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Maryland's Certificate of Need Requirements

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Chair Pena-Melnyk, Vice-Chair Cullison and Distinguished Members of the Health and Government Operations Committee:

My name is Matthew Mitchell. I am an economist at the Knee Regulatory Research Center at West Virginia University and I have been studying Certificate of Need (CON) Laws in health care for over a decade. Today I plan to share with you some of what I have learned in that time. The evidence I share with you today is based on my own research as well as on that of others. I share it to help you make an informed decision. But as a researcher I do not take any formal position on legislation.

I will focus on the scientific study of CON and the approach to reform that others have taken in recent years.

1. The Economics of a CON Law

CON laws are intended to reduce costs, increase access (especially for vulnerable populations), and improve the quality of care. Neither economic theory nor decades of empirical research suggest that CON laws achieve any of these goals. In fact, the balance of evidence suggests that the regulatory regime drives up costs, limits access, and diminishes the quality of care. The case against CON is especially strong when it limits care in underserved areas or when it limits care for vulnerable populations such as those seeking psychiatric care or substance use treatment.

Standard economic theory tells us that a supply restriction such as CON will tend to limit supply relative to what it would otherwise be, raising the costs per unit and limiting the quantity and quality of care. These effects are likely exacerbated by the fact that CON laws have several anticompetitive features:

1. In most CON jurisdictions—including Maryland—the process empowers incumbent providers to challenge the applications of their would-be competitors.
2. Even without objecting to an application, existing providers can lower the odds that a competitor's CON will be granted by underutilizing their own resources. This is because health planning authorities are more likely to deny new applications if current utilization falls under a certain threshold.
3. Incumbents can also refuse to enter into transfer agreements with new providers, and these new providers will often be denied their own CONs without such agreements.
4. Statutory and regulatory language can also compel regulators to deny applications if a new service will "duplicate" (i.e., compete with) an existing service.

5. Finally, states often apply CONs in a discriminatory manner. In Maryland, for example, non-hospital providers must obtain CONs for expenditure above $6.2 million while hospitals only need to obtain CONs for expenditures over $12.4 million (Cavanaugh et al. 2020; *Md. Code Regs. § 10.24.01.02(A)(5)*. 2025).

By their nature, then, it seems that CON laws are unlikely to achieve their stated goals.

2. The Evidence

But we don't have to rely on theory alone. We can look to the real-world experience of Americans. About one-in-three live in a state with either limited or no CON regulation in health care. Many more live in states that have reformed or pared their CON programs back. Relying on this variation across time and across geography, researchers have spent decades comparing outcomes in CON and non-CON markets.

The scientific literature studying CON laws is voluminous. To date, there have been 146 academic peer-reviewed assessments of CON laws. Together, these papers contain 448 separate tests. I have recently reviewed this literature in a paper published in the *Southern Economic Journal* (Mitchell 2024).[1] Most tests find that CON laws undermine their stated goals. By a margin of 4-to-1, the regulation is associated with higher spending, less access, and diminished quality of care. The evidence is especially lopsided when it comes to spending per service (where the evidence is 9-to-1 against CON), availability of services (10-to-1 against CON), and care for underserved or vulnerable populations (where the evidence is unanimously against CON).

Among those tests assessing the effect of CON on spending, researchers find:

- Hospital charges in states without CON are 5.5% lower five years after repeal (Bailey 2016);
- In Ohio, reimbursements for coronary artery bypass grafts fell 2.8% following repeal of CON and in Pennsylvania, they fell 8.8% following repeal (Ho and Ku-Goto 2013);
- Acute care costs rise with the rigor of CON programs from the most resource-intense diagnoses (Custer et al. 2006);
- CON laws are associated with higher Medicaid costs for home health services (Custer et al. 2006);
- There is some evidence that CON is associated higher Medicaid long-term care costs (Custer et al. 2006); and
- Medicare reimbursement for total knee arthroplasty are 5 to 10 percent lower in non-CON states (Browne et al. 2018).

Among those tests assessing the effect of CON on access to care, researchers find:

- Patients in CON states have access to fewer dialysis clinics and reduced capacity at existing clinics (Ford and Kaserman 1993);
- Patients in CON states have access to 30 to 48% fewer hospitals (Stratmann and Koopman 2016; Eichmann and Santerre 2011);
- Patients in CON states have access to 30% fewer *rural* hospitals and 13% fewer *rural* ambulatory surgery centers (Stratmann and Koopman 2016);
- Patients in CON states have access to 25% fewer open-heart surgery programs (Robinson et al. 2001);
- Hospitals in CON states were more likely to run out of beds during COVID (Mitchell and Stratmann 2022); and

[1] In this testimony I am including a few additional papers that have been published since my review.

- Of particular interest to this committee at this time, patients in CON states have access to 20% fewer psychiatric care facilities (Bailey and Lewin 2021).

Among those tests assessing the effect of CON on quality of care, researcher find that in states with CON laws:

- Patients experience higher mortality rates for heart attack, heart failure, and pneumonia (Stratmann 2022; Chiu 2021);
- Patients have higher mortality rates for natural death, septicemia, diabetes, chronic lower respiratory disease, influenza/pneumonia, Alzheimer's, and COVID-19 (Roy Choudhury, Ghosh, and Plemmons 2022); and
- There are lower nursing staff-to-patient ratios and greater use of physical force in nursing homes (Zinn 1994).

Among those tests that assess the effect of CON on vulnerable and underserved populations, researchers find:

- A large black-white disparity in the use of angiography disappeared when the procedures were exempted from CON (Cantor et al. 2009; DeLia et al. 2009);
- There is no evidence of cross-subsidization and no evidence that CON laws increase charity care (Stratmann and Russ 2014; Stratmann, Bjoerkheim, and Koopman 2024);
- Safety-net hospitals in states without CON had higher margins than similar hospitals in states with the regulation (Dobson et al. 2007);
- Patients in CON counties bordering non-CON counties have 10% less access to substance use care (Shakya and Bretschneider-Fries 2024);
- Patients in states that require CONs for substance use treatment facilities have higher rates of ER visits and are more likely to have infants born with neonatal abstinence syndrome (Plemmons, Deyo, and Drain 2024); and
- There is no evidence of "cream skimming." That is, when CON is repealed, the entry of new ASCs does not seem to lead to the closure of rural hospitals. In fact, there is evidence that rural hospital closures are less common in repealing states. (Stratmann, Bjoerkheim, and Koopman 2024).

3. Options for Reform

The balance of evidence suggests that without CON laws, Marylanders would have greater access to lower cost and higher quality care and that these effects would be especially valuable to vulnerable populations. But short of full repeal, the state has plenty of other options, including:

- Elimination of CONs such as psychiatric care and substance use care that limit services for vulnerable populations;
- Phased repeal of all CONs, with longer phase-outs for expensive capital purchases that might require longer cost-recovery times;
- Elimination of CONs that limit low-cost alternatives to care such as ambulatory surgical care, hospice care, and home health care;
- Elimination of CONs for procedures that are unlikely to be overprescribed such as burn care, substance use care, and neonatal intensive care;
- Raising the threshold of capital expenditures that trigger a CON;
- Equalizing thresholds between hospital and non-hospital providers;
- Altering the standards for assessing need by, for example, allowing services that duplicate existing services;
- Barring competitors from taking part in the process (as Indiana, Louisiana, Michigan, Nebraska, New Jersey, and New York have done);

- Requiring providers to use CONs or lose them; and
- Increasing transparency in the process, by, for example, reporting the share of applications that are denied as well as the share that are opposed by incumbent providers.

4. Conclusion

We need not speculate about what would happen in a Maryland without this regulation. Decades of evidence drawn from hundreds of sophisticated empirical investigations makes it clear that Marylanders can expect greater access to lower cost and higher quality care without CON. Vulnerable and underserved populations such as those in need of substance use treatment or psychiatric care are especially likely to benefit from repeal.

Thank you for the opportunity to offer my testimony today. I am happy to discuss my research in further detail with you or with any of your staffs.

Sincerely,

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Works cited:

Anderson, Keith B. 1991. “Regulation, Market Structure, and Hospital Costs: Comment.” *Southern Economic Journal* 58 (2): 528–34. https://doi.org/10.2307/1060194.

Bailey, James. 2016. “Can Health Spending Be Reined In through Supply Constraints? An Evaluation of Certificate-of-Need Laws.” Mercatus Working Paper. Arlington, VA: Mercatus Center at George Mason University. https://www.mercatus.org/publications/certificate-need/can-health-spending-be-reined-through-supply-constraints-evaluation.

Bailey, James, and Eleanor Lewin. 2021. “Certificate of Need and Inpatient Psychiatric Services.” Social Science Research Network working paper.

Browne, James A., Jourdan M. Cancienne, Aaron J. Casp, Wendy M. Novicoff, and Brian C. Werner. 2018. “Certificate-of-Need State Laws and Total Knee Arthroplasty.” *The Journal of Arthroplasty* 33 (7): 2020–24.

Cantor, Joel C., Derek DeLia, Amy Tiedemann, Ava Stanley, and Karl Kronebusch. 2009. “Reducing Racial Disparities In Coronary Angiography.” *Health Affairs* 28 (5): 1521–31. https://doi.org/10.1377/hlthaff.28.5.1521.

Cavanaugh, Jaimie, Caroline Grace Brothers, Adam Griffin, Richard Hoover, Melissa LoPresti, and John Wrench. 2020. “Conning the Competition: A Nationwide Survey of Certificate of Need Laws.” Arlington, VA: Institute for Justice. https://ij.org/wp-content/uploads/2020/08/Conning-the-Competition-WEB-08.11.2020.pdf.

Chiu, Kevin. 2021. “The Impact of Certificate of Need Laws on Heart Attack Mortality: Evidence from County Borders.” *Journal of Health Economics*. https://doi.org/10.2139/ssrn.3678714.

Custer, William S., Patricia Ketscche, Bernette Sherman, Glenn M. Landers, Mei Zhou, Dawud Ujamaa, and Karen J. Minyard. 2006. “Report of Data Analyses to the Georgia Commission on the Efficacy of the CON Program.” *Aysps.Gsu.Edu*, November. https://www.academia.edu/81395977/Report_of_Data_Analyses_to_the_Georgia_Commission_on_the_Efficacy_of_the_CON_Program.

DeLia, Derek, Joel C. Cantor, Amy Tiedemann, and Cecilia S. Huang. 2009. “Effects of Regulation and Competition on Health Care Disparities: The Case of Cardiac Angiography in New Jersey.” *Journal of Health Politics, Policy and Law* 34 (1): 63–91. https://doi.org/10.1215/03616878-2008-992.

Dobson, Al, W. Pete Welch, David Bender, Kristina D. Ko, Namrata Sen, Audrey El-Gamil, Terry West, and Ted Kirby. 2007. “An Evaluation of Illinois’ Certificate of Need Program.” Prepared for: State of Illinois Commission on Government Forecasting and Accountability.

Eichmann, Traci L, and Rexford E Santerre. 2011. “Do Hospital Chief Executive Officers Extract Rents from Certificate of Need Laws.” *Journal of Health Care Finance* 37 (4): 1–14.

Ford, Jon M., and David L. Kaserman. 1993. “Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry.” *Southern Economic Journal* 59 (4): 783–91. https://doi.org/10.2307/1059739.

Ho, Vivian, and Meei-Hsiang Ku-Goto. 2013. “State Deregulation and Medicare Costs for Acute Cardiac Care.” *Medical Care Research and Review* 70 (2): 185–205. https://doi.org/10.1177/1077558712459681.

Md. Code Regs. § 10.24.01.02(A)(5). 2025. https://casetext.com/regulation/maryland-administrative-code/title-10-maryland-department-of-health/part-4/subtitle-24-maryland-health-care-commission/chapter-102401-procedural-regulations-for-health-care-facilities-and-services/section-10240102-coverage.

Mitchell, Matthew D. 2024. “Certificate-of-Need Laws in Healthcare: A Comprehensive Review of the Literature.” *Southern Economic Journal* 91 (2). https://doi.org/10.1002/soej.12698.

Mitchell, Matthew D., and Thomas Stratmann. 2022. “The Economics of a Bed Shortage: Certificate-of-Need Regulation and Hospital Bed Utilization during the COVID-19 Pandemic.” *Journal of Risk and Financial Management* 15 (1): 10. https://doi.org/10.3390/jrfm15010010.

Plemmons, Alicia, Darwyyn Deyo, and Sarah Drain. 2024. “The Effect of Certificate-of-Need Laws on Substance Use Disorder Care for Vulnerable Populations.” *Southern Economic Journal* 91 (2). https://doi.org/10.1002/soej.12696.

Robinson, Jamie L., David B. Nash, Elizabeth Moxey, and John P. O’Connor. 2001. “Certificate of Need and the Quality of Cardiac Surgery.” *American Journal of Medical Quality: The Official Journal of the American College of Medical Quality* 16 (5): 155–60. https://doi.org/10.1177/106286060101600502.

Roy Choudhury, Agnitra, Sriparna Ghosh, and Alicia Plemmons. 2022. “Certificate of Need Laws and Health Care Use during the COVID-19 Pandemic.” *Journal of Risk and Financial Management* 15 (2): 76. https://doi.org/10.3390/jrfm15020076.

Shakya, Shishir, and Christine Bretschneider-Fries. 2024. “The Effect of Substance Use Certificate-of-Need Laws on Access to Substance Use Disorder Treatment Facilities.” *Southern Economic Journal* 91 (2). https://doi.org/10.1002/soej.12689.

Stratmann, Thomas. 2022. “The Effects of Certificate-of-Need Laws on the Quality of Hospital Medical Services.” *Journal of Risk and Financial Management* 15 (6): 272. https://doi.org/10.3390/jrfm15060272.

Stratmann, Thomas, Markus Bjoerkheim, and Christopher Koopman. 2024. “The Causal Effect of Repealing Certificate-of-Need Laws for Ambulatory Surgical Centers: Does Access to Medical Services Increase?” *Southern Economic Journal* 91 (2). https://doi.org/10.1002/soej.12710.

Stratmann, Thomas, and Christopher Koopman. 2016. “Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community.” Working Paper. Arlington, VA: Mercatus Center at George Mason University. http://mercatus.org/sites/default/files/Stratmann-Rural-Health-Care-v1.pdf.

Stratmann, Thomas, and Jacob Russ. 2014. “Do Certificate-of-Need Laws Increase Indigent Care?” Working Paper 14–20. Arlington, VA: Mercatus Center at George Mason University. http://mercatus.org/sites/default/files/Stratmann-Certificate-of-Need.pdf.

Zinn, J. S. 1994. “Market Competition and the Quality of Nursing Home Care.” *Journal of Health Politics, Policy and Law* 19 (3): 555–82. https://doi.org/10.1215/03616878-19-3-555.