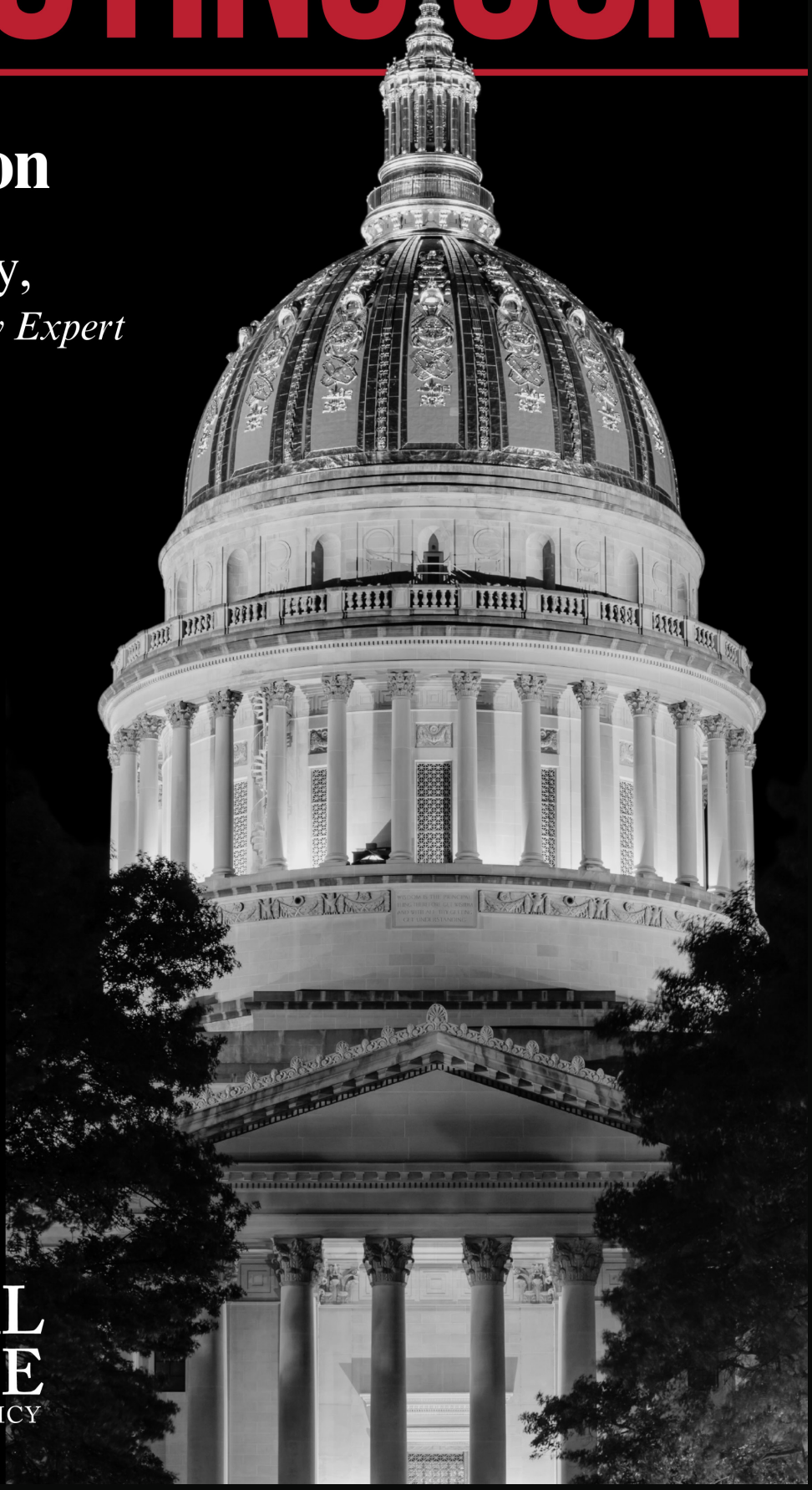

CARDINAL INSTITUTE
FOR WEST VIRGINIA POLICY

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BACKGROUND

The first edition of *Convicting CON*, authored by Jessica Dobrinsky, was published in January 2022. The following report, *Convicting CON: DeCONstruction,* is an updated version, incorporating new data, and offers a comprehensive analysis of the detrimental impact of West Virginia's Certificate of Need (CON) laws on rural communities, the foster care system, and the state's healthcare market.

AUTHOR

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Before assuming her current role, Jessica served as Cardinal's Policy Analyst and Staff Writer, specializing in healthcare policy. Her work has appeared in prominent outlets such as The Spectator, The Washington Examiner, Forbes, and Real Clear Markets. She also worked as a Columnist for a national magazine, offering insights into healthcare issues at both the state and national levels.

Jessica earned her Bachelor's degree in Criminology from West Virginia University in 2020. As an undergraduate, she was selected as a Judith A. Herndon Fellow in the West Virginia State Senate, where she conducted legislative research, assisted in bill drafting, and gained hands-on experience with committee operations and the legislative process.

Following her fellowship, Jessica worked as a Policy Analyst for the Department of Health and Human Resources, addressing critical issues such as homelessness, teen pregnancy, foster care, and Medicaid. That same year, she successfully managed a statewide campaign.

In 2021, Jessica completed her Master of Public Administration and Policy at American University, further enhancing her expertise in public service and policy development.

BLOCKED AT THE START: AN INTRODUCTION TO CERTIFICATE OF NEED

It's a snowy morning in West Virginia. As the crisp air of winter bites at your cheeks, you stand on the edge of an empty lot. Before you, the potential to build something that could change lives—a new medical facility or healthcare service. Your vision is clear: a place where families can receive care without traveling miles or waiting months for an appointment. But as you begin to take the first steps toward making that dream a reality, you quickly realize you're facing an unexpected barrier: a tangle of bureaucratic red tape. You ask what the cause could be and uncover the answer: **Certificate of Need**.

These laws, originally proposed to prevent unnecessary duplication of healthcare services, require that you—along with every other healthcare provider—ask for permission from the state before expanding, building, or offering healthcare services. Initially intended to protect resources, hoping to curb unnecessary duplication and ensure resources are allocated where they are most needed, CON laws have had the opposite effect. Instead of fostering growth, they stifle innovation and limit access to much-needed healthcare.

To move forward, you'll need to prove to a state regulatory board that your facility or service is truly necessary—a process that can be expensive, unpredictable, and time-consuming. Far from being based on the needs of the patients or the quality of care delivered, these decisions are often swayed by established competitors and bureaucratic interests, leaving the true beneficiaries—your community—stuck waiting. What was once a land of opportunity is now a landscape where growth and innovation are throttled, and the promise of better healthcare slips further away.

The intent behind Certificate of Need is often framed as a safeguard against the overexpansion of healthcare facilities, ensuring that resources are used efficiently. However, research has shown that the impact of CON laws is not as straightforward as proponents suggest.

Studies on CON laws highlight several key issues that emerge from their implementation. First, despite the restrictions on new providers entering the market, evidence suggests that these laws do not always lead to lower healthcare costs or better resource allocation. Instead, they often create barriers to entry for new healthcare providers, which can stifle innovation and delay access to critical services. Furthermore, the process of obtaining approval is frequently criticized for being opaque and influenced more by political and economic factors than by actual patient needs.

The following analysis examines the broader effects of CON laws, supported by recent research and case studies, to better understand how they shape the healthcare landscape in West Virginia.

PART ONE: CERTIFICATE OF NEED

A Barrier to Healthcare Innovation

As appealing as the idea of a more accessible healthcare future may be, the reality of navigating the Certificate of Need system presents significant challenges.

Certificate of Need (CON) laws were designed to regulate the growth of healthcare services, requiring healthcare providers to seek approval from state authorities before offering new services, building new facilities, or expanding existing practices.

Instituted in thirty-five states, these laws were meant to curb unnecessary duplication of healthcare services and ensure resources were allocated where they were needed most. However, they've had the opposite effect, stifling innovation and limiting access to healthcare.

Under the CON system, healthcare providers must demonstrate to a state regulatory board (i.e., the West Virginia Healthcare Authority) that there is a "true need" for the service or facility they wish to provide. Eager providers must reason the need for their business to function or expand in a lengthy application to determine eligibility. The process becomes long, expensive, and unpredictable, often leading to decisions based not on patient need, but on the concerns of established competitors and bureaucratic interests. Unlike familiar regulatory processes that examine quality standards of care and safety, CON only determines a need based on:

(1) the anticipated investments of a prospective provider, and
(2) possible commercial impact on existing regional providers

Healthcare markets that involve CON have made business decisions contingent on state bureaucrats who have the authority to consent to or deny service, making investments costly and risky. In the case of denial, in which boards are not required to indicate a reason, providers are forbidden from establishing or expanding any healthcare facility or service. The result is a healthcare landscape where innovation and competition are restricted, and where the individuals who would benefit the most from new healthcare options are left without them.

The Origins of Certificate of Need Laws.

The roots of CON laws trace back to 1964 when New York became the first state to adopt them. Proponents argued that these laws would control healthcare costs and prevent the overbuilding of healthcare facilities, ultimately ensuring that quality care was accessible to all. By the early 1970s, the federal government stepped in, incentivizing states to adopt CON laws by tying Medicaid and Medicare funding to their implementation. The National Health Planning and Resources Development Act of 1974 further bolstered these laws, providing federal funding for health planning and encouraging states to adopt regulatory mechanisms to control healthcare expansion.

The method by which hospitals were being reimbursed by Medicare was a contributing factor to ballooning healthcare costs. At the time, hospitals were reimbursed on a retrospective cost basis,[1] a reimbursement scheme sometimes referred to as a "cost plus basis" due to the embedded perverse incentives. In lay terms, whatever hospitals spent treating a patient was reliably reimbursed by Medicare. As such, there were slim incentives in

1 Guterman, Stuart, and Allen Dobson. "Impact of the Medicare Prospective Payment System for Hospitals." *Health Care Financing Review*, vol. 7, no. 3, Spring 1986, pp. 97–114. PubMed Central, https://pmc.ncbi.nlm.nih.gov/articles/PMC4191526/.

place to control costs over the course of patient's care. The more a hospital could bill Medicare for, the more it could expect to receive in reimbursements.

As Congress recognized the problems associated with the retrospective cost basis reimbursement in Medicare, it crafted legislation to address the problem and better align incentives for controlling costs. This was ultimately addressed in P.L. 98-21, the Social Security Amendments Act of 1983 which implemented a prospective cost reimbursement scheme to Medicare that incentivized hospitals to control costs in providing care.[2]

At its peak, 49 states had some form of CON regulation, with federal funding driving the push for more oversight. However, by 1987, Congress recognized that the promise of CON laws—namely, reducing costs and improving access—had not been realized. In a 2004 joint report from the Department of Justice and Federal Trade Commission, they declared "CON programs can pose serious competitive concerns that generally outweigh CON programs' purported economic benefits."[3] Since federal support has disappeared, the regulation was largely dismantled, though some states, like West Virginia, chose to continue with their CON regulations, even as other states moved to repeal or scale them back.

Free-Market Debate: Is Healthcare an Exception?

The controversy surrounding CON laws is closely tied to a larger debate about the role of free market principles in healthcare. In his seminal 1963 paper, *Uncertainty and the Welfare Economics of Medical Care*, economist Kenneth Arrow argued that healthcare differs fundamentally from other industries due to its inherent uncertainty. Unlike traditional markets, where consumers make informed choices, healthcare decisions are often dictated by physicians, with patients unable to predict their needs or assess costs. This uncertainty, Arrow posited, justifies government intervention to ensure equitable access to care.

Critics of Arrow's view counter that healthcare is not fundamentally different from other markets.

They argue that government interventions, such as CON laws, often exacerbate the issues they aim to address. By limiting competition and creating regulatory barriers, these laws can drive up costs and restrict access, particularly for vulnerable populations.

Advocates of market-based solutions contend that competition and consumer choice are more effective in fostering innovation and reducing costs.

Arrow's arguments remain central to contemporary healthcare debates, underpinning the case for government regulation to address information asymmetries and price uncertainty. However, empirical analyses of the U.S. healthcare system suggest that such regulations may have unintended consequences, raising questions about their efficacy in achieving equitable and efficient care.

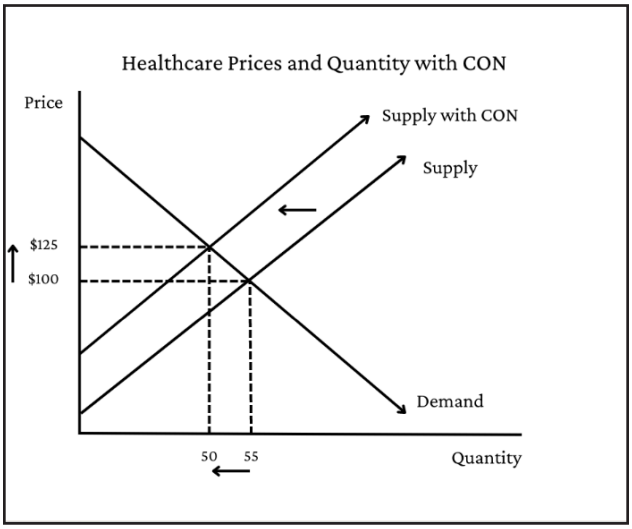
While uncertainties and asymmetric information are present in healthcare markets, the fundamental principles of supply and demand persist. Consumers demand greater quantities of a good or service as prices fall. Suppliers provide greater quantities of a good or service as the price they can sell their wares to consumers in the market rises. In graphical representations, these correspond to different points along a given supply or demand curve without altering the curve itself and only represent changes in prices.

2 **United States, Social Security Administration.** "Compilation of the Social Security Laws." *Title 42—The Public Health and Welfare, Chapter 7—Social Security Act.* https://www.ssa.gov/OP_Home/comp2/F098-021.html.

3 Federal Trade Commission and Department of Justice. *Improving Health Care: A Dose of Competition.* 2004, https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf.

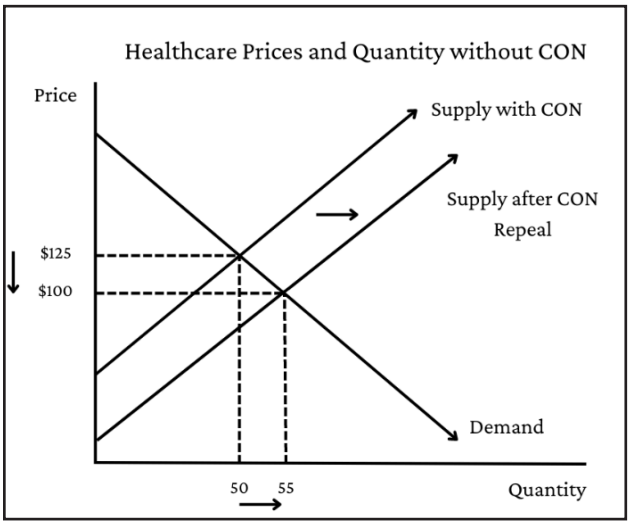
Overall demand shifts occur due to changes in consumer income, the number of consumers, the price of a related good, expectations, consumer tastes and preferences, and demographic changes. Correspondingly, supply shifts occur due to factors such as changes in taxes, production costs, technology, elements of nature, or political disruptions. Graphically, these shift the entire demand or supply curve to the left or the right depending on the nature of the changes.

The imposition of CON laws causes a shift in supply. More precisely, CON laws decrease the supply of healthcare through regulation.

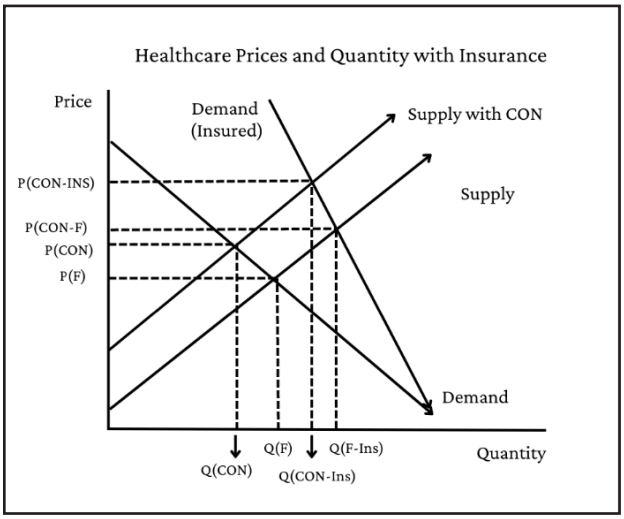


The diagram above demonstrates the impact of CON. These laws decrease the total supply of healthcare services available, results in higher prices for healthcare services, and decrease the quantity of services consumed by individuals living in areas subject to these laws.

Conversely, the diagram below demonstrates the broad market effect of removing the supply restrictions imposed by CON laws. In this instance, removing CON results in an increase in the total supply of healthcare services available, lowers prices of those services, and increases the quantities of services consumed by individuals living in areas without CON laws. In a state like West Virginia, with a high number of services currently constrained by these regulations, this graph highlights how eliminating CON will lead to a greater number of healthcare providers and more affordable services.



With the inclusion of health insurance in the equation, supply restrictions enforced by CON regulations produce similar effects. Regardless of whether an individual is insured or not, CON laws remain restrictive on the supply of healthcare services available to consumers in the market. While the effects may be blunted for those with coverage, CON laws still clearly limit the healthcare market, reducing the availability and affordability of health services.



Certificate of Need's Hidden Costs

Kenneth Arrow's study was published just before CON practices were implemented nationwide. It was certainly no coincidence that entities began to believe price competition deteriorated healthcare quality. Thus, CON laws were enacted under the assumption that limiting the number of healthcare providers would prevent the wasteful duplication of services and reduce overall healthcare costs. However, research shows that in states with CON laws, healthcare costs are actually higher. A study from The Kaiser Family Foundation revealed that healthcare spending in CON states is 11% higher[4] than in states without such regulations. Moreover, CON laws reduce the number of hospital beds available (131 fewer per 100,000) to the public, leading to higher mortality rates and poorer health outcomes.

For example, studies have shown that states without CON laws have a greater number of hospitals per capita, better access to medical technologies like MRI and CT scans, and generally lower mortality rates for common conditions such as heart attacks and pneumonia. Specifically, the Mercatus Center at George Mason University discovered a mortality rate 5.5% higher[5] in CON states.

The Federal Trade Commission (FTC) and the Department of Justice (DOJ) have both called for the repeal of CON laws, citing evidence that these regulations stifle competition, misallocate resources, and ultimately harm patients. In a 2016 report, the two agreed that:

"it is apparent that CON laws can prevent the efficient functioning of health care markets… By interfering with the market forces that normally determine the supply of facilities and services, CON laws can suppress supply, misallocate resources, and shield incumbent health care providers from competition from new entrants.[6]"

4 **"Health Care Expenditures per Capita by State of Residence."** *KFF*, 19 June 2017, www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D.

5 Stratmann, Thomas, and David Wille. "Certificate-of-Need Laws and Hospital Quality." *Mercatus Center*, 22 Sept. 2020, www.mercatus.org/publications/corporate-welfare/certificate-need-laws-and-hospital-quality.

6 **United States Federal Trade Commission and Department of Justice.** *Joint Statement of the FTC and the Antitrust Division of the U.S. DOJ on Certificate-of-Need Laws and South Carolina House Bill 3250*. Jan. 2016, www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice.

Since the Reagan Administration, every presidential administration has called on states to repeal their CON laws.

Incumbent Providers and Bureaucrats

One of the most concerning aspects of CON laws is the way they empower incumbent healthcare providers, consolidating control over a market. When a new healthcare facility or service is proposed, competitors can intervene in the regulatory process, arguing that the new provider would harm their business. This level of resistance creates a prolonged debate resembling legal proceedings, where aspiring market entrants may feel pressured to withdraw their applications or agree not to infringe upon the incumbent's claimed space. Such activity, which would typically violate the Sherman Antitrust Act, is only permissible due to state facilitation.

Moreover, the regulatory formula used to assess "need" examines the utilization of existing health services: if the share of bed utilization is low, CON regulators may determine no new business offering beds are needed. Yet, this incentivizes incumbents to keep beds unoccupied to encourage further application rejection in the CON process.[7]

CON leaves community doctors at the mercy of large systems, facing unfavorable schedules and bureaucratic delays, while patients suffer the consequences: **longer waits, higher bills, and fewer options.** Rather than fostering competition, CON laws protect existing monopolies and prevent new providers from offering innovative solutions that could benefit patients.

The Impact of CON Laws on Rural Healthcare

In states like West Virginia, CON laws are particularly harmful because they limit the availability of healthcare in rural areas.

West Virginia already faces a severe shortage of healthcare providers, and the state's high rates of chronic diseases such as obesity, heart disease, and diabetes make access to care even more critical.[8] Yet, despite these challenges, the state has clung to its CON laws, arguing that they are necessary to preserve rural healthcare services. The idea is that by limiting competition, existing hospitals will remain financially viable and continue to provide care in these underserved areas.

However, research suggests that this reasoning is flawed. States without CON laws actually have more rural hospitals and ambulatory surgical centers (ASC). Research from the Cato Institute examined six states that repealed ASC CON laws between 1991 and 2019, observing a 44–47% increase in ASCs statewide, with a notable 92–112% increase in rural areas.[9] Several studies also highlight that CON laws contribute to longer wait times[10], greater travel distances[11], and increased reliance on out-of-state care[12], all of which exacerbate challenges in accessing timely, life-saving healthcare. The idea that CON laws protect rural healthcare by restricting competition is not supported by evidence.

7 Mitchell, M. D. "Certificate of Need Laws in Health Care: Past, Present, and Future." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, vol. 61, 2024, doi:10.1177/00469580241251937.

8 Baker, Matthew C., and Thomas Stratmann. "Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws." *Socio-Economic Planning Sciences*, vol. 77, 2021, 101007, https://doi.org/10.1016/j.seps.2020.101007.

9 *Cato Institute*. "Certificate of Need and Ambulatory Surgical Centers." *Cato Regulation*, Fall 2024, www.cato.org/regulation/fall-2024/con-ambulatory-surgical-centers.

10 Myers, M., and K. Sheehan. "The Impact of Certificate of Need Laws on Emergency Department Wait Times." *Journal of Private Enterprise*, vol. 35, no. 1, 2020, pp. 59-75.

11 Carlson, M. D., E. H. Bradley, Q. Du, and R. S. Morrison. "Geographic Access to Hospice in the United States." *Journal of Palliative Medicine*, vol. 13, no. 11, 2010, pp. 1331-1338.

12 Baker, Matthew C., and Thomas Stratmann. "Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws." *Socio-Economic Planning Sciences*, vol. 77, 2021, https://doi.org/10.1016/j.seps.2020.101007.

The Myth of Rural Health Protection

Proponents of CON laws "for the sake of" rural areas argue that competition could lead to hospital closures, particularly in smaller communities. However, evidence shows that states without CON laws do not experience widespread closures of rural hospitals. In fact, the Mercatus Center's research found that rural areas in states without CON regulations have a greater number of community hospitals and access to outpatient surgical centers.[13]

The real problem facing rural healthcare is not over-competition but the failure of a system that limits access to new providers and services.

The Economic Inefficiencies of Certificate of Need

Economic theory tells us that when competition is restricted, prices rise, and quality suffers. By artificially limiting the supply of healthcare services, CON laws create monopolies that drive up costs and reduce access. Studies have found that states with CON laws have higher per-unit healthcare costs and greater overall spending.[14] These inefficiencies can be attributed to the lack of competition and the regulatory burden that limits the expansion of services.

Researchers have found[15]:

- **10% higher variable costs in acute hospitals[16] associated with CON**, likely due to the restricted ability to expand or improve services without regulatory approval.
- **5.5% lower hospital charges[17] after state CON repeal**, demonstrating the downward pressure on prices when competition is increased.
- **An increase in the cost of Medicaid for home health services in CON states**,[18] likely stemming from the limited availability of care providers, which drives up service costs.
- **Out of 52 empirical studies, 44% link CON to increased overall spending**:[19]
    - Hospital expenditures per capita are 20.6% greater[20] in CON states, a result of reduced competition and the market inefficiencies introduced by the laws.
    - Nursing homed CONs are linked to increased expenditures per resident,[21] showing that limiting the number of facilities leads to higher costs per individual in those facilities.

13 Stratmann, Thomas, and Christopher Koopman. "Entry Regulation and Rural Health Care." *Mercatus Center*, 2021, www.mercatus.org/publications/entry-regulation-rural-health-care.

14 Mitchell, Matthew D. "Do Certificate-of-Need Laws Limit Spending?" *Mercatus Center*, Sept. 2016, www.mercatus.org/system/files/mercatus-mitchell-con-healthcare-spending-v1a.pdf.

15 Mitchell, M. D. "Certificate of Need Laws in Health Care: Past, Present, and Future." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, vol. 61, 2024, doi:10.1177/00469580241251937.

16 Anderson, K. B. "Regulation, Market Structure, and Hospital Costs: Comment." *Southern Economic Journal*, vol. 58, no. 2, 1991, pp. 528-534.

17 Bailey, J. "Can Health Spending Be Reined In through Supply Constraints? An Evaluation of Certificate-of-Need Laws." *Mercatus Center at George Mason University*, 2016, www.mercatus.org/publications/certificate-need/can-health-spending-be-reined-through-supply-constraints-evaluation.

18 Custer, W., P. Ketscche, B. Sherman, et al. "Report of Data Analyses to the Georgia Commission on the Efficacy of the CON Program." *Georgia State University Andrew Young School of Policy Studies*, Nov. 2006, www.academia.edu/81395977/Report_of_Data_Analyses_to_the_Georgia_Commission_on_the_Efficacy_of_the_CON_Program.

19 Mitchell, M. "Certificate of Need Laws in Health Care: A Comprehensive Review of the Literature." *Southern Economic Journal*, forthcoming.

20 Rivers, P. A., M. D. Fottler, and M. Z. Younis. "Does Certificate of Need Really Contain Hospital Costs in the United States?" *Health Education Journal*, vol. 66, no. 3, 2007, pp. 229-244.

21 Ettner, S. L., J. S. Zinn, H. Xu, et al. "Certificate of Need and the Cost of Competition in Home Healthcare Markets." *Home Health Care Services Quarterly*, vol. 39, no. 2, 2020, pp. 51-64.

The Failure to Achieve Quality and Quantity Goals

Quality

Proponents of CON laws argue that they promote quality by ensuring that only the best providers are allowed to expand. **However, evidence does not support this claim:**

- **Hospitals in non-CON states often perform better in quality metrics, including mortality rates for heart attack, heart failure,[22] and pneumonia.[23]**

- **West Virginia's CON application process does not address quality measures related to facilities or providers.**

- **Patients in CON states face worse outcomes for specific conditions**:
  - Pneumonia and heart failure mortality rates are estimated to be 1.7 to 3.2% higher.[24]
  - Hospitals in CON states average six more deaths per 1,000 surgical discharges with complications.[25]
  - Higher mortality risks for conditions such as septicemia, diabetes, Alzheimer's, and COVID-19.[26]
  - Increased physical force incidents in nursing homes.[27]

Quantity

The impact of CON laws on healthcare access is significant, reducing available resources:

- **190 studies evaluated CON's effect on access**:[28]
  - 52% linked CON to reduced access.
  - 38% showed minimal impact.
  - 10% associated it with improved access.

- **Patients in CON states experience:**
  - 30% to 48% fewer hospitals overall.[29]
  - 30% fewer rural hospitals and 13% fewer rural ambulatory surgery centers.[30]
  - 25% fewer open-heart surgery programs.[31]
  - 20% fewer psychiatric care facilities.[32]
  - Fewer dialysis clinics and reduced capacity.[33]
  - Fewer imaging devices.[34]

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22 Chiu, K. "The Impact of Certificate of Need Laws on Heart Attack Mortality: Evidence from County Borders." *Journal of Health Economics*, vol. 79, 2021, 102518, https://doi.org/10.1016/j.jhealeco.2021.102518.

23 Stratmann, T. "The Effects of Certificate-of-Need Laws on the Quality of Hospital Medical Services." *Journal of Risk and Financial Management*, vol. 15, no. 6, 2022, 272.

24 Stratmann, T. "The Effects of Certificate-of-Need Laws on the Quality of Hospital Medical Services." *Journal of Risk and Financial Management*, vol. 15, no. 6, 2022, 272.

25 Stratmann, T. "The Effects of Certificate-of-Need Laws on the Quality of Hospital Medical Services." *Journal of Risk and Financial Management*, vol. 15, no. 6, 2022, 272.

26 Roy Choudhury, A., S. Ghosh, and A. Plemmons. "Certificate of Need Laws and Health Care Use During the COVID-19 Pandemic." *Journal of Risk and Financial Management*, vol. 15, no. 2, 2022, 76, https://doi.org/10.3390/jrfm15020076.

27 Zinn, J. S. "Market Competition and the Quality of Nursing Home Care." *Journal of Health Politics, Policy and Law*, vol. 19, no. 3, 1994, pp. 555-582.

28 Mitchell, M. D. "Certificate of Need Laws in Health Care: Past, Present, and Future." *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, vol. 61, 2024, doi:10.1177/00469580241251937.

29 Stratmann, T., and C. Koopman. "Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community." *Mercatus Center at George Mason University*, 2016, www.mercatus.org/research/working-papers/entry-regulation-and-rural-health-care-certificate-need-laws-ambulatory

30 Stratmann, T., and C. Koopman. "Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community." *Mercatus Center at George Mason University*, 2016, www.mercatus.org/research/working-papers/entry-regulation-and-rural-health-care-certificate-need-laws-ambulatory.

31 Robinson, J. L., D. B. Nash, E. Moxey, and J. P. O'Connor. "Certificate of Need and the Quality of Cardiac Surgery." *American Journal of Medical Quality*, vol. 16, no. 5, 2001, pp. 155-160.

32 Bailey, J., and E. Lewin. "Certificate of Need and Inpatient Psychiatric Services." *Journal of Health Economics*, vol. 24, no. 4, 2021, pp. 117-124.

33 Ford, J. M., and D. L. Kaserman. "Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry." *Southern Economic Journal*, vol. 59, no. 4, 1993, pp. 783-791.

34 Stratmann, T., and J. Russ. "Do Certificate-of-Need Laws Increase Indigent Care?" *Mercatus Center at George Mason University*, 2014, www.mercatus.org/students/research/working-papers/do-certificate-need-laws-increase-indigent-care.

Racial Disparity and Underserved Populations

CON architects thought this regulation could redirect healthcare resources to underserved populations, but evidence has shown CON hasn't achieved this objective—No study has found that CON improves care for underserved populations.[35]

Findings among the studies conclude that CON states:

- **Are less likely to accept Medicaid patients at substance use treatment centers[36]**
- **Are more likely to make uninsured patients pay out of pocket[37]**

Racial disparities in healthcare access are another important consideration. In many CON states, minority communities face significant barriers to care, and these disparities are exacerbated by restrictive laws that limit access to services. For example, a study in New Jersey showed that removing CON restrictions on cardiac catheterization services led to improved access and eliminated racial disparities in care.[38] Removing regulatory barriers can lead to more equitable healthcare outcomes, especially for underserved populations.

35 Mitchell, M. "Certificate of Need Laws in Health Care: A Comprehensive Review of the Literature." *Southern Economic Journal*, forthcoming.
36 Bailey, J., T. Lu, and P. Vogt. "Certificate-of-Need Laws and Substance Use Treatment." *Substance Abuse Treatment, Prevention, and Policy*, vol. 17, 2022, https://doi.org/10.1186/s13011-022-00491-2.
37 Custer, W., P. Ketscche, B. Sherman, et al. "Report of Data Analyses to the Georgia Commission on the Efficacy of the CON Program." *Georgia State University Andrew Young School of Policy Studies*, Nov. 2006, www.academia.edu/81395977/Report_of_Data_Analyses_to_the_Georgia_Commission_on_the_Efficacy_of_the_CON_Program.
38 DeLia, Derek, et al. "Effects of Regulation and Competition on Health Care Disparities: The Case of Cardiac Angiography in New Jersey." *Journal of Health Politics, Policy and Law*, vol. 34, no. 1, 2009, pp. 63-91, https://doi.org/10.1215/03616878-2008-992.

PART TWO: WEST VIRGINIA'S STRUGGLE WITH CON

A State in Crisis

West Virginia suffers from some of the worst health outcomes in the country. The state's high rates of obesity, heart disease, and chronic illness are compounded by limited access to healthcare services. Despite these challenges, West Virginia has continued to rely on its CON laws, even as neighboring states have moved away from them. West Virginians are unable to access the care they need, and the state's healthcare infrastructure is in dire need of reform.

The Real Impact of Certificate of Need Laws on West Virginia

According to *West Virginia State Code*. Chapter 16, Article 2D, the following health services may not be acquired, offered, or developed within West Virginia until approval of and receipt of a certificate of need is granted:

- The construction, development, acquisition, or other establishment of a health care facility
- The partial or total closure of a health care facility with which a capital expenditure is associated
- An obligation for a capital expenditure incurred by or on behalf of a health care facility in excess of the expenditure minimum; or
    - An obligation for a capital expenditure incurred by a person to acquire a health care facility.
- An obligation for a capital expenditure is considered to be incurred by or on behalf of a health care facility:
    - When a valid contract is entered into by or on behalf of the health care facility for the construction, acquisition, lease, or financing of a capital asset
    - When the health care facility takes formal action to commit its own funds for a construction project undertaken by the health care facility as its own contractor; or
    - In the case of donated property, on the date on which the gift is completed under state law.
- A substantial change to the bed capacity of a health care facility with which a capital expenditure is associated
- The addition of ventilator services by a hospital
- The elimination of health services previously offered on a regular basis by or on behalf of a health care facility which is associated with a capital expenditure
- A substantial change to the bed capacity or health services offered by or on behalf of a health care facility, whether or not the change is associated with a proposed capital expenditure
    - If the change is associated with a previous capital expenditure for which a certificate of need was issued; and
    - If the change will occur within two years after the date the activity which was associated with the previously approved capital expenditure was undertaken.
- The acquisition of major medical equipment
- A substantial change in an approved health service for which a certificate of need is in effect
- An expansion of the service area for hospice or home health agency regardless of the time period in which the expansion is contemplated or made; and
- The addition of health services offered by or on behalf of a health care facility which were not offered on a regular basis by or on behalf of the health care facility within the 12-month period prior to the time the services would be offered.

- The following health services are required to obtain a certificate of need regardless of the minimum expenditure:
    - Providing radiation therapy
    - Providing computed tomography
    - Providing positron emission tomography
    - Providing cardiac surgery
    - Providing fixed magnetic resonance imaging
    - Providing comprehensive medical rehabilitation
    - Establishing an ambulatory care center
    - Establishing an ambulatory surgical center
    - Providing diagnostic imaging
    - Providing cardiac catheterization services
    - Constructing, developing, acquiring, or establishing kidney disease treatment centers, including freestanding hemodialysis units
    - Providing megavoltage radiation therapy
    - Providing surgical services
    - Establishing operating rooms
    - Adding acute care beds
    - Providing intellectual developmental disabilities services
    - Providing organ and tissue transplants
    - Establishing an intermediate care facility for individuals with intellectual disabilities
    - Providing inpatient services
    - Providing hospice services
    - Establishing a home health agency
    - Providing personal care services; and
    - Establishing no more than six four-bed transitional intermediate care facilities: *Provided*, That none of the four-bed sites shall be within five miles of another or adjacent to another behavioral health facility. This subdivision terminates upon the approval of the sixth four-bed intermediate care facility.
        - Only individuals living in more restrictive institutional settings, in similar settings covered by state-only dollars, or at risk of being institutionalized will be given the choice to move, and they will be placed on the Individuals with Intellectual and Developmental Disabilities (IDD) Waiver Managed Enrollment List. Individuals already on the IDD Waiver Managed Enrollment List who live in a hospital or are in an out-of-state placement will continue to progress toward home- and community-based waiver status and will also be considered for all other community-based options, including, but not limited to, specialized family care and personal care.
        - The department shall work to find the most integrated placement based upon an individualized assessment. Individuals already on the IDD waiver will not be considered for placement in the 24 new intermediate care beds.
        - A monitoring committee of not more than 10 members, including a designee of Mountain State Justice, a designee of Disability Rights of West Virginia, a designee of the Statewide Independent Living Council, two members or family of members of the IDD waiver, the Developmental Disabilities Council, the Commissioner of the Bureau of Health and Health Facilities, the Commissioner of the Bureau for Medical Services, and the Commissioner of the Bureau for Children and Families. The secretary of the department shall chair the first meeting of the committee at which time the members shall elect a chairperson. The monitoring committee shall provide guidance on the department's transitional plans for residents in the 24 intermediate care facility beds and monitor progress toward home- and community-based waiver status and/or utilizing other community-based

options and securing the most integrated setting for each individual.
- Any savings resulting from individuals moving from more expensive institutional care or out-of-state placements shall be reinvested into home- and community-based services for individuals with intellectual developmental disabilities.

CON solicitation is not straightforward; those who seek to provide care must follow strict guidelines outlined in State Code to make the case to start or expand their business.

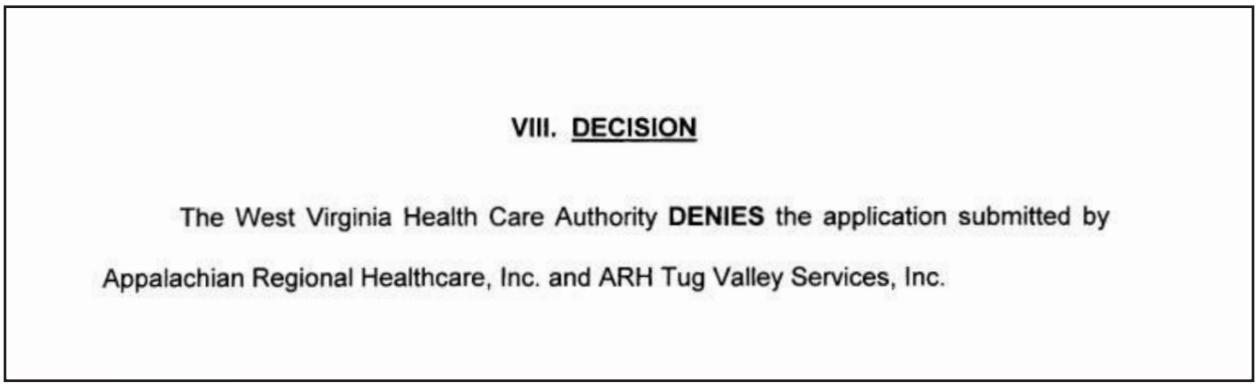
Providers who desire to offer a CON-regulated service must first file a "Letter of Intent" 10 days before submitting their completed application to the West Virginia Health Care Authority (HCA)[39]The letter must contain "sufficient information to advise the Board of the nature, scope, cost and timing of the project, as well as the location and name of the proposed applicant."[40] It is habitually unclear what is considered "sufficient information."

Once a "Letter of Intent" is offered to the HCA, an application must be delivered[41] with a fee based on expected capital expenditure[42]:

- Expenditures up to $1,500,000 a fee of $1,500
- Expenditures from $1,500,001 to $5,000,000 a fee of $5,000
- Expenditures from $5,000,001 to $25,000,000 a fee of $25,000
- Expenditures from $25,000,001 and above a fee of $35,000

W. Va. Code §16-2D-2(15) also stipulates a catch-all CON that requires expenditure minimums of $100,000,000 to obtain their certificate[43].

It is striking to notice that denied applications fail to specify the points for denial:



VIII. DECISION

The West Virginia Health Care Authority **DENIES** the application submitted by

Appalachian Regional Healthcare, Inc. and ARH Tug Valley Services, Inc.

Certificate of Need Decision for Appalachian Regional Healthcare, Inc. (2015)

West Virginia's continued reliance on CON laws has created significant barriers to healthcare access. While the state's lawmakers argue that these laws protect rural healthcare, the evidence suggests otherwise. Research shows that states without CON regulations have more and better access to care. By clinging to its CON laws, West Virginia is effectively limiting the availability of healthcare services, particularly in underserved regions.

39 *West Virginia Code of State Regulations*. § 65-32-8.
40 *West Virginia Code of State Regulations*. § 65-32-8.
41 *West Virginia Code of State Regulations*. § 65-32-8.
42 *West Virginia State Code*. § 16-2D-13(b)(2).
43 *West Virginia Code*. § 16-2D-2(15). "Expenditure minimum" means the cost of acquisition, improvement, or expansion of any facility, equipment, or services, including the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting, at and above $5 million.

Opioid Treatment

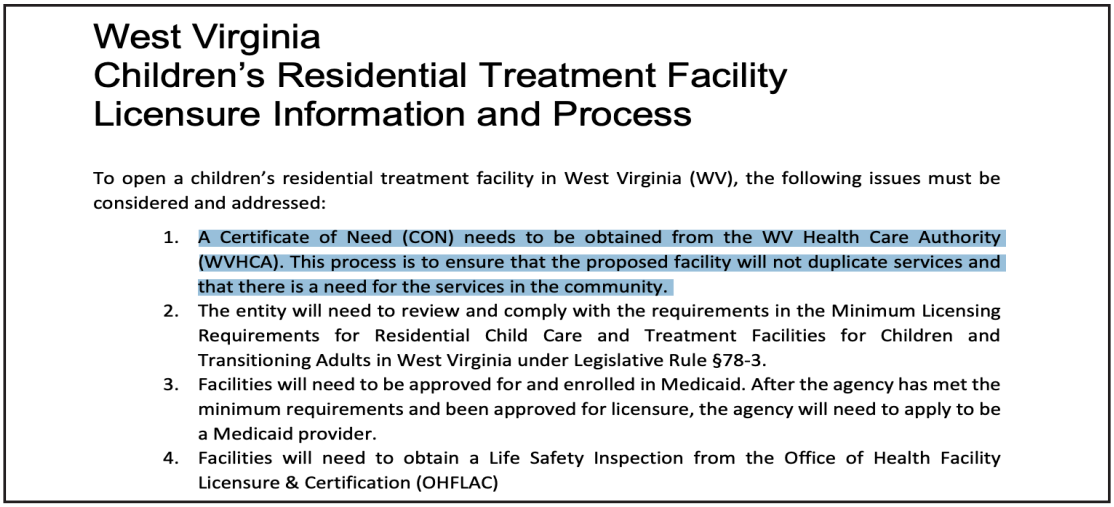
W. Va. Code § 16-2D-11(b)(8) provides for a concerning number of statutory bases for prohibiting new opioid treatment programs and facilities. Effective June 10, 2016, the legislature enacted a moratorium on CON regarding the licensure of new opioid treatment.[44] Said differently, no new opioid treatment centers may be established unless they acquired a CON prior to June 10, 2016.[45]

W. Va. Code § 16-2D-9, or "Health services that cannot be developed," establishes moratoriums on CON issuance for five services including opioid treatment programs (OTP). (Notably, OTPs are the sole facilities that can provide all three FDA approved medications for opioid use disorder.) This odd restriction at the epicenter of the drug epidemic, is the most restrictive laws in the nation when it comes to methadone regulation, considered the gold standard when treating addiction. This has prevented any new OTP provider from opening in the state since 2016.

Foster Care

Directives from the West Virginia Bureau for Social Services explain[46] that those who seek to open a "Residential Child Care" and/or "Child Placing Agency" must receive a CON[47]. According to the Bureau[48]:

- **Child Placing Agency:** Means a child welfare agency organized for the purpose of placing children in private family homes for foster care or for adoption. The function of a child placing agency may include the investigation and certification of foster family homes and foster family group homes as provided in this chapter. The function of a child placing agency may also include the supervision of children who are sixteen or seventeen years old and living in unlicensed residences.
- **Residential Child Care:** Means childcare which includes the provision of nighttime shelter and the personal discipline and supervision of a child by guardians, custodians or other persons or entities on a continuing or temporary basis



West Virginia
Children's Residential Treatment Facility
Licensure Information and Process

To open a children's residential treatment facility in West Virginia (WV), the following issues must be considered and addressed:

1. A Certificate of Need (CON) needs to be obtained from the WV Health Care Authority (WVHCA). This process is to ensure that the proposed facility will not duplicate services and that there is a need for the services in the community.
2. The entity will need to review and comply with the requirements in the Minimum Licensing Requirements for Residential Child Care and Treatment Facilities for Children and Transitioning Adults in West Virginia under Legislative Rule §78-3.
3. Facilities will need to be approved for and enrolled in Medicaid. After the agency has met the minimum requirements and been approved for licensure, the agency will need to apply to be a Medicaid provider.
4. Facilities will need to obtain a Life Safety Inspection from the Office of Health Facility Licensure & Certification (OHFLAC)

Source: West Virginia Department of Human Services, Bureau for Social Services Licensing Agency

44 *West Virginia State Code*. § 16-5Y-12.
45 *West Virginia State Code*. § 16-5Y-12.
46 *West Virginia Department of Health and Human Resources*. "West Virginia Children's Residential Treatment Facility Licensure Process 2024." *West Virginia Department of Health and Human Resources*, 2024, dhhr.wv.gov/bss/policy/Documents/WV%20Children%27s%20Residential%20Treatment%20Facility%20Licensure%20Process%202024.pdf.
47 *West Virginia Department of Health and Human Resources*. "Licensing Agency." *West Virginia Department of Health and Human Resources*, www.dhhr.wv.gov/bss/services/Pages/Licensing-Agency.aspx.
48 *West Virginia Department of Health and Human Resources*. "Licensing Definitions and Demographics." *West Virginia Department of Health and Human Resources*, dhhr.wv.gov/bss/policy/Documents/Licensing_definitions_and_demographics.pdf.

There may be permissible exceptions for this requirement, but only if: "A behavioral health service selected by the Department of Human Services in response to its request for application for services intended to return children currently placed in out-of-state facilities to the state or to prevent placement of children in out-of-state facilities is not subject to a certificate of need[49]" or "A person providing specialized foster care personal care services to one individual and those services are delivered in the provider's home[50]."

The requirement for a CON to open these facilities or agencies creates significant barriers for organizations that aim to address the needs of vulnerable children in foster care—a system crying for help in West Virginia. By imposing additional administrative hurdles, the current system restricts the availability of essential services while workers and families are left with limited resources. While exceptions exist, they are narrowly defined and insufficient to meet the broader needs of the foster care population.

Repealing the CON would encourage more organizations to participate in providing critical foster care services, ultimately ensuring better outcomes for children and reducing the reliance on out-of-state placements and supporting the well-being of West Virginia's most at-risk youth.

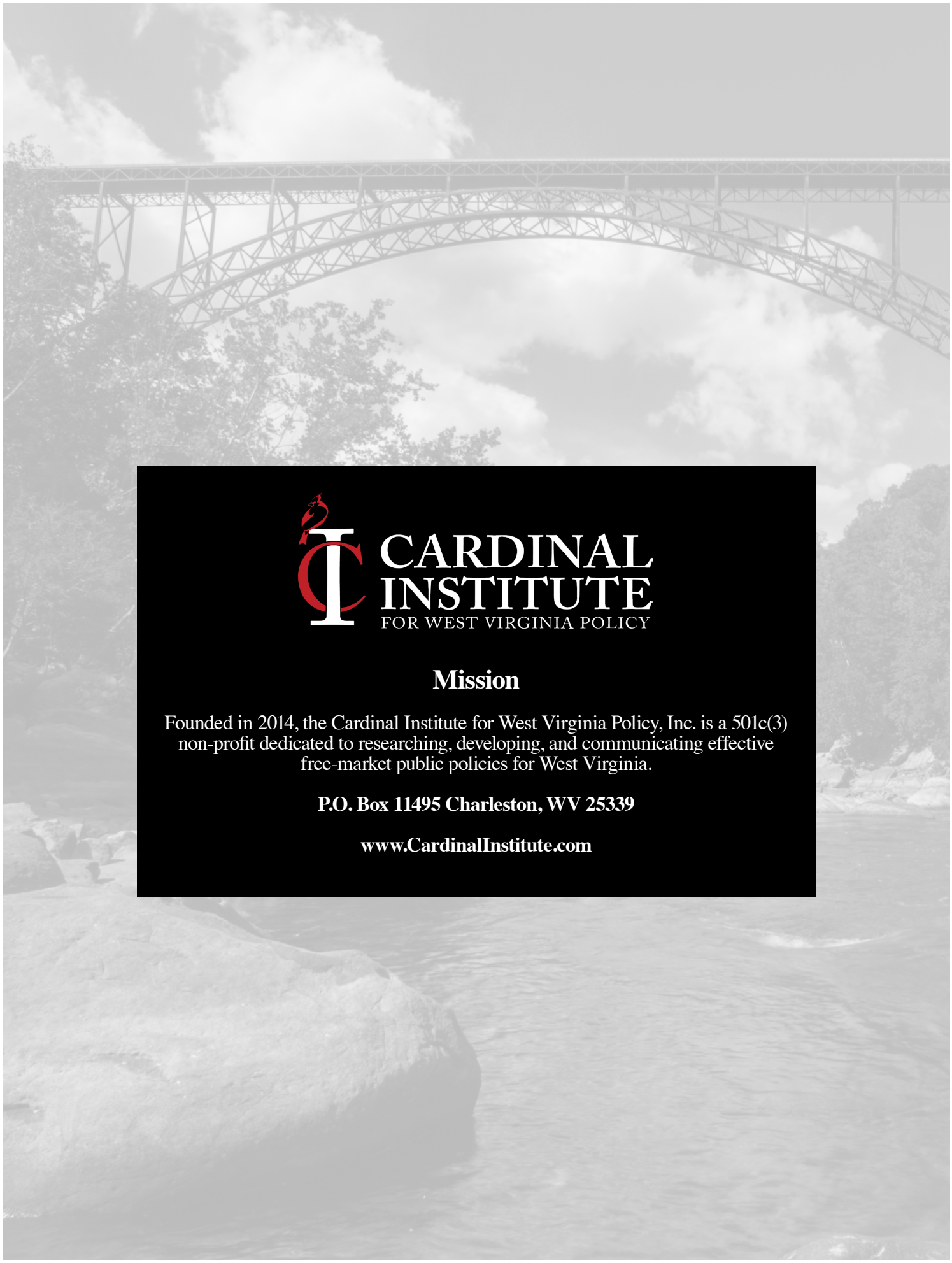
49 *West Virginia State Code*. § 16-2D-11(b)(7).
50 *West Virginia State Code*. § 16-2D-11(b)(12).

PART THREE: THE SOLUTION

Repeal Certificate of Need

The evidence is clear: **Certificate of Need laws are not achieving their intended goals.** Rather than reducing costs, improving access, or ensuring quality, CON stifles innovation, limits competition, and prevents the expansion of necessary healthcare services.

As states like West Virginia continue to struggle with healthcare shortages, particularly in rural areas, it is time to reconsider the reality surrounding effectiveness of these laws. Repealing CON laws will provide the freedom and flexibility necessary to address our state's healthcare crisis and ensure that all residents have access to the care they need.



CARDINAL INSTITUTE
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Mission

Founded in 2014, the Cardinal Institute for West Virginia Policy, Inc. is a 501c(3) non-profit dedicated to researching, developing, and communicating effective free-market public policies for West Virginia.

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