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Mississippi State Department of Health (MSDH)

Assessment of CON Requirements
Dialysis Services, Geriatric Psychiatric Services,
and Uninsured Access in Adult Psychiatric Units

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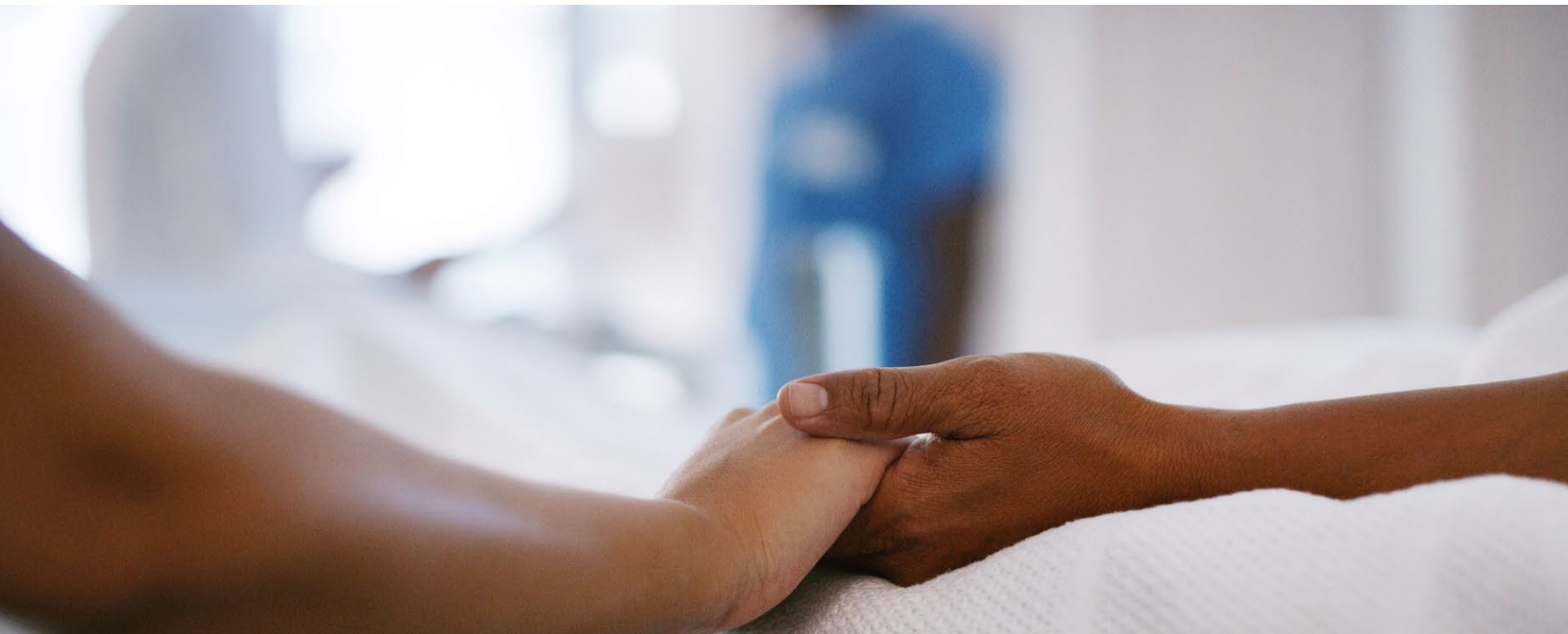


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EXECUTIVE SUMMARY

Purpose of the Study

The Mississippi State Department of Health (MSDH) commissioned this independent assessment to examine three areas of Certificate of Need (CON) policy with significant implications for access, quality, and system stability across the state. The Mississippi State Board of Health requested a review of (1) dialysis services and the uninsured access requirement, (2) geriatric psychiatric capacity and the feasibility of exempting small rural hospitals from the judicial appeal court filing allowable process to a policy board final hearing or public hearing process, and (3) access and feasibility considerations for adult psychiatric services for uninsured patients. The purpose of the study is to clarify current conditions, assess feasibility and operational realities, and provide policymakers with an evidence-based foundation for deliberation.

Legislative Direction and Study Questions

Lawmakers asked MSDH to explore whether specific modifications to CON policy could improve access without compromising quality or destabilizing the system. Key questions included the feasibility of allowing small hospitals to establish dialysis or geriatric psychiatric services without CON review, whether adult psychiatric units should be required to treat a defined percentage of uninsured patients or remit a fee, and whether disparities exist between facilities with emergency departments and those without meeting uninsured care obligations.

Approach and Data Sources

The assessment incorporated multiple sources: statutory and regulatory analysis, the CON Manual, *Draft* FY25 State Health Plan chapters, MSDH utilization and transfer data, facility-submitted information, and interviews with hospitals across Mississippi. Comparative research was conducted to understand how other states structure dialysis oversight, psychiatric service exemptions, and uninsured care requirements. Financial and access modeling examined the effects of potential policy changes on patient travel distances, provider operations, payer mix, and regional service distribution. Modeling was descriptive and intended to identify patterns rather than estimate financial impacts or produce predictive outputs.

Cross-Cutting Statewide Themes

Across all three evaluation areas, workforce availability is the single most consistent constraint on service activation and sustainability. Hospitals repeatedly emphasized that licensed capacity does not reflect staffed capacity. Geographic disparities are pronounced, with rural regions facing the longest travel distances, the least redundancy in services, and the greatest vulnerability to workforce shortages. Small hospitals differ substantially from larger systems in administrative structure, financial margins, and readiness to operate specialized services, which influences the feasibility of exemptions or new requirements. Facilities with emergency departments shoulder the majority of

EMTALA-driven uninsured care, which shapes operational realities differently from standalone psychiatric facilities.

Key Findings

This legislative assessment examines three evaluation areas directed by MSDH:

- Whether a CON exemption for small rural hospitals could reduce patient transfers for dialysis services
- Geriatric psychiatric capacity and the request for a timeline approval exemption for small rural hospitals
- Access and feasibility considerations for adult psychiatric services for uninsured patients

Together, these areas provide a statewide view of how licensed capacity, staffing availability, financial readiness, and regulatory processes influence the delivery of care across Mississippi. The analysis draws on the Mississippi State Health Plan¹, MSDH administrative data, provider interviews, and the statutory framework guiding CON review.

Dialysis services. Travel time, distribution of facilities, and staffing shortages are the primary factors influencing access. Rural regions experience the longest travel distances and the highest dependence on hospital-based dialysis. Hospitals consistently reported that staffing, not the number of licensed stations, limits functional capacity. The uninsured access requirement is feasible in many regions but presents strain in areas with low margins, limited staffing, and high levels of unreimbursed care.

Geriatric psychiatric services. Mississippi's aging population and limited specialized capacity contribute to prolonged emergency department stays and long-distance transfers for older adults with dementia-related behavioral conditions or acute psychiatric needs. Workforce availability, census stability, and financial readiness are the primary barriers to establishing or maintaining geriatric psychiatric units. These challenges are more acute in rural regions with fewer administrative and clinical resources.

Adult psychiatric services for uninsured patients. Hospitals reported high occupancy levels, persistent staffing shortages, and extended emergency department boarding times. The number of licensed beds does not reflect the number that can be consistently staffed. Facilities that serve higher proportions of uninsured patients experience financial pressures that complicate sustained operations. Rural communities face additional challenges because of limited referral options and longer transfer distances.

¹ The State Health Plan (SHP) utilized for purposes of this report is the *Draft* FY 2025 State Health Plan and, accordingly, references, data and citations to the SHP throughout pertain to that specific version.

Across all three areas, consistent statewide patterns emerge: workforce shortages limit operational capacity, rural regions experience the most significant access gaps, and financial feasibility varies based on payer mix, staffing costs, and operational requirements.

CON Processes and Timelines

The assessment confirms that MSDH meets its statutory responsibilities for reviewing CON applications, including the requirement to issue a Staff Analysis within 45 days of receiving a complete application. Delays in CON outcomes typically stem from external factors such as opposition filings, administrative hearings, court appeals, or applicant-driven delays between the Notice of Intent and submission of a complete application.

Comparative Policy Analysis

Other states provide examples of how changes to dialysis oversight, geriatric psychiatric exemptions, or uninsured care requirements influence access and provider stability. States that have liberalized or removed CON for dialysis often pair these changes with state licensure and minimum standards to preserve oversight. States that have altered psychiatric CON requirements show mixed impacts on safety-net providers, particularly where ER-associated hospitals absorb disproportionately high levels of uninsured care. Comparative approaches also include fee mechanisms or explicit uninsured care thresholds to ensure shared responsibility across facilities.

High-Level Policy Option Considerations

This assessment does not recommend a specific policy direction but outlines feasible options for consideration. For dialysis, options range from maintaining CON with refinements to exempting small hospitals under defined conditions or removing dialysis from CON while establishing state licensure and minimum operating standards. For geriatric psychiatry, options include maintaining current CON, targeted exemptions, or additional supports for small hospitals. For adult psychiatric units, options include a designated uninsured care threshold, a fee-based mechanism, or hybrid approaches, each with implications for access and safety-net stability.

Next Steps for Legislative Deliberation

This report is intended to support legislative evaluation of Mississippi's CON framework in the three targeted areas. Policymakers may consider additional data collection, refinement of modeling assumptions, or further examination of specific regions where gaps are most pronounced. The findings highlight the importance of balancing improved access with workforce realities, financial feasibility, quality oversight, and the stability of existing providers.

INTRODUCTION AND METHODS

Background

MSDH engaged Health Management Associates to conduct an independent, third-party assessment of three Certificate of Need topics identified by legislative stakeholders. The assessment responds to questions raised during the 2025 legislative session regarding dialysis services, geriatric psychiatric capacity, and uninsured access expectations in acute adult psychiatric units. These areas were identified to support focused analysis during the 2026 session and to clarify how current planning requirements and operational realities affect access to essential services across Mississippi.

The Board of Health requested an evaluation that is descriptive and evidence based. The intent of the assessment is to document current conditions, examine how existing processes function, and outline considerations that may assist policymakers in understanding the implications of potential statutory or regulatory changes. The assessment does not provide recommendations and does not propose modifications to the CON program.

Scope of Work and Study Objectives

The scope of work directed Health Management Associates to examine three specific evaluation areas:

1. Dialysis services, including the feasibility and implications of exempting small hospitals from CON requirements.
2. Geriatric psychiatric units, including the feasibility of small hospital exemptions and factors that influence operational readiness.
3. Uninsured access in acute adult psychiatric units, including patterns of care among facilities with and without emergency departments and the potential structure of a designated uninsured access requirement or alternative mechanism.

The objectives were to document existing statewide patterns, identify operational and regulatory considerations relevant to each evaluation area, and present clear, descriptive findings that reflect Mississippi's current environment.

Study Approach and Methods

The assessment was conducted in three phases consistent with the contract deliverables.

- Phase 1 included policy and regulatory review. The assessment evaluated Mississippi statutes, the Certificate of Need Manual, administrative procedures, and relevant sections of the *Draft* FY25 State Health Plan. Comparative analysis reviewed how other states structure oversight for dialysis and psychiatric services where comparable information was available.

- Phase 2 included descriptive analysis of available data. This phase incorporated information from MSDH, End-Stage Renal Disease (ESRD) Network 8, federal data sets, and publicly available demographic sources. The analysis focused on geographic distribution, capacity, travel distances, and characteristics relevant to the three evaluation areas. As previously indicated, modeling was descriptive and intended to identify patterns rather than estimate financial impacts or produce predictive outputs.
- Phase 3 synthesized findings for legislative and Board of Health stakeholders. This phase integrated policy review and descriptive analysis to summarize statewide patterns relevant to the three evaluation areas. The synthesis is designed to support informed discussion during the 2026 legislative session. It does not include recommendations or statutory drafting.

Data Sources and References

The assessment relied on a consolidated set of state and federal data sources, including Mississippi State Department of Health licensure statistics, ESRD Network 8 reports, federal datasets from the Centers for Medicare and Medicaid Services, and demographic information from the United States Census Bureau. Chapters from the *Draft FY25 State Health Plan* were used for planning definitions and capacity indicators with the understanding that while the narrative sections remain under revision, the data and statistics



included in these chapters represent the most current information available. Data were compared across sources, when possible, to ensure consistency and accuracy.

Supporting documents include the Certificate of Need Manual, Mississippi Code Annotated § 41-7-171 and related statutes, administrative rules, and facility supplied information provided to MSDH. These references provide the policy, regulatory, and operational context for the three evaluation areas.

Scope and Limitations

This assessment focuses on dialysis services, geriatric psychiatric units, and uninsured access in acute adult psychiatric units. The analysis is descriptive, and documents current service patterns, relevant regulatory requirements, and operational considerations associated with these three areas. No new primary data collection or financial auditing was conducted. All analyses rely on the most recent information available from the MSDH, ESRD Network 8, federal sources, and publicly available datasets.

Some datasets include reporting lags or variation in local operational practices, and the findings should be interpreted within these constraints. The assessment is intended to support review by MSDH, the Board of Health, and legislative stakeholders. It does not extend beyond the selected evaluation areas and does not include recommendations or proposed statutory changes.

Organization of the Report

The report is organized into three evaluation areas that reflect the topics identified by legislators. Each evaluation area includes the study question, relevant policy and planning context, current service landscape, operational considerations, and key findings. A summary section describes statewide patterns observed across all three evaluation areas. Appendices provide statutory references, MSDH data tables used in the assessment, and other supporting materials.

MISSISSIPPI HEALTHCARE CONTEXT

Demographic and Population Health Overview

Mississippi is home to approximately 2.9 million residents, and statewide demographic patterns influence demand for dialysis services, geriatric psychiatric care, and adult inpatient psychiatric services. According to the U.S. Census Bureau, about 17 percent of Mississippi residents are age 65 and older, and roughly 28 percent are age 55 and older. Several rural counties, including Alcorn, Prentiss, Tishomingo, Itawamba, Amite, Perry, and Webster, report that residents aged 65 and older comprise 20 percent or more of their populations. These demographic patterns shape the geographic distribution of healthcare needs relevant to the three evaluation areas.

Chronic disease prevalence in Mississippi is higher than national averages². CDC state-level indicators show elevated rates of hypertension, diabetes, and chronic kidney disease, all of which contribute to the development of end-stage renal disease. These conditions influence the demand for dialysis services and may affect access patterns in regions with limited local capacity.

Behavioral health indicators also vary across the state. SAMHSA state profiles note persistent adult behavioral health needs, and some communities rely on emergency departments as entry points for individuals experiencing psychiatric symptoms when outpatient options are limited. These dynamics have implications for acute adult psychiatric bed utilization and the distribution of available inpatient resources.

For older adults, cognitive conditions are relevant for understanding the need for inpatient geriatric psychiatric care. State and federal sources estimate that between 11 and 12 percent of Mississippi residents aged 65 and older are living with Alzheimer's disease or related dementias, which represents approximately 55,000 to 60,000 individuals statewide. Counties with higher concentrations of older residents may experience greater demand for geriatric psychiatric services, particularly in areas where inpatient behavioral health resources are limited.

² Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS) and Chronic Disease Indicators (CDI), state-national comparison tables.

Uninsured rates continue to vary across Mississippi. American Community Survey estimates indicate that the statewide uninsured rate remains above the national average, with some rural counties reporting uninsured rates above 15 percent. These patterns influence access to adult inpatient psychiatric services, including variation in how facilities manage care for uninsured adults.

These demographic and population health indicators provide context for understanding dialysis capacity, geriatric psychiatric readiness, and uninsured access in acute adult psychiatric units. They describe environmental factors that shape statewide service demand without implying causation or extending beyond available data.

Hospital and Facility Landscape

Mississippi's healthcare infrastructure includes regional referral centers, community hospitals, rural hospitals, state-operated psychiatric hospitals, crisis stabilization units, and freestanding ESRD facilities. According to FY 2025 State Health Plan data provided by the Mississippi State Department of Health, Mississippi has 89 non-federal medical/surgical hospitals. Of these, 31 are designated Critical Access Hospitals (CAHs) and 6 are designated Rural Emergency Hospitals (REHs). When including CAHs, REHs, and small rural PPS hospitals, approximately 50 hospitals meet rural definitions across the state's 65 rural counties. Rural hospitals typically operate with smaller clinical and administrative staffing, which may limit their capacity to develop or sustain specialized services such as dialysis units or geriatric psychiatric programs.

Dialysis services are provided through a network of licensed ESRD facilities across the state. According to FY25 SHP data, 96 licensed ESRD facilities provided maintenance dialysis services and home programs in 2023, operating 1,955 stations and delivering 924,171 treatments. Facilities are more concentrated in higher-population counties such as Hinds, DeSoto, Lee, Harrison, and Jackson, while four counties in the Delta and southwest Mississippi do not have an in-county dialysis facility, requiring residents to travel to adjacent counties for treatment.

Inpatient psychiatric capacity also varies across Mississippi. Four state-operated psychiatric hospitals provide a combined total of 552 licensed adult psychiatric beds, and private adult psychiatric facilities provide an additional 675 licensed adult beds. Geriatric psychiatric services are more limited, with 20



hospitals operating distinct-part geriatric psychiatric units that together provide 286 beds and supported 45,649 inpatient days in FY 2023. These geriatric units are located in a limited number of counties, which leaves most counties without local access to age-specific inpatient psychiatric services. Licensed adult psychiatric beds are more widely distributed but remain concentrated in counties that host larger hospital systems or statewide psychiatric facilities.

Psychiatric hospitals and distinct-part psychiatric units differ in their admission pathways. Private psychiatric hospitals generally admit patients through referral or transfer from other healthcare providers, while general hospitals with psychiatric units may admit patients through emergency screening. These differing structures shape how individuals enter inpatient psychiatric care in various regions of the state.

These facility and capacity patterns form the structural context for evaluating statewide dialysis availability, geriatric psychiatric readiness, and access to adult inpatient psychiatric care for uninsured individuals.

Certificate of Need Program Overview in Mississippi

Mississippi's CON Program operates under Mississippi Code Annotated § 41-7-171 et seq. and is administered by MSDH as the statutorily designated Health Planning and Development Agency. The program is intended to prevent unnecessary duplication of health resources, promote cost-effective service development, and support the availability of needed healthcare services across the state.

A CON is required before developing or expanding certain categories of healthcare services or facilities. These include the construction or renovation of health facilities, the establishment of new institutional health services, the acquisition of major medical equipment above specified thresholds, and the relocation of designated services. The Mississippi CON Manual defines the types of facilities and services subject to review and provides the statutory and regulatory requirements that govern the CON process.

The State Health Plan (SHP) serves as the planning document used in CON review and establishes service-specific need methodologies, planning standards, and criteria for services such as psychiatric care and ESRD treatment. Applicants must demonstrate compliance with the applicable SHP standards and show that the proposed project is consistent with statewide planning goals. In addition to service-specific requirements, applications are evaluated against the General Review Criteria outlined in the CON Manual. These criteria address community need, the availability of existing services, economic feasibility, access for underserved populations, and the project's overall impact on the healthcare system.

The CON program functions alongside Mississippi's licensure system, but each process serves a distinct purpose. CON approval authorizes the establishment or expansion of specific healthcare services, while licensure governs the ongoing operational requirements of health facilities that have already been approved to provide those services.

Mississippi does not maintain a separate licensure category for dialysis facilities and currently relies on CON approval as the primary mechanism for oversight. If dialysis services were excluded from CON review, additional statutory or regulatory structures would be required to maintain appropriate oversight and define minimum operational standards, because such requirements do not exist within the state's current licensure framework.

MSDH has indicated that if dialysis services are removed from CON review, any statutory change would need to be paired with adopting state licensure requirements and minimum standards of operation for ESRD facilities in order to preserve state-level quality and safety oversight.

The CON Program and licensure processes together guide the orderly development of healthcare services and ensure that Mississippi residents have access to services that are appropriately planned, authorized, and regulated.

Certificate of Need Process and Timelines

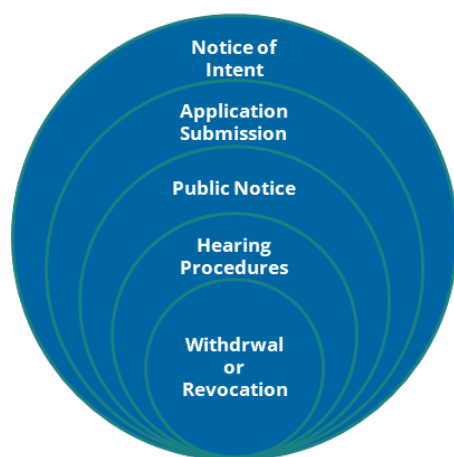
Mississippi's CON process is governed by Mississippi Code Annotated § 41-7-171 et seq. and the Mississippi Certificate of Need Review Manual. The Department conducts all reviews in accordance with the statutory timelines established in these governing documents. The process includes a Notice of Intent, application submission, completeness review, public notification, staff analysis, an opportunity for hearing, and issuance of a final decision.

Notice of Intent

Applicants must submit a Notice of Intent at least 15 calendar days before filing a CON application. The Notice of Intent outlines the proposed project and remains valid for 180 days from the date of receipt by MSDH.

Application Submission and Completeness Review

Upon filing, applications are reviewed for completeness within 15 calendar days. If the application is incomplete, the Department provides written notice specifying the additional information required. Applicants have 15 calendar days to submit the requested information. Failure to respond within the required timeframe results in administrative withdrawal unless a deferral has been requested. During the review, if the Department requests clarifying information, applicants have 15 calendar days to respond, and upon request, the review period is extended for an additional 15 days.



Public Notice and Affected Persons

Once an application is deemed complete, the Department provides notice to affected persons and posts public notice on its website. Public notice includes information such as the project description, review schedule, the public comment period, and the approximate publication date of the staff analysis. After publication of the staff analysis, affected persons may request a hearing. Hearing requests must be submitted within ten calendar days of the publication date.

Hearing Procedures and Final Decision

If a hearing is requested, the Department conducts the hearing within 45 calendar days of receiving the written

request. Notice of the hearing date, time, and location is provided to affected persons at least five calendar days before the hearing. Following the conclusion of the hearing, the State Health Officer issues a written decision within 30 calendar days. All meetings related to the CON process are open to the public, and public meeting notices are posted at least ten calendar days in advance. The approval process is commonly extended due to the right of the public to appeal to the court system tying up time and cost in Mississippi's Chancery Court system. In addition, these factors compiled often extend the approval process causing a financial burden on the applicant discouraging new applicants to apply for CON approval.

[Withdrawal or Revocation of a Certificate of Need](#)

If the Department initiates withdrawal or revocation of a previously approved CON, written notice is provided to the holder and affected persons. The holder has 30 calendar days to respond or request a hearing. If a hearing is requested, the Department holds the hearing within 45 calendar days and issues a written decision within 30 calendar days thereafter.

The statutory timelines and administrative procedures outlined above guide all stages of the CON review process and provide the framework within which applications are evaluated.

Evaluation Areas

The following evaluation areas reflect topics identified by legislative stakeholders and MSDH for review during the 2025 legislative session. Each area examines how potential policy changes may affect access, safety, and the unique health care landscape across Mississippi communities.



EVALUATION AREA 1 – SMALL HOSPITAL DIALYSIS UNIT EXEMPTION

Study Question and Policy Context

Evaluation Area 1 examines the feasibility of exempting small hospitals from CON requirements for establishing dialysis services. This evaluation area provides context for understanding how statewide planning standards relate to hospital operations and the circumstances in which hospitals support individuals who require dialysis services. Information shared during the review process noted that hospitals may encounter challenges when managing patients who require dialysis during an inpatient stay, particularly when arranging clinical support for individuals who present with urgent or emergent needs. Stakeholders explained that these challenges relate to staffing availability, clinical capability, and coordination with regional ESRD providers rather than community travel patterns.

Acute inpatient dialysis is provided as part of hospital services under existing CMS hospital certification. This service is distinct from chronic outpatient dialysis, which requires separate federal ESRD certification and compliance with federal Conditions for Coverage. A state CON exemption would apply only to hospital-based inpatient services and would not modify federal requirements governing outpatient ESRD programs. It is recommended that rural hospitals be approved for a CON exemption to have the ability to offer outpatient ESRD at inpatient locations to increase access of care.

Mississippi regulates ESRD services through the CON statute and the planning standards in the State Health Plan, which outlines the criteria MSDH uses when reviewing proposed dialysis capacity and the methodology for evaluating new or expanded services. MSDH also maintains licensure files identifying facilities authorized to provide dialysis services statewide, establishing the framework for how dialysis services are developed and reviewed. Oversight is provided through the CON program and federal ESRD certification, and the state does not maintain a separate licensure category for dialysis facilities, reflecting how these services are assessed under existing state and federal requirements. Additional administrative interpretations used in reviewing health services are contained in the Mississippi Health Facilities Licensing and Operational Standards Reference, supporting consistent application of definitions and documentation expectations. Hospitals and dialysis providers participating in the review process described general considerations relevant to this evaluation area. These included variation in the availability of staff trained to perform inpatient dialysis, reliance on coordination with regional outpatient ESRD providers for continuity of care, and staffing and operational factors that influence whether hospitals can support acute dialysis when required. These observations offer context for understanding how statewide planning requirements may relate to hospital operations in different regions of the state.

This evaluation area summarizes the planning and regulatory framework that guides dialysis service development in Mississippi and the operational considerations identified through this assessment. The sections that follow provide additional detail on the state's dialysis landscape and the factors relevant to evaluating the feasibility of a small hospital exemption.

Mississippi Dialysis Landscape

According to the *Draft* FY25 State Health Plan, Mississippi has 96 licensed ESRD facilities. These facilities are distributed statewide, with higher concentrations in more populated areas, including the Jackson metropolitan region, northern counties such as DeSoto and Lee, and coastal counties such as Harrison and Jackson. These areas contain multiple outpatient dialysis centers, reflecting the distribution of licensed ESRD facilities documented in MSDH records.

Several rural and lower-population counties have fewer dialysis facilities, and 20 of Mississippi's 82 counties do not have an in-county outpatient dialysis center. In these instances, patients typically receive chronic dialysis treatment in neighboring counties. These patterns describe outpatient ESRD service availability, which is governed by federal certification requirements and is not affected by a state-level CON exemption for hospitals. Chronic outpatient dialysis services in Mississippi are primarily delivered by freestanding ESRD facilities. Hospital-based dialysis capability is generally limited to acute or emergent care provided as part of hospital operations. Most hospitals in the state do not operate chronic outpatient dialysis units, as reflected in MSDH licensure files and the facility types identified in the State Health Plan.

Overall, dialysis services in Mississippi are distributed in alignment with population density and existing healthcare infrastructure, while many rural counties rely on regional outpatient ESRD facilities for chronic treatment. These outpatient access patterns provide context for understanding statewide service distribution, but do not serve as criteria for evaluating a rural inpatient hospital exemption to allow a CON exemption to have the ability to offer outpatient ESRD at inpatient locations to increase access of care.

Regulatory and Oversight Framework

Mississippi's oversight of dialysis services relies on two components: the CON program and federal certification under the Centers for Medicare and Medicaid Services. The state does not maintain a separate ESRD licensure category. This means that if dialysis units were exempted from CON, the state would have no mechanism for ensuring safety, reporting, or compliance unless new statutory authority were created.

Under current law, applicants proposing new or expanded outpatient dialysis services must meet the standards outlined in the State Health Plan. These include population-based need formulas, minimum utilization levels for existing stations before expansion, travel-time considerations, staffing requirements, and demonstration of operational readiness. The Planning and Resource Development staff also review compliance with CON Manual definitions and administrative procedures, including geographic service area designations and documentation requirements.

Small and rural hospitals often cannot meet SHP need criteria because the formulas rely on population thresholds and utilization levels that are difficult to achieve in low-population counties. Although these hospitals may manage a small but clinically meaningful number of inpatient dialysis cases, the reimbursement is typically insufficient to justify the establishment of an inpatient dialysis

unit under current standards. Mobile dialysis units are most often the standard of care for these hospitals, allowing the high cost of care to be only charged when the patient requires dialysis. The standards would need to be changed to allow a CON exemption to have the ability to offer outpatient ESRD at inpatient locations to increase access of care. Subcommittee testimony highlighted this mismatch between statewide planning formulas and the operational needs of rural hospitals.

The Policies, Procedures, and Definitions document provides further detail on how MSDH interprets need methodologies, service areas, and application requirements. It reinforces the importance of consistent reporting and planning across regions and clarifies that ESRD services are treated distinctly from other health services due to federal outpatient certification requirements that operate independently of CON review. These policies help ensure that ESRD capacity remains aligned with demonstrated need and does not exceed levels that would jeopardize service stability or workforce distribution.

The current structure reinforces how planning, certification, and regulatory expectations intersect to support dialysis oversight in Mississippi. Understanding these requirements helps clarify the practical considerations involved when exploring any targeted exemption for small hospitals and illustrates the careful balance between access, safety, and statewide coordination that underpins Mississippi's approach to ESRD services.

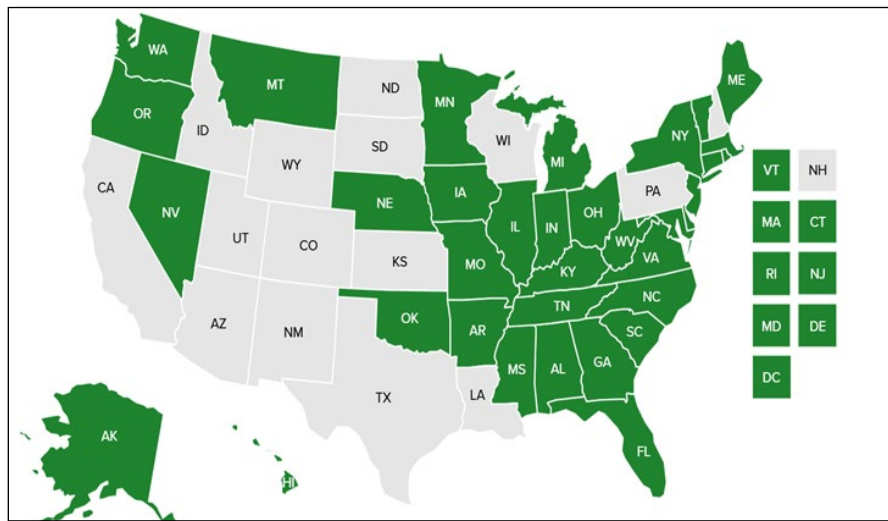
Comparative Policy Analysis

States vary in how they regulate dialysis services, particularly with respect to the role of CON authority. These differences reflect each state's approach to balancing service expansion, access in rural areas, facility utilization, and administrative oversight. According to MSDH's current regulations, Mississippi reviews dialysis services through the broader CON process, paired with federal certification, and does not maintain a separate licensure framework specific to ESRD services. To inform consideration of alternative regulatory models, this section outlines how other states oversee dialysis facility development and expansion, including those that maintain full CON, those that have removed CON requirements, and states that utilize hybrid or modified oversight mechanisms. These comparisons offer insight into how oversight structures may influence service distribution and access, and how states have managed growth under different regulatory approaches.

States Maintaining Full CON Oversight

As of 2024, 24 states continue to regulate dialysis services under CON authority³. In these states, proposals for new or expanded dialysis facilities are reviewed based on defined need methodologies, often incorporating population-based formulas, utilization thresholds, and documented demand indicators. These regulatory frameworks are intended to guide facility development based on demonstrated need and support monitoring of geographic service patterns.

Figure 2. State Certificate-of-Need (CON) Programs by State (2025)³



North Carolina

In North Carolina, dialysis facility development is governed by the State Medical Facilities Plan (SMFP), which includes a detailed methodology for determining county-level need. The SMFP incorporates historical treatment volumes, patient origin data, prevalence trends, and growth projections to calculate whether additional dialysis stations are warranted in a given area⁴. The result is a published facility inventory and need determination, updated annually. As of 2017, the state reported 204 ESRD facilities and 4,972 certified stations⁵. New station approvals are limited to counties where the SMFP indicates a projected need, based on standardized thresholds.

Georgia

Georgia also retains CON oversight for dialysis through its State Health Planning and Development program. Its regulatory approach incorporates adult ESRD prevalence, county-level utilization rates, and minimum treatment volumes. Additional stations may be approved when existing units reach defined utilization thresholds, typically set at 80 percent of capacity, equivalent to an average of 3.2 patients per station based on a three-treatment weekly schedule. Public reports from Georgia's

³ National Academy for State Health Policy (NASHP), "50-State Scan of State Certificate-of-Need Programs," accessed December 10, 2025, <https://nashp.org/state-tracker/50-state-scan-of-state-certificate-of-need-programs/>.

⁴ North Carolina Department of Health and Human Services, State Medical Facilities Plan (SMFP), "End-Stage Renal Disease (ESRD) Need Methodology," accessed December 10, 2025.

⁵ North Carolina State Medical Facilities Plan, ESRD Facility Inventory, 2017 Edition info.ncdhhs.gov/dhsr/ncsmfp/2017/2017smfp.pdf

Department of Community Health describe how these criteria guide application decisions and are intended to support balanced service distribution across counties.

In both North Carolina and Georgia, annual data updates and standardized planning formulas provide a structured approach to dialysis facility expansion. These models demonstrate how regulatory review processes can align new development with population-level indicators of demand and allow for ongoing tracking of regional service patterns.

Additional Full-CON States

Delaware maintains CON requirements for dialysis facility development and incorporates geographic access metrics into licensure mapping. Hawaii applies ESRD-specific CON standards and requires a demonstrated need prior to federal certification approval. Both states utilize need-based review criteria as part of their broader facility planning efforts.

States That Eliminated CON Requirements for Dialysis

A smaller number of states have removed CON requirements for dialysis. In these jurisdictions, oversight is generally limited to federal certification and any applicable state-level health facility licensure requirements, though most do not maintain a distinct licensure pathway for ESRD services.

South Carolina repealed its CON statute in 2023. Following repeal, the South Carolina Department of Health and Environmental Control (DHEC) reported a noticeable increase in applications for outpatient services, including dialysis, in suburban and metropolitan counties. During the MSBOH Subcommittee discussion, this trend was referenced as an example of post-repeal growth patterns that appear concentrated in already-served areas. Available public notices from DHEC did not show corresponding increases in dialysis applications from rural counties in the same timeframe.

Other states that do not currently require CON review for dialysis include Texas, California, Arizona, Utah, Colorado, and Idaho. In these states, dialysis providers typically expand based on market factors and reimbursement conditions. Absent formal state planning tools, there is limited state authority to influence facility placement or monitor regional service distribution.

Other No-CON States

States such as Texas, California, Arizona, Utah, Colorado, Wyoming, Idaho, and Minnesota do not currently require CON review for ESRD services. In these states, dialysis providers typically expand based on market demand and reimbursement conditions, rather than through a centralized need-based planning process. Most do not publish statewide dialysis inventories or utilization thresholds specific to ESRD facility development.

States Using Hybrid or Modified Oversight Structures

Several states retain partial regulatory mechanisms through hybrid models. These approaches often incorporate elements such as utilization thresholds, operational readiness criteria, and modified approval processes for certain geographic areas.

- West Virginia permits defined categories of dialysis expansion under its Health Care Authority rules. Projects may proceed when facilities meet sustained utilization thresholds and provide documentation related to staffing, compliance history, and service demand. The framework allows for facility-level flexibility while maintaining minimum oversight requirements.

These hybrid approaches reflect attempts to balance regulatory structure with access considerations in rural and frontier areas. In both cases, state rules outline clear criteria for conditional expansion, allowing for limited adjustments in response to geographic disparities or utilization changes.

Implications for Mississippi

The state regulatory models reviewed in this section illustrate different approaches to dialysis oversight, each with varying implications for facility distribution, service monitoring, and access in rural areas. States such as North Carolina and Georgia rely on structured, data-driven planning tools to guide dialysis facility expansion. These tools incorporate utilization thresholds, published inventories, and population projections, offering transparency and consistency in service growth. In Mississippi, dialysis projects are reviewed through the general CON process, and there is currently no separate licensure framework specific to ESRD services. During MSBOH Subcommittee discussions, it was noted that Mississippi does not maintain a dialysis-specific annual third-party data collection similar to those used in other states. As a result, the state may have fewer mechanisms for tracking localized demand or forecasting growth on a facility-level basis.

Recent changes in other states offer additional context. Following the repeal of its CON law in 2023, South Carolina experienced an increase in dialysis and outpatient facility applications, particularly in metropolitan counties. In contrast, states like Montana and West Virginia have adopted hybrid models that allow for conditional expansion in rural or high-need areas while maintaining defined oversight requirements. These examples highlight how other states have adjusted their regulatory structures to manage dialysis growth, access, and operational standards. For Mississippi, understanding the range of existing frameworks may help inform ongoing evaluations of how oversight tools can be calibrated to support service distribution goals, particularly in rural and underserved counties.

Financial and Access Analysis

Mississippi's dialysis system reflects the interplay between facility distribution, population need, and the operational realities of hospitals and outpatient providers. The *Draft* FY25 State Health Plan demonstrates that urban and higher-population areas sustain multiple ESRD facilities due to larger patient bases and more stable staffing pools. These regions also operate at consistently high utilization, which supports financial stability for providers.

In rural areas, the patient population is typically too small to sustain a full outpatient dialysis program. Hospitals in these counties often treat ESRD patients only during acute episodes, and the volume of inpatient dialysis is rarely sufficient to meet the State Health Plan's outpatient expansion criteria. Several hospitals reported managing between two and five inpatient dialysis cases per month. This

caseload represents meaningful clinical need but does not meet SHP population-based thresholds for station establishment.

National Medicare cost reporting and CMS analyses reflect that maintaining dialysis readiness requires stable staffing, equipment maintenance, biomedical support, and reliable census. These factors make it difficult for small hospitals to operate dialysis programs without consistent patient volume. High fixed costs and variable staffing availability increase the likelihood that small hospitals would experience financial strain if they attempted to maintain chronic outpatient dialysis capability without sufficient demand.

These financial and access patterns help explain why the question of a small-hospital exemption arises in certain regions more than others. They reveal a landscape where patient need, facility capacity, and the operational realities of rural hospitals intersect in complex ways, influencing both the challenges and potential opportunities associated with modifying dialysis requirements for inpatient service readiness rather than outpatient service expansion.

Operational Feasibility

Operational readiness is a determining factor in whether small hospitals can feasibly establish and maintain dialysis capability. Input shared by participants in the Mississippi State Board of Health (MSBOH) subcommittee meeting consistently pointed to workforce as the central constraint. Dialysis-trained nurses, technicians, and biomedical staff are in limited supply across rural areas of the country. HRSA national shortage designations and CMS workforce analyses reflect that Mississippi faces shortages that mirror national patterns.

During the MSBOH subcommittee meeting, participants described that the ability to offer even intermittent acute dialysis often depends on one or two individuals with specialized training. Staffing gaps, turnover, or temporary absences can make service delivery infeasible. Even when hospitals contract with regional ESRD providers or traveling dialysis personnel, staffing availability remains unpredictable and costly. Infrastructure also varies across hospitals. Acute dialysis capability requires dedicated treatment space, reliable water treatment systems, appropriate biomedical support, and clinical oversight. Small hospitals often lack the capital or physical space to develop these systems, particularly when anticipated patient volume is low. These infrastructure needs relate to inpatient readiness and do not eliminate the separate federal requirements associated with outpatient ESRD services. Federal ESRD Conditions for Coverage set standards related to infection control, staffing qualifications, patient monitoring, and equipment maintenance. Complying with these requirements can be difficult for small hospitals operating with limited financial and administrative capacity.

Coordination with outpatient ESRD facilities is another operational factor. Many hospitals rely on transfer agreements or contracted staff to support clinical stabilization. These arrangements work effectively in some cases but also contribute to care delays when staff availability is limited or when travel distances are long. Hospitals emphasized that outpatient ESRD centers play a critical role in supporting acute care readiness, especially when hospitals cannot offer dialysis on site.

Data reporting capacity was also highlighted. Mississippi's planning and oversight functions require accurate reporting from all facilities providing ESRD care. Hospitals noted that their reporting capability differs significantly depending on whether they provide dialysis directly or rely on external contractors. Maintaining comprehensive data collection remains essential for any model involving hospital-based dialysis capability.

These feasibility considerations suggest that clinical training requirements, staffing stability, infrastructure, and coordination will remain defining factors in whether small hospitals can sustain dialysis under any exemption framework.

From a statewide planning perspective, the balance between geographic need and financial sustainability remains central. Additional facilities in areas with low patient volume could create operational challenges rather than support stable access. Conversely, limited access in certain rural areas continues to create strain for both patients and hospitals.

Although individual hospitals vary widely in their capabilities, these operational considerations underscore the practical factors that determine whether on-site dialysis can be maintained. Staffing, infrastructure, and coordination shape how hospitals manage acute dialysis needs and illustrate the types of challenges that persist across many rural settings.

Key Findings

This evaluation area identifies several themes that shape how small-hospital dialysis considerations intersect with Mississippi's planning framework.

- Dialysis access varies significantly across Mississippi. Urban and higher-population counties support multiple outpatient ESRD facilities, while several rural counties lack local dialysis



capacity. These outpatient access patterns describe the statewide distribution of services but do not provide a basis for an inpatient hospital exemption.

- The current regulatory structure is central to maintaining quality and oversight. Mississippi does not have a separate ESRD licensure category, and removing dialysis from the CON process without establishing licensure and minimum operating standards would leave the state without a mechanism to ensure safety, reporting, and compliance.
- Financial and operational constraints limit the ability of small hospitals to sustain dialysis capability. Low inpatient dialysis volume, limited staffing availability, and infrastructure requirements make continuous inpatient dialysis service difficult to maintain.
- Comparative models show that exemptions or deregulation produce varied results depending on how they are designed. National experience indicates that deregulation often leads to increased growth in high-volume markets rather than improved access in rural or underserved communities.
- Workforce shortages remain a significant constraint across inpatient and outpatient settings. Staffing availability directly influences whether hospitals can initiate, maintain, or expand dialysis services and shapes the feasibility of any policy approach.

Viewed collectively, these themes illustrate how regulatory structure, geography, provider capacity, and patient need shape dialysis access in Mississippi. They also show how the current planning approach intersects with the operational realities of rural hospitals and help clarify how inpatient dialysis considerations fit within the broader distribution of services across the state.

EVALUATION AREA 2 – GERIATRIC PSYCHIATRIC UNIT EXEMPTION

Study Question and Policy Context

Mississippi is experiencing increasing demand for inpatient psychiatric services designed specifically for adults aged 55 and older. This population represents a growing share of state residents, and hospitals report rising rates of dementia-related behavioral disturbances, depression, and complex co-occurring medical and psychiatric conditions. These needs require secure inpatient environments with specialized staffing models and care protocols that differ from those used in standard adult psychiatric units.

The Legislature and MSDH have expressed sustained interest in whether small hospitals should be eligible for a targeted CON exemption to establish geriatric psychiatric units in underserved regions. During subcommittee discussions, Board members noted that current access limitations contribute to extended emergency department boarding for older adults, fragmented care transitions, and long-distance transfers. MSDH also identified inconsistencies in reported geriatric psychiatric capacity and clarified the need for accurate distinctions between licensed capacity and staffed capacity to support reliable statewide planning.

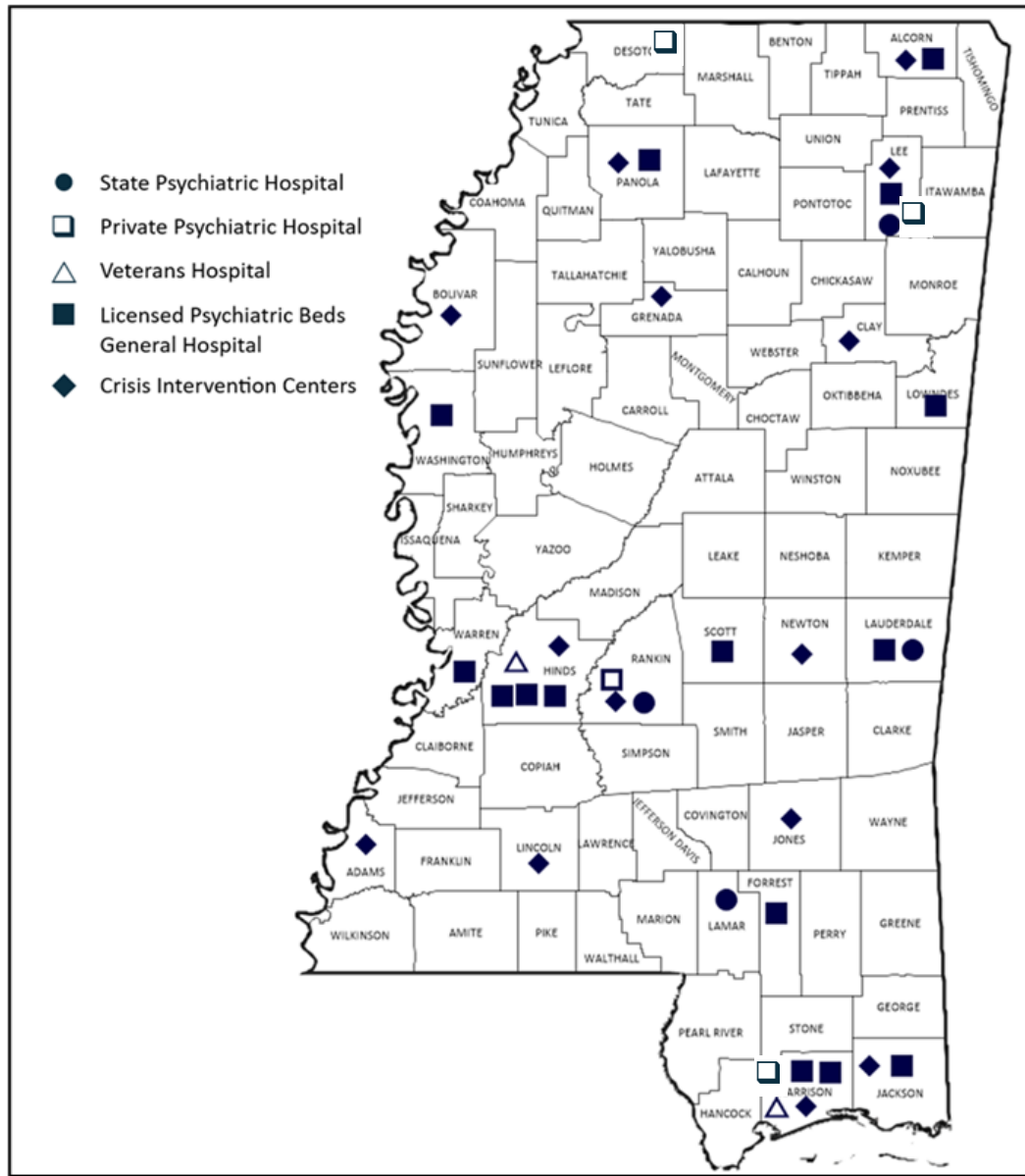
This evaluation area examines Mississippi's existing geriatric psychiatric landscape, the regulatory framework that governs new unit development, and the operational feasibility of a small hospital exemption in regions with persistent access gaps.

Mississippi Geriatric Psychiatric Landscape

Geriatric psychiatric capacity remains limited relative to the growing demand for age-appropriate inpatient services. According to the draft mental health chapter of the FY25 State Health Plan, Mississippi hospitals operated 286 licensed geriatric psychiatric beds in 2023 located in 19 counties. Sixty-seven counties have zero licensed geriatric beds. Of the 19 counties that offer geriatric inpatient services, the median bed count is 14, causing deferral of care until a bed is available and transfer of available care to be up to six hours of travel distance. The draft state plan also explains that geriatric psychiatry inpatient units served a total of 45,649 inpatient days of psychiatric services to patients aged fifty-five (55) and older. The State Health Plan applies a planning standard of 0.5 beds per 1000 adults aged 55 and older. Applying this standard to projected population growth⁶ yields a statewide need of approximately 541 geriatric psychiatric beds by 2028, indicating a shortfall of 255 beds.

⁶ According to the State Data Center of Mississippi, University of Mississippi Center for Population Studies, the state population of adults age 55+ is projected to total 1,081,983 individuals in 2028.

Figure 1. Inpatient Facilities Serving Adult Acute Psychiatric Patients
 FY 2025 State Health Plan (draft), Chapter 3, Map 3-1



The State Health Plan’s facility listings show that geriatric psychiatric units are concentrated in a limited number of counties, leaving large areas of the state without local access to age-specific inpatient services. Hospitals participating in the subcommittee hearings described how this uneven distribution contributes to extended travel distances and delays in identifying available placements, particularly when nearby units are at or near full occupancy. In many cases, older adults remain in emergency departments or medical units for prolonged periods while awaiting transfer. These delays mirror patterns documented in national behavioral health research, which shows that extended boarding is associated with increased agitation, medical complications, and heightened care needs for older adults experiencing psychiatric crises.

Hospitals also noted that older adults are sometimes cared for in settings not designed for high-acuity geriatric psychiatric needs, including general adult psychiatric units or long-term care facilities. These environments may lack the physical design features, staffing ratios, or specialized training required to manage dementia-related behaviors or complex medical comorbidities. Such situations place sustained operational strain on emergency departments, medical floors, and existing behavioral health units.

Population projections included in the *Draft* FY25 State Health Plan and state aging reports indicate that adults aged 55 and older represent a growing share of Mississippi’s population, with conditions such as dementia, major depressive disorder, and behavioral disturbances becoming more common. Inpatient psychiatric hospitalizations for older adults frequently involve co-occurring chronic medical conditions that require coordinated behavioral health and medical management. This combination of rising demand limited geographic distribution of specialized units, and high clinical complexity contributes to ongoing pressure across the hospital system.

Table B.4. Mississippi Geriatric Population

(Neilsberg Research, 2025, based on U.S. Census Bureau ACS 2019–2023 data)

Age Group	Population	Percent of Total
55–59 years	182,334	6.18%
60–64 years	194,624	6.59%
65–69 years	164,910	5.59%
70–74 years	135,378	4.59%
75–79 years	88,700	3.01%

80–84 years	56,346	1.91%
85 years and over	49,781	1.69%

Regulatory and Oversight Framework

Mississippi regulates the establishment and expansion of geriatric psychiatric units through the CON statute and its implementing regulations. Hospitals proposing to develop a new unit or expand an existing one must demonstrate alignment with statewide behavioral health planning objectives, and the ability to meet hospital licensure and federal certification standards. The CON review process is intended to support coordinated growth of inpatient psychiatric services while ensuring that new development strengthens access and maintains clinical quality across the state.

State Health Plan Framework and Planning Criteria

The *Draft* FY25 State Health Plan identifies geriatric psychiatric services as a distinct component of the behavioral health continuum and applies planning criteria on a statewide basis. For private distinct-part geriatric psychiatric units, the State Health Plan relies on the established industry formula of 0.5 beds per 1,000 adults aged 55 and older to assess need. Applicants must demonstrate that proposed bed capacity aligns with this statewide planning standard and that the unit can be staffed and operated safely on a consistent basis. The Mississippi Health Facilities Licensing and Operational Standards Reference and related MSDH guidance inform how planning requirements are interpreted, including expectations for historical utilization documentation, physical environment standards, and evidence of staffing feasibility needed to support sustained operations.

Under current regulations, CON applicants must show that the proposed unit can meet occupancy expectations, comply with Medicare Conditions of Participation, and operate within a physical environment that meets applicable life-safety and psychiatric care standards. The application process includes submission of architectural documents, staffing plans, financial feasibility analyses, and a description of how the unit will integrate with the hospital's broader behavioral health services. MSDH's review includes assessment of the applicant's ability to recruit and retain qualified clinical staff, a factor noted consistently in subcommittee discussions and hospital interviews as a central determinant of whether a geriatric psychiatric unit can be sustained.

Regulatory Oversight and Interpretation

MSDH relies on the CON statute, State Health Plan standards, and the Mississippi Health Facilities Licensing and Operational Standards regulations to ensure that inpatient psychiatric services develop in alignment with statewide planning goals. Subcommittee discussions highlighted the importance of distinguishing between licensed capacity and staffed capacity when evaluating geriatric psychiatric availability. *This distinction is critical because the number of licensed beds does not necessarily reflect the number of beds a hospital can operate safely on a daily basis.*

Administrative Considerations for Applicants

Hospitals have indicated that the analytic and administrative components of the CON process can be challenging, particularly for smaller facilities that may have limited planning or architectural support. Preparing a complete application requires assembling financial projections, staffing models, utilization analyses, and clinical program descriptions that satisfy statutory and regulatory expectations. These requirements are designed to ensure that proposed units are both clinically appropriate and financially viable, reinforcing the state's objectives for regional coordination and sustainable psychiatric service development.

At the same time, MSDH and Board members emphasized that the CON program plays a critical role in maintaining an organized statewide framework for psychiatric service development. The review process helps prevent fragmentation of limited behavioral health resources and supports balanced regional distribution of specialized services. By requiring applicants to demonstrate need, staffing feasibility, and alignment with statewide goals, the CON program seeks to preserve access to geriatric psychiatric services for older adults across diverse regions of Mississippi.

Comparative Policy Analysis

States regulate inpatient psychiatric services for older adults through a range of oversight mechanisms, and these approaches provide insight into how different regulatory structures influence access, staffing feasibility, and the viability of specialized geriatric psychiatric units. Several states that maintain full CON authority for psychiatric beds, including North Carolina and Georgia, rely on population-based planning criteria, historical occupancy, demonstrated regional need, and staffing feasibility to guide decisions about psychiatric bed expansion. North Carolina's State Medical Facilities Plan uses detailed regional need methodologies to determine whether psychiatric beds may be added, and geriatric units must operate within these broader psychiatric categories. Georgia applies similar criteria and requires applicants to demonstrate their ability to staff specialized behavioral health services, which remains a central constraint nationwide.

Other states have implemented targeted flexibilities intended to expand behavioral health capacity while still maintaining oversight. Tennessee uses an expedited process for certain behavioral health projects, particularly when applicants document significant access gaps or prolonged emergency department boarding. While Tennessee's flexibilities do not explicitly isolate geriatric psychiatric beds, hospitals have used these pathways to expand behavioral health services that include older adults with dementia-related conditions and complex behavioral health needs. Montana provides another example through limited exemptions that allow small rural hospitals to add a small number of psychiatric beds without undergoing full CON review. These exemptions are paired with licensure, staffing, and safety requirements, demonstrating how states balance rural access needs with oversight.

These approaches show how states use regulatory design to influence where and how geriatric psychiatric services can develop. Although none of these models provide a direct template for

Mississippi, they illustrate the factors states consider when addressing the unique challenges of providing inpatient psychiatric care for older adults, particularly in rural regions.

Cross-State Observations


Across the states reviewed, several patterns appear consistently in how regulators approach geriatric psychiatric capacity:

- States that maintain full CON oversight rely on structured planning tools to align psychiatric bed growth with documented need, occupancy trends, and staffing feasibility.
- States that use targeted flexibilities to pair those exemptions with licensure requirements, reporting expectations, or post-implementation monitoring.
- Workforce limitations shape outcomes regardless of regulatory design, with staffing feasibility often determining whether units open or sustain operations. Expansion efforts tend to occur more readily in metropolitan areas with deeper workforce pools, while rural regions typically experience slower or more limited growth.

These observations do not point to a single model for Mississippi to follow and instead reflect the range of regulatory approaches other states use for geriatric psychiatric services.

Financial and Access Analysis

Financial and access considerations for geriatric psychiatric services reflect the relationship between statewide demand, geographic availability, and the operational capacity of hospitals that provide age-specific inpatient care. The *Draft* FY25 State Health Plan identifies a projected need for approximately 541 geriatric psychiatric beds by 2028, compared to 286 licensed beds in 2023. Only 19 of Mississippi's 82 counties have licensed geriatric psychiatric beds, highlighting both a statewide shortage and a distributional imbalance. Most counties do not have local geriatric psychiatric units, which contributes to variation in access depending on location.

Information shared during the legislative subcommittee review process described how limited availability affects patient flow. When nearby units are operating close to their staffed capacity, hospitals reported longer waits for placement and extended periods in which older adults remain in emergency departments or medical units while waiting for an appropriate bed. These delays place additional demands on hospital staff and can increase the intensity of clinical management required for older adults with complex needs. National studies of inpatient psychiatric utilization describe similar patterns in systems where capacity is limited, particularly for higher acuity populations. 

Staffing feasibility has a central role in financial modeling. The State Health Plan identifies workforce availability as a key factor in determining whether new or existing psychiatric beds can be staffed consistently. Hospitals noted that recruiting clinicians with geriatric behavioral health training, as well as nurses who have experience caring for older adults with cognitive impairment, remains difficult in many regions. Workforce shortages can limit the number of beds a hospital can safely operate, even when licensed capacity is sufficient, and can affect the long-term financial sustainability of a unit.

Mississippi demographic projections included in the State Health Plan and statewide aging reports indicate that adults aged 55 and older represent a growing share of the population. As this population expands, demand for psychiatric services that address dementia, depression, behavioral disturbances, and co-occurring medical conditions is expected to increase. This anticipated growth interacts with current capacity limitations and geographic gaps, influencing the assumptions used to evaluate both access and financial feasibility.

These financial and access considerations help describe how bed capacity, workforce availability, demographic trends, and geographic distribution shape the delivery of geriatric psychiatric services across Mississippi.

Operational Feasibility

Hospitals participating in the CON review process reported that staffing availability is a central factor in determining whether geriatric psychiatric services can be developed or maintained in smaller facilities. Facilities described ongoing challenges recruiting psychiatrists, psychiatric nurse practitioners, and registered nurses with experience caring for older adults who present with cognitive impairment or behavioral symptoms. These staffing constraints affect both the initiation of a specialized unit and the ability to sustain continuous operations throughout the year.

State licensure requirements also influence feasibility. The Mississippi Health Facilities Licensing and Operational Standards reference outlines expectations for the physical environment of inpatient psychiatric services, including secured areas, appropriate observation capability, and safety features that accommodate the needs of older adults. Hospitals indicated that meeting these requirements may require modifying existing space or adding unit-specific design features, depending on facility age and configuration. The level of modification varies across hospitals, but facilities noted that aligning current infrastructure with licensure expectations is a significant planning consideration.

Stakeholder input gathered for this evaluation highlighted that sustaining geriatric psychiatric units depends on maintaining occupancy levels that support clinical readiness and stable staffing. Some hospitals noted that the size of their service areas and the number of older adults requiring inpatient psychiatric care may not be sufficient to support consistent census levels. Others described how staffing fluctuations or variation in local demand can limit their ability to keep licensed beds active even when physical space is available.

Information shared during the MSBOH Subcommittee meeting process noted that these operational factors shape whether small facilities can develop geriatric psychiatric units that meet regulatory expectations and support the needs of older adults. Workforce constraints, facility requirements, and the need to maintain reliable clinical operations all contribute to a complex feasibility environment for smaller hospitals.

Key Findings

- Mississippi's current geriatric psychiatric capacity does not meet the projected need identified in the State Health Plan. The draft 2025 plan documents 286 licensed geriatric psychiatric beds in 2023 and applies to a planning standard of 0.5 beds per 1,000 adults aged fifty-five and older. Using population projections, the plan estimates a statewide need for approximately 541 beds by 2028, which reflects both a numerical shortfall and an uneven geographic distribution of services.
- Hospitals participating in the CON review process reported that limited local availability contributes to extended travel distances, delayed admissions, and periods of prolonged emergency department stays for older adults awaiting age-appropriate inpatient psychiatric care. Facilities described frequent challenges of securing placements when nearby units are operating near their staffed capacity. These operational issues align with the broader capacity shortfall identified in the planning criteria.
- Stakeholder input gathered for this evaluation indicated that staffing availability, licensure requirements, and the ability to sustain consistent operations are central determinants of whether geriatric psychiatric services can be developed in smaller hospitals. Providers noted that recruiting clinicians and nursing staff with geriatric experience is difficult, particularly in rural regions, and that physical environment requirements outlined in Mississippi's licensure standards may require facility modifications before a unit can be opened.

Information shared during the MSBOH Subcommittee meeting process noted that the combination of limited capacity, persistent workforce constraints, and variation in local demand contributes to inconsistent access to geriatric psychiatric services across the state. These factors influence whether hospitals can meet planning standards, operate units safely, and support the specialized clinical needs of older adults. The statewide landscape reflects both an overall shortage of geriatric psychiatric beds and regional gaps in access that affect hospitals and patients differently depending on location.

EVALUATION AREA 3 – ACUTE ADULT PSYCHIATRIC UNITS AND UNINSURED ACCESS

Study Question and Policy Context

This evaluation area examines how a potential uninsured access requirement for acute adult psychiatric units would interact with Mississippi's existing planning standards for psychiatric services. The question reflects interest in understanding whether a population-specific access expectation could function within the current regulatory structure, which includes CON criteria, State Health Plan methodologies, and licensure requirements.

The State Health Plan establishes the framework used to determine need for adult psychiatric beds and identifies the programmatic standards that govern service operation. Within this structure,

providers operate under varying conditions shaped by staffing capacity, financial considerations, and the distribution of inpatient psychiatric facilities across regions. These operational differences form the context in which an uninsured access policy concept would be evaluated, as they influence whether facilities are able to activate licensed beds and maintain consistent admission capacity.

The study therefore focuses on how the uninsured access policy concept aligns with existing planning tools, how it would relate to current operational conditions reported by providers, and what considerations arise when applying a population-specific standard within Mississippi's psychiatric service environment.

Current Uninsured Access Landscape

Mississippi regulates acute adult psychiatric services through the CON law and the Mississippi State Health Plan. The State Health Plan establishes the statistical need for adult acute psychiatric beds at 0.21 beds per 1,000 adults age 18 and older for 2025. It also includes staffing standards, program design elements, and size limits of no more than 60 beds for freestanding facilities and no more than 30 beds for hospital-based psychiatric units. Beds operated by the Department of Mental Health are excluded from the inventory used to determine need.

Information shared during the MSBOH Subcommittee meeting process noted that 14 adult psychiatric facilities are documented in the State Health Plan with 675 licensed adult psychiatric beds located in 13 counties. These data are presented in the State Health Plan with maps illustrating the geographic distribution of facilities across the state.

Hospitals participating in the CON review process described how geographic placement and staffing capacity directly shape the ability to admit uninsured adults who require psychiatric care. Facilities noted that inpatient psychiatric resources are clustered in specific regions, leaving large areas of the state with limited staffed bed availability. In some regions, the presence of beds held in abeyance further reduces operational capacity. As a result, uninsured adults often travel longer distances for admission, which may delay placement after stabilization in an emergency department.

Stakeholder input gathered for this evaluation described differences in how general acute care hospitals and freestanding psychiatric hospitals interact with uninsured access pressures. General hospitals receive a higher volume of uninsured individuals through emergency departments and reported challenges securing timely inpatient placement when staffed beds are limited. Freestanding psychiatric hospitals, which do not operate in emergency departments, emphasized that their admission pathways depend on clinical eligibility, existing bed availability, and referral relationships. Both facility types reported that staffing shortages affect the ability to activate licensed beds and maintain consistent admission flow.

Information shared during the MSBOH Subcommittee meeting process also referenced uncompensated care pressures associated with providing inpatient psychiatric services to uninsured adults. Facilities indicated that uncompensated care could influence decisions about whether to activate beds that are currently held in abeyance and may affect the degree to which facilities are able

to maintain continuous admission capacity. These pressures were described as more pronounced in regions where hospitals serve a higher share of uninsured residents or where psychiatric care is concentrated among a small number of facilities.

Stakeholders noted that limited local inpatient options also affect continuity after emergency department stabilization. In rural areas, longer travel distances, the availability of transportation, and caregiver support influence whether uninsured adults can reliably access inpatient psychiatric treatment. These factors shape the overall landscape in which the uninsured access policy concept is being evaluated.

Regulatory and Oversight Framework

Mississippi regulates acute adult psychiatric services through the CON statute and the accompanying regulations administered by MSDH. Under Miss. Code § 41-7-191, the construction, expansion, or relocation of acute adult psychiatric beds requires CON review. Psychiatric beds operated by the Department of Mental Health are excluded from the inventory used to determine need.

The Mississippi State Health Plan provides the planning standards that guide CON review for psychiatric services. These standards include the statistical need formula of 0.21 beds per 1,000 adults age 18 and older, expectations for program design and staffing, and size limits for both freestanding psychiatric facilities and hospital-based psychiatric units. The State Health Plan also outlines minimum service and operational requirements that must be met by any facility seeking approval to establish or expand psychiatric services.

Facilities engaged in the CON process have explained that licensure rules and operational standards help define the environment in which psychiatric services operate. These rules address physical plant requirements, clinical staffing levels, patient safety expectations, and documentation practices. Facilities are additionally expected to maintain admission and discharge protocols, ensure appropriate coordination with community providers, and operate consistently with their approved scope of services.

Across stakeholder discussions for this evaluation, participants observed that Mississippi's regulatory framework does not include standards specific to the admission or treatment of uninsured individuals in acute adult psychiatric units. Admission decisions today are based on clinical status, staffing availability, and operational bed capacity. Variability in acceptance practices was described as a function of resource differences among providers, including uncompensated care levels and the ability to staff licensed or abeyant beds.

Participants in the MSBOH Subcommittee meeting described challenges serving uninsured patients. Separately, review of the State Health Plan and prior CON approvals shows that indigent-care commitments already exist, though enforcement mechanisms have been limited. The uninsured access policy concept would add an enforcement mechanism rather than create a new requirement.

Comparative Policy Analysis

States use a range of regulatory mechanisms to oversee acute psychiatric services, including CON processes, licensure standards, Medicaid requirements, and reporting obligations. While no state imposes a defined admission percentage for uninsured adult psychiatric patients, several states use regulatory tools that shape access expectations or transparency in ways that offer relevant comparison points for Mississippi's uninsured access policy concept.

Several states apply behavioral health licensure standards that establish expectations for admission practices, coordination with outpatient providers, and discharge planning. For example, Virginia's psychiatric hospital licensure regulations set out requirements for admission criteria, documentation, discharge coordination, and linkage to community mental health providers. Massachusetts regulates inpatient psychiatric units through hospital licensure rules that require individualized treatment planning, continuity-of-care expectations, and documented coordination with community-based behavioral health services. These models illustrate how other states use licensure as a mechanism to influence facility responsibilities for populations with complex needs.

Other states reinforce behavioral health access expectations through Medicaid or state-operated behavioral health system requirements. Colorado's Behavioral Health Administration, which oversees Medicaid-funded behavioral health services, requires facility participation in care coordination processes, data reporting on service provision, and adherence to statewide behavioral health standards. While these rules do not impose uninsured-specific admission mandates, they demonstrate how statewide program requirements can shape behavioral health access and oversight.

Some states incorporate financial transparency rules that indirectly relate to access for uninsured patients. Illinois requires hospitals to report community benefit activities, charity care levels, and financial assistance data as part of annual filings with the state. Maryland requires similar reporting through its hospital community benefit system administered under the state's rate-setting authority. Although these requirements are not specific to psychiatric units, they establish expectations for documenting hospital activity related to uninsured and underserved populations.

States with active CON oversight for psychiatric services demonstrate additional variation in planning criteria. North Carolina uses regional service-area planning, occupancy benchmarks, and statewide facility-to-population ratios when evaluating psychiatric bed needs. Georgia's CON framework considers historical utilization, regional distribution, and documentation of service gaps when assessing applications for psychiatric beds. These models differ from Mississippi's statistical-need methodology, which relies primarily on state-level formulas and bed-size thresholds and does not incorporate access-based criteria or population-specific admission expectations.

Across the comparative landscape, several themes appear. No state reviewed imposes a defined uninsured admission requirement for adult psychiatric units. Licensure frameworks in states such as Virginia and Massachusetts outline detailed expectations for coordination and discharge planning that influence facility responsibilities for behavioral health populations. Behavioral health program

requirements in states such as Colorado establish system-level access and reporting expectations. Community benefit and uncompensated-care reporting requirements in states such as Illinois and Maryland increase transparency regarding services provided to uninsured patients. Planning criteria in states such as North Carolina and Georgia illustrate how other jurisdiction's structure psychiatric bed oversight to account for geographic distribution and demonstrated need.

Across the states reviewed, several observations emerge regarding how regulatory structures influence access to inpatient psychiatric services:

- Licensure standards in states such as Virginia and Massachusetts include explicit requirements for admission documentation, discharge planning, and coordination with community-based providers.
- Behavioral health system rules in states such as Colorado establish expectations for care coordination, reporting, and participation in statewide behavioral health frameworks.
- Community benefit reporting requirements, including those used in Illinois and Maryland, create transparency around uncompensated care and services delivered to uninsured individuals.
- CON planning approaches in states such as North Carolina and Georgia incorporate regional distribution criteria, historical utilization, and demonstrated need when evaluating psychiatric bed expansion.
- No state reviewed imposes a defined uninsured admission requirement or percentage standard for adult psychiatric units. Existing regulatory tools focus on licensure, reporting, and coordination standards rather than population-specific admission mandates.

These observations do not point to a single model for Mississippi to follow and instead reflect the range of regulatory approaches other states use for geriatric psychiatric services.

Financial and Access Analysis

Financial and access considerations shape the environment in which the uninsured access policy concept would operate. Mississippi's State Health Plan documents licensed adult psychiatric bed capacity and establishes a statistical planning standard of 0.21 beds per 1,000⁷ adults age 18 and older. This framework provides the basis for comparing modeled psychiatric bed need to the number of beds that are both licensed and operational across the state.

Applying the planning ratio to adult population projections allows planners to identify areas where licensed capacity exceeds or falls below modeled need. Information shared during the MSBOH Subcommittee meeting process indicated that this comparison frequently highlights differences

⁷ Mississippi State Health Plan, FY 2025 (draft), Chapter 3 (Mental Health)

between licensed capacity and staffed capacity, particularly in regions where a notable share of psychiatric beds are held in abeyance. In areas where staffed beds fall below modeled need, stakeholders reported longer travel distances for admission and delays in placement following emergency department stabilization.

Hospitals participating in the CON review process described how financial pressures influence their ability to activate licensed beds or return abeyant beds to service. Facilities serving higher proportions of uninsured or low-income patients reported greater exposure to uncompensated care, which may affect their ability to maintain staffing levels required for full activation of licensed psychiatric capacity. These financial conditions were described as more pronounced in rural regions, where lower patient volumes and staffing constraints can limit the feasibility of operating additional beds even when statistical need is identified.

Stakeholder input gathered for this evaluation also referenced operational impacts that arise when uninsured adults require inpatient psychiatric admission. Facilities noted that payer status can influence the sequence of placement activities, coordination with external providers, and discharge planning processes. In settings with limited staffed capacity, uninsured adults may experience longer waits for placement into available beds. These access patterns were described as interconnected with the location of staffed capacity, the rate of uncompensated care, and the availability of qualified psychiatric staff.

Across these considerations, the Financial and Access Analysis context for the uninsured access policy reflects the relationship between Mississippi's planning standards, the distribution of staffed psychiatric beds, and the operational conditions reported by providers. Understanding these factors is necessary for evaluating how the policy concept aligns with the state's current psychiatric service landscape.

Operational Feasibility

Operational factors reported by providers shape how psychiatric facilities admit and manage uninsured adults. Hospitals participating in the CON review process noted that admission decisions begin with clinical eligibility but are also influenced by whether staffed psychiatric beds are available. When licensed beds cannot be activated due to staffing constraints, facilities explained that operational capacity may fall below licensed capacity, which affects the number of patients they can admit.

During the MSBOH Subcommittee meeting process, providers described uncompensated care as an operational consideration that can influence how uninsured admissions are managed. They noted that coordination activities related to admission, placement, and discharge planning often require additional time and staff resources, particularly when arranging follow-up with community mental health services.

Rural hospitals identified distinct operational challenges. Stakeholder input gathered for this evaluation indicated that smaller clinical teams and limited access to psychiatric specialists can extend

the time needed to arrange transfers for uninsured adults. When a psychiatric unit is not available locally, staff reported that coordinating transportation and identifying available beds in other regions is resource intensive and dependent on fluctuating bed availability.

Facilities also commented on the operational impact of licensed beds held in abeyance. Information shared through the review process indicated that bringing an abeyant bed into service requires sufficient workforce coverage, administrative preparation, and clinical oversight. Providers noted that workforce variability influences whether these beds can be activated consistently.

These operational factors represent the setting in which the uninsured access policy concept would interface with Mississippi's current psychiatric service system.

Key Findings

Mississippi's adult psychiatric system shows a clear distinction between licensed capacity and the number of beds that are staffed and available for use. State Health Plan data identify a substantial number of licensed beds in abeyance, and providers noted that staffing availability determines whether these beds can be activated and kept in service.

- Facilities reported that uncompensated care influences several operational tasks associated with uninsured admissions. Staff described additional coordination requirements during admission, placement, and discharge when patients lack third party coverage, particularly in settings with fewer administrative and clinical resources.
- Geographic variation plays a role in access for uninsured adults. Hospitals located outside regional hubs described longer travel distances and fewer local psychiatric options, which can extend the time between emergency department stabilization and inpatient admission. These challenges were described most frequently by rural facilities with smaller clinical teams and limited specialty coverage.
- Workforce variability also affects the sustainability of staffed capacity. Providers noted that fluctuations in psychiatric nursing, social work, and physician coverage influence how many beds can be maintained in active operation and whether abeyant beds can be brought into service consistently.

Across the information gathered for this evaluation, providers described operational and financial conditions that interact with the existing planning standards and facility structures within Mississippi's psychiatric system. These conditions form the backdrop against which the uninsured access policy concept is being assessed.

SUMMARY OF FINDINGS

The Mississippi Legislature directed MSDH to examine dialysis service availability, geriatric psychiatric access, and adult psychiatric services for uninsured adults. These evaluation areas address distinct components of statewide healthcare capacity and rely on MSDH data sources, facility-reported

information, licensure records, transfer patterns, and the statutory framework that guides CON oversight. The evaluation describes how service availability, operating capacity, workforce conditions, and geographic distribution influence access across the three areas.

Dialysis services in Mississippi include freestanding centers and hospital-based units that vary in availability across regions. MSDH data show that several counties do not have local dialysis capacity, and facilities participating in the review process reported that some hospitals rely on transfers to larger centers when inpatient dialysis support is required. Information drawn from the State Health Plan and facility reports indicates that dialysis need differs across regions, with some areas experiencing growth in end-stage renal disease prevalence while others maintain limited but stable capacity. Providers described these distribution patterns as influenced by staffing availability, market participation, and the operating conditions faced by hospitals that manage emergency dialysis cases.

Geriatric psychiatric services reflect a similar pattern of regional variation. MSDH data indicate that only a small number of specialized geriatric psychiatric units operate statewide, and large portions of Mississippi do not have dedicated beds for older adults with psychiatric needs. Facilities noted challenges related to staffing specialized clinical roles, supporting patients with dementia-related behavioral symptoms, and maintaining census in smaller markets. Planning standards reviewed in this evaluation show that projected statewide need exceeds licensed capacity, and hospitals in areas without dedicated units reported extended transfer times and longer emergency department stays for older adults awaiting placement.

Adult psychiatric services for uninsured individuals demonstrate capacity and placement challenges across multiple hospital types. Several facilities reported that licensed psychiatric beds remain in abeyance due to staffing shortages, and MSDH licensing records indicate that staffed capacity fluctuates with workforce availability. Transfer information and provider accounts described longer emergency department stays for uninsured adults and variable access to staffed beds, particularly in smaller or rural hospitals. These observations were associated with staffing constraints, payer mix considerations, and operational differences across regions.

Workforce availability, geographic variation, and operational readiness were identified throughout the evaluation as factors that influence whether facilities can activate licensed capacity and sustain specialized services. Providers across dialysis, geriatric psychiatric, and adult psychiatric settings described how staffing levels, local resource availability, and uncompensated care obligations affect daily operations and the coordination required to secure appropriate placements.

This summary presents a descriptive overview of the statewide conditions documented in the evaluation areas. It provides context for understanding how service capacity aligns with Mississippi's statutory planning framework and reflects the operational and geographic factors that influence access to care across the state.

RECOMMENDATIONS

Based on the evaluation of Mississippi's current oversight structure, access conditions, utilization trends, workforce feasibility, and comparative experience from peer states, the following recommendations outline policy options that the Legislature and the Mississippi State Department of Health may wish to consider. These options translate the findings of this assessment into potential pathways for improving access, reinforcing accountability, and supporting the long-term stability of dialysis and psychiatric services across the state.

Oversight Structure and Minimum Standards

The Legislature and MSDH may wish to consider:

- **Developing a licensure framework for dialysis facilities if dialysis is exempted from Certificate of Need.**

States that do not regulate dialysis through CON typically rely on licensure to maintain enforceable safety, staffing, and reporting standards. A comparable structure in Mississippi could preserve oversight functions that protect patients and support continuity of care.

- **Aligning state oversight with CMS Conditions for Coverage while addressing gaps specific to Mississippi's service landscape.**

Peer states find that coupling federal certification with state expectations improves accountability without duplicating federal workload. Mississippi could use a similar alignment to ensure minimum standards across facilities statewide.

- **Clarifying the division of responsibilities between MSDH and federal regulators if CON oversight changes.**

Comparative analysis shows that states with clear statutory roles experience fewer oversight gaps and more predictable compliance processes.

- **Evaluating alternatives to the current judicial appeal structure to improve predictability and timeliness of final decisions.**

Comparative review indicates that extended approval timelines driven by court-based appeals can introduce uncertainty, increase costs for applicants, and discourage participation in the CON process. Many states rely on 30-day administrative review periods, public hearing windows, or policy board final determinations to preserve due process while reducing prolonged delays.

- **Clarifying the point at which CON decisions become administratively final.**

Establishing a clear and bounded decision pathway may reduce procedural uncertainty while maintaining transparency and public input.

- **Assessing whether alternative appeal or hearing models could relieve administrative burden while preserving stakeholder engagement.**

Other states utilize time-limited public hearings or board-level review processes that allow concerns to be addressed without extended litigation.

Planning Standards, Need Determination, and Geographic Access

The Legislature and MSDH may wish to consider:

- **Updating population-based need methodology and utilization thresholds.**
The current methodology is tied to historic assumptions that may not reflect evolving demand, shifts in treatment modalities, or demographic changes. Other states periodically update these formulas to ensure facility placement aligns with population trends.
- **Incorporating travel-time expectations or refined service area definitions.**
Several states use travel standards to protect access in rural and frontier areas. Mississippi's documented travel burdens in Delta, southwest, and other regions indicate that recalibrated standards may help reduce missed treatments and improve geographic balance.
- **Using cross-county utilization patterns to update planning definitions.**
Comparative analysis suggests that aligning planning regions with observed patient behavior improves facility placement decisions.

Workforce Capacity and Operational Readiness

The Legislature and MSDH may wish to consider:

- **Requiring applicants to demonstrate staffing feasibility before approval or licensure.**
Staffing limitations were repeatedly identified in Mississippi, especially in rural hospitals and dialysis facilities. Other states use staffing plans or minimum qualification evidence to avoid authorizing services that cannot be sustainably staffed.
- **Supporting partnerships that expand the dialysis technician and behavioral health workforce pipeline.** Peer states collaborate with community colleges and certification programs to increase workforce supply in underserved regions. Mississippi could adopt similar strategies to mitigate staffing shortages.
- **Defining expectations for operational readiness, including emergency operations, scheduling protocols, and equipment redundancy.** These standards are common in states that combine licensure with facility oversight and can reduce operational disruptions.

Safety, Quality, and Reporting

The Legislature and MSDH may wish to consider:

- **Expanding state-level reporting requirements to monitor safety and quality across dialysis and psychiatric services.** States without CON often reinforce reporting and

inspection authority to ensure performance transparency. Mississippi could apply similar practices to reinforce accountability.

- **Aligning Mississippi's reporting expectations with CMS systems to reduce burden while increasing statewide visibility.** This would allow Mississippi to monitor infection control, adverse events, and continuity of operations more systematically.
- **Establishing expectations for patient education, transitions of care, and care coordination.** These areas affect access and quality but are inconsistently addressed by federal regulations alone.

Uninsured Access and Financial Commitment

The Legislature and MSDH may wish to consider:

- **Creating a clear mechanism to enforce uninsured access expectations.** Other states tie indigent care reporting to licensure or other oversight structures. Mississippi could adopt a similar process to ensure consistency statewide.
- **Requiring routine reporting of uninsured or indigent care performance.** This would give MSDH the ability to evaluate whether access obligations are met and allow the Legislature to assess whether policy adjustments are needed.
- **Linking any new reporting or enforcement mechanism to the broader oversight structure.** This would ensure that uninsured access expectations remain enforceable regardless of whether CON applies.

Access in Rural and Underserved Areas

The Legislature and MSDH may wish to consider:

- **Evaluating whether targeted adjustments to planning standards could support additional capacity in areas with persistent travel burdens.** Other states have used modified need thresholds, rural weighting, or special access criteria to encourage service placement in underserved communities.
- **Considering partnerships with transportation and community organizations.** Comparative observations show that transportation barriers are a determinative factor in dialysis adherence and inpatient psychiatric access.
- **Reviewing options for rural incentives or technical assistance.** Some states use planning supports or readiness assistance to help small facilities navigate licensure and operational requirements.

Data Infrastructure and Ongoing Evaluation

The Legislature and MSDH may wish to consider:

- **Establishing a recurring review cycle of statewide access, capacity, and performance.** States with predictable review schedules are better able to monitor changes and adjust planning standards. Mississippi could benefit from a similar structure given the dynamic nature of both dialysis and psychiatric care.
- **Improving integration of CMS, MSDH, and other public datasets.** Cross-validated data enhances accuracy and supports evidence-based deliberation.
- **Developing a transparent statewide reporting process that allows policymakers to evaluate the impact of future statutory or regulatory changes.** This aligns with best practices in states where legislative bodies routinely review health planning performance.

APPENDIX A. LEGISLATIVE MANDATE AND STATUTORY REFERENCES

A.1 Legislative Direction for the Assessment

During the 2025 legislative session, the Mississippi State Legislature requested that the Mississippi State Department of Health (MSDH) evaluate three specific Certificate of Need topics:

1. Dialysis services, including whether small rural hospitals should be allowed to establish dialysis capability without CON review.
2. Geriatric psychiatric units, including whether small rural hospitals should be exempt from CON requirements for developing specialized geriatric psychiatric services.
3. Uninsured access to acute adult psychiatric units, including whether adult psychiatric units should be required to treat a designated percentage of uninsured patients or remit a fee.

These three evaluation areas form the scope of this report.

A.2 Statutory Authority for the MS CON Program

Mississippi's CON program is established in Mississippi Code Annotated § 41-7-171 et seq. Key statutory sections relevant to this assessment include:

Legislative Intent- Miss. Code Ann. § 41-7-171

Establishes that CON prevents unnecessary duplication of health resources and ensures the availability of needed services.

Definitions- Miss. Code Ann. § 41-7-173

Provides the terms used in CON review, including institutional health services and major medical equipment.

Services and Activities Requiring CON Review- Miss. Code Ann. § 41-7-191

Lists activities requiring CON approval, including development of ESRD facilities and expansion of psychiatric services.

Review Criteria- Miss. Code Ann. § 41-7-197

Sets criteria for evaluating CON applications, including community need, economic feasibility, service availability, and consistency with the State Health Plan.

Procedures and Timelines- Miss. Code Ann. § 41-7-201

Establishes the statutory timelines for completeness review, staff analysis, public notice, hearing requests, and final determinations.

A.3 State Health Plan Regulatory Authority

Under Miss. Code Ann. §§ 41-7-171 and 41-7-191, the Mississippi State Department of Health is required to use the State Health Plan as the planning document for CON review. Relevant sections of the FY 2025 State Health Plan Draft referenced in this assessment include:

- Chapter 7, Section 704 – End-Stage Renal Disease Services
Provides ESRD facility inventory, station distribution, utilization levels, need methodology, and planning criteria used in evaluating dialysis service capacity and geographic access.
- Chapter 3 – Mental Health Services
Includes adult and geriatric psychiatric bed inventories, occupancy patterns, planning formulas, and the standards applied to psychiatric service development.
- Chapter 5 – Acute Care Facilities and Services Overview
Summarizes statewide acute care capacity, inpatient utilization, hospital service distribution, and related operational context that informs considerations for rural hospitals across all evaluation areas.

The State Health Plan serves as the primary framework guiding assessments of service need, distribution, and planning expectations for the CON program.

APPENDIX B. MSDH DATA TABLES AND FIGURES USED IN THE REPORT

This appendix includes only MSDH-sourced tables, maps, and facility-level data referenced in the report. The following tables and figures were drawn directly from MSDH licensure files and the FY 2025 State Health Plan (draft).

B.1 ESRD Facilities and Station Distribution (FY 2025 State Health Plan Draft)

- Table B-1. Mississippi Licensed ESRD Facilities and Station Inventory (2023) (Source: FY25 SHP Draft, Chapter 7)
- Licensed ESRD Facilities: 96
- Total Stations: 1,955
- Total Annual Treatments: 924,171
- Counties With No In-County ESRD Facility: 20 counties (patients rely on adjacent counties)

Areas of highest facility concentration:

- Hinds County
- DeSoto County
- Lee County
- Harrison County
- Jackson County

B.2 Adult Psychiatric Capacity

Table B-2. Adult Psychiatric Bed Inventory (FY 2025 SHP Draft, Chapter 3)

Category	Value
Licensed Adult Psychiatric Beds	675
Beds Held in Abeyance	231
Reported Occupancy Rate	57.8%
Inpatient Days Reported	143,144

B.3 Geriatric Psychiatric Capacity

(FY 2025 SHP Draft, Chapter 3)

Category	Value
Licensed Geriatric Psychiatric Beds	286
Number of Hospitals Operating Geriatric Units	20
Total Inpatient Days	45,649
Statewide Planning Standard	0.5 beds per 1,000 adults age 55+
Projected 2028 Statewide Need	~541 beds
Documented Shortfall	~255 beds

B.4 Maps Used in the Report

MSDH-approved maps include:

- Map 3-1: Inpatient Facilities Serving Adult Acute Psychiatric Patients
- ESRD Facility Distribution Map (*Draft* FY25 SHP, Chapter 7)
- Regional Coverage Travel Patterns

These maps illustrate statewide geographic variation and should be inserted in high-resolution formats.

B.4 Mississippi Geriatric Population

(Neilsberg Research, 2025, based on U.S. Census Bureau ACS 2019–2023 data)

The age-group distribution for Mississippi’s 55+ population (see Table B.4) is derived from Neilsberg Research’s 2025 compilation, which is based on U.S. Census Bureau American Community Survey (ACS) 2019-2023 estimates. Although this data is not an official state-plan document produced by any Mississippi agency, it is grounded in official ACS data and compiled by a third-party source. It represents one of the most recent and comprehensive nationwide-standard demographic breakdowns available for Mississippi, making it a useful reference for analyses requiring age-distribution information. Because the ACS is a survey rather than a full census, all reported figures are estimated. However, they are generally considered reliable for most analytical purposes, particularly the 5-year ACS estimates, which smooth annual variability. This reliability assessment is supported by the Surveillance, Epidemiology, and End Results (SEER) program of the (NIH) National Institute of Health (SEER Program, NIH, n.d.).

APPENDIX C. METHODOLOGY AND ANALYTICAL

This report uses a descriptive, evidence-based approach consistent with MSDH's direction. Analytical components include:

- Review of MSDH licensure files and SHP data tables
- Geographic analysis of ESRD and psychiatric facility distribution
- Assessment of travel patterns using county-level service access
- Evaluation of utilization and planning standards
- Review of operational readiness and workforce feasibility
- Comparative review of regulatory models in peer states
- Synthesis of stakeholder insights shared during prior CON processes

APPENDIX D. DEFINITIONS OF KEY TERMS

Includes definitions consistent with Mississippi statutes, SHP standards, and federal terminology:

- Certificate of Need (CON)
- End-Stage Renal Disease (ESRD)
- Inpatient Psychiatric Services
- Geriatric Psychiatric Services
- Licensure vs. Certification
- Service Area and Planning Area
- Occupancy and Utilization

APPENDIX F. REFERENCES

- Primary data sources include:
- MSDH Licensure and Facility Data
- *Draft FY 2025 State Health Plan, Chapters 3 and 7*
- Mississippi Code Annotated Title 41, Chapter 7
- CMS Conditions for Coverage for ESRD Services
- Neilsberg Research (ACS 2019-2023 population data)
- U.S. Census Bureau ACS 5-Year Estimates
- MSDH Internal Facility and Planning Tables

REFERENCES

Primary Data Sources and References

- **Mississippi State Department of Health (MSDH)** - Licensure and facility data, Certificate of Need application records, and State Health Plan criteria.
- **Mississippi State Health Plan (2020 and 2025 editions)**- Benchmarks and formulas used to determine facility need, service thresholds, and regional capacity standards.
- **Mississippi State Health Plan FY 2025 – Chapter 3 (Mental Health Services)**- Psychiatric bed counts, CSU capacity, PRTF utilization, child/adolescent psychiatric data, and psychiatric CON criteria and standards.
- **Mississippi State Health Plan FY 2025 – Chapter 7 (Other Health Services & End-Stage Renal Disease)** – Dialysis facility counts, station distribution, treatments, ESRD need methodology, ESRD CON criteria and standards.
- **Mississippi Code Annotated, Title 41, Chapter 7**-Statutory provisions governing the Certificate of Need program, including definitions, requirements, and review criteria.
- **Mississippi State Health Plan data tables prepared for MSDH’s FY 2025 update** – Data tables and facility-level information incorporated into draft planning chapters for mental health and ESRD services.
- **Neilsberg Research. (2025).** *Mississippi population by age* (based on U.S. Census Bureau American Community Survey 2019–2023 data).[Mississippi Population by Age - 2025 Update | Neilsberg](#)
- **SEER Program. (n.d).** *Static County Attributes* – *SEER Datasets*. Retrieved December 10, 2025, from <https://seer.cancer.gov/seerstat/variables/countyattribs/static.html>
- **U.S. Census Bureau**- American Community Survey (ACS) 5-year estimates for population, age, and socioeconomic indicators.

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