

Certificate for the Needy: How the Iowa CON Statute Harms the Mentally Ill

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ABSTRACT: This Note discusses Iowa’s regulatory certificate of need (“CON”) program. The CON program requires healthcare providers to seek and receive permission from the State prior to changing their facilities and services. This Note focuses on how this regulatory regime has had unintended consequences for mental healthcare and the people who rely on it for treatment. After providing a history of CON legislation and the mental health crisis in the United States, this Note specifically addresses how Iowa’s CON statute contributes to a poor mental health infrastructure and the increased rate of incarceration of people suffering from mental illness. This Note concludes with possible solutions that diminish the role of the CON process or increase the attention paid to mental health.

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* J.D. Candidate, University of Iowa College of Law, 2022; B.A., Truman State University, 2019. I would like to dedicate this Note to my mother, Linda Favero. I would also like to thank my parents for their unconditional support of my educational journey and thank you to my colleagues on the *Iowa Law Review* for their thoughtful feedback and thorough edits. This Note would not have been possible without you all.

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I. INTRODUCTION

It is not hard to imagine the difficulties of raising a child who has a form of mental illness. But what if the mental illness (or perhaps multiple illnesses) is so severe that it makes the child unpredictably aggressive and dangerous? For one Iowa mother, this hellish scenario became a reality when her mentally ill adult son, John, assaulted her.¹ Fearing for her safety, she called the police, who arrested her son.² Instead of being admitted for treatment, John sat in the limbo of the criminal justice system despite clearly not belonging there.³ In fact, the judges who handled John's case could immediately identify the fact that he had no capacity to be criminally responsible, and the charges against him were ordered to be dropped.⁴ But John was still left waiting for treatment, not because he did not need the treatment—he did—but because there was nowhere to treat him. There were no psychiatric beds available anywhere in Iowa.⁵ What is to be done with a mentally ill individual who cannot control their aggression and for whom treatment is unavailable? In this case, the solution was to place John in the county jail, where he stayed for

1. Mark Flatten, *CON Job: Certificate of Need Laws Used to Delay, Deny Expansion of Mental Health Options*, GOLDWATER INST. 2 (Sept. 25, 2018), <https://goldwaterinstitute.org/wp-content/uploads/2018/09/Mark-CON-paper-web.pdf> [<https://perma.cc/D9KJ-HSG0>]. In his article, Flatten offers a pseudonym for the son, but it happens to be the same name as the Author of this Note. The name has been changed to avoid confusion.

2. *Id.*

3. *Id.* According to Richard Vander Mey, one of the judges who handled John's case, John spent five days in the Tama County jail and an additional three days waiting in a hospital emergency room while people were searching for a psychiatric institution that would admit him. *Id.* at 2–3.

4. *Id.* at 2.

5. *Id.*

five days.⁶ This outcome, as bad as it was for John, is not the most egregious example. In September 2020, police in Salt Lake City, Utah shot a 13-year-old boy with autism after his mother called for help to address his mental health crisis.⁷ Across the United States, law enforcement programs are ill-equipped to handle individuals with mental illness, resulting in necessary treatment being the last thing administered to those in need.⁸ In John's case, there is a culprit behind the system's failure to help him: Iowa's "certificate of need" ("CON") law.⁹ Grappling with this law and its effects could help individuals like John.¹⁰

A CON law establishes "a state regulatory [program] that controls the number of health care resources in an area."¹¹ Generally, these programs "require a hospital or health system to demonstrate community need before establishing or expanding a health care facility or service."¹² Iowa's CON law requires medical providers "to get approval from a state regulatory board before building or expanding a facility or service."¹³ This process has been manipulated by a powerful healthcare lobby to prevent market competition.¹⁴ For instance, when a company sought to open a "72-bed inpatient mental health facility," the neighboring providers convinced Iowa's regulatory board that the services were not needed, even though tragedies like the one John endured were still occurring.¹⁵

Despite what powerful medical providers say, Iowa is not adequately addressing the needs of its mentally ill population, and the CON law is at least partially to blame. This Note will discuss how Iowa's CON law contributes to the growing problem of incarcerating mentally ill individuals and argues that the CON law should be repealed for the greatest positive effect¹⁶ or, in the alternative, amended to provide an exception for mental health facilities and

6. *Id.*

7. Rachel Treisman, *13-Year-Old Boy with Autism Disorder Shot by Salt Lake City Police*, NPR (Sept. 9, 2020, 6:46 AM), <https://www.npr.org/2020/09/09/910975499/autistic-13-year-old-boy-shot-by-salt-lake-city-police> [<https://perma.cc/WRP5-AKTX>].

8. See Mike Maciag, *The Daily Crisis Cops Aren't Trained to Handle*, GOVERNING (Apr. 27, 2016), <https://www.governing.com/archive/gov-mental-health-crisis-training-police.html> [<https://perma.cc/NAX4-843H>].

9. See generally Flatten, *supra* note 1 (discussing how Iowa's CON law restricts psychiatric bed access, resulting in mentally ill individuals being put in jail).

10. For solutions to the problems caused by CON laws, see *infra* Part IV.

11. Adney Rakotoniaina & Johanna Butler, *50-State Scan of State Certificate-of-Need Programs*, NAT'L ACAD. FOR STATE HEALTH POL'Y (May 22, 2020), <https://www.nashp.org/50-state-scan-of-state-certificate-of-need-programs> [<https://perma.cc/6W26-XCFS>].

12. *Id.*

13. Flatten, *supra* note 1, at 3.

14. See *id.* at 3-4.

15. *Id.* at 4.

16. In addition to the humanitarian impact of CON laws, they have increased healthcare costs despite being implemented to decrease them. The economic failures of CON laws are discussed further in Section II.A.2.

services. Part II delves into the history of the federal CON program and the corresponding Iowa program. Additionally, it takes stock of the current mental health crisis, both in and out of prisons, and how the crisis developed. Part III discusses the developments in Iowa's prison system and how mental illness is dealt with, placing emphasis on the perpetual effect that prison life has on mental health issues and how many facets of Iowa prisons denigrate those who are suffering. Part III provides a closer look at how Iowa's arduous and anticompetitive CON process has erected an obstacle for the proper treatment of mental illness, outside of the criminal justice system. Part IV proposes several solutions: (1) the complete repeal of the CON statute; (2) amend the statute to provide an exception for medical providers who seek to provide access to mental health treatment and psychiatric beds; or (3) state intervention to provide more mental health institutions and better care in prisons. Part V concludes with a call to action: CON statutes must be relegated to the history books, or the problems facing mentally ill individuals will persist.

II. THE HISTORY OF CON LAWS AND THE MENTAL HEALTH CRISIS

This Part unravels the history of the CON laws and how they became widespread throughout the country. More specifically, this Part outlines how CON laws were implemented in Iowa and how they are currently being used today. Furthermore, this Part will give an overview of the mental health crisis facing the United States and the State of Iowa. Discussing these two developments in healthcare history will demonstrate the link between the Iowa CON program and the unintended human consequences it has wrought on people with mental illness and the prison system.

A. FEDERAL INVOLVEMENT IN HEALTHCARE INFRASTRUCTURE

While the modern CON landscape began with the federal government's first forays into regulating the expansion of national healthcare infrastructure, the program virtually failed to achieve any one of its goals.¹⁷ Faced with these failures and rising healthcare costs, the federal government abandoned its CON program, leaving the decision to carry the CON mantle to the states.¹⁸ Therefore, because CON programs are matters of state regulation, this Section highlights how improvements must address the particular shortcomings of a given state's program.

17. See MATTHEW D. MITCHELL, MERCATUS CTR. GEO. MASON UNIV., CERTIFICATE-OF-NEED LAWS: ARE THEY ACHIEVING THEIR GOALS? 2-5 (2017), <https://www.mercatus.org/system/files/mitchell-con-qa-mop-mercatus-v2.pdf> [<https://perma.cc/gS7K-6QAR>].

18. See *infra* Section II.A.2.

1. Laying the Groundwork: The Hill–Burton Act of 1946
and Section 1122

In 1946, just under three decades before the federal government would mandate that the states adopt CON programs,¹⁹ Congress made its first foray into regulating the healthcare market’s infrastructure with the passage of the Hospital Survey and Construction Act,²⁰ also known as the Hill–Burton Act. Designed to remedy “perceived shortages of healthcare facilities” in the post-war era, the Hill–Burton Act offered funds to the states so that they could build new medical facilities.²¹ To qualify for this funding, state agencies would have to draft “a medical facilities plan” that inventoried the available facilities within the state, their operational capacity, and the need for new healthcare facilities.²² Consequently, healthcare providers were required to follow the plans created by state agencies to receive the funds allocated by the federal government.²³

The Hill–Burton Act did help eliminate the healthcare shortage targeted by the Truman administration. “By 1975, Hill-Burton had been responsible for [the] construction of nearly one-third of U.S. hospitals.”²⁴ This boom in healthcare infrastructure was not without its downsides, however. As more facilities became eligible for the grants,²⁵ the concern shifted to whether extensive availability of health services “would . . . lead to rising health care cost.”²⁶ After the creation of the Medicare and Medicaid programs in 1965,²⁷ reimbursement provisions—designed to benefit healthcare providers and

19. See Jessica C. Burt, *Certificate of Need (CON) Law Series: Part I – A Controversial History*, 5 HEALTH CAP. TOPICS 1, 1 (2012), https://www.healthcapital.com/hcc/newsletter/9_12/CERT.pdf [<https://perma.cc/H25A-KM45>] (discussing how the federal government required states to pass CON laws or funds would be withheld).

20. Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. § 291 (1976)).

21. Burt, *supra* note 19, at 1.

22. James B. Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 IND. L. REV. 1025, 1033 (1986).

23. *Id.*

24. John Henning Schumann, *A Bygone Era: When Bipartisanship Led to Health Care Transformation*, NPR (Oct. 2, 2016, 6:00 AM), <https://www.npr.org/sections/health-shots/2016/10/02/495775518/a-bystone-era-when-bipartisanship-led-to-health-care-transformation> [<https://perma.cc/43VF-8SSX>].

25. Simpson, *supra* note 22, at 1033–34. By the time the Hill–Burton Act had been on the books for a decade, a wide array of medical and healthcare facilities were eligible for grants. This included “nursing homes, rehabilitation facilities, chronic disease hospitals, diagnostic or treatment centers, outpatient facilities, hospital-related extended care facilities and home health services, equipment acquisitions, and emergency rooms.” *Id.* (footnote omitted).

26. Chad A. Heiman, Note, *Shifting Purpose: Why Iowa’s Certificate of Need Law is a Form of Economic Protectionism for Certain Iowa Health Care Providers and Should Be Repealed*, 104 IOWA L. REV. 385, 390 (2018); see also Simpson, *supra* note 22, at 1037 (considering the rising “Congressional concern with the costs of institutional health services” in the context of the ever-increasing cost of Great Society healthcare programs).

27. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).

decrease overall healthcare costs—added to the increasing healthcare costs.²⁸ To rectify the cost situation, Congress passed the Social Security Amendments of 1972.²⁹ In this statutory amendment, Congress included “Section 1122 [which] was designed to be an oversight mechanism requiring states that wanted to participate in the . . . reimbursement program to review and submit recommended capital expenditures to the Secretary of Health, Education, and Welfare . . . for approval.”³⁰ Section 1122 thus provided the foundation for later health planning legislation.³¹

2. The Federal CON Mandate: The National Health Planning and Resources Development Act

In 1974, the National Health Planning and Resources Development Act (“NHPDA”) was passed by Congress.³² The act became law the following year when it was signed by President Gerald Ford.³³ Finding that “equal access to quality health care at a reasonable cost is a priority of the federal government,”³⁴ “the purpose of [the NHPDA] was] to facilitate the development of recommendations for a national health planning policy” and “augment areawide and State planning for health services.”³⁵ More specifically, the goals of the NHPDA were

to 1) ensure an adequate supply of healthcare resources, 2) ensure access to health care for rural communities, 3) promote high-quality health care, 4) ensure charity care for those unable to pay or for otherwise undeserved communities, 5) encourage appropriate levels of hospital substitutes and healthcare alternatives, and 6) restrain the cost of healthcare services.³⁶

In order to achieve these goals, “[t]he act withheld federal funds from states that failed to adopt [CON] laws regulating healthcare facilities.”³⁷ This was not a hollow threat. The funding at stake “could amount to tens or even

28. Heiman, *supra* note 26, at 390–91. Medicare reimbursed “capital cost” for healthcare providers. *Id.* “Capital cost” is “actual cost[] of interest on capital indebtedness, an allowance for depreciation on capital assets, and a fixed rate of return on equity capital used by . . . health facilities for patient care.” Simpson, *supra* note 22, at 1037–38.

29. Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972).

30. Heiman, *supra* note 26, at 391. Projects that were reviewable under Section 1122 included those “that . . . ha[d] capital expenditures over \$100,000,” increased the number of beds, or altered the services offered by the facility. *Id.* These requirements reflect those of modern state CON laws. *Id.*

31. *Id.* at 391–92.

32. National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (repealed 1986).

33. *Id.*

34. *Id.* § 2(a)(1).

35. *Id.* § 2(b).

36. MITCHELL, *supra* note 17, at 1–2.

37. *Id.* at 1.

hundreds of millions of dollars” if the state did not comply with the federal directive.³⁸ To meet this directive states had to enact programs requiring any healthcare provider seeking to expand their facilities to obtain permission from a state regulatory board.³⁹ Faced with a loss of considerable federal funding, every state except Louisiana adopted some version of a CON program by 1982.⁴⁰

Pursuant to the NHPRDA, states were required to establish regulatory bodies called State Health Planning and Development Agencies (“SHPDA”).⁴¹ The SHPDA’s were tasked with “develop[ing] a state health plan incorporating [“local health planning” agency] plans and . . . administer[ing] [state] certificate of need programs.”⁴² Additionally, SHPDA’s performed much the same oversight and review functions that were prescribed to the Secretary of Health, Education, and Welfare by Section 1122 of the Social Security Amendment.⁴³ Bound by procedural review requirements and application criteria outlined in the NHPRDA, the state agencies reviewed projects submitted by healthcare providers that involved substantial capital expenditures or facility modification.⁴⁴

Congress viewed the establishment of a national health planning system as necessary to mitigate the problem of rising healthcare costs. Indeed, in 1974, the Senate published a report that found the price of medical care was increasing at a rate of 16.6 percent annually.⁴⁵ The report noted that this rate of increase was “higher than those recorded for all previous periods.”⁴⁶ Additionally, charges for hospital services were increasing at an annual rate of 18.7 percent.⁴⁷ With the consumer price index lagging behind at a rate of 13.7 percent per year, the concerns over increasing medical costs were

38. Simpson, *supra* note 22, at 1042. See *Manor Healthcare Corp. v. Nw. Cmty. Hosp.*, 472 N.E.2d 492, 494 n.3 (Ill. App. Ct. 1984) (describing how Illinois would lose \$465 million over a period of four years if its CON program were not in compliance with federal rules).

39. MITCHELL, *supra* note 17, at 1.

40. CON – Certificate of Need State Laws, NAT’L CONF. OF STATE LEGISLATURES (Dec. 1, 2019), <https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx> [<https://perma.cc/K7TV-L682>] [hereinafter NCSL].

41. Heiman, *supra* note 26, at 393.

42. Simpson, *supra* note 22, at 1042. The NHPRDA provided for Health System Agencies (“HSA’s”) to replace the local health planning boards. “HSA’s had the task of providing community based health planning for specified geographical areas. . . . HSA’s also were required to be allowed to participate in state certificate of need reviews by conducting a public meeting on proposed projects and submitting recommended findings with respect to projects.” *Id.*

43. *Id.* See *supra* note 30 and accompanying text.

44. Simpson, *supra* note 22, at 1042.

45. S. REP. NO. 93-1285, at 51 (1974), reprinted in U.S.C.C.A.N. 7842, 7893; see Patrick John McGinley, Comment, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a “Managed Competition” System*, 23 FLA. ST. U. L. REV. 141, 149 (1995) (discussing the Senate’s report on rising healthcare costs).

46. S. REP. NO. 93-1285, at 54.

47. *Id.*

exacerbated.⁴⁸ The cost of medical care was outpacing the average rising prices in other sectors of the economy. Thus, as the cost of medical care increased, consumers were only willing to pay for less expensive, more affordable services.

Congress interpreted the surplus of hospital beds as a contributor to the increasing costs. The Hill–Burton Act of 1946, designed to fix the shortage of available medical facilities, had “overcorrected” and produced a surplus.⁴⁹ In 1974, the Senate noted a surplus of 20,000 hospital beds; that surplus was expected to increase to over 67,000 beds in 1975.⁵⁰ Ironically, this incredible surplus of hospital beds failed to adequately address the country’s needs. Certain areas of the country were experiencing a shortage of beds as a result of population growth.⁵¹ Due to the clear misallocation of resources, Congress sought to control the distribution of new medical facilities with the regulatory CON programs, and thus control the rising healthcare costs.⁵²

Unfortunately for Congress, the NPHRDA failed to achieve its goals and healthcare costs across the United States continued to grow at astronomical rates. Some data indicated “prices and expenses [were] actually higher in areas with CON regulations than they [were] in areas without CON.”⁵³ Over a period of 15 years after the NPHRDA was enacted, “national hospital care expenditures increased from \$52.4 billion . . . to an estimated \$230.1 billion . . .”⁵⁴ “[T]he Department of Health and Human Services reported that America’s 1982 medical bill reached \$332 billion, or 10.5 percent of the gross national product.”⁵⁵ For the first time, the cost of medical care comprised over 10 percent of the U.S. GNP.⁵⁶ Empirical studies have overwhelmingly demonstrated that CON programs have increased healthcare expenditures, rather than decreased them.⁵⁷ In 2015, a Federal Trade Commissioner reported that CON programs are anti-competitive because they “restrict new entry and expansion” and “help incumbent firms amass or defend dominant

48. See McGinley, *supra* note 45 at 149 (discussing Congressional reports on the severity of inflation in the healthcare market during the 1970s).

49. Heiman, *supra* note 26, at 392.

50. S. REP. NO. 93-1285, at 24.

51. *Id.*

52. See Heiman, *supra* note 26, at 392; see also McGinley, *supra* note 45, at 150 (highlighting the government’s acknowledgement that the surplus of beds was a “maldistribution of health care facilities and manpower”) (quoting 42 U.S.C. § 300k(a)(3)(B) (Supp. V 1975)).

53. Mark E. Kaplan, Comment, *An Economic Analysis of Florida’s Hospital Certificate of Need Program and Recommendations for Change*, 19 FLA. ST. U. L. REV. 475, 487 (1991). Studies also suggest that CON programs cause “less efficient resource use and [thus,] higher [healthcare] costs.” *Id.*

54. McGinley, *supra* note 45, at 157.

55. Maja Campbell-Eaton, Note, *Antitrust and Certificate of Need: A Doubtful Prognosis*, 69 IOWA L. REV. 1451, 1451 (1984).

56. *Id.*

57. MITCHELL, *supra* note 17, at 5. As of 2017, only one out of twelve studies found that CON programs decrease healthcare spending across the board. *Id.*

market positions.”⁵⁸ Faced with the economic realities of the healthcare market, Congress repealed the NHRDA in 1986.⁵⁹ The federal repeal, however, did not stop states from continuing their CON programs. Since 1986, 12 states have fully repealed their CON laws,⁶⁰ with New Hampshire most recently enacting a repeal in 2016.⁶¹ However, 38 states (including Iowa), the District of Columbia, Puerto Rico, and the U.S. Virgin Islands all continue to maintain some form of the CON program.⁶² Despite having repealed its original CON law in 1999, Indiana rejoined the ranks of states that have a CON program in 2018.⁶³ Though the failures of these programs are demonstrable, CON programs are still a hurdle to the healthcare industry and the consumers that rely on it.

B. IOWA'S CON PROGRAM

Like most states, Iowa enacted a CON program in compliance with the NHRDA.⁶⁴ But, despite the data-driven concerns and subsequent repeal of the federal CON mandate,⁶⁵ Iowa has maintained its CON program. Much like any other regulatory structure, there is a complex process that healthcare providers must navigate to acquire the ability to expand their businesses.⁶⁶ These statutory provisions dictate the scope of the program, application and appeal procedures, and fees associated with the CON process.⁶⁷

58. Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs*, 30 ANTITRUST 50, 52 (2015); see FED. TRADE COMM'N & DEP'T OF JUST., JOINT STATEMENT OF THE FEDERAL TRADE COMMISSION AND THE ANTITRUST DIVISION OF THE U.S. DEPARTMENT OF JUSTICE ON CERTIFICATE-OF-NEED LAWS AND SOUTH CAROLINA HOUSE BILL 3250, at 1 (2016), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf [<https://perma.cc/LXT6-VRF6>] (“CON laws create barriers to entry and expansion, limit consumer choice, and stifle innovation.”). See generally Heiman, *supra* note 26 (criticizing Iowa’s CON law for being a form of economic protectionism).

59. See Pub. L. No. 99-660, § 701, 100 Stat. 3743, 3799 (1986) (repealing the NHRDA and ending the federal government’s CON mandate).

60. See NCSL, *supra* note 40 (providing a map that denotes what states have CON laws and listing the states that have fully repealed their CON programs to include North Dakota, South Dakota, Wyoming, Idaho, Colorado, California, Utah, Kansas, New Mexico, Texas, Pennsylvania, and New Hampshire).

61. *Id.*

62. *Id.* Arizona, Minnesota, and Wisconsin do not have official CON programs, “but they maintain several approval processes that function similarly to CON.” *Id.*

63. *Id.*

64. See NCSL, *supra* note 40.

65. See *supra* Section II.A.2.

66. See *infra* Section II.B.2.

67. See *id.*

1. Origins and Applicability

Following the passage of the NHPRDA, the Iowa Legislature established its own state CON program in 1978.⁶⁸ Pursuant to this statute, the Iowa Department of Public Health (“IDPH”) administers the CON program through the State Health Facilities Council (“Council”).⁶⁹ The primary purpose of the Council is “to assure that growth and changes in the health care system occur in an orderly, cost-effective manner and that the system is adequate and efficient.”⁷⁰ Accordingly, the Council is the final decision maker on CON applications.⁷¹

Iowa’s CON law applies to a huge swath of healthcare facilities and services. The statute provides that “[a] new institutional health service or changed institutional health service shall not be offered or developed in this state without prior application to the department for a receipt of a certificate of need.”⁷² Thus, any “institutional health facility” must apply for a certificate of need and be approved by the Council.⁷³ As defined by statute, these facilities include hospitals, “health care facilit[ies,]” “organized outpatient health facilit[ies,]” “outpatient surgical facilit[ies,]” “community mental health facilit[ies,]” and “birth center[s].”⁷⁴ “Health care facility” is further defined as “a residential care facility, a nursing facility, an intermediate care facility for persons with mental illness, or an intermediate care facility for persons with an intellectual disability.”⁷⁵ Under the statutory definitions, a “new institutional health service” or “changed institutional health service” includes the building or relocation of an institutional health facility, capital expenditures in excess of \$1.5 million over a one-year period, bed capacity changes, and the removal of services.⁷⁶ Plainly, the statute covers most, if not all, actions that healthcare providers can take regarding changes to their business, therefore requiring approval from the Council before the project may proceed.

68. See IOWA CODE §§ 135.61–135.70 (2019).

69. *Id.* §135.62(1).

70. Heiman, *supra* note 26, at 396 (quoting *Certificate of Need*, IOWA DEP’T OF PUB. HEALTH, <http://idph.iowa.gov/cert-of-need> [<https://perma.cc/9DGN-HFZ4>]).

71. IOWA CODE §§ 135.62(2)(e)(1), 135.69.

72. *Id.* § 135.63.

73. Heiman, *supra* note 26, at 396 n.100 (explaining that “Institutional Health Facilities are subject to the CON requirements because [they provide] institutional health [services]”).

74. IOWA CODE § 135.61 (14)(a)–(f).

75. *Id.* § 135C.1(8).

76. *Id.* § 135.61(18). The statute list of 18 examples of “new institutional health service” or “changed institutional health service” encompasses nearly all actions a healthcare provider could take to establish or modify its facilities and services. *Id.*

2. Practice and Procedure

Of course, Iowa's CON statute does more than define who or what it applies to. The majority of Section 135 of the Iowa Code is dedicated to outlining the procedures that healthcare providers must follow when seeking CON approval.⁷⁷ This subsection undertakes a detailed analysis of the Iowa CON statute provisions. From the filing of the initial application to the appeals process, the byzantine provisions of Iowa's CON law impose a significant burden on healthcare providers. Understanding the many facets of the statute helps give insight into why many providers are deterred from applying for a CON despite a desire or need to expand their market presence.

In Iowa, the process of obtaining a CON begins when an applicant medical provider submits a "letter of intent" to the IDPH.⁷⁸ This letter must be submitted at least 30 days prior to the submission of the CON application, and it must "include a brief description of the proposed new or changed service, its location, and its estimated cost."⁷⁹ Upon the receipt of a letter of intent, the IDPH conducts a preliminary review to identify any factors that could result in a denial so that the sponsor of the project may fix any errors before application.⁸⁰ Within 60 days after the submission of the letter of intent, the sponsor "may submit an application for a CON, pay a fee, and thereby commence a formal review of the application."⁸¹

Once an application is submitted, the IDPH must send notice that formal review has begun to "all affected persons."⁸² Notably, this includes other healthcare providers.⁸³ Additionally, the Council must conduct a public hearing on the application,⁸⁴ and the IDPH must "give at least ten days' notice

77. *Id.* §§ 135.63–135.70 (establishing the CON procedures that Iowa healthcare providers must follow).

78. *Id.* § 135.65(1).

79. *Id.*

80. *Id.* § 135.65(2). The factors are based on the application criteria outlined in section 135.64. *Id.* These criteria include, but are not limited to, the contribution of the proposed project to underserved populations, the need of the population where the proposed project will be located, and the availability of more effective alternative methods to provide the proposed services. *Id.* § 135.64(1).

81. *Planned Parenthood of Greater Iowa, Inc. v. Atchison*, 126 F.3d 1042, 1044 (8th Cir. 1997). Iowa's required application fees are substantial. The amount of the fee is set at "three-tenths of one percent of the anticipated cost of the [proposed] project," with a floor of \$600 and a ceiling of \$21,000. IOWA CODE §135.63(1) (2021). Thus, if a project's anticipated cost was \$1,000,000, the applicant would have to pay a fee of \$3,000. There are also refund procedures in the event that the application is withdrawn. *Id.*

82. IOWA CODE § 135.66(2).

83. *Id.* Other than the sponsor of the project and the geographical competitors, "affected persons" includes "[c]onsumers who would be served by the new institutional health service[,] . . . [a]ny other person designated as an affected person by . . . the department[, and] . . . [a]ny payer or third-party payer for health services." *Id.* § 135.61(1)(a)–(f).

84. *Id.* § 135.66(3)(b).

of the time and place of the hearing.”⁸⁵ At application hearings, “any affected person or” their representative can present testimony.⁸⁶ This public hearing process demonstrates the weakness of CON programs identified by the Federal Trade Commission.⁸⁷ In light of the lack of representative limitations in the statute, affected persons can essentially lobby against the proposed project. “In practice, the public hearing provides the applicant’s potential competitors with a platform to speak against the project and protect their interests.”⁸⁸

After the hearing stage, the application enters the evaluation stage.⁸⁹ During evaluation by the Council, the application is measured against an extensive list of criteria outlined in the statute.⁹⁰ However, meeting these criteria are not sufficient for an application to receive approval from the Council. A CON application will be granted only if data supplied to the IDPH demonstrates that: (1) “[l]ess costly, more efficient, or more appropriate alternatives to the proposed institutional health service are not available and the development of such alternatives is not practicable[.]”⁹¹ (2) “[a]ny existing facilities providing institutional health services similar to those proposed are being used in an appropriate and efficient manner[.]”⁹² (3) “[i]n the case of new construction, alternatives including but not limited to modernization or sharing arrangements have been considered and have been implemented to the maximum extent practicable[.]”⁹³ and (4) “[p]atients will experience serious problems in obtaining care of the type which will be furnished by the proposed new institutional health service or changed institutional health service, in the absence of that proposed new service.”⁹⁴

Upon the completion of the review process, the Council must issue a written decision with findings in support of confirmation or denial,⁹⁵ or it can table the application until the ninety-day review period expires, which automatically denies the application.⁹⁶ An applicant can appeal the decision made by the Council through administrative and, ultimately, judicial review.⁹⁷ In 2020, Iowa’s CON statute was challenged by two Iowa outpatient medical providers and their patients on the grounds that it violated the constitutional

85. *Id.* § 135.66(4).

86. *Id.*

87. *See supra* note 58 and accompanying text.

88. Heiman, *supra* note 26, at 399.

89. IOWA CODE § 135.66(3)(a)–(b).

90. *Id.* § 135.64(1)(a)–(r).

91. *Id.* § 135.64(2)(a).

92. *Id.* § 135.64(2)(b).

93. *Id.* § 135.64(2)(c).

94. *Id.* § 135.64(2)(d).

95. *Id.* § 135.69.

96. *Id.*

97. *Id.* § 135.70; *see also* Heiman, *supra* note 26, at 401 (discussing Iowa’s decision review process).

rights of certain medical providers and patients.⁹⁸ The U.S. Court of Appeals for the Eighth Circuit upheld the constitutionality of the Iowa statute, concluding that the statute “is rationally related to a legitimate state interest in full-service hospital viability.”⁹⁹

C. THE MENTAL HEALTH CRISIS AT HOME AND BEHIND BARS

The United States has begun battling an emerging mental health crisis over the last decade. In 2019 the National Institute of Mental Health (“NIMH”) reported that over 51.5 million Americans (over 20 percent of the population) are suffering from any mental illness (“AMI”).¹⁰⁰ The NIMH also reported that, of the total number of individuals with a mental health diagnosis, around one-fourth had a serious mental illness (“SMI”).¹⁰¹ SMI “is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities,” whereas AMI generally refers to all mental illness regardless of severity.¹⁰²

In 2015, the Substance Abuse and Mental Health Services Administration (“SAMHSA”) reported that Iowa had a slightly higher percentage of individuals with a SMI than the national average.¹⁰³ Providing positive context against that subpar statistic, however, is that a 2020 Mental Health America report ranked Iowa fourth among all states and the District of Columbia for its high access to mental health treatment.¹⁰⁴ Curiously, this data does not account for the number of mental health facilities or beds within the state.¹⁰⁵

98. See *Birchansky v. Clabaugh*, 955 F.3d 751, 754–55 (8th Cir. 2020). Appellant’s argument was primarily based on the Due Process and Equal Protection Clauses of the Fourteenth Amendment. *Id.*

99. *Id.* at 757–58.

100. *Mental Illness*, NAT’L INST. OF MENTAL HEALTH (Jan. 2021), <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml> [<https://perma.cc/DC56-4YXT>].

101. *Id.* at fig.3. This accounts for roughly 5.2 percent of all U.S. adults, or 13.1 million people.

102. *Id.* There are many recognized mental illnesses that differ in severity, including anxiety disorders, depression, and dissociative disorders. See *Mental Health Conditions*, NAT’L ALL. ON MENTAL ILLNESS (2021), <https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions> [<https://perma.cc/P5GW-DXAX>].

103. SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., BEHAVIORAL HEALTH BAROMETER: IOWA, 2015, at 10 (2015), <https://idph.iowa.gov/Portals/1/userfiles/205/Health%20Barometer%202015%20Report.pdf> [<https://perma.cc/H3W6-YTQM>].

104. MADDY REINERT, THERESA NGUYEN & DANIELLE FRITZE, MENTAL HEALTH AM., THE STATE OF MENTAL HEALTH IN AMERICA 2020 19 (2020), <https://www.mhanational.org/sites/default/files/State%20of%20Mental%20Health%20in%20America%20-%202020.pdf> [<https://perma.cc/5CPD-5ZYB>]. *Contra* E. FULLER TORREY, LISA DAILEY, H. RICHARD LAMB, ELIZABETH SINCLAIR & JOHN SNOOK, TREATMENT ADVOC. CTR., TREAT OR REPEAT: A STATE SURVEY OF SERIOUS MENTAL ILLNESS, MAJOR CRIMES AND COMMUNITY TREATMENT 54 (2017), <https://www.treatmentadvocacycenter.org/storage/documents/treat-or-repeat.pdf> [<https://perma.cc/MKU3-J3QU>] (assigning Iowa a “D-” and noting that Iowa only had 1.2 psychiatric beds per 100,000 adults in 2016).

105. See REINERT ET AL., *supra* note 104, at 19.

While mental illness is a widely recognized problem, the treatment and handling of individuals experiencing a mental health crisis are poor. In the United States, “2 million . . . people with . . . mental illness are booked into jails [each year].”¹⁰⁶ Consequently, those individuals in dire need of treatment are placed situations where they will not receive medical or psychological therapy and their conditions will worsen.¹⁰⁷ In fact, a U.S. Department of Justice report from 2006 found that “more than half of all prison and jail inmates had a mental health problem”¹⁰⁸ The mentally ill “represented 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates.”¹⁰⁹ Iowa fares no better. The Iowa Department of Corrections (“IDOC”) reported in 2017 that “one-third of the prison population in Iowa was suffering from a serious mental illness” while the total population with a mental illness “constituted fifty-seven percent of the prison population.”¹¹⁰

Mental illness is so prevalent among prison populations because the care these people need cannot be provided.¹¹¹ Around the middle of the twentieth century, public opinion of psychiatric institutions dramatically shifted, becoming critical of hospitals “for inhumane and disturbing treatments.”¹¹² The stigma surrounding “asylums” caused these facilities to shutter, spurring a process known as deinstitutionalization.¹¹³ Deinstitutionalization dramatically reduced the number of patients held in state psychiatric

106. *Mental Health by the Numbers*, NAT’L ALL. ON MENTAL ILLNESS (Mar. 2021), <https://www.nami.org/mhstats> [<https://perma.cc/MYH5-N8WV>].

107. *See id.*

108. DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUST. STAT., U.S. DEP’T OF JUST., *MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1* (2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf> [<https://perma.cc/3T3Z-PN7B>].

109. *Id.*

110. Robert R. Rigg, *Patient One: An Exploration of Criminal Justice and Mental Health*, 16 *IND. HEALTH L. REV.* 67, 67–68 (2018).

111. *See* Paul Wood, Joy Burwell & Kaitlyn Rawlett, *New Study Reveals Lack of Access as Root Cause for Mental Health Crisis in America*, NAT’L COUNCIL FOR MENTAL WELLBEING (Oct. 10, 2018), <https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america> [<https://perma.cc/UWL2-8gZG>].

112. Ana Swanson, *A Shocking Number of Mentally Ill Americans End Up in Prison Instead of Treatment*, *WASH. POST* (Apr. 30, 2015), <https://www.washingtonpost.com/news/wonk/wp/2015/04/30/a-shocking-number-of-mentally-ill-americans-end-up-in-prisons-instead-of-psychiatric-hospitals> [<https://perma.cc/9E8R-C4Y9>].

113. *See* E. FULLER TORREY, AARON D. KENNARD, DON ESLINGER, RICHARD LAMB & JAMES PAVLE, NAT’L SHERIFFS’ ASS’N & TREATMENT ADVOC. CTR., *MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 2* (2010), https://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf [<https://perma.cc/GD53-MKG5>] (describing the faults of deinstitutionalization). Deinstitutionalization began after a period of what could simply be termed “institutionalization”. In the nineteenth century, “most mentally ill persons were being housed in local jails and prisons” and “[s]uch conditions were regarded as inhumane.” *Id.* Through the efforts of reformers like Dorothea Dix, the United States went from having one psychiatric bed “for every 5,000 people in the” mid-1800s to having one psychiatric bed “for every 300 people in” 1955. *Id.* at 14. This incredible ratio was achieved and maintained over the course of a century and a population growth of around 140 million. *See id.*

institutions from 558,922 in 1955, to around 35,000 in 2015.¹¹⁴ Though patients were removed from the overcrowded state mental health institutions, “[b]y the early 1970s, it was becoming evident that the emptying of the state mental hospitals had resulted in a marked increase in the number of mentally ill individuals in jails and prisons.”¹¹⁵ Deinstitutionalization effectively criminalized mental illness: Mentally ill patients were moved from one ill-equipped institution to another, perhaps more ill-equipped institution. One psychiatrist commented on the increase of incarcerated mentally ill individuals: “We are literally drowning in patients Many more men are being sent to prison who have serious mental problems.”¹¹⁶ These trends have continued into the twenty-first century. From 2005 to 2010, the number of available “state psychiatric beds decreased by 14%” nationwide.¹¹⁷

Over that same period, Iowa reduced its number of beds by 38 percent.¹¹⁸ While Iowa was reducing bed capacity, the number of mentally ill prisoners increased. A 2014 report stated that the Iowa state-operated psychiatric hospitals held a total of 231 patients, while the Polk County Jail—housing 2,500 prisoners—held more inmates with SMIs than all of the state hospitals combined.¹¹⁹

Iowa is facing a mental health crisis. Instead of treating individuals with mental illness, Iowa has been incarcerating them. This phenomenon does not necessarily represent any animus towards those with mental illness, but it is representative of an ignorance of need. Shortages of psychiatric beds have resulted in vulnerable individuals being locked away without access to the care they desperately need.¹²⁰ By inhibiting fair competition and necessary expansion of healthcare infrastructure, Iowa’s CON law has produced this shortage of psychiatric care facilities and—indirectly—incarcerated some of Iowa’s most vulnerable citizens.

114. Swanson, *supra* note 112.

115. TORREY ET AL., *supra* note 113, at 2.

116. *Id.* (quoting Marc F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 HOSP. & CMTY. PSYCHIATRY, 13, 16 (April 1972)).

117. E. FULLER TORREY, DORIS A. FULLER, JEFFREY GELLER, CARLA JACOBS & KRISTINA RAGOSTA, TREATMENT ADVOC. CTR., NO ROOM AT THE INN: TRENDS AND CONSEQUENCES OF CLOSING PUBLIC PSYCHIATRIC HOSPITALS 5 (2012), https://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf [<https://perma.cc/2HM8-BHEW>].

118. *Id.* at 22 tbl.1.

119. E. FULLER TORREY, MARY T. ZDANOWICZ, AARON D. KENNARD, H. RICHARD LAMB, DONALD F. ESLINGER, MICHAEL C. BIASOTTI & DORIS A. FULLER, TREATMENT ADVOC. CTR. & NAT’L SHERIFFS’ ASS’N, THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 49 (2014), <https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf> [<https://perma.cc/A77D-XJKB>]. If one-third of Iowa’s prisoners have a SMI, then Polk County Jail house has roughly 825 prisoners with a SMI. *See id.* The report also notes that five state prisons have more individuals with SMIs than the largest state hospital in Mount Pleasant. *See id.*

120. *See generally* Flatten, *supra* note 1 (connecting Iowa’s CON law to mentally ill individuals being placed in jail).

III. IOWA'S CON LAW HAS HARMED MENTAL HEALTH

Since the repeal of the NHPRDA in the 1980s, CON programs have received harsh criticism and “[have] elicited a remarkable evaluative consensus—that [they] do[] not work.”¹²¹ This Part addresses how Iowa's CON law has failed, in the economic and humanitarian contexts. Iowa's CON statute has failed to achieve its purpose of controlling healthcare costs, and it has simultaneously restricted access to healthcare services.¹²² The overly complicated CON process in Iowa has contributed to this failure and has allowed anticompetitive interests to have a significant say in how Iowa's healthcare market is structured.¹²³

As a result, Iowa's mental health infrastructure has suffered. Despite a clear need for more facilities and services that treat and care for the mentally ill, Iowa currently does not have enough of these services. This lack of adequate mental health facilities and services has left Iowa with one predominant option: incarceration. Iowa's prisons have become saturated with mentally ill inmates who are unable to be treated.¹²⁴ The prison system either refuses, or is incapable of, offering treatment to its mentally ill population. This leads to abuses and a cycle of incarceration for the mentally ill. While Iowa's CON law remains on the books it is unlikely that this cycle will be broken.

A. IOWA'S CON STATUTE INHIBITS COMPETITION IN THE HEALTHCARE MARKET

Scholars who have analyzed the history and effects of CON regulatory programs observe that the goal of reducing healthcare costs has not been achieved.¹²⁵ In fact, CON programs have contributed to the increased cost of healthcare.¹²⁶ An economic analysis of the practical effects of CON laws demonstrates this antithetical outcome. CON programs are designed to decrease healthcare costs by decreasing the supply of healthcare services.¹²⁷ In turn, “[b]y decreasing the supply of health care . . . CON regulations also reduce the quantity of services consumed.”¹²⁸ The shift in supply results in a

121. Heiman, *supra* note 26, at 402 (quoting Kaplan, *supra* note 53, at 487).

122. *Id.*

123. *See infra* Section III.A.

124. *See* Rigg, *supra* note 110, at 67–68 (finding that over half of Iowa's prison population has some form of mental illness).

125. *See* Heiman, *supra* note 26, at 403; MITCHELL, *supra* note 17, at 5.

126. MITCHELL, *supra* note 17, at 5, 6 tbl.1; *see supra* Section II.A.2 (noting economic trends in the healthcare market following the enactment of the NHPRDA).

127. MITCHELL, *supra* note 17, at 2.

128. *Id.* at 5; *see also* Grace Bogart, Note, *Iowans Need Change: The Case for Repeal of Iowa's Certificate of Need Law*, 45 J. CORP. L. 221, 235–36 (2019) (illustrating the economic principles behind CON laws). Bogart compares CON laws to coal mines to illustrate how decreasing supply

rise in the equilibrium price for healthcare services.¹²⁹ So despite having the noble purpose of decreasing the cost of medical services, CON programs have instead “increase[d] the cost per unit of each service.”¹³⁰ Although it is possible that this CON supply shift could decrease overall expenditures in the healthcare market,¹³¹ the inelastic nature of healthcare services and increased per-unit cost has driven up the total cost for consuming healthcare.¹³²

If it is the case that CON programs are not achieving their goals, why keep them on the books? The answer is that these regulatory programs benefit powerful providers in the healthcare market.¹³³ When an Iowa healthcare provider has obtained a CON from the Council, it does not have to seek permission for each additional change in institutional health services or facilities so long as the subsequent proposed project costs less than \$1.5 million.¹³⁴ However, if a provider wants to introduce new institutional health services or facilities and it does not yet have a CON, it must go through a “prohibitively expensive, time-consuming, and potentially fruitless” process that is unpredictable and subject “to political influence.”¹³⁵ The regulatory scheme established by Iowa’s CON statute makes it difficult for newcomers to establish a foothold in the Iowa healthcare market. The fees for an application are often steep,¹³⁶ and the application process involves substantial time and investment.¹³⁷

Iowa’s CON statute grants procedural relief—that is, a ticket to skip the normal steps of the process—to those providers that are able to obtain a CON while forcing other providers to slog through the bureaucratic red tape with only the hope for a chance to receive approval from the Council.¹³⁸ The exemption from the CON process was not created out of the goodness of the Iowa Legislature’s heart; it likely came as a result of political influence.

can also decrease expenditures, noting that “as a coal mine depletes its resources and as time passes, less coal will be purchased overall.” *Id.*

129. MITCHELL, *supra* note 17, at 5.

130. *Id.* (emphasis omitted); see also Bogart, *supra* note 128, at 235–36.

131. See MITCHELL, *supra* note 17, at 5 (acknowledging the possibility that CON laws can decrease overall expenditures); see also Bogart, *supra* note 128, at 235–36 (noting that consumers “benefit [more] from a decrease in per-unit cost rather than a decrease in total health care expenditures”).

132. Bogart, *supra* note 128, at 236 (noticing that this effect is common among “regulated health care services”).

133. See Heiman, *supra* note 26, at 409 (highlighting how Iowa’s CON program “benefit[s] some health care providers at the expense of others”).

134. IOWA CODE § 135.61(18)(c)–(j) (2021); see Heiman, *supra* note 26, at 409 (discussing the exemption for CON holders and how it results in a disparate application of the law among those in the healthcare market).

135. Heiman, *supra* note 26, at 406.

136. *Id.*; see *supra* Section II.B.2.

137. See Heiman, *supra* note 26, at 406 (noting that applicants not only have to pay fees, but they often require outside counsel and consultation to assist in the acquisition of a CON).

138. See *supra* notes 133–37.

Reports demonstrate “that medical interest groups have a sizable presence at the Iowa State Capitol.”¹³⁹ Because “very few . . . industries . . . are as regulated and as affected by government action,” healthcare interest groups were among the top spenders for payments to lobbyist in 2017.¹⁴⁰ Two large medical interest groups ranked second and third in spending, collectively spending nearly \$500,000 in Des Moines.¹⁴¹ There is no clear confirmation that lobbying has any bearing on the decisions made by the Council, but it is at least a possibility that healthcare providers with a smaller market share struggle to navigate the CON process because it is “influenced by established health care providers and their opportunity to exert political influence.”¹⁴² Indeed, in other industries—like fireworks and alcohol—Iowa has legislated favorably in response to increased lobbying expenditures.¹⁴³ Thus, it is plausible that large healthcare providers may exercise control over their market through the Iowa Legislature. While in recent years the Council has approved CON applications far more often than it has denied them,¹⁴⁴ this recent trend does not account for medical providers who have opted not to go through the CON process.

B. IOWA’S MENTAL HEALTH INFRASTRUCTURE DOES NOT SERVE THE NEEDS OF THE POPULATION

Iowa’s prisons would not need to bear responsibility for mentally ill individuals if adequate care were available elsewhere in the state. Following legislation reworking Iowa’s mental health infrastructure, 14 Mental Health and Disabilities (“MHDS”) Regions govern the administration of mental health care within their jurisdictions.¹⁴⁵ The administrator of each region applies “guidelines and standards of care” set by the IDPH and the Iowa Department of Human Services (“IDHS”).¹⁴⁶ This administrative framework does not allocate equal funding to each MHDS region. Rather, state funding

139. Heiman, *supra* note 26, at 408.

140. Brienne Pfannenstiel, *Special Interest Groups Spend Big at Iowa Capitol*, DES MOINES REG. (Aug. 26, 2017, 2:43 PM), <https://www.desmoinesregister.com/story/news/politics/2017/08/24/special-interest-groups-spend-big-iowa-capitol/579725001> [<https://perma.cc/DF2X-QT6Q>]. The five big spenders were (in order of rank): (2) Iowa Hospital Association, (3) Iowa Medical Society, (4) Wellmark, Inc., (9) Mercy Health Network, and (10) Iowa Health Care Association. *Id.* Collectively, they spent \$968,026 on lobbying. *Id.*

141. *See id.* (reporting that the Iowa Hospital Association, ranking second, paid \$265,800 to ten differently lobbyists and Iowa Medical Society, ranking third, paid \$204,759 to lobbyist groups).

142. Heiman, *supra* note 26, at 408.

143. *See* Pfannenstiel, *supra* note 140.

144. *Annual Reports*, IOWA DEP’T OF PUB. HEALTH (2021), <https://idph.iowa.gov/policy-and-workforce-services/cert-of-need/reports> [<https://perma.cc/CX8X-MRLS>]. Between Fiscal Year 2017 and 2020, the Council only denied three applications, all in 2018. *Id.*

145. David L. Rappenecker, Note, *Lost Causes? Why Iowans with Mental Illness Face an Uphill Battle for Social Security Disability Benefits*, 106 IOWA L. REV. 1555, 1572 (2021) (discussing legislation that redesigned publicly funded mental health and disability services).

146. *Id.*

is distributed according to “performance-based contract[s] between the state and each regional administrator.”¹⁴⁷ Most mental health resources are concentrated in counties with higher populations.¹⁴⁸ Left with few resources, rural parts of Iowa are unable to overcome the performance-based allocation system to improve their mental health services. In turn, the services remain inadequate and yield less funding under the contracts.¹⁴⁹ Despite receiving a high ranking for low prevalence of mental illness and high access to care,¹⁵⁰ Iowa does not have enough mental health resources to serve its mentally ill population.¹⁵¹ As of July 1, 2019, Iowa had an estimated population of 3,155,070 people,¹⁵² of whom approximately “600,000 [individuals] live with some form of mental illness.”¹⁵³ In “2019, there were 3,672 mental healthcare professionals licensed in the State of Iowa.”¹⁵⁴

This means that for every one mental healthcare professional there are nearly 4,000 people to serve.¹⁵⁵ The National Alliance on Mental Illness reported that Iowa ranked “47th in psychiatrists [and] 44th in mental health workforce availability,” making it one of “the worst states in the nation for treatment.”¹⁵⁶ A 1:4000 ratio makes it effectively impossible for all those who need treatment to actually receive it.

Predictably, the mental health resources of the state are primarily used in more populated areas, so there is a serious “degree of disparity” between high and low populated areas.¹⁵⁷ For some sparsely populated counties, there are no licensed psychologists or psychiatrists, and there may only be a few social workers or mental health counselors.¹⁵⁸ Thus, some Iowans are unable

147. *Id.*

148. *Id.* (noting that three counties possess around 70 percent of “acceptable medical sources”).

149. *See id.* at 1577.

150. REINERT ET AL., *supra* note 104, at 15. The report ranked Iowa number nine out of the fifty states and the District of Columbia. *Id.*

151. *See* Rappenecker, *supra* note 145, at 1572–75 (measuring the amount of mental health professionals in relation to Iowa’s population). *But see* REINERT ET AL., *supra* note 104, at 19 (ranking Iowa #4 for access to mental health services).

152. *QuickFacts: Iowa*, U.S. CENSUS BUREAU (July 1, 2019), <https://www.census.gov/quickfacts/IA> [<https://perma.cc/UVY5-YKY5>].

153. *Facts and Figures*, NAT’L ALL. ON MENTAL ILLNESS: IOWA, <https://namiiowa.org/about-mental-illness/facts-figures> [<https://perma.cc/84QX-FCC5>]. 37,000 Iowans have a serious mental illness. *Id.*; *see also* Rappenecker, *supra* note 145, at 1573–74 (using national averages to conclude that Iowa has roughly 546,575 citizens with a mental illness).

154. Rappenecker, *supra* note 145, at 1573. This number is comprised of psychiatrists, psychologists, licensed clinical social workers, and mental health counselors. *Id.*

155. Rappenecker, *supra* note 145, at 1573–74.

156. *Iowa Must Act to Alleviate Mental Health Care Deficit*, NAT’L ALL. ON MENTAL ILLNESS: IOWA, <https://namiiowa.org/iowa-must-act-to-alleviate-mental-health-care-deficit> [<https://perma.cc/CNU9-UFME>]; *but see* REINERT ET AL., *supra* note 104, at 19 (giving Iowa a high ranking for access to care).

157. Rappenecker, *supra* note 145, at 1574.

158. *Id.* app. 1.

to obtain mental healthcare because there are no geographically proximate providers.¹⁵⁹ In situations like this, the traditional options are stark: forgo treatment, or incur additional personal expense travelling across the state to find an available provider. Encouragingly, the social distancing measures implemented due to the COVID-19 pandemic have given rise to increased use of teletherapy.¹⁶⁰ But as the pandemic wanes, it remains to be seen whether teletherapy can be a lasting solution.¹⁶¹

Not only are licensed mental healthcare professionals in short supply and scattered around the state, but mental healthcare facilities are also lacking in Iowa. In 2019, SAMHSA conducted a national survey, finding that Iowa had 143 mental health facilities, nearly ninety percent of which were private institutions.¹⁶² Of those 143 facilities, 70 percent specialize in the treatment of mental health.¹⁶³ As with mental healthcare professionals, mental healthcare facilities are scattered across the state, with most being located near major population centers such as Polk, Johnson, or Linn Counties.¹⁶⁴ While most counties have at least one facility, 36 of Iowa's 99 counties do not have any facilities within their borders.¹⁶⁵

Per Treatment Advocacy Center, to meet the minimum standards for adequate treatment, a state must provide “[a] minimum of 50 beds per

159. *See id.* at 1577.

160. Jeffrey Kluger, *Online Therapy, Booming During the Coronavirus Pandemic, May Be Here to Stay*, TIME (Aug. 27, 2020, 8:00 AM), <https://time.com/5883704/teletherapy-coronavirus> [<https://perma.cc/2SG6-9XAG>]. The American Psychiatric Association reported that “before COVID-19 hit, only 2.1% reported using tele-psych 76-100% of the time. During the pandemic that figure has soared to 84.7%.” *Id.*

161. *See Teletherapy During COVID-19: What The Research Says*, MENTAL HEALTH AM. (2021), <https://mhanational.org/teletherapy-during-covid-19-what-research-says> [<https://perma.cc/QC8B-TMKZ>] (arguing that teletherapy “shouldn’t permanently replace face-to-face therapy – at least not for everyone”).

162. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., 2019 STATE PROFILE — UNITED STATES AND OTHER JURISDICTIONS NATIONAL MENTAL HEALTH SERVICES SURVEY (N-MHSS) 65 (2019), https://www.samhsa.gov/data/sites/default/files/reports/rpt29398/2019_NMHSS_StPro_combined.pdf [<https://perma.cc/NC8S-STE5>]. The complete breakdown is as follows: 120 private non-profit, eight private for-profit, one state mental health agency, two other state government agencies or departments, three regional/district authority or county, local, or municipal government, and nine Department of Veterans Affairs facilities. *Id.*

163. This number is comprised of psychiatric hospitals, community mental health centers, partial hospitalization/day treatment facilities, outpatient mental health facilities, and multi-setting mental health facilities. *Id.* at 66.

164. For a map showing the distribution of mental health facilities in Iowa, *see id.* at 68.

165. *Id.* In comparing the map of facilities with the counties that have no psychiatrists or psychologists, 22 of the 36 Iowa counties that do not have a mental health facility also do not have any psychiatrists or psychologists. *See Rappenecker, supra* note 145 app. 1. While some of these counties are fortunate enough to border more populous counties with adequate mental health resources, some of them do not have convenient access to professional or institutional help, leaving them in a lurch when treatment is desperately needed.

100,000 people.”¹⁶⁶ According to Iowa Mental Health Advocacy, there are only 731 psychiatric beds available across the state.¹⁶⁷ These beds are distributed across the state in 20 of Iowa’s 99 counties.¹⁶⁸ Most beds are operated by private institutions, with only 96 of the recorded psychiatric beds in Iowa attributed to public mental health institutions.¹⁶⁹ Only 64 of these beds can serve adult patients with mental illness, while 32 serve children or adolescents.¹⁷⁰ Thus, Iowa is drastically short of the necessary beds to provide adequate care, providing only two beds per 100,000 people.¹⁷¹ So few beds per 100,000 people ranks Iowa as the worst in beds per capita out of any state and the District of Columbia.¹⁷²

The situation is not improving. Over the course of six years, Iowa’s number of adult psychiatric beds diminished by 85 beds.¹⁷³ This came as a result of Governor Terry Branstad’s closure of “two state institutes in Clarinda and Mount Pleasant.”¹⁷⁴ The closures seem to have been spurred by a reluctance to pay for mental healthcare, though low patient counts may have also been a contributing factor.¹⁷⁵ While it should be easy to decrease the

166. *Iowa*, TREATMENT ADVOC. CTR. (2018), <https://www.treatmentadvocacycenter.org/browse-by-state/iowa> [<https://perma.cc/JB68-W7TC>] [hereinafter TAC *Iowa*]. See DORIS A. FULLER, ELIZABETH SINCLAIR, JEFFREY GELLER, CAMERON QUANBECK & JOHN SNOOK, TREATMENT ADVOC. CTR., GOING, GOING, GONE: TRENDS AND CONSEQUENCES OF ELIMINATING STATE PSYCHIATRIC BEDS, 2016, at 11 (2016), <https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf> [<https://perma.cc/HP2A-55ZE>] (describing the 50 per 100,000 standard as “widely accepted”).

167. *Iowa Mental Health Institutes*, IOWA MENTAL HEALTH ADVOC. (2021), <https://iamentalhealth.com/iowa-psych-beds> (last visited July 12, 2021). This number considers both adult and child beds. *Id.*

168. For a map showing the distribution of psychiatric beds throughout Iowa, see *id.*

169. *Id.*

170. *Id.* Iowa defines children as a person younger than eighteen years old. IOWA CODE § 225.C.2(2); TAC *Iowa*, *supra* note 165. Iowa has the lowest number of psychiatric beds out of any state and the District of Columbia, excluding Vermont, which has 25 beds. See *id.* However, Vermont has an estimated population of 623,989, while Iowa has a population around 3.1 million. *QuickFacts: Vermont*, U.S. CENSUS BUREAU (July 1, 2019), <https://www.census.gov/quickfacts/VT> [<https://perma.cc/BC6P-8EJC>].

171. TAC *Iowa*, *supra* note 166; Michael Ollove, *Amid Shortage of Psychiatric Beds, Mentally Ill Face Long Waits for Treatment*, PBS NEWS HOUR (Aug. 2, 2016), <https://www.pbs.org/newshour/nation/amid-shortage-psychiatric-beds-mentally-ill-face-long-waits-treatment> [<https://perma.cc/7S4R-SUY3>].

172. TAC *Iowa*, *supra* note 166. Though Iowa is ranked last among its state colleagues, “every state . . . fails to meet [the] minimum standard” of fifty beds per 100,000 people. *Id.*

173. *Id.*; Ollove, *supra* note 171.

174. Editorial, *Iowa Ranks Last for State Psychiatric Beds*, DES MOINES REG. (June 13, 2016, 12:17 PM), <https://www.desmoinesregister.com/story/opinion/editorials/2016/06/11/editorial-mentally-ill-locked-out-psychiatric-care/85550738> [<https://perma.cc/NN79-9PMN>].

175. See Tony Leys & Brianne Pfannenstiel, *Branstad Open to Closing Two Remaining Mental Hospitals*, DES MOINES REG. (July 6, 2015, 5:25 PM), <https://www.desmoinesregister.com/story/news/health/2015/07/06/branstad-open-closing-two-remaining-mental-hospitals/29783363> [<https://perma.cc/2C6D-X762>].

number of beds, increasing bed capacity is complicated by the CON process. Under Iowa's CON statute, an exemption is given for the reduction of bed capacity so long as the institutional health facility "reports to the department the number and type of beds reduced" and "reports the new bed total on its next annual report to the department."¹⁷⁶ However, if an institutional health facility wants to permanently increase its bed capacity, it is subject to the CON process.¹⁷⁷ The obstacles imposed by the CON process will deter private mental health providers from adding new beds. Moreover, if the state continues to close its public institutions,¹⁷⁸ available beds will become even more rare in Iowa.

All this data suggests that Iowa has a mental healthcare deficit. There are not enough services or facilities to serve the needs of the population. But what can be done to solve this problem? At the moment, the only option for mental healthcare providers is to abide by the CON process.¹⁷⁹ Under the Iowa CON statute, the definition of "institutional health facility" is extraordinarily broad, encompassing most healthcare providing entities, and more specifically "community mental health facilit[ies]."¹⁸⁰ "Institutional health service" is also defined very broadly as "any health service furnished in or through institutional health facilities or health maintenance organizations."¹⁸¹ New facilities or new services require a CON issued from the Council.¹⁸² Thus, if a hospital wanted to add a psychiatric wing, permanently change their number of psychiatric beds, or add a mental health counseling program, it would be required to obtain a CON from the Council. Because the CON process is complicated,¹⁸³ it is difficult to provide new mental health services and

176. IOWA CODE § 135.63(g)(1)(a)-(b) (2019).

177. § 135.61(18)(d) (including "[a] permanent change in bed capacity . . . of an institutional health facility" under the definition of "[n]ew institutional health service" and "changed institutional health service"); § 135.63 (requiring a CON for new or changed institutional health services).

178. Governor Branstad left "open the possibility of closing one or both of the remaining two located in Independence and Cherokee." Editorial, *supra* note 174. At the time this Note was written, both the Independence and Cherokee facilities remain in operation. *Mental Health Institutes*, IOWA DEP'T OF HUM. SERVS. (2021), <https://dhs.iowa.gov/mhds-providers/facilities/mental-health-institutes> [<https://perma.cc/3CCU-MAZ7>]. Interestingly, Iowa seems to be headed in a different direction. In July 2020, Governor Kim Reynolds committed "\$50,000,000 in federal funds allocated through the CARES Act" to mental health. *Gov. Reynolds Steers \$50M CARES Funds Toward Iowa's Mental Health System*, OFF. OF THE GOVERNOR OF IOWA (July 7, 2020, 2:45 PM), <https://governor.iowa.gov/press-release/gov-reynolds-steers-50m-cares-funds-toward-iowa%E2%80%99s-mental-health-system> [<https://perma.cc/GJ2K-DWWT>] [hereinafter *Iowa CARES*]. None of the \$50 million, however, is to be allocated toward increasing bed capacity. *See id.*

179. *See supra* Section II.B (discussing the scope of Iowa's CON law and how the application process works).

180. § 135.61(14)(a)-(f).

181. § 135.61(15) (emphasis added).

182. § 135.63(1); *see also* § 135.61(18)(a)-(m) (defining what qualifies as a "new institutional health service" or a "changed institutional health service").

183. *See supra* Section II.B.2 (detailing Iowa's CON process as outlined by the statute).

facilities when they are needed. Therefore, Iowa's CON program has erected an obstacle for mental health care providers who recognize the need for additional facilities and services.

C. IOWA'S CRIMINAL JUSTICE SYSTEM IS STRAINED DUE TO LACK
OF PSYCHIATRIC CARE

As a result of shuttering mental health facilities and dwindling access to mental health treatment brought on by deinstitutionalization,¹⁸⁴ individuals who suffer from mental illness often experience crises that place them in contact with law enforcement.¹⁸⁵ Law enforcement officers, however, are usually not equipped to handle individuals in crisis.¹⁸⁶ The standard training for law enforcement makes it “far easier and more convenient for an officer to arrest that person than subject him to a mental health evaluation.”¹⁸⁷ As a result, “in the United States there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals.”¹⁸⁸ Not only are there more mentally ill individuals in jails and prisons, but they are being confined longer than their non-mentally ill counterparts.¹⁸⁹ The unfortunate reality, though, is that mentally ill individuals are being placed into the criminal justice system for committing “a petty, nuisance-type offense” or no offense at all.¹⁹⁰

A review of Iowa's prison system reveals how Iowans with an SMI are impacted by the criminal justice system. As of 2017, Iowa prisons housed 8,207 inmates across nine penitentiary facilities.¹⁹¹ Of the total inmate population, around one-third had a SMI.¹⁹² Over half of the prison population had some form of mental illness.¹⁹³ These numbers continue to grow. In 2020, the IDOC reported that its prison population had risen to 8,475.¹⁹⁴ In a 2021 daily statistics report, the IDOC calculated that the prison system was

184. See discussion *supra* Section II.C.

185. See Frank M. Webb, *Criminal Justice and the Mentally Ill: Strange Bedfellows*, 49 TEX. TECH L. REV. 817, 821 (2017) (finding that around “7%-10% of all police contacts involve interactions with persons experiencing a form of mental illness”).

186. *Id.*

187. *Id.* at 822.

188. *Id.* (quoting TORREY ET AL., *supra* note 113, at 1).

189. JAMES & GLAZE, *supra* note 108, at 9 (noting that state prisoners with mental health issues served an average of four months longer).

190. Webb, *supra* note 185, at 821. Petty offenses are crimes like shoplifting or trespassing. *Id.* at 823–24.

191. Rigg, *supra* note 110, at 67 n.1.

192. *Id.* at 67.

193. *Id.* at 67–68.

194. IOWA DEP'T OF CORR., IOWA DEP'T CORR., FY2019 ANNUAL REPORT 20 (2020), https://doc.iowa.gov/sites/default/files/documents/2019/11/fy2019_doc_annual_report.pdf [<https://perma.cc/ZRR5-BV7L>]. Strangely, this report does not contain statistics on mental illness in Iowa prisons.

overcrowded by 11.53 percent.¹⁹⁵ Thus, the mentally ill are being placed into facilities that cannot hold them and cannot treat them. Because prisons are ill-equipped to treat the wide range of mental illnesses that come through the door, many inmates who are released end up behind bars again.¹⁹⁶ Over a three-year period, the Iowa Board of Parole (“IBOP”) found that of the individuals with some form of mental illness around two-thirds of them found their way back into the prison system.¹⁹⁷

Perhaps if jails and prisons were better equipped to address mental illness, the current crisis would subside. But correctional facilities are not designed to be treatment centers for the mentally ill.¹⁹⁸ Even though mental illness is not criminally sanctioned, jails and prisons—the places least able to help—are a likely destination for sufferers. These institutions generally lack the necessary equipment to safely treat and respond to mental illness and the personnel with the knowledge and training necessary to treat inmates.¹⁹⁹ A Bureau of Justice statistical report found that only around one-third of state prisoners with mental illness received treatment for their condition after being admitted.²⁰⁰ Consequently, two-thirds of mentally ill inmates who need treatment are not receiving it after they are incarcerated.

Furthermore, many mentally ill prisoners are treated with only medication.²⁰¹ In Iowa, nearly one-third of county jails “do not provide mental

195. *Daily Statistics: 09/01/21*, IOWA DEP’T OF CORR., <https://doc.iowa.gov/daily-statistics> [<https://perma.cc/7LW2-BP3G>]. The total prison population on September 1, 2021, was 7,779, while the capacity was 6,933. *Id.* This dramatic decrease from the 2019 population total likely reflects efforts to remove prisoners from their overcrowded facilities in the wake of the COVID-19 pandemic. If one were to use the 2019 population figures, the prisons would be overcrowded by 22.24 percent ($8,475 - 6,933 = 1,542$; $1,542 \div 6,933 = 22.24\%$). If it were not for the pandemic, the overcrowding situation would be much worse.

196. See Kristen M. Zgoba, Rusty Reeves, Anthony Tamburello & Lisa DeBilio, *Criminal Recidivism in Inmates with Mental Illness and Substance Use Disorders*, 48 J. AM. ACAD. PSYCHIATRY L. 1, 1 (2020), <http://jaapl.org/content/jaapl/early/2020/02/12/JAAPL.003913-20.full.pdf> [<https://perma.cc/8FAR-GNAA>] (noting that “83 percent [of inmates] will be returned to the criminal justice system within nine years of release”).

197. IOWA Bd. OF PAROLE, IOWA BOARD OF PAROLE ANNUAL REPORT FISCAL YEAR 2018, at 17 (2020), https://bop.iowa.gov/sites/default/files/documents/2018/12/final_annual_report_fy18_1.pdf [<https://perma.cc/A5F5-JUQ4>]. The rate among men was 65.7 percent while the rate among women was notably higher at 69.8 percent. *Id.*

198. See Chris Lehman, *Prison Mental Health Unit Not Designed for Treatment*, NPR (Feb. 24, 2012, 8:11 PM), <https://www.npr.org/templates/story/story.php?storyId=147384637> [<https://perma.cc/7UG4-S8DB>]; Maggie Puniewska, *The Prison System Is Designed to Ignore Mental Illness*, VICE (June 1, 2017, 12:00 PM), <https://www.vice.com/en/article/bj8gy4/the-prison-system-is-designed-to-ignore-mental-illness> [<https://perma.cc/8DVZ-6694>].

199. DISABILITY RTS. IOWA, IN JAIL AND OUT OF OPTIONS: AN EXAMINATION OF THE SYSTEMIC ISSUES AFFECTING THE HOUSING AND TREATMENT OF IOWANS WITH MENTAL ILLNESS IN COUNTY JAILS 4–5 (2016), <https://disabilityrightsiowa.org/wp-content/uploads/In-Jail-and-Out-of-Options.pdf> [<https://perma.cc/CU62-UGLP>].

200. James & Glaze, *supra* note 108, at 9. Inmates in local jails were treated far less often, with only 17 percent reporting treatment since admission. *Id.*

201. See DISABILITY RTS. IOWA, *supra* note 199, at 5.

health treatment beyond medication.”²⁰² Under Eighth Amendment jurisprudence, these jails may be failing to meet their constitutional burden to their mentally ill inmates.²⁰³ “Courts have determined that an inmate’s right to mental health treatment is no different than their right to physical health treatment.”²⁰⁴ However, proving that a correctional facility has failed to meet the needs of its mentally ill inmates is very difficult.²⁰⁵ The abuse of mentally ill individuals by the prison system is also a serious problem for a system that is not designed to treat these illnesses in the first place.²⁰⁶ Abuse compounds “the extraordinary stresses of incarceration” resulting from a lack of treatment.²⁰⁷ “Once behind bars, [mentally ill inmates] may go long periods without needed medication and likely [are] subjected to noise, the loss of sleep, isolation, and rules and punishments they don’t understand, all of which can lead to deterioration in their mental condition.”²⁰⁸

Fortunately, the psychiatric institutions in Iowa seem to be meeting the constitutionally required level of care that jails and prisons cannot. These institutions provide other forms of treatment in addition to medication, such as in-house psychiatric care, or virtual or outside care.²⁰⁹ Seeking treatment for inmates is difficult, though, because Iowa’s sparse mental health network imposes “significant logistical and financial burdens on jail[s].”²¹⁰ In fact, housing and treating a mentally ill inmate costs up to three times more than treating them with “community mental health services.”²¹¹ If the CON statute did not require state permission to establish care facilities, it is possible that jails and prisons would have more inexpensive and proximate options for the treatment of inmates. Iowa’s CON process contributes to the increasing numbers of mentally ill individuals in the prison system. Because there is a

202. *Id.*

203. *Id.* at 19 (referring to *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) and *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977)).

204. *Id.*

205. See Lori A. Marschke, *Proving Deliberate Indifference: Next to Impossible for Mentally Ill Inmates*, 39 VAL. U.L. REV. 487, 519–32 (2004) (discussing the difficulty of proving “that a serious medical need exists and that the prison officials were deliberately indifferent to that need” when making a claim for cruel and unusual punishment).

206. See Timothy Williams, *Mentally Ill Inmates Are Routinely Physically Abused, Study Says*, N.Y. TIMES (May 12, 2015), <https://www.nytimes.com/2015/05/12/us/mentally-ill-prison-inmates-are-routinely-physically-abused-study-says.html> [<https://perma.cc/U6AH-2925>] (documenting several types of serious physical abuse such as “being doused with chemical sprays, shocked with electronic stun guns and strapped for hours to chairs or beds”).

207. *Id.*

208. Fresh Air, *Behind Bars, Mentally Ill Inmates Are Often Punished for Their Symptoms*, NPR, at 0:15 (July 10, 2018), <https://www.npr.org/transcripts/627519801> [<https://perma.cc/W4MY-NAJ9>].

209. DISABILITY RTS. IOWA, *supra* note 199, at 20.

210. *Id.*

211. See Mary Giliberti, *Treatment, Not Jail: It’s Time to Step Up*, NAT’L ALL. ON MENTAL ILLNESS: FROM THE CEO: BLOG (May 5, 2015), <https://www.nami.org/Blogs/From-the-CEO/May-2015/Treatment-Not-Jail-It%E2%80%99s-Time-to-Step-Up> [<https://perma.cc/YH2A-2UgG>].

lack of mental health resources in Iowa,²¹² there is an increased likelihood that mentally ill people will end up incarcerated. If the CON process were not so burdensome on the mental healthcare providers required to navigate it, the establishment of new facilities and services tailored to the treatment of mental health would help alleviate the stress currently placed on jails and prisons.²¹³ However, in its current state, the CON law makes preventative measures designed to keep the mentally ill out of the prison system too difficult an undertaking. Thus, some of society's most vulnerable individuals will continue to go untreated in a system diametrically opposite of the ideal [one].

IV. SOLUTIONS

Because CON programs have demonstrably failed in their goal to cut healthcare costs²¹⁴ and have had serious unintended consequences for the mental healthcare infrastructure and the people it serves,²¹⁵ the Iowa Legislature should consider changes to the CON regime. This Note suggests three possible solutions to the problematic CON process and the unintended damage it has wrought: (1) a full repeal of the Iowa CON law; (2) amendment of the statute to add either a permanent or temporary exemption for institutional health facilities and services pertaining to mental health; or (3) increased state involvement and expenditure in mental healthcare infrastructure.

The full repeal solution would have the widest impact, remedying the economic and human problems caused by the CON program. Alternatively, the amendment-exemption solution would target the specific evils done to mental healthcare in Iowa. The third solution for increased state intervention focuses primarily on correcting the infrastructural issues caused by the CON program without disturbing the statutory regime. This Part involves a deeper discussion of each solution.

A. COMPLETE REPEAL

This Note contends that a full repeal by the Iowa Legislature would be the most economical and most humane solution to the CON problem. The reasons for repeal are clear: The CON statute does not achieve its goals and harms healthcare businesses and citizens in Iowa.²¹⁶ Iowa's CON statute was enacted with the purpose of "[i]ncreasing Iowan's access to health care services, while controlling cost."²¹⁷ However, this purpose has not been

212. See *supra* Section III.B.

213. See *infra* Part IV.

214. See *supra* Section II.A.2.

215. See *supra* Section III.B–C.

216. See *supra* Section III.

217. Heiman, *supra* note 26, at 402.

achieved.²¹⁸ Moreover, a complete repeal would not frustrate the legislature's purpose. "[S]tudies indicate that no decrease in patients' access to health care services or quality of care results following CON's repeal. In fact, following repeal access and quality typically increase, while the per capita cost of health care decreases."²¹⁹ It is estimated that "healthcare spending in Iowa could drop by \$217 per capita, and rural hospital access could increase from 89 to 127.1 hospitals, if CON laws were to be repealed."²²⁰ Additionally, repealing the statute would "likely lead to increased investment throughout the state by health care providers who . . . were wary of investing previously due to the burdensome, expensive, and unpredictable CON process."²²¹ Consequently, apprehensive *mental* healthcare providers would be more likely to invest and fill the gaps in Iowa's mental healthcare infrastructure.²²² With greater access to care, resources could be focused "on diverting the individual with mental illness to treatment, rather than to jail, with the general understanding that it is more effective, vastly more cost efficient . . . and the morally right thing to do."²²³ Thus, Iowa's CON law stands in the way of its intended purpose. There has been some movement to deal with the problematic CON law. In 2018, a bill was introduced in the Iowa Senate to repeal the CON program, however it "did not receive a vote in committee, thus it died during the . . . legislative session."²²⁴

B. AMENDMENT

Another possible solution this Note proposes is amendment of the Iowa CON law to provide an exemption for new institutional health facilities and services that primarily focus on the treatment of mental illness. In its current form, the CON statute requires healthcare providers to obtain a CON from the Council for a wide range of projects, some of which are directly implicated in mental healthcare operations.²²⁵ This administrative burden should be lessened by providing an explicit exemption for mental healthcare providers or to remove the provisions of the statute that inhibit the development of

218. See *id.* at 412 n.221 (recognizing "that no empirical research or study has been done specifically on the effect of CON in the state of Iowa" and CON failures are based on general conclusions); see also *supra* Section II.A.2 (discussing national healthcare cost increases following the enactment of the federal CON mandate).

219. Heiman, *supra* note 26, at 413 (footnote omitted).

220. Bogart, *supra* note 128, at 239, 239 nn.141-42 (recognizing that this data is based on a speculative profile compiled from other state CON data).

221. Heiman, *supra* note 26, at 413.

222. See *supra* Section III.B (assessing Iowa's widespread lack of mental health resources).

223. DISABILITY RTS. IOWA, *supra* note 199, at 28. These kinds of efforts are called "prevention interventions" because they are designed to prevent the mentally ill individuals from "being introduced or reintroduced to the criminal justice system." *Id.*

224. See Heiman, *supra* note 26, at 414 (discussing S.F. 2021, introduced by Senator Brad Zaun).

225. See *supra* notes 70-77 and accompanying text.

mental health resources.²²⁶ Should full repeal prove politically infeasible, several states have already enacted similar amendments.²²⁷ Florida repealed parts of their CON law to provide exemptions to “general hospitals, complex medical rehabilitation beds and tertiary hospital services” while still retaining oversight for other facilities, like nursing homes.²²⁸ An amendment similar to this form would give mental healthcare providers more freedom to address the glaring lack of available resources. Ideally, this would result in resources being allocated to areas throughout the state rather than a continuation of the current concentration around major population centers.²²⁹

A recently proposed amendment in the Iowa House of Representatives would achieve this goal.²³⁰ H.F. 422 would have the Iowa Legislature amend the CON statute to redefine “institutional health facility” to mean only “an assisted living program or a nursing facility.”²³¹ By removing the large number of healthcare providers from the definition of institutional health facility, H.F. 422 would no longer require these institutions to receive certificates of need for projects involving institutional health services.²³² Unfortunately, H.F. 422 failed to pass panel discussions.²³³ Reviving this proposal may be unpopular with established healthcare providers,²³⁴ but it would effectively shrink the CON program to controlling a relatively insignificant portion of the healthcare market. This Note supports the adoption of the revised language found in H.F. 422 because not only would it liberate mental healthcare providers from the strictures of the CON regime, but it would also allow regular healthcare providers to freely conduct their business as they see fit without seeking state approval.

226. To achieve the latter suggestion, IOWA CODE ANN. § 135.61(14)(2019) must be amended to remove “community mental health facilit[ies]” from the list of institutional health facilities that are required to obtain a CON. Additionally, § 153.61(18)(d) should be removed to give mental healthcare providers greater latitude in determining the bed capacity necessary to serve the community.

227. See Matthew D. Mitchell, Elise Amez-Droz & Anna Miller (Parsons), *Phasing Out Certificate-of-Need Laws: A Menu of Options*, MERCATUS CTR. (Feb. 25, 2020), <https://www.mercatus.org/publications/healthcare/phasing-out-certificate-need-laws-menu-options> [<https://perma.cc/4A36-UVV3>] (discussing Florida and West Virginia’s CON carve-outs); Jack Pitsor, *States Modernizing Certificate of Need Laws*, NAT’L CONF. OF STATE LEGISLATURES (Dec. 6, 2019), <https://www.ncsl.org/research/health/states-modernizing-certificate-of-need-laws.aspx> [<https://perma.cc/6T63-972Z>] (listing nine states that modified their CON laws in 2019 to “exempt[] several health facilities and services from regulation”).

228. Pitsor, *supra* note 227.

229. See *supra* note 148 and accompanying text.

230. See H.F. 422, 87th Gen. Assemb. (Iowa 2017); see also Heiman, *supra* note 26, at 415 (discussing H.F. 422).

231. H.F. 422, 87th Gen. Assemb. (Iowa 2017); see Heiman, *supra* note 26, at 415.

232. See H.F. 422, 87th Gen. Assemb. (Iowa 2017).

233. Heiman, *supra* note 26, at 415.

234. See *supra* notes 133–36 and accompanying text; Heiman, *supra* note 26, at 414.

C. STATE INTERVENTION IN MENTAL HEALTHCARE

As a third solution to the growing number of mentally ill individuals in the prison system and a lack of mental health resources throughout Iowa, this Note proposes that the State of Iowa invest in public mental healthcare facilities and services. This option may be unlikely considering the number of state psychiatric hospitals was reduced from four to two,²³⁵ but Governor Reynolds's use of federal funds to improve mental health resources demonstrates a willingness to invest in this needed infrastructure.²³⁶

For this solution to be effective, it is imperative that the State increase and efficiently distribute mental health resources throughout Iowa. Because both facilities and services are lacking, the State of Iowa needs to address both. First, the Iowa Legislature should “[i]ncrease the number of inpatient mental health beds that serve the specific needs of individuals with mental illness . . . in all geographic regions of the state.”²³⁷ Part of this increase in beds should involve the reopening of the public psychiatric institutions closed by Governor Branstad.²³⁸ Doing so would restore 85 adult psychiatric beds.²³⁹ Additionally, the State must “[i]ncentivize attraction and retention of psychiatrists, psychologists and other qualified mental health professionals” and “[e]nsure that there are qualified mental health professionals in every region of the state.”²⁴⁰ Ensuring that qualified professionals are accessible throughout the state will allow those who need treatment to be tended to by experts instead of correctional officers in the event the mentally ill are incarcerated. Increasing and improving mental health resources will also help jails and prisons treat their inmates considering that around 43 percent of Iowa jails transport inmates for outside treatment.²⁴¹ Easier access to outside resources would allow inmates to receive better treatment and would alleviate some of the burden placed on jails and prisons.²⁴²

Given the risk of recidivism among mentally ill inmates,²⁴³ it is important for the State to invest in resources to “ensure continuity of care” upon release.²⁴⁴ Though jails and prisons may not provide the best mental health treatment, they may be the only way for individuals to receive medication or

235. See *supra* note 174 and accompanying text.

236. See *supra* note 178 and accompanying text.

237. DISABILITY RTS. IOWA, *supra* note 199, at 39.

238. See *supra* notes 174–78 and accompanying text.

239. TAC Iowa, *supra* note 166.

240. DISABILITY RTS. IOWA, *supra* note 199, at 39.

241. *Id.* at 21 fig.12.

242. See *supra* note 198 and accompanying text.

243. See *supra* notes 196–97 and accompanying text.

244. *Access to Mental Health Care and Incarceration*, MENTAL HEALTH AM. (2021), <https://www.mhanational.org/issues/access-mental-health-care-and-incarceration> [<https://perma.cc/F4GP-XSJH>] [hereinafter MHA *Incarceration*].

care.²⁴⁵ Therefore, it is critical that the State work to identify needs and prepare a support system for recently released inmates prior to their actual release.²⁴⁶ A robust continuity of care system “helps ensure that the benefits of treatment and the investment of resources . . . are not squandered upon release.”²⁴⁷ Continuing the care for released inmates can help address the problem of recidivism.²⁴⁸

The State could also invest in prophylactic measures to avoid placing the mentally ill in the criminal justice system in the first place. A good first step would be intervening at the earliest stages to support students with mental health conditions.²⁴⁹ Students that struggle with mental illness are more likely to encounter the criminal justice system at some point in their life.²⁵⁰ Screenings and community resources may help avoid the often-negative outcomes for these students.²⁵¹ Furthermore, the State could utilize diversion programs rather than the criminal justice system.²⁵² These programs establish courts designed to “work in collaboration with mental health and substance use treatment providers.”²⁵³ 24 states have diversion programs for mental illness, and 39 states have diversion programs for substance abuse.²⁵⁴ However, Iowa does not have diversion programs tailored to these areas and, instead, only has a general diversion program.²⁵⁵ That said, diversion programs are not a panacea. Access to treatment through these programs requires a guilty plea and subjects the person to possible incarceration.²⁵⁶ Thus, Mental Health America suggests that states should “explore the use of pre-bookings diversion.”²⁵⁷ Because the mentally ill often come into contact with police due to their mental illness, it is better to seek treatment right away instead of arresting someone for factors outside of their control.²⁵⁸

Strangely, the COVID-19 pandemic has given Iowa an opportunity to take some steps in the right direction. In July 2020, Governor Kim Reynolds

245. *See id.*

246. *See id.*; M. Jarrett, G. Thornicroft, A. Forrester, M. Harty, J. Senior, C. King, S. Huckle, J. Parrott, G. Dunn & J. Shaw, *Continuity of Care for Recently Released Prisoners with Mental Illness: A Pilot Randomised Controlled Trial Testing the Feasibility of a Critical Time Intervention*, 21 EPIDEMIOLOGY & PSYCHIATRIC SCIS. 187, 192 (2012) (discussing the viability of “a transitional role between prison and community mental health services” in England).

247. Matt McKillop, *Health Care Continuity After Prison Protects Investments and Progress*, PEW (June 22, 2018), <https://www.pewtrusts.org/en/research-and-analysis/articles/2018/06/22/health-care-continuity-after-prison-protects-investments-and-progress> [<https://perma.cc/FJT6-M77Y>].

248. *See id.*

249. *See MHA Incarceration, supra* note 244.

250. *See id.*

251. *See id.*

252. *Id.*

253. *Id.*

254. *Pretrial Diversion*, NAT’L CONF. OF STATE LEGISLATURES (Sept. 28, 2017), <https://www.ncsl.org/research/civil-and-criminal-justice/pretrial-diversion.aspx> [<https://perma.cc/T3Q3-Q4US>].

255. *Id.*

256. *MHA Incarceration, supra* note 244.

257. *Id.*

258. *See id.*

earmarked some CARES Act funds for investment in mental health resources.²⁵⁹ Ten million dollars is dedicated to Medicaid mental healthcare providers, while another 30 million is to be divided equally among each MHDS region to support the increased demand caused by the pandemic.²⁶⁰ Though it is unclear exactly what this money will be spent on, investing in the aforementioned programs or institutions would address some of the most pressing issues of the mental health crisis.

Though state intervention would require various legislative actions and adjustments to the budget to accommodate for new spending, this solution is the only one that allows the CON program to continue unfettered. This Note does not endorse the continuation of the CON regime, but a state-backed solution would render any repeal or amendment significantly less necessary. If new public resources adequately address the many holes in Iowa's mental healthcare infrastructure and help redirect the mentally ill from prison toward treatment, there is no need to repeal the CON statute.

V. CONCLUSION

CON programs have failed to reduce healthcare costs. Yet, that was their design. Many states and the federal government have recognized this failure and retreated from regulating the expansion of the healthcare market with CON laws. However, Iowa has not. In Iowa, the CON law has failed in another way: It prevents help from reaching one of the State's most vulnerable populations—the mentally ill. Consequently, Iowa faces a serious mental health crisis in its criminal justice system. The CON program is a large contributing factor to the difficulties in solving Iowa's mental health crisis, but it is not the only factor. As this Note suggests, several solutions could alleviate this burden on the criminal justice system. The CON hurdle must be eliminated, or the State must step in to help its citizens in need.

259. See *Iowa CARES*, *supra* note 178.

260. See *id.*