

CON JOB:

CERTIFICATE OF NEED LAWS USED TO DELAY, DENY EXPANSION OF MENTAL HEALTH OPTIONS



MARK FLATTEN
NATIONAL INVESTIGATIVE REPORTER
GOLDWATER INSTITUTE
SEPTEMBER 25, 2018

Jared was violent and dangerous.
But he was not a criminal.

He was sick.

Not the kind of sick that can be treated in a hospital emergency room. His was a mental illness. And because of that, there was no place to take him for the crisis care he needed.

Jared (not his real name) was big and strong; in his early 20s, autistic, and intellectually challenged with an IQ of 54. He lived with his mother, who struggled to deal with a full-grown man who had the mind of a troubled child.

Then one day, for no apparent reason, Jared assaulted her.

Police were called. Jared was arrested.

That's when his nightmare began.

He was taken in front of Richard Vander Mey, a magistrate judge in Tama County, Iowa. It was clear from the start that the man was not criminally responsible for what he had done, Vander Mey said in an interview with the Goldwater Institute. He needed treatment, not punishment.

Frantic calls went out from county officials trying to find an inpatient mental health facility that would take Jared. None was available. Not in the entire state of Iowa.

That left Vander Mey in a bind. He knew he could not release Jared, who would have no place to go except back home with his mother. If that happened, there was a high risk he would harm himself or attack his mother again, perhaps causing serious injury.

To buy time, Vander Mey encouraged police to file criminal charges so Jared could be held safely in jail as the search for the coveted bed in a mental health hospital could continue.

The search went on for days. Not a single bed could be found.

Jared's case soon reached a county district court judge, who ordered the criminal charges dropped and that he get appropriate mental health treatment.

Still there were no mental health beds available in the state.

Finally, Libby Reekers, the county's mental health advocate, told Vander Mey that he would either have to find someplace that would take Jared or let him go. Together, they devised a plan to send him to the medical hospital at the University of Iowa, 75 miles away, which also had a psychiatric unit. Once he was in the hospital's emergency room, the facility would have no choice but to admit Jared for psychiatric treatment, they reasoned.

They were wrong. Hospital officials said there was no room in its mental health unit, and Jared would not be admitted.

A standoff ensued. The hospital refused to admit Jared, and the judge refused to take him back into custody.

Days continued to pass as county officials and hospital staff called psychiatric hospitals and mental health wards across Iowa begging them to take Jared. Because he was not getting the mental health treatment he needed, he remained dangerous and volatile. The only way to protect his safety and that of others was to shackle him to a hospital bed and station a sheriff's deputy in his room all day, every day.

"He sat in the Tama County jail for five days—five days for this kid with mental retardation and autism, sitting in a jail because there was not one hospital bed



available,” Vander Mey said in recounting the story last year during a hearing to assess whether a new inpatient mental health hospital would be allowed in eastern Iowa. “That young man sat in the emergency room at the University of Iowa hospital for three days and three nights chained to a bed in the emergency room because there was not a psychiatric hospital in the state that was willing to take him.”

Eventually, Vander Mey and Reekers enlisted the aid of state legislators to pressure the state mental hospital to admit Jared into its psychiatric ward. The strong-arming worked, and, after more than a week locked in jail or chained to a hospital bed, he finally began receiving the treatment he needed.

“What we are doing now to the mentally ill, to the mentally impaired people, the people who are the most vulnerable and the least able to protect themselves, what we are doing to them is criminal,” Vander Mey said. “It is criminal. We as a state ought to be ashamed of ourselves.”

Jared’s case is not unusual. It was one of a litany of horror stories described by a parade of witnesses who testified last year about the dire shortage of inpatient mental health facilities in the area of eastern Iowa around Davenport.

Emergency room doctors, social workers, and mental health advocates described deranged and dangerous patients being forced to sit untreated in hospital emergency rooms for hours, days, and sometimes more than a week because there were no psychiatric hospital beds available in the entire state.

Sheriffs described having their deputies crisscrossing the state, routinely driving four and five hours or more, to deliver inmates in psychological crises to far-flung mental health facilities that had a single open inpatient bed available. They talked about having to assign deputies to sit with patients for days at a time in emergency room corridors or hospital cubicles because no psychiatric hospital would accept those having mental health emergencies.

Yet the existing providers of mental health services in the area insisted there was no crisis, that there were plenty of psychiatric beds, and that if there was a problem, they were the ones to fix it.

POLITICAL INSULATION

The context of the testimony was a proposal by Strategic Behavioral Health (SBH) to build a 72-bed mental health hospital in what’s called the Quad Cities area of eastern Iowa. SBH planned to use about \$15 million of its own money, without any subsidy or tax breaks, to build the facility. Officials at the private, for-profit company had determined there was a desperate need for their services in the area and selected the location after a nationwide search.

But before they could do anything, they would need to get permission from the state by first obtaining what’s called a certificate of need.

Iowa is [one of 38 states](#) that have certificate of need (CON) laws, according to the National Conference of State Legislatures. Though they vary greatly, these laws generally require would-be providers of health-related services to get approval from a state regulatory board before building or expanding a facility or service.

The idea behind CON laws is that medical costs can be controlled by limiting the supply of services and facilities to only what is needed, as determined by the state board or agency. Requiring government approval will prevent overbuilding and excess capacity, which drive up costs, the thinking goes.

Congress linked federal funding to state passage of CON laws in 1974. By 1980, all states except Louisiana had them.

But soon thereafter, it became clear that the national experiment in cost control was a failure. CON laws did not limit the cost of healthcare. In fact, by eliminating competition from the healthcare industry, CON laws tended to drive up costs, lower quality, and limit the availability of needed services, according to a [series of assessments](#) from the U.S. Federal Trade Commission and Department of Justice.

The primary beneficiaries of CON laws are existing providers of medical services within a state, which effectively use them to block competitors from encroaching on their markets, the agencies found. The results of that stifled competition are higher costs and lower quality, FTC commissioner Maureen Ohlhausen said in a [2015 analysis](#).

“These laws remain on the books in 36 states through a combination of legislative inertia and the fact that incumbent providers benefit when the state protects them from competition,” Ohlhausen wrote, referring to the number of states with CON laws at the time. “CON laws insulate politically powerful incumbents from market forces, and those providers naturally are loathe to give up the special government preferences that CON laws bestow.”

Amid the growing evidence that CON laws were a failure, Congress repealed the directive to states in 1987. Since then, 12 states have eliminated their CON laws, most recently New Hampshire in 2016. Indiana imposed a new CON requirement earlier this year.

The FTC and Justice Department have pressured other states to scrap their CON programs for more than a decade, through both Republican and Democratic presidential administrations. In 2004, the [agencies jointly published](#) an extensive study on the effects of CON laws and concluded the primary beneficiaries were entrenched special interests—existing medical providers in communities—who used their political clout to preserve the laws and protect themselves from would-be competitors.

Finally, the FTC and DOJ reject the other oft-cited justification used to defend CON laws: that limiting competition protects the profitability of existing providers and thereby [allows them to subsidize](#) charity care.

“Empirical evidence contradicts the assertion that dominant providers use their market power to cross-subsidize charity care,” the FTC stated in an October 2017 letter to state healthcare regulators.

‘FAILED PUBLIC POLICY’

Academic studies back the findings of the federal agencies.

An exhaustive study [published in 2016](#) by the Mercatus Center at George Mason University found that in states with CON laws, the cost of healthcare is higher, the quality is lower, and access is scarcer.

Even the American Medical Association [advocates repeal](#) of CON laws. The AMA concludes CON laws

“have failed to achieve their intended goal of containing costs,” restrict patient choice, and do nothing to improve the quality of healthcare.

The AMA agrees with federal regulators that the primary beneficiaries of CON laws are existing providers, who effectively use them to prevent competition that would force them to control costs and improve quality.

“CON programs tend to be influenced heavily by political relationships, such as a provider’s clout, organizational size, or overall wealth and resources, rather than policy objectives,” the medical association says.

The bottom line for the AMA:

“CON laws represent a failed public policy.”

SYSTEM IN CRISIS

It was against this backdrop that Strategic Behavioral Health applied for its certificate of need to build the 72-bed inpatient mental health facility in Bettendorf, on the eastern edge of the state near the Illinois border.

SBH is a Tennessee-based company that owned and operated 10 other mental health facilities across the country at the time it made its application in mid-2015. All of the beds would be certified for acute care, meaning it would be able to house the most severe cases of people having mental health meltdowns, including children, adolescents, and geriatric patients. Company officials said they also planned to take a large percentage of low-income patients through both Medicaid and charity care, as they do at the other hospitals they operate.

Two other companies controlled the market. Genesis Health System operated a free-standing psychiatric unit on the grounds of a hospital it operated in nearby Davenport. UnityPoint Health-Trinity operated a second psychiatric inpatient facility across the Mississippi River in Illinois.

Genesis and Trinity led the opposition to granting the certificate of need for the new psychiatric hospital, claiming the additional beds were not needed and that they were in the process of fixing any deficiencies in the mental health safety net in the region.

Allowing SBH to open such a large facility in the region would also endanger their financial footing by bleeding off the most profitable patients, those with private insurance, and thereby jeopardize their ability to treat Medicaid patients and charity cases, they argued.

The two existing providers managed to stall a final decision for more than two years. Twice, the Iowa State Health Facilities Council, the five-member board that determines whether a certificate of need will be issued, deadlocked on the SBH application. Since the votes ended in 2-2 ties because of council absences, the application was neither approved nor rejected. That meant SBH could not proceed with construction, but that it could apply a third time.

The disarray and delays eventually drew the attention of then-Gov. Terry Branstad, a Republican, who began to publicly question the value of CON laws.

“The established health care provider uses this as a way to keep out competition,” he said.

Branstad said the CON requirement did [nothing to control](#) rising medical costs, and that he was “somewhat skeptical about its continuation.”

The governor also replaced a member of the state review council.

Following up on Branstad’s comments, [a bill was introduced](#) in the 2017 legislative session that would reform the certificate of need process. It did not pass, but it did help heighten the public outcry for reform of the law in general and approval of the SBH proposal in particular.

While Branstad’s criticism and the subsequent legislation focused on the certificate, few except the existing providers in the area questioned the need for a new mental health facility in eastern Iowa.

Two years before SBH filed its CON application, Genesis and Trinity had partnered with other community-based mental health advocates in the area to [produce a report](#) on the deplorable condition of mental health services in the region.

“The Quad-Cities mental health care system is in crisis,” the study by existing providers concluded. “Long fragile and insufficient, it is now in serious peril.”

“The needs of the sickest and the poorest of our community are not being met. It is time for the local Quad-City community to recognize this crisis.”

Inpatient mental health beds were in particularly short supply, the report stated.

That conclusion was echoed by front-line health workers, law enforcement officers and local officials who deal with the mentally ill on a daily basis when the SBH application reached the state board for the third time in July 2017.

TERRIFYING WAIT

People having a severe mental health crisis can become deranged and violent, a danger to themselves or others. Sometimes they are arrested, usually on minor charges such as disturbing the peace or trespassing, and are taken to jail. Sometimes they seek treatment in hospital emergency rooms, which are prohibited by federal law from discharging unstable patients.

Neither is a good option, said Dr. Kara Thompson, an emergency room physician and associate dean at Des Moines University’s College of Medicine.

“If you come in for help to a place that is known for providing help, and you are sitting there for days not getting help, that must make you feel like you’re not very important.”

- Dr. Kara Thompson,
ER-Physician and Associate Dean
Des Moines University’s College
of Medicine

Most emergency rooms, particularly in rural areas, are set up to deal with medical emergencies. They do not have the facilities, staff, or expertise to deal with people having a mental health crisis, who might be delusional, disruptive, or violent.

In the Quad Cities region of Iowa, Genesis has the only hospital with its own inpatient psychiatric unit. So other hospitals must hold the patient until a suitable placement can be found, usually in their emergency rooms.

“It really is a risk to the patient, to the staff, and it could be even to other patients who are in the ER,” Thompson told the Goldwater Institute. “We’re just not set up for that. We’re just kind of set up to stabilize people with mental health issues and get them to the correct place. Holding them is a disservice really to the patient and to the staff.”

Some patients come to the ER on their own, thinking the medical staff will be able to treat them. Others are brought by police or family members.

What’s supposed to happen is the patient is stabilized and given any necessary medical treatment. Once a psychiatrist determines the patient needs inpatient care, a facility with an available inpatient bed is contacted and the patient is transported there.

Often the reality is [no beds are available](#), and patients routinely wait hours and sometimes days for one to open.

When a bed is found, it is frequently at a facility three or four hours away, meaning the patient will have to be transported by ambulance or by law enforcement officers. Even then, existing providers typically have restrictions on the patients they will take based on factors such as age, sex, and mental condition.

So even if statistics show psychiatric beds are available, the patients often don’t meet the strict requirements for acceptance. That is particularly true for violent or disruptive patients most in need of inpatient care.

If they get too unruly, police are called and the patient is taken to jail.

Beyond disrupting the emergency room staff and other patients seeking medical treatment, holding

people who are already having a psychological crisis for days without treatment is also doing damage to them, Thompson said.

“If you come in for help to a place that is known for providing help, and you are sitting there for days not getting help, that must make you feel like you’re not very important,” Thompson said. “They’re just waiting. So I think it’s terrifying. It’s boring, and it must be terribly frustrating.”

PSYCHOTIC MELTDOWN

Thompson was one of more than a dozen witnesses who testified about the dire need for more inpatient beds in eastern Iowa during the nine-hour certificate of need hearing last year. Healthcare providers, mental health advocates, and law enforcement officials all had their own horror stories to tell.

Mentally disturbed patients wandering through emergency room corridors or handcuffed to hospital beds for days.

Violent individuals who needed treatment being locked in jail cells because there were no mental health hospitals that would take them.

Sheriff’s deputies driving for hours, crisscrossing the state to deliver disturbed men and women to the single facility in Iowa that would admit them.

Social workers, mental health advocates, sheriff’s deputies, and jail administrators all working the phones through the night to find a psychiatric hospital in the state with that single, ever-elusive inpatient bed.

Vander Mey, the magistrate judge, recounted the story of Jared, as well as another patient he ordered to an inpatient facility for evaluation. The woman was in “full psychotic meltdown,” Vander Mey said. Yet as with Jared, no psychiatric bed was available. So the woman was forced to sit in the back of a patrol car on a hot summer day for six hours as the scramble to find a bed went on.

Lori Elam, chief executive officer of the Eastern Iowa Mental Health and Disability Services Region, a coalition of counties to deal with area health issues, described seeing a psychiatric patient wandering through a hospital emergency room where Elam had

gone for her own medical issues. The man had been to her office a week before with serious mental problems. He'd stopped taking his medications and was violent and belligerent. By the time Elam went to the emergency room, the man had already been there for 55 hours, wandering in and out of patient rooms, and disrupting doctors and nurses trying to care for the sick and injured. He ended up spending more than 80 hours in the emergency room because no facility with an inpatient bed would take him.

STOMPING THE COMPETITION

The average distance a patient is transported when a bed is found is 180 miles, said Doug Wilson, president of Integrated Telehealth, a service that provides crisis assessments and finds mental health inpatient beds for hospitals that do not have their own psychiatric units. Because the patients who show up in emergency rooms are typically unstable, the transportation is usually handled by police. Sheriff's deputies routinely have to wait in the emergency room with a violent or disruptive patient until a bed is found, Wilson said.

Wilson recounted one case in which a 14-year-old patient spent 11 days in an emergency room, with deputies monitoring him continually, waiting for an inpatient mental health bed. Another patient, a 9-year-old boy, was forced to spend two days in a hospital

emergency room while the search for a mental health bed was conducted.

"I remember wondering if he understands why he is feeling like this, and if he knows why he can't leave the ER," Wilson said. "I also wonder if his parents understand why it's so hard for him to get help, and if waiting in the ER makes them question doing the right thing."

Several witnesses testified that even the Genesis hospital, which has its own inpatient psychiatric unit, frequently refuses to admit patients, particularly those with the most severe conditions. Arrests of mental health patients who become unruly at the Genesis hospital are common, according to local police.

Janet Huber, owner of an outpatient mental health counseling company in Bettendorf, held out hope that competition would make all of the area providers better and more responsive to the needs of the people they are supposed to serve.

"The decision needs to be on what is in the best interests of these people that are suffering with mental illness," Huber said. "The decision should never be based on what is best for our two local hospital systems."

"They seem to have the money and the political power to do whatever they want," she added. "We must stand up to big business and not let Trinity and Genesis stomp on their competition."



LAST RESORT

Sheriff Tony Thompson of Black Hawk County, which includes Waterloo, said in a recent interview with the Goldwater Institute that county jails have essentially become the mental health providers of last resort in much of Iowa because of the shortage of inpatient mental health facilities. Thompson testified at the hearing last year that about 60 percent of his jail population at the time were people with mental illnesses. The situation has improved some, largely because of efforts he and other local officials have made to deal with people in psychological crisis more quickly.

But there still are few placement options for the worst cases.

For most people with psychological problems, community-based alternatives such as outpatient counseling are viable alternatives. But those who wind up in Thompson's jail tend to be the most extreme cases, people who are delusional, violent, destructive, or suicidal.

Most of them do not belong in jail, Thompson said, both in his testimony and the recent interview. But when no inpatient facility is willing or able to take them, jail becomes the "treatment facility of last resort," he said.

"It's not the environment where you are supposed to be treating mental illness," Thompson told the Goldwater Institute.

Thompson has a licensed social worker on his staff, who spends much of her time finding placements for the mentally ill who have been arrested for minor crimes or are subject to a judicial commitment order. That makes the sheriff the largest provider of mental health services in Black Hawk County.

Beyond the fact that jails are not equipped to properly treat the mentally ill, Thompson and officials from other sheriff's offices expressed frustration at the cost and manpower needed to ferry psychotic inmates across the state because of the scarcity of inpatient facilities willing to take the most severe cases.

Deputies routinely take on the dangerous task of shuttling mental patients to facilities with an open bed that are hours away, Thompson and others testified. Aside from the expense of paying the deputies, who

are often on overtime, those long transports take law enforcement officers out of the communities for entire shifts, particularly in smaller counties, they said.

Thompson said it was astounding that officials from Genesis repeatedly testified that the certificate of need should be denied because the area did not need an additional inpatient mental health facility. Through the three hearings on the SBH application, it was clear that existing providers were using the CON process to thwart their competition for financial reasons unconnected to treating those in need.

"For me that process of certifying need was a slam dunk. It was simple. It was obvious," Thompson told the Goldwater Institute. "Feel our pain for just a minute, and then try and justify voting against a private entity.

"It was baffling for me to sit there and listen to this, that they were trying to use fuzzy math and fake numbers as to how and why this hospital shouldn't be built," he added. "When somebody from Trinity or Genesis, these large healthcare systems, says there's not a problem because 'we are making our own investments,' then it was clear this is a marketing piece, this is a competition-elimination piece."

SAFETY NET

Doug Cropper, chief executive officer of Genesis, stands by his assessment that more inpatient mental health beds were not needed in the region when the SBH application was reviewed a year ago. The 2013 assessment by Genesis and Trinity was correct in declaring the area was in crisis, and that inpatient beds were in short supply, Cropper said in a recent interview. Genesis responded by developing its own plans to expand psychiatric capacity from the 18 beds it had at the time to 60.

By the time SBH filed its application in mid-2015, Genesis and Trinity were fixing the problem, and no additional facilities beyond those already in the works were needed, he said.

Cropper denied that the existing providers were trying to stifle competition by opposing the certificate of need requested by SBH. However, he does acknowledge their opposition was driven by economics.

Like other providers, Genesis uses the more lucrative patients with private insurance to subsidize the treatment of low-income Medicaid patients and those who receive charity care, Cropper said.

SBH will cater largely to clients who have private insurance, he said. That means the two nonprofit providers will be left primarily with the low-income clients, and the entire business model for subsidizing their care will collapse.

“The biggest concern we had about the Strategic Behavioral Health hospital was that it was going to destroy the safety net, and I still think that’s going to happen,” Cropper said. “Once you introduced a for-profit company skimming off the profitable business, you weaken the whole safety net, which makes all of these wraparound services at risk.”

That is the same cross-subsidization argument the Federal Trade Commission says is bogus.

Ultimately, after three daylong hearings, two deadlocked votes, intervention from the governor, hundreds of pages of paperwork, and more than two years of delay, the [state council approved](#) the SBH application 4-1.

Groundbreaking on the new hospital [was in April](#). It is expected to be complete sometime next year.

Officials at SBH would not agree to an interview.

After the approval, Genesis scrapped its plans to expand to 60 inpatient beds. It now has 36.

EMERGENCY ‘BOARDING’

The crisis in mental healthcare is [not unique to Iowa](#). Neither is the use of certificate of need laws by entrenched interests to block new providers from encroaching on an existing market.

Holding mental health patients in hospital emergency rooms because there is no alternative, a practice known as “boarding,” has become a problem nationwide, according to a [2016 report](#) by the American College of Emergency Physicians (ACEP).

Of the emergency room physicians surveyed by ACEP, 84 percent reported psychiatric patients being

boarded in their facilities, a practice that can lead to violent behavior, distracted staff, and medical bed shortages.

Almost half of the physicians reported psychiatric patients being boarded in their emergency departments one or more times per day, and more than 10 percent said they had six to 10 psychiatric patients awaiting inpatient placement on their last shift.

About 20 percent of the doctors said patients often wait two to five days for an inpatient mental health bed.

“The emergency department has become the dump-ground for these vulnerable patients who have been abandoned by every other part of the health care system,” the ACEP report concludes.

One of the key recommendations of the organization was more inpatient facilities and staffing.

The situation is much the same in county jails, the other provider of last resort.

In Los Angeles County, for instance, about [30 percent of the inmates](#) are mentally ill, according to local officials. The Los Angeles County jail is often derisively—and accurately, according to many experts—described as the largest de facto mental health provider in the nation.

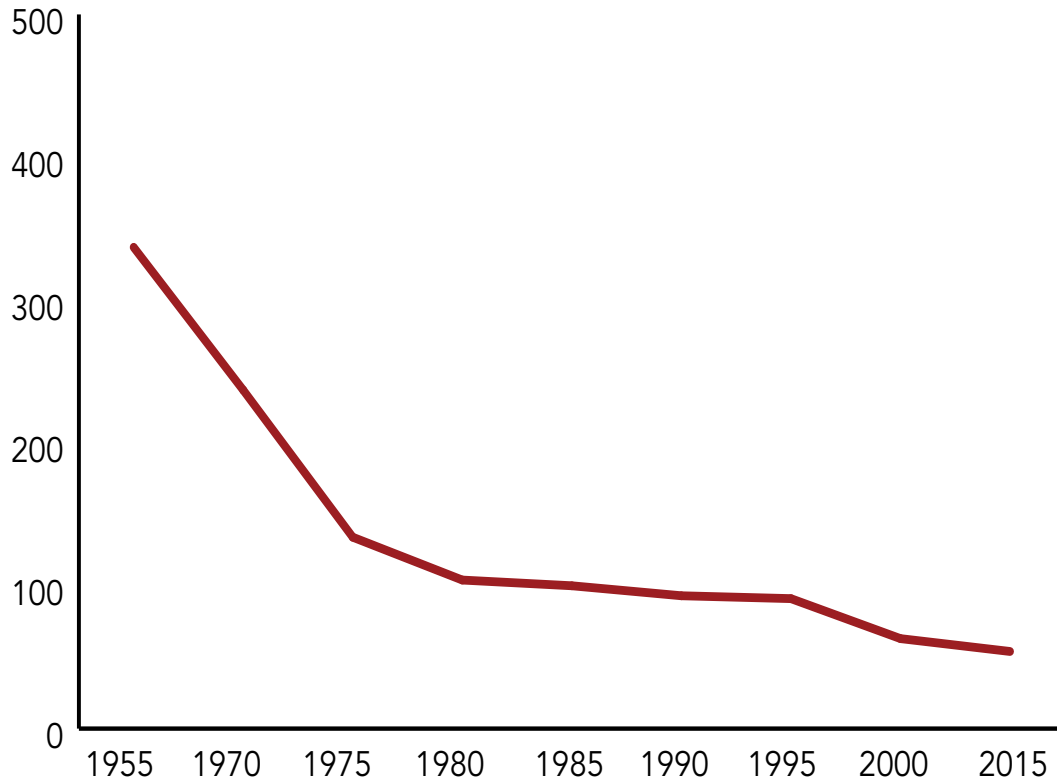
The problem has gotten progressively worse in the past five to 10 years, said Ron Honberg, senior policy advisor at the National Alliance on Mental Illness, a nonprofit research and advocacy group.

During the great recession that began a decade ago, many states [slashed the number](#) of inpatient mental health beds they operated. This was in part a cost-saving move. But it also played into the [legal and ethical mandate](#) that the mentally ill should be treated in the least restrictive setting possible, such as outpatient care and counseling where appropriate.

The problem is some patients need inpatient care, Honberg said. Particularly in short supply are acute care beds, places where patients in crisis can go for a month or so to stabilize, have their medications adjusted, and receive the intense treatment they need to be successful when released for outpatient follow-up care.

Downward Spiral

Inpatient psychiatric bed capacity per 100,000 people in the U.S.*



* The 1955 figure shows state government inpatient beds only. All other years show total inpatient psychiatric treatment capacity, including in private hospitals, based on patient populations.

Source: National Association of State Mental Health Program Directors and Mental Health America.

As states have reduced the number of inpatient beds, some by [as much as 50 percent](#), private hospitals also have been converting mental health beds to more lucrative medical beds, Honberg said.

The shortage of inpatient psychiatric facilities coupled with the desire to treat patients in the least restrictive setting often means patients in mental crisis are discharged into the community for outpatient treatment before they are ready.

So when their crisis worsens, they show up at the emergency room or commit a crime and get arrested, both of which are far more expensive than properly treating the patients in the first place, Honberg said.

“The system is broken at all levels,” he said. “We have a penny-wise, pound-foolish approach to responding to people with the most serious mental illnesses. We wait until they go into crisis, then we spend

a lot of money and a lot of resources in responding to them until the crisis is alleviated, then we wait until the next crisis occurs.”

PROVIDER PROTECTION

Yet despite the severe shortage of both public and private mental health options for the most severe patients, private companies routinely face stiff opposition from existing providers and entrenched special interests when they seek certificates of need to open new facilities.

In Oregon, a company called NEWCO Oregon Inc. [had to battle](#) existing mental health providers, state bureaucrats, and local labor unions when it sought to build a 100-bed inpatient psychiatric hospital near Portland.

NEWCO is a subsidiary of Universal Health Services, one of the largest operators of psychiatric hospitals in the nation. It filed its application for a certificate of need with the Oregon Health Authority in January 2016. The estimated cost of the proposed facility was about \$35.8 million, all of which would be paid by the company, which did not seek any government money or tax breaks.

Oregon has been in the midst of a mental health crisis for years. It consistently ranks at or near the bottom among states in terms of access to mental health facilities and services, according to research from Mental Health America, a nonprofit advocacy group that rates the availability and need for psychiatric and substance abuse services.

In 2017, when the NEWCO application was under review, Oregon [ranked 49th](#) out of 50 states and the District of Columbia in terms of overall access to mental health services, according to the MHA rankings. In 2018, it [improved slightly](#) to 44th.

Oregon also scored the worst in the nation in terms of the prevalence of the population with mental health needs both years.

Beyond the high need and lack of available services, Oregon was under pressure to improve its delivery of mental healthcare because of a 2012 agreement between the state and the U.S. Department of Justice. As part of that agreement, the state was required to take steps to alleviate emergency room boarding of mental health patients.

About 15 percent of the people seeking care in Oregon emergency rooms are there for mental health issues, and about 15 percent of those patients end up being boarded for more than six hours, according to a study conducted for the Oregon Health Authority [that was published](#) in February 2017.

Among those identified as having a severe psychiatric disorder, about a fourth were boarded in the emergency room for more than six hours, and 9 percent for more than 24 hours, because there were no other options available.

NEWCO officials argued their inpatient facility was needed to alleviate emergency room boarding of mental health patients.

The average occupancy rate for inpatient psychiatric hospitals in the Portland region was 86 percent of full capacity. At a separate inpatient facility owned by the company, the occupancy rate consistently ran at 90 to 95 percent.

Yet despite all of that, state health officials concluded there was no need for an additional inpatient facility in the Portland area.

The existing hospital companies in the region [had already collaborated](#) to open a joint facility in February 2017, the Unity Center for Behavioral Health, which provides emergency, inpatient, and outpatient care. The hospitals pooled funding and transferred their inpatient beds to the Unity Center, resulting in 101 beds at the facility. That is actually five beds fewer than the hospital chains operated separately.

In its analysis of the NEWCO application, state health authorities concluded the needs of the mentally ill in the area would best be served by adding community-based services such as outpatient care, the solution favored by existing providers. The Oregon Health Authority's review also raised concerns that competition from a new hospital operated by NEWCO, a for-profit company, would "have a negative financial impact on other providers."

The two unions—which are both Service Employees International Union locals—also argued against awarding a certificate of need to a for-profit company.

The existing providers in the area are unionized. The proposed NEWCO hospital would not be.

A month after the state denied the certificate of need, NEWCO filed a [notice of claim](#), the precursor to filing a lawsuit against the state. It alleges the Oregon Health Authority was doing the bidding of existing providers by "unnecessarily and artificially limiting the availability of in-patient psychiatric hospital facilities, promoting anti-competitive collusion between hospital monopolies, facilitating anti-competitive agreements, limiting consumer choice, and otherwise denying Oregon consumers the benefits of an effective remedy for these and other violations."

The lawsuit was not filed. Instead, NEWCO officials entered into mediation with the state to determine whether the rejection of the certificate of need can be overturned or modified.

‘ONLY A SADIST’

A similar situation played out in the Johnson City area of northeastern Tennessee, where a private, for-profit company sought to open a methadone treatment center to help local residents shake their addictions to heroin and other opioids.

Tennessee in general and Johnson City in particular have among the nation’s highest rates of opioid abuse. A study published in December 2017, by Castlight Health, a healthcare information company, rated Johnson City as the [ninth most opioid-addicted community](#) in the nation.

Yet treatment options in the area were virtually nonexistent in 2013, when a company called Tri-Cities Holdings LLC filed an application for a certificate of need to build and operate a nonresidential opioid treatment center in Johnson City.

Steve Kester, co-owner of Tri-Cities, had already opened nine drug treatment centers in several states when he filed the application for the \$670,000 facility. As with the applicants in Iowa and Oregon, Tri-Cities would build the center with its own money and did not seek government subsidies or tax breaks.

The nearest methadone treatment center in Tennessee was in Knoxville, more than 100 miles away. The closest one was across the state line in Weaverville, N.C., more than 50 miles away.

Aside from the overall rates of drug addiction, the Johnson City area also has high rates of [drug-related deaths](#) from overdoses and suicides, as well as high infant mortality and addiction rates as a result of women being addicted to opioids during pregnancy, company officials argued. Methadone treatment has been the preferred treatment method for heroin addicts for more than 40 years, particularly for pregnant women.

“It was politics at its worst and people died.”

- Steve Kester,
Co-Owner Tri-Cities Holdings

Methadone itself is addictive. But it is used in therapy as a substitute drug because it allows people to wean themselves from their more destructive opioid addiction and lead more normal lives.

For the first 90 days of methadone treatment, the patient must show up at the clinic in person and have the dose administered by a physician. That means in Johnson City, recovering addicts were being forced every day to drive a minimum of 100 miles round-trip, across winding mountain roads, Tri-Cities officials noted.

“Only a sadist could consider this situation acceptable,” they argued in court filings associated with their case.

The application drew opposition from existing healthcare companies in the region, the Mountain States Health Alliance and Frontier Health, and from East Tennessee State University.

They argued a methadone clinic was not needed, and even if it was, Tri-Cities was not the right company to operate it.

There also [was stiff opposition](#) from local residents, and from Johnson City officials, who did not want any methadone clinic in their community because of fears it would attract drug addicts and crime. Local opposition through the certificate of need process had killed multiple attempts by different companies to open an opioid treatment center in the Johnson City area since 2002.

In June 2013, the Tennessee Health Services Development Agency sided with the opposition and rejected the Tri-Cities application, declaring “need has not been clearly established.”

In May 2016, three years after the Tri-Cities application was rejected, Mountain States and East Tennessee State University announced plans to [open their own methadone clinic](#) in Johnson City. Frontier Health also was part of the deal.

Those companies raised the same justifications used by Tri-Cities when they filed for their own certificate of need in May 2016. As with Tri-Cities, their plan was to primarily dispense methadone, at least initially.

The Tennessee Health Services and Development Agency, which rejected the Tri-Cities proposal as unneeded three years earlier, [unanimously approved](#) the certificate of need for the existing providers in August 2016, three months after it was filed.

Kester, the primary applicant in the Tri-Cities proposal, said Tennessee's certificate of need law was used in his case both to benefit the existing providers and enforce the wishes of local politicians who did not want any methadone clinic in their communities. When it eventually became clear that a methadone clinic could not be kept out of the Johnson City area forever, the state board chose to award the certificate to the politically powerful healthcare companies already in the area, he said.

"How do these people justify a decade of resistance to this treatment when it's pregnant women making the drive? Then they flip-flop and say it's needed," he said. "For every patient who makes that awful drive, two or three won't. And nine out of 10 people who struggle with opioid addiction are not in treatment. So they are either going to overdose and die, or go to jail, or get proper treatment and recover.

"It was politics at its worst and people died. Addicts didn't get treatment and died because they opposed this for a decade."



500 East Coronado Road | Phoenix, Arizona 85004

Office (602) 462-5000 | Fax (602) 256-7045

www.GoldwaterInstitute.org