

**Certificate of Public Need Process Reform and Improvement**  
Pursuant to SB1283

**Initial Findings and Recommendations**



*Report of*

**Virginia Hospital & Healthcare Association  
COPN Task Force**

**June 2015**

## I. Introduction

Virginia’s certificate of public need (“COPN”) law – a cornerstone of Virginia health care policy for over 40 years – is a regulatory mechanism through which the state ensures efficient use of resources, access to care for the indigent, availability of essential health services, and patient safety and quality of care. The policy rationale underlying the COPN law recognizes the unique roles that hospitals play for their communities (*e.g.*, access to emergency care for all 24/7, public health and disaster readiness, treating all members of their community regardless of their ability to pay) and the cross-subsidies that are inherent in our health care finance system.

Virginia Hospital & Healthcare Association (“VHHA”) has historically supported the continuation of the COPN law and has maintained that any changes to the COPN law must be done in a thoughtful manner to avoid destabilizing our health care delivery system. This is especially true in light of current market conditions where health care providers are already under financial stress and undergoing a transformation from volume to value in the delivery of health care services. At the same time, however, VHHA has recognized that COPN process improvements and related efficiencies should be pursued.

In response to a resurgence of interest in possible reforms to the COPN law heading into the 2015 General Assembly session, the VHHA Board established a COPN Committee to develop a consensus public policy position on COPN. Ultimately, the Board adopted a public policy position that reaffirmed support for a comprehensive approach to any deregulation, while at the same time working to advance process and regulatory reforms aimed at improved efficiency and effectiveness of COPN performance.

The actions of the General Assembly were largely consistent with this public policy position. The General Assembly passed SB1283 and Item 278 #2C of the budget (the “COPN study legislation”), both of which direct the Secretary of Health and Human Resources (“Secretary”) to establish a work group “to review the current certificate of public need process and the impact of such process on health care services in the Commonwealth, and the need for changes to the current certificate of public need process.”

In order to prepare VHHA and its members to meaningfully participate in the Secretary’s work group on COPN pursuant to this legislation (the “Secretary’s Work Group”), VHHA created a COPN task force (the “COPN Task Force”). The COPN Task Force was charged with developing specific recommendations in each area identified in the legislation for consideration by the Board COPN Committee.

The COPN Task Force was encouraged to relate its analysis and recommendations back to the principles for COPN regulation reaffirmed by the Board COPN Committee and the Board in 2014:

1. ***Access to Care for the Uninsured.*** Any changes to COPN regulation must be paired with policies to expand coverage or otherwise assure access to safety net health care for the uninsured.

2. ***Availability of Essential Health Services for all Virginians.*** Any changes to COPN must not jeopardize the availability of services that are essential, but not necessarily financially self-sustaining (e.g., trauma, burn care, psychiatric, and OB in some communities).
3. ***Readiness for Public Health and Disaster Care Needs.*** Any changes to COPN regulation should not compromise the health system's or community's ability to effectively respond to public health crises (e.g., highly infectious disease outbreaks), a natural or other disaster.
4. ***Training the Future Healthcare Workforce.*** Any changes to COPN regulation should assure continued support for medical and health professional education.
5. ***Assuring Quality of Care Oversight and Accountability.*** Any changes to COPN regulation should require similar quality of care standards and accountability for all providers delivering similar services in all practice settings.

The COPN Task Force is composed of a Chair, Mary N. Mannix, VHHA Board Chair-Elect and President and CEO, Augusta Health, and six subgroups that report to the Chair. Each subgroup was assigned one or more areas enumerated in the COPN study legislation to research, analyze and prepare findings and recommendations for consideration by the Board COPN Committee and ultimately the VHHA Board.

The COPN Task Force limited the scope of its work to the specific directives identified in the COPN study legislation and an interpretation of the language therein that the Secretary's Work Group is intended to address the current COPN *process*, the impact of such *process* on health care services in the Commonwealth, and the need for any changes to the current COPN *process*. Accordingly, it did not consider deregulation of COPN in whole, or in part, or evaluate alternatives to COPN review.

This report summarizes the initial findings and recommendations of the COPN Task Force related to each area specified in the COPN study legislation. The initial findings and recommendations of the COPN Task Force are subject to change and further refinement in response to requests for further review by the VHHA Board, the Secretary, or the General Assembly or additional information obtained from proceedings of the Secretary's Work Group or other sources.

## **II. Process by which Applications for Certificates of Public Need are Reviewed, the Criteria upon which Decisions about Issuance of Certificates of Public Need are Based, and Barriers to Issuance of a Certificate of Public Need (Subgroup 1)**

### **a. Overview**

Virginia implemented its COPN law in 1973, one year before the National Health Planning and Resources Development Act (P.L. 93-641) was passed by Congress. This federal legislation required all states to enact a health planning and certificate of need review process. The federal mandate was repealed effective January 1, 1987, but Virginia, like many states, retained its certificate of need law.

The Division of Certificate of Public Need (“DCOPN”) of the Virginia Department of Health, Office of Licensure and Certification has primary responsibility for administering the certificate of need review process in Virginia. DCOPN processes and reviews applications and makes a recommended decision to the State Health Commissioner (the “Commissioner”) who is responsible for making a final decision to approve or deny applications for a COPN. In some regions of the state, currently only Northern Virginia (Planning District 8), a Regional Health Planning Agency (“RHPA”) also reviews applications and makes a recommended decision to the Commissioner.<sup>1</sup> Decisions by the Commissioner are required to address eight different considerations required by statute<sup>2</sup> (“Eight Statutory Considerations”) and to be consistent with the State Medical Facilities Plan (“SMFP”) established by regulation.<sup>3</sup>

There are nineteen different project types that are subject to the requirement to obtain a COPN. The project types include, but are not limited to, general hospitals, ambulatory surgical centers, operating rooms, psychiatric facilities, diagnostic imaging services, lithotripsy, radiation therapy, and nursing home beds.<sup>4</sup> Virginia ranks 24th out of 36 states and the District of Columbia based upon the number of different types of facilities and services regulated by certificate of need (tied with Alaska at 19 different types).<sup>5</sup>

The COPN process begins with the applicant filing a letter of intent (“LOI”) with DCOPN (and in Northern Virginia, with the RHPA) stating the intent, scope and location of the proposed project. The LOI must be filed at least thirty (30) days prior to the applicable batch filing deadline. All COPN applications for reviewable services are grouped in “batches” and processed according to a schedule established by the Board of Health.<sup>6</sup> For example, applications for open heart surgery, cardiac catheterization, ambulatory surgical centers, operating rooms, and transplant services are included in batch Group B. Some project types can be included in more than one batch cycle. For example, while most COPN applications involving CT services are reviewed as part of Batch Group D, CT services can be reviewed as part of Batch Group A (when CT is part of a hospital relocation) and Batch Group F (when CT is part of a radiation therapy project). For most COPN-regulated services, there are two batch cycles each year.

As shown in the table below, the filing of the LOI establishes the deadlines and timeframe for completion of various stages within the review process. Applicable regulations establish that the review cycle for a COPN application is 190 days or as many as 235 days if an Informal Fact Finding Conference (“IFFC”) is required. In practice, however, the review process may take a shorter or longer time depending upon the circumstances.<sup>7</sup>

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<sup>1</sup> Va. Code Ann. § 32.1-122.05.

<sup>2</sup> Va. Code Ann. § 32.1-102.3.

<sup>3</sup> 12 Va. Admin. Code § 5-230 *et seq.*

<sup>4</sup> Va. Code Ann. § 32.1-102.1.

<sup>5</sup> See National Conference of State Legislatures, *Certificate of Need: State Health Laws and Programs*, available online at <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx#Regulated>.

<sup>6</sup> 12 Va. Admin. Code § 5-220-200.

<sup>7</sup> *Id.*

0 days	File LOI with DCOPN and, if applicable, RHPA.
30 days	File application for COPN.
40 days	Deadline for DCOPN and, if applicable, RHPA to conduct application Completeness Review.
65 days	Deadline for applicant to respond to Completeness Review Questions.
70 days Cycle Begins	Deadline for DCOPN notification of acceptance of application and review begins.
70-120 days	Public hearing is held.
130 days	If applicable, RHPA review complete and staff report issued evaluating the application based upon the Eight Statutory Considerations and consistency with the SMFP. Includes recommendation to Commissioner for denial or approval.
140 days	DCOPN review complete and staff report issued evaluating the application based upon the Eight Statutory Considerations and consistency with the SMFP. Includes recommendation to Commissioner for denial or approval.
150 days	Determination of whether IFFC is required. If not, record closes.
155 days	If IFFC required, conference dates are scheduled between fifth and fifteenth day of issuance of DCOPN Staff Report. IFFC is required if DCOPN or the RHPA, if applicable, recommend denial of the application. In addition, if the applicant is competing with another project in the same planning district, or health planning region, as applicable, and a denial is recommended for either project, an IFFC is required.
165 days	<b>If no IFFC, Commissioner issues decision.</b>
175 days	If IFFC required, record remains open and is closed on the date 30 days following the IFFC date.
235 days	<b>If IFFC required, Commissioner issues decision</b> (may request an additional 25 days to render decision).

The IFFC is an administrative hearing presided by an Adjudication Officer. Typically, the applicants are represented by legal counsel. The IFFC hearing is not adversarial; however, witnesses are sworn under oath and the process involves the preparation of exhibits and often the use of expert witness testimony on behalf of the applicant or against a competing applicant. A record of the proceedings is recorded by a court reporter and a transcript is prepared. DCOPN and, if applicable, RHPA are parties to the IFFC and testify in support of their recommendations to the Commissioner.

Once the IFFC is complete and the record is closed, the Adjudication Officer reviews the transcript and all information presented at the hearing and in subsequent submissions by the applicant, DCOPN, RHPA, and any other parties to the IFFC. Based upon the record, the Adjudication Officer prepares a recommendation to the Commissioner summarizing the information contained in the application and evaluating whether the Eight Statutory Considerations are met and whether the application is consistent with the SMFP.

Virginia's statutes and regulations implementing the COPN program have undergone many changes since the program's inception, but the process has remained largely intact. The most recent significant changes to the COPN process occurred in 2009. HB 1598 (Hamilton) undertook a series

of reforms to the COPN law including revisions to the application procedures and review criteria and initiating other process improvements. Changes to COPN process improvements under the law included:

- Streamlining and reducing the criteria for determining need from 21 down to eight criteria;
- Transitioning the review process for psychiatric beds to a Request for Application process, ensuring that conversion of these psychiatric beds to general acute care beds requires a COPN;
- Expediting the review process for certain capital projects, generally non-clinical;
- Requiring the Commissioner to follow the applicable portions of the SMFP and the statutory criteria when a relevant SMFP provision has been set aside;
- Requiring all providers of COPN-reviewable services to submit utilization data to Virginia Health Information;
- Requiring the Virginia Department of Health to hold public hearings in regions where no RHPA is designated as the health planning agency for COPN application review;
- Increasing penalties and processes to identify those commencing regulated projects without a COPN;
- Enabling providers to meet charity care conditions by making direct payments to free clinics or other efforts or initiatives to provide primary or specialized care to underserved populations; and
- Clarifying project categories of radiation therapy and stereotactic radiosurgery.

The VHHA Board principles for regulation of COPN establish that any statutory changes that eliminate COPN requirements for currently regulated services must be tied to specific policy actions aimed at maintaining critical aspects of our health care delivery system and correcting market failures inherent in health care economics and financing. At the same time, the principles recognize that COPN process improvements and related efficiencies – including many of those that are addressed in the COPN study language - are worthy of pursuit.

The COPN study legislation directs the Secretary to evaluate the process by which applications for certificates of public need are reviewed, the criteria upon which decisions about issuance of certificates of public need are based, and barriers to issuance of a certificate of public need. This area was assigned to Subgroup 1, which was composed of subject matter experts, including legal counsel routinely representing providers in COPN applications. Following completion of tasks and review, analysis, and discussion of related information, Subgroup 1 produced the following findings and recommendations:

## **b. Findings**

### **i. *Greater Transparency is Needed in Public Records Pertaining to COPN Applications and Review Process***

DCOPN retains public records pertaining to COPN applications and the COPN review process, including, but not limited to LOI filings, applications, DCOPN and RHPA staff reports and recommendations, IFFC transcripts and exhibits, Adjudication Officer's recommended decisions, and Commissioner decisions. Access to this information is necessary to evaluate whether and when COPN applications should be filed, whether a COPN application is likely to be approved or denied, how the Commissioner has rendered decisions on similar projects in the past, and other information critical to assessing the COPN review process.

In order for any public citizen to access such information, it is necessary to request the information by telephone or in writing from DCOPN staff or in some instances to file a Freedom of Information Act ("FOIA") request. DCOPN staff fulfills these requests by searching through paper and electronic files maintained by DCOPN and provide responses by a variety of means including hard copy, digital files transmitted by electronic mail, or digital files on storable memory made available for delivery or pick-up by the requestor. Fulfilling these requests can be resource-intensive and time consuming for DCOPN staff and create delays in accessing this information by the public.

The ability to have prompt access to LOI filings is particularly important. Because of the way the COPN process is structured, the timing and filing of LOIs affect the ability to file competing applications within a review cycle. Without prompt access to information on LOI filings, potential applicants are forced to continually query DCOPN for information on the status of LOIs that have been filed. Again, this is resource-intensive and time consuming for potential applicants and for DCOPN staff and could put some applicants at a disadvantage.

### **ii. *The Public Hearing Process May Not Be the Most Effective Means of Eliciting Public Input***

The current process to obtain public input on COPN applications is to conduct a public hearing following notice in a newspaper of general circulation in the county or city where the project is proposed to be located.<sup>8</sup> These public hearings rarely elicit significant or substantive public input. The public may not be aware of most public hearings because few people regularly read newspapers of general circulation today and even fewer review the notices section. Even with this published notice, many times the applicant(s) is the only party in attendance or the public that does attend and comment is related to or attending at the request of an applicant (*e.g.* employee of the applicant). Furthermore, while public input plays a role in the COPN process, the public hearing itself does not determine the outcome of COPN decisions. Lastly, requiring a public hearing in all cases adds to the costs incurred by the applicant as well as the Commonwealth and increases the timeframe required for obtaining a decision on an application.

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<sup>8</sup> See Va. Code Ann. § 32.1-102.6(B); 12 Va. Admin. Code § 5-220-230.

### **iii. *Application Forms Do Not Reflect Current COPN Review Requirements***

Subgroup members report that COPN application forms request information that is not needed to process applications or evaluate the Eight Statutory Considerations and SMFP requirements. At the same time, the application form does *not* include information that is routinely requested by DCOPN staff for purposes of completeness review. This results in production of unnecessary information and delays in determining the information needed to complete applications. For example, the nursing home application form requires submission of substantial information such as staffing by shift, hours per staff member, pro forma data by payor mix, and bed complement by type of unit, which is not relevant to evaluation of the Eight Statutory Considerations or SMFP requirements. Additionally, the nursing home application requires a copy of the state licensing survey, which is available to DCOPN through the Office of Licensure and Certification; so it is unclear why it is requested as part of the COPN application process.

### **iv. *Greater Clarity and Guidance is Needed in COPN Review***

Subgroup members report that there are many terms used in the COPN application forms, DCOPN guidance documents, the Efficiency and Productivity Information Collection System (“EPICS”) managed by Virginia Health Information (“VHI”), and the Eight Statutory Considerations that are not clearly defined in statute or by regulations. For example, the fourth consideration requires the Commissioner to consider “The extent to which the proposed service or facility fosters institutional competition that benefits the area to be served while improving access to essential health care services for all persons in the area to be served.” The terms “institutional competition” and “essential health care services” are not defined. Both of these terms could encompass a wide array of factors, especially depending upon the context in which they are presented, but there is no definition or available guidance instructing the applicant or DCOPN as to how these terms are to be interpreted or applied. Similarly, the SMFP operating room need calculation requires “the average hours per general purpose operating room visit . . . as reported by VHI,” but VHI separates operating room use into several categories and does not report average hours per visit. There is no guidance as to what data should be used to calculate the average hours per visit in order to determine operating room need.

The need for additional guidance is not limited to definitions. For example, there is no detailed guidance on what constitutes a valid letter of intent or the applicability of the COPN law to certain project types and whether they are subject to COPN review (*e.g.*, whether COPN review is required for mobile units).

In the absence of clear definitions or guidance, applicants, DCOPN, RHPAs, the Hearing Officer, and the Commissioner are left to interpret these terms and review standards on their own. Clarity and certainty in guidance is needed to avoid inconsistency in COPN review and decision making across applications and to prevent undermining the integrity and objectivity of the COPN process.

**v. *Eight Statutory Considerations Could be Further Consolidated***

The statutory considerations included in the COPN law were greatly consolidated in 2009, which helped to streamline the COPN review process and helped to clarify the factors that the Commissioner is required to consider in rendering a decision on a COPN application. The Eight Statutory Considerations have been in place now for over six years and practical experience with application of the Eight Statutory Considerations reveals that further consolidation may be possible. Consolidation would streamline the COPN process by reducing the amount of time it takes to complete and review an application.

**vi. *Timely Updates to the SMFP Are Needed to Avoid Adverse Impacts on COPN Process***

As discussed in further detail in Section IX, *infra*, the SMFP has not been timely updated in accordance with statutory requirements. This undoubtedly has an impact on the COPN review process. Of the eight COPN decisions in 2014 that denied an application, four cited inconsistency with the SMFP as a reason for denial. This is troubling in light of the fact that the SMFP has not been updated since 2009. A corollary to the concerns about the application of outdated SMFP requirements is that it is possible that outdated standards create the need for DCOPN, the Hearing Officer, and/or the Commissioner to apply greater discretion in the determination that an application is consistent or inconsistent with the SMFP.

**vii. *More Timely and Accurate Data Sources are Needed to Evaluate SMFP Requirements***

DCOPN uses data derived from EPICS to evaluate various utilization measures contained in the SMFP and other COPN review requests. Medical care facilities that own or operate COPN-reviewable services are required to report utilization data through EPICS pursuant to Va. Code Ann. § 32.1-276.5. EPICS is operated and maintained by the state through a contract with VHI. Subgroup members report that utilization data available through VHI lags several months behind reporting dates and there have been examples of inaccuracies compared against or discrepancies with reported data. In addition, there is currently no mechanism to ensure that data needed to evaluate whether a COPN application is consistent with SMFP requirements is actually collected by VHI.

**viii. *Expedited Review is Underutilized in COPN Review***

An expedited review process is available for capital expenditures of \$15 million or more (adjusted for inflation) included in the definition of “project” at Va. Code Ann. § 32.1-102.1 or for projects that involve certain bed relocations described in the regulations.<sup>9</sup> Thus expedited review is available only for a narrow category of project types. Use of expedited review will become even more narrow as a result of recent legislation eliminating from the definition of “project” at Va. Code Ann. § 32.1-

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<sup>9</sup> 12 Va. Admin. Code § 5-220-280.

102.1, capital expenditures of \$15 million or more by a general hospital effective July 1, 2015.<sup>10</sup> Expedited review is an available means of streamlining the COPN review process for a number of different project types for which a more abbreviated review is appropriate, but currently its use is permitted only under the limited circumstances described above.

**c. Recommendations**

**i. *Develop Alternative Process to Obtain Public Input***

Public input should be elicited through methods other than a public hearing that increase the amount and substance of public input while simultaneously reducing the time and costs associated with the current process. Eliminating the requirement for a public hearing in certain instances would reduce the amount of time and resources involved in the COPN review process for both applicants and the Commonwealth. The public hearing requirement should be eliminated except in the following circumstances:

- (i) When there are competing applications (for the same or similar services and facilities that are proposed for the same health planning district, or same health planning region for projects reviewed on a regional basis, and are in the same batch review cycle); or
- (ii) When an applicant or member of the public specifically requests in writing to DCOPN that a public hearing be held.

While the public hearing may not be the most effective means of eliciting public input, this is not to suggest that public input is not an important aspect of COPN review. Public input is essential to transparency and is valuable in ensuring that the health care needs of the citizens living within regions impacted by COPN applications are being met. This can be particularly true in rural areas of the state. These findings and recommendations do, however, recognize that public input can be elicited through more effective and less resource-intensive means.

To this end, DCOPN should post public notice and project summaries online through a dedicated portal or through existing electronic notice boards used by the Commonwealth and solicit public comments by e-mail or letter to the project review analyst reviewing each project. More members of the public would be put on notice of a pending project if a project summary was available online, thereby improving transparency. Furthermore, the ability to submit comments electronically directly to the project analyst reviewing the project as opposed to through physical attendance at a public hearing could increase the amount and substance of public input.

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<sup>10</sup> 2015 Acts of Assembly, Chs. 541, 651.

**ii. *Implement a System to Make All Public Records Pertaining to COPN Applications and Review Process Available in Digital Format Online***

All public records pertaining to COPN applications and the COPN review process should be digitized and made available to the public through an online portal on a “real-time” basis. Information digitized should be searchable to assist the public in locating relevant information. To accommodate the need to digitize this information, all COPN applicants could be required to submit all filings in an electronic format determined by DCOPN.

By making this information available through an online portal, DCOPN should recognize cost-savings and greater efficiencies that would offset the associated information technology costs. Once an online portal is implemented, DCOPN staff would no longer need to respond to routine requests for information from the public. This would allow DCOPN staff to re-direct resources to other more substantive demands such as application review and preparation of staff reports and recommended decisions.

**iii. *Update Application Forms to Reflect Current Information Needs***

Application forms should be updated and streamlined to reflect current information needs of DCOPN. Requests for information that are not needed by DCOPN should be eliminated. Application forms should further be amended to reflect any information that is routinely requested by DCOPN, but not included in the current application forms.

**iv. *Clarify Definitions in Application Forms, Guidance Documents, EPICS, and Required Considerations***

In an effort to ensure consistency in COPN decision making across applications, key terms should be defined in statute or by regulation and those definitions should be uniformly applied throughout the COPN review process and in all related documents. For example, “charity care” should be defined in statute or by regulation and that definition should be used consistently in COPN application forms, DCOPN guidance documents, EPICS and in the application of the Eight Statutory Considerations. Additionally, DCOPN should issue and routinely update guidance on matters that are regularly left open to interpretation by project reviewers such as analysis of effects on institutional competition and availability of essential health care services. Greater clarity could help streamline the COPN review process and would result in greater certainty and predictability in the outcome of COPN applications.

**v. *Undertake Further Consolidation of the Eight Statutory Considerations***

Practical experience with application of the Eight Statutory Considerations reveals that the considerations could be further consolidated to streamline the COPN review process. For example, the first, fourth, and fifth statutory considerations all address in some fashion financial and geographic access to health care services, which may be redundant. The Secretary’s Work Group or other body identified or appointed by the General Assembly should undertake a review of the Eight

Statutory Considerations in the context of an evaluation of how they are being applied in current practice. Such body should be directed to develop a proposal to combine any redundant considerations in an effort to streamline the COPN review process.

**vi. *A More Robust and Timely Revised SMFP is Needed to Streamline and Avoid Adverse Impacts on the COPN Process***

Subgroup members have determined that the outdated SMFP is creating adverse impacts on the COPN process. As discussed in greater detail in Section IX, *infra*, the SMFP has not been reviewed and updated in accordance with statutory requirements and was last updated in 2009. Furthermore, the SMFP in its current form, even if updated with current information, allows for broad discretion and the potential for inconsistent application in COPN review. The SMFP should be made more robust by including more data-driven, objective measures and formulas for determining need and providing greater clarification in definitions so as to eliminate the need for discretionary set asides and improve consistency in COPN review.

**vii. *Improve Timeliness and Reliability of Utilization Data***

A more robust, data-driven SMFP and COPN application review process requires access to all necessary data elements in a timely manner and a reliable process for verification of reported and published data. Reporting requirements and timeframes for verification of data should be revisited in the context of revisions to the SMFP to ensure that all needed data elements are available for COPN review in a timely and reliable manner.

**viii. *Expand Use of Expedited or Intermediate Level Review for Certain Project Types***

The expedited review process described at 12 Va. Admin. Code § 5-220-280, *et seq.* should be made available to additional categories of projects. Project types that are considered non-controversial in nature might be particularly well suited for some form of expedited review. Examples could include lithotripsy services, substance abuse treatment services, intermediate care facility/mental retardation services, and nuclear medicine. In addition, consideration could be given to developing intermediate levels of review for different project types. For example, in Michigan, the certificate of need review process includes three review types: nonsubstantive, substantive, and comparative. Nonsubstantive review applies to projects not requiring a full review, requiring less information, and is processed more quickly (*e.g.*, equipment replacements and addition of mobile host sites). Substantive review applies to projects requiring a full review, but on an individual basis, such as initiation of an MRI service. Comparative review applies to competing applications for project types for which the need is limited (*e.g.*, beds, and transplantation services). While these review categories and project types may not readily translate to COPN-reviewable services in Virginia, establishing intermediate levels of review could present another means of streamlining the COPN process and avoiding a “one-size fits all” approach to COPN review.

### **III. The Frequency with which Applications for a Certificate Are Approved or Denied (Subgroup 2)**

#### **a. Overview**

The COPN study legislation directs the Secretary to evaluate the frequency with which applications for a certificate are approved or denied. This area was assigned to Subgroup 2, which was composed of subject matter experts, including individuals with business development and decision systems support expertise. Following completion of tasks and review, analysis, and discussion of related information, Subgroup 2 produced the following findings and recommendations:

#### **b. Findings**

##### ***i. A Majority of COPN Applications are Approved***

According to the DCOPN Activity and Decision History Report, in 2013 50 out of 56 COPN decisions or 89 percent were decisions for approval. Including applications for which no decision was rendered (*e.g.*, applications that were withdrawn or expired), the approval rate remains relatively high at 79 percent. The approval rate has varied over the past few years, for example, ranging from a low of 79.6 percent in 2010 to a high of 89.6 percent in 2012. VHHA performed an analysis of all COPN decisions included in the DCOPN Monthly Activities Report (version last updated Oct. 21, 2014) and calculated an overall approval rate of 85 percent, excluding applications for which no decision was rendered.

##### ***ii. COPN Application Approval Rates Vary by Project Type***

VHHA analysis of COPN decisions also calculated approval and denial rates by project type based upon the batch cycle and project description. This analysis revealed that approval rates vary by project type. The lowest approval rate calculated was 63 percent for neonatal special care services, excluding applications for which no decision was rendered.

##### ***iii. Approval Rates are of Limited Value in Assessing COPN Performance***

Subgroup members generally agreed that approval and denial rates are not necessarily indicative of the efficiency or effectiveness of the COPN review process. The most significant reason why approval rates are of limited value in assessing COPN performance is that approval and denial rates do not account for decisions not to file a COPN application based upon an assessment that approval is impossible or unlikely. Potential applicants typically perform an internal assessment before submitting a LOI for purposes of gauging the feasibility of receiving a COPN.

#### **c. Recommendations**

Approval and denial rates should not be solely relied upon in any decision to change the COPN process. Approval and denial rates could be considered as a factor in assessing whether a more expedited or intermediate review process may be appropriate for particular project types as

discussed in Section II, *supra*, but other factors, such as decisions not to file an application because approval is unlikely, or information about how or why applications have been approved for a specific project type in the past, should also be taken into account.

#### **IV. Fees Charged for Review of Applications for a COPN and the Cost to the Commonwealth of Processing Applications for a Certificate of Public Need (Subgroup 2)**

##### **a. Overview**

The COPN study legislation directs the Secretary to evaluate fees charged for review of applications for a COPN and the cost to the Commonwealth of processing applications for a COPN. This area was assigned to Subgroup 2, which was composed of subject matter experts, including individuals with business development and decision systems support expertise. Following completion of tasks and review, analysis, and discussion of related information, Subgroup 2 produced the following findings and recommendations:

##### **b. Findings**

###### ***i. Virginia's Maximum Fee is on the Lower End of the Spectrum Compared to Other States***

Like many other states, Virginia's application fees include a range of fees and vary based upon project cost. COPN regulations specify that the fee required for an application shall be 1.0% of the proposed expenditure for the project, but not less than \$1,000 and no more than \$20,000.<sup>11</sup>

Virginia's \$20,000 maximum fee is on the lower end of the spectrum compared to other states and some states do not have a maximum fee cap at all. The highest maximum fee is \$300,000 (D.C.) followed by \$250,000 (Maine) and \$100,000 (Illinois). Ten states have a maximum fee lower than Virginia. Seven states have a maximum fee of \$20,000-\$25,000, similar to Virginia. Nineteen states have a maximum fee higher than Virginia or do not specify a maximum fee.<sup>12</sup>

###### ***ii. Virginia's Application Fee has Not Been Changed in Several Years***

COPN application fees were last changed by the General Assembly in 1996.<sup>13</sup> The change in the law established a minimum fee of \$1,000 and increased the maximum fee from \$10,000 to \$20,000. Since that time, there have been legislative proposals to increase the maximum fee to \$50,000.<sup>14</sup>

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<sup>11</sup> See Va. Code Ann. § 32.1-102.2(A)(5); 12 Va. Admin. Code § 5-220-180.

<sup>12</sup> American Health Planning Association, *National Directory State Certificate of Need Programs Health Planning Agencies* (Winter 2013).

<sup>13</sup> 1996 Acts of Assembly, Ch. 1050 [HB 1194].

<sup>14</sup> SB 1334 (2009 General Assembly Regular Session).

**iii. *Application Fees are not a Factor in a Hospital or Health System's Decision to File a COPN Application***

Because the application fee varies with the value of the project, the fees are equitable and are not cost-prohibitive for hospital and health system applicants.

**iv. *Application Fees are Used to Subsidize the Costs to the Commonwealth of Processing COPN Applications***

The current budget includes a \$1.245 million general fund appropriation for the COPN program for each of SFY 2015 and SFY 2016. The budget further specifies that special funds from COPN application fees in excess of those required to operate the COPN program are to be used to provide supplemental funding to RHPAs, subject to DCOPN retaining a special fund balance to meet any revenue shortfalls.<sup>15</sup>

**c. Recommendations**

**i. *Review COPN Application Fees to Determine Whether they Address Current Program Needs***

Because Virginia's COPN program currently operates in a budget neutral manner in which fees from applications are expected to cover the costs of administering effective operations, application fees are directly tied to funding needs. Accordingly, Virginia's COPN application fees should be reviewed to determine whether or not they are appropriate and reflective of the costs of efficiently and effectively administering the COPN program. This review should take into account current program requirements and related staffing needs. The review should specifically address whether there is an adequate number of project analysts, possibly including a comparative analysis of staffing levels in other states with similar programs. The review should also specifically address the costs of implementing system improvements and other cost-saving initiatives and needed updates to the COPN program, such as a system to make all public records pertaining to COPN applications and review process available in digital format online as discussed in Section II(c)(ii), *supra*, or updates to the SMFP as discussed in Section IX *infra*.

An increase in application fees may be appropriate if such increase were used to fund (i) real-time online access to COPN LOIs, applications, DCOPN and RHPA staff reports and recommendations, Commissioner decisions and applicability letters; (ii) timely updates to the SMFP; (iii) development of a more robust, data-driven SMFP, (iv) more timely updates to and verification of utilization data used in COPN review; and (v) other COPN process improvement initiatives. In order to avoid creating any barrier to applying for a COPN, the fee structure should be established in an equitable manner. Furthermore, as part of any proposal to increase application fees, appropriate safeguards should be included in statute in order to ensure that amounts collected are

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<sup>15</sup> 2015 Acts of Assembly, Ch. 665, Item 278.

dedicated and used for the intended purpose of funding COPN process improvement initiatives, not other Virginia Department of Health purposes or state budgetary priorities.

**V. Applications for and the Impact of the Current Certificate of Public Need Process on Establishment of New Health Care Services at Existing Medical Care Facilities (Subgroup 2)**

**a. Overview**

The COPN study legislation directs the Secretary to evaluate applications for and the impact of the current certificate of public need process on establishment of new health care services, including the establishment of new intermediate-level or specialty-level neonatal special care services and open heart surgery services and the addition of new beds or operating rooms at existing medical care facilities. This area was assigned to Subgroup 2, which was composed of subject matter experts, including individuals with business development and decision systems support expertise. Following completion of tasks and review, analysis, and discussion of related information, Subgroup 2 produced the following findings and recommendations:

**b. Findings**

***i. New Health Care Services Identified in Study Have Been Recognized as High Complexity/High Cost***

Neonatal special care services, open heart surgery services, operating rooms, and hospital beds are among the highest complexity and highest cost services included in COPN review. This was recognized in the Report of the Joint Commission on Health Care, A Plan to Eliminate the Certificate of Public Need Program Pursuant to Senate Bill 337 (December 2000) (the “JCHC Deregulation Plan”). The JCHC Deregulation Plan was designed to accomplish deregulation of COPN in three phases. Decisions regarding which COPN projects to be included in each phase were based primarily on the cost impact on hospitals of deregulating the project type, and the complexity/risk of the project type. Those project types with the greatest cost impact and complexity/risk were included in Phase III. Neonatal special care services, open heart surgery services, and operating rooms were included in Phase III. Hospital beds, also being of high complexity/risk, were not considered for deregulation at that time.

***ii. Approval Rates Vary among New Health Care Services***

The number of applications for which COPN review was completed and approval rates for selected health care services since 2010 are shown in the table below:

<b>Project Type</b>	<b># of Applications</b>	<b>Approval Rate</b>
Neonatal Special Care Services	8	63%
Open Heart Surgery	6	83%
Bed Additions	26	85%
Operating Room Additions	82	93%

Compared to an overall approval rate of 85% for applications for all project types for the same time period, these approval rates are relatively high for all services except for neonatal special care services, but as discussed above, approval rates do not reflect factors such as the decision not to file a COPN application based upon an assessment that approval would be unlikely. The approval rates do, however, provide some relative measure of the impact of the COPN process on applications for these services. Where approval rates are lower than overall approval rates or approval rates for other project types for the same period, it could suggest that the COPN process has a greater impact on the establishment of new health care services for this project type.

**iii. *The COPN Process Does not Impact Establishment of Selected Project Types, But Standards May***

Subgroup members did not identify any elements of the COPN process that apply differently to applications for these select project types than to all other project types; however, subgroup members did observe that applicable review standards for these project types, particularly those contained in the SMFP may impact the establishment of these project types. The SMFP contains specific utilization figures, travel times, and other requirements for these services and the inability to meet these specific requirements are often determinative in whether a COPN application will be approved, or whether it is feasible to file the application at all.

**c. Recommendations**

**i. *Applicable Review Standards Should be Carefully Evaluated to Ensure they Reflect Policy Goals***

The Secretary's Work Group or other body identified or appointed by the General Assembly should undertake an in-depth evaluation of applicable review standards applicable to the project types identified in the COPN study legislation (neonatal special care services, open heart surgery services, bed additions, operating rooms), particularly those contained in the SMFP. The purpose of the evaluation is to ensure that review standards advance policy goals of providing strong quality protections that correspond to service intensity and patient risk, and ensuring access to care within geographic regions, particularly for the indigent and uninsured, promoting competition and patient choice.

In evaluating standards, it may be helpful to focus on some of the more controversial decisions for the project types as a way of identifying those components of the SMFP or other review standards that are having the greatest impact. Such evaluation should involve an assessment of occupancy/utilization rates for these services and whether there is wide disparity in occupancy/utilization rates within the Commonwealth; geographic distribution and access to these services; minimum volume proficiencies for these services; and the role of COPN review in ensuring market competition and adequate patient choice for these services.

## **VI. Relationship between the Certificate of Public Need Process and the Provision of Charity Care in the Commonwealth and the Impact of the Certificate of Public Need Process on the Provision of Charity Care in the Commonwealth (Subgroup 3)**

### **a. Overview**

Va. Code Ann. § 32.1-102.2(C) establishes the authority of the Commissioner to place conditions on the issuance of a COPN where determined to be appropriate. Specific conditions can include an obligation to:

- i. provide an acceptable level of care at a reduced rate to indigents (charity care);
- ii. provide care to persons with special needs; or
- iii. facilitate the development and operation of primary medical care services in a designated medically underserved area.

One of the most common conditions is the obligation to provide an acceptable level of charity care to indigents. Applicable law and regulations provide monetary penalties for failure to comply with these conditions.<sup>16</sup> In addition, licensure regulations are required to specify that the issuing or renewing of any license shall be conditioned upon the applicant's compliance with any agreement to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care pursuant to a condition placed upon a certificate. Va. Code Ann. § 32.1-102.4.

The VHHA Board principles for regulation of COPN establish that changes to COPN regulation must be paired with policies to expand coverage or otherwise assure access to safety net health care for the indigent and uninsured. This principle acknowledges the relationship between the COPN law and charity care and recognizes that changes to COPN law or regulation could have deleterious effects on the health care safety net in Virginia.

The COPN study legislation directs the Secretary to evaluate the relationship between the COPN process and the provision of charity care in the Commonwealth and the impact of the COPN process on the provision of charity care in the Commonwealth. This area was assigned to Subgroup 3, which was composed of subject matter experts, including individuals with finance and business development expertise. Following completion of tasks and review, analysis, and discussion of related information, Subgroup 3 produced the following findings and recommendations:

### **b. Findings**

#### ***i. COPN Conditions are an Important Policy Tool that Ensures a Strong Health Care Safety Net***

COPN charity care conditions are a policy tool that the government uses to ensure that there is an adequate health care safety net within regions of the Commonwealth. Virginia is not alone in

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<sup>16</sup> See Va. Code Ann. § 32.1-102.4; 12 Va. Admin. Code § 5-220-270.

conditioning certificate of need approval on the requirement to provide a minimum level of charity care. Several other states including Delaware, District of Columbia, Mississippi, Rhode Island, and South Carolina include charity care as a provision of certificate of need laws.

By approving COPN for applicants that will agree to provide a modest level of charity care, the state and its citizens are thereby assured that regulated services will be available to the indigent and uninsured. Since Virginia does not have an extensive network of public hospitals, the charity care conditions are one mechanism by which the Commonwealth is able to ensure that an adequate safety net exists to meet the health care needs of low-income uninsured individuals.

The JCHC Deregulation Plan addresses the relationship of the COPN law to charity care provided by hospitals and health systems:

*One of the protections that COPN provides to hospitals is the ability to “cost-shift” reimbursement received from paying patients to help offset the cost of providing care to persons who have no financial means (e.g., indigent and/or uninsured patients), and to subsidize the cost of certain services which generate relatively little revenue.*

Report of the Joint Commission on Health Care, A Plan to Eliminate the Certificate of Public Need Program Pursuant to Senate Bill 337 (December 2000). However, charity care conditions can apply to all COPN applicants, not just hospitals, and provide a direct means through which COPN plays a role in supporting the health care safety net.

Since many hospital services are subject to COPN requirements, hospitals and health systems are routinely subject to charity care conditions as a part of their operations. Additionally, all hospitals have generous charity care policies. In most instances, conformance with these charity care policies allows hospitals to meet or exceed any charity care conditions that a hospital or health system may be subject to under a COPN.

An ambulatory surgery center, freestanding imaging center, radiation therapy center, physician practice, or other health care provider that is not affiliated with a hospital or health system may not have similar charity care policies or may not be located in an area for which there is a need for access by the indigent or uninsured. Accordingly, COPN charity care conditions can serve to “level the playing field” as it pertains to the government’s role in ensuring that an adequate safety net exists to meet the health care needs of low-income uninsured individuals.

According to reports developed by DCOPN, indigent care valued at \$856,950,546 was reported as provided in meeting the obligations of COPN conditions in FY 2011. An additional \$15,528,163 of in-kind and cash donations were made to free clinics and other safety net providers as part of plans of compliance in meeting the obligations of COPN conditions.

These in-kind and cash donations are noteworthy because they represent a significant amount of funds that are donated in compliance with COPN charity care conditions and provide direct support to the health care safety net, mainly free clinics that provide primary care and other basic health care

services helping to alleviate the need for more costly services such as emergency department visits and hospital admissions. If these funds were to be discontinued through charity care conditions, any shortfall incurred by the health care safety net would need to be filled through other sources or additional appropriations by the General Assembly. In the current budget, the General Assembly has appropriated \$1.7M in SFY15 and \$4.8M in SFY16 to fund free clinic operating costs for services provided to the uninsured.<sup>17</sup>

**ii. *There is Ongoing Need to Support the Health Care Safety Net***

Virginia has a large number of uninsured and many of them have incomes at or below the federal poverty level (“FPL”). In 2014, there were an estimated 899,100 uninsured working age adults in Virginia with over 400,000 of these uninsured having incomes under 138% FPL. An August 2014 survey released by Gallup showed that Virginia was one of only three states where the rate of uninsured increased from 2013 to mid-year 2014. Current eligibility limits for the Medicaid program do not provide any coverage for childless adults, parents above 31% FPL, or elderly disabled above 80% FPL. The health care safety net, supported in part through COPN and charity care conditions and other government funding sources, is essential to providing some form of access to health care services to these low-income uninsured.

**iii. *Hospitals and Health Systems Report a Significant Amount of Charity Care***

Virginia’s health information data reporting regulations require hospitals to report charity care amounts to VHI. VHI defines charity care as care for which no payment is received and that is provided to a person whose gross annual family income is equal to or less than a certain percentage of the federal non-farm poverty level as published for the then current year in the Code of Federal Regulations. VHI collects data regarding (i) charity care at 100% of the FPL, (ii) charity care between 100% and 200% of the FPL, and (iii) charity care in excess of 200% of the FPL.

According to VHI, hospitals provided a total of \$2,619,849,817 in charity care in 2013. This represents a 6.9 percent increase from 2012 (\$2,451,133,223) and a 24.9 percent increase from 2011 (\$2,096,815,072).<sup>18</sup> These amounts are in addition to other means of community support, including state and local taxes paid by many Virginia hospitals. It is important to note that if a hospital or ambulatory surgery center receives just a small partial payment from a patient, the unpaid balance does not qualify as charity care for purposes of reporting to VHI. Rather, the unpaid portion of the bill most likely would be written off by the provider, and would be accounted for as “bad debt.”

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<sup>17</sup> 2015 Acts of Assembly, Ch. 665, Item 291 F.3

<sup>18</sup> Historically, to offset the gross amount of charity care provided by hospitals, the state has made payments to hospitals for the purpose of supporting the provision of health care to the indigent. The state has made three different types of indigent care-related payments to hospitals: enhanced disproportionate share hospital (DSH) payments, payments from the Indigent Health Care Trust Fund (IHCTF), and payments from the State and Local Hospitalization (SLH) program. However, the IHCTF was repealed in 2009 and the SLH was discontinued in the same time period. While enhanced DSH payments continue to be available, a majority of these payments are made to the state’s two academic medical centers, UVA Medical Center and VCU Hospitals.

Subgroup members report that these bad debt figures are on the rise at hospitals and physician offices, due in part to the increasing popularity of high-deductible plans that have more significant out-of-pocket costs. In 2013, bad debt at Virginia hospitals and health systems totaled \$533 million.

Virginia does not have a charity care reporting requirement for freestanding imaging centers, radiation therapy centers, physician practices, or other health care providers not affiliated with a hospital. Therefore, while many of these health care providers may offer charity care, there is no mechanism in place to quantify the amount of such care that is provided in the state. As discussed below, reports of compliance with charity care conditions are the only available means of quantifying these amounts, but compliance reports only apply to COPN regulated services.

**iv. *Conditions are Commonly Applied to COPNs***

According to a VHHA analysis of the DCOPN Monthly Activity Report, about 66% or 2/3 of all certificates issued from 2005 to 2014 had conditions applied to them. About 60% of certificates issued during that time period had conditions requiring the provision of a minimum amount of charity care ranging from 1.28% to 13.3% of gross revenues. The average charity care condition applied was 3.3% of gross revenues.

**v. *Virginia has Established Guidelines for Reporting Compliance with COPN Conditions***

The Virginia Department of Health has issued a guidance document to provide guidance to COPN certificate holders and DCOPN. See Virginia Department of Health, Center for Quality Health Care Services and Consumer Protection *Guidance Document: Compliance with Conditions on Certificates of Public Need* (March 24, 2004). The guidance document establishes the procedures that providers are required to follow in reporting compliance with conditions and includes a form Report of Compliance. Since there is no form of required reporting of charity care in Virginia other than for hospitals and ambulatory surgical centers, the guidance document is an important component of monitoring the provision of charity care in the Commonwealth and the adequacy of the health care safety net.

**vi. *Greater Transparency is Needed in Application of Charity Care Conditions***

Subgroup members report that in response to inquiries regarding the methodology DCOPN uses to determine a specific percentage for charity care conditions, DCOPN has described a process whereby the DCOPN bases the percentage off of the average percentage of charity care provided in the Health Planning Region using the most current charity care data available from VHI Industry Reports. While the methodology described above appears to be an established practice of DCOPN, it is not set forth in any statute, regulation, or sub-regulatory guidance. Likewise, subgroup members report other established practices such as the ability to negotiate a facility-wide or system-wide percentage for charity care conditions that are not set forth in any statute, regulation, or sub-regulatory guidance.

Because some charity care conditions are applied to a specific project, there may be instances where charity care conditions are not met for the service line related to that project, but the facility for which the COPN is approved exceeds the charity care condition overall when combining all service lines. If applied on a facility-wide or system-wide basis, no shortfall in meeting charity care conditions would result. These variations in how charity care conditions are applied and satisfied highlight the need for greater transparency.

**vii. *Virginia has a Mechanism for Monitoring Compliance with Charity Care Conditions***

DCOPN has developed a Condition Compliance Report for FY 2011 and FY 2012. These Condition Compliance Reports monitor compliance on a retrospective historic basis. According to sources from DCOPN, Condition Compliance Reports are not available for prior fiscal years. The most recent Condition Compliance Report available, FY 2012, is current through March 31, 2013.

**c. Recommendations**

**i. *Continue Application of Conditions***

Because Virginia continues to have a large number of uninsured, particularly those at low-income levels, the need for the Commonwealth to ensure an adequate safety net continues to be necessary. Charity care conditions are one mechanism the Commonwealth currently has available to fulfill this policy goal. In light of this continuing need, charity care conditions should continue to be applied.

Furthermore, consideration should be given to whether there are other policy goals that could be addressed through COPN conditions. For example, to the extent policymakers are concerned that there is inadequate supply of primary care or specialist physicians accepting Medicaid patients, the statute and regulations could be modified to include the ability to condition an application on an agreement by the applicant to participate in Medicaid and accept Medicaid patients.

**ii. *Charity Care Reporting Guidelines Should be Revised to be Consistent with Industry Standards and Practices***

The established procedures and definitions used to demonstrate compliance with conditions should be revised to be consistent with industry standards and practices. For example, DCOPN's guidance document defines "charity care" as "health care services delivered for which it was determined at the time of service provision that no payment was expected." As a practical matter, health care providers are more often than not unable to definitively ascertain at the time services are delivered whether or not payment should be expected and whether or not a patient is eligible for charity care. Health benefits information is often outdated or cannot be verified on a real-time basis and income levels and other information needed to determine eligibility under charity care policies may not be available or complete prior to the need to render services to the patient. In the instance of a hospital emergency department, the Emergency Medical Treatment and Active Labor Act (EMTALA)

specifically prohibits a hospital from assessing a patient's ability to pay prior to offering a medical screening examination or stabilizing treatment.

Another example is that the definition of "indigent" is limited to a person whose gross annual family income is equal to or less than 200 percent FPL. However, many hospitals have charity care policies that provide financial assistance to patients above 200 percent FPL, some up to 400 percent FPL.

Charity care reporting guidelines also overlook bad debt and uncollectable amounts. Subgroup members report that these figures are on the rise at hospitals and physician offices, due in part to the increasing popularity of high-deductible insurance plans that have more significant out-of-pocket costs. As mentioned above, in 2013, bad debt at Virginia hospitals and health systems totaled \$533 million. These amounts should be taken into account or factored in when assessing the amount of charity care provided by an applicant and compliance with charity care conditions.

The definition of "charity care" should be revised to be compatible with industry standard definitions and practices related to the provision of care to individuals without an ability to pay. To the extent possible, mechanisms for reporting charity care information should be consistent with or incorporated into mechanisms already in place for health care providers. Health care providers routinely report financial information through a variety of mechanisms, including requirements to electronically submit to VHI data on utilization for services reviewable under the COPN law pursuant to Va. Code § 32.1-276.5, as well as, reporting of efficiency and productivity information through the Efficiency and Productivity Information Collection System (EPICS) maintained by VHI pursuant to Va. Code § 32.1-276.7. Hospitals that have federal tax exempt status are required to file IRS Form 990, Schedule H, which requires classification of spending for charity care and bad debt, as well as how much of their activities should be considered as community benefit. These existing mechanisms may provide an alternative or streamlined approach for charity care reporting to reduce the need to maintain a separate process and set of definitions for COPN charity care reporting.

### ***iii. Increase Transparency in Application of Charity Care Conditions***

The methodology for determining application of charity care conditions should be set forth in regulation or sub-regulatory guidance. Facility-wide or system-wide conditions that streamline and simplify reporting and compliance should be applied where appropriate to avoid variations in how charity care conditions are applied and satisfied within a facility or system.

### ***iv. Improve Monitoring and Enforcement of Conditions***

Because charity care conditions play an important role in supporting the health care safety net, DCOPN should develop and maintain more timely information on compliance with charity care conditions. The availability of this information would allow DCOPN to more effectively monitor and enforce compliance and would also allow the Office of Licensure and Certification to incorporate this information into review of licensing applications. Current licensing regulations for hospitals require applications for initial licensure to include a statement of any COPN charity care conditions imposed on the applicant and renewals are conditioned upon demonstrating substantial

compliance with such conditions as well as paying any civil penalties for failure to comply.<sup>19</sup> More timely information would also allow the state to better assess possible gaps in the health care safety net and improve the ability to enforce compliance, both of which are needed in order for the state to achieve the policy goal of making needed health care services available to low-income uninsured.

## **VII. Impact of the Certificate of Public Need Process on Graduate Medical Education Programs and Teaching Hospitals in the Commonwealth (Subgroup 4)**

### **a. Overview**

The VHHA Board principles for regulation of COPN establish that changes to COPN regulation should assure continued support for medical and health professional education. Application of this principle and the rationale for this policy goal have implications not only for state funded medical schools and academic medical centers, but also for private teaching hospitals.

The COPN study legislation directs the Secretary to evaluate the impact of the COPN process on graduate medical education programs and teaching hospitals in the Commonwealth. This area was assigned to Subgroup 4, which was composed of subject matter experts from our academic medical center and private teaching hospital members. Following completion of tasks and review, analysis, and discussion of related information, Subgroup 4 produced the following findings and recommendations:

### **b. Findings**

#### ***i. Provisions in the COPN Law are Designed to Indirectly Subsidize Funding for Medical Schools and Graduate Medical Education***

One of the Eight Statutory Considerations requires the Commissioner, in making a decision whether or not to approve an application for a COPN proposed by or affecting a teaching hospital associated with a public institution of higher education or a medical school in the area to be served, to consider “(i) the unique research, training, and clinical mission of the teaching hospital or medical school, and (ii) any contribution the teaching hospital or medical school may provide in the delivery, innovation, and improvement of health care for citizens of the Commonwealth, including indigent or underserved populations.”<sup>20</sup>

This consideration was first included in the COPN law in 2009 when the statutory criteria for determining need were revised pursuant to legislation passed in the 2009 General Assembly session. The legislation (HB1598 (Hamilton)) revised COPN application procedures and streamlined and reduced the criteria for determining need from 21 considerations to eight considerations. Prior to changes included in the legislation, the criteria for determining need made reference to “the relationship of the project to the clinical needs of health professional training programs in the area in

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<sup>19</sup> Va. Code Ann. § 32.1-102.4; 12 Va. Admin. Code § 5-410-70(A)(6); 12 Va. Admin. Code § 5-410-70(B).

<sup>20</sup> Va. Code Ann. § 32.1-102.3(B)(8).

which the project is proposed” and “the special needs and circumstances of an applicant for a certificate, such as a medical school . . . if a substantial portion of the applicant’s services or resources or both is provided to individuals not residing in the health service area in which the project is to be located.” The previous criteria included in the statute also referenced “the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.” See Acts of Assembly 2009, Ch. 175. The revised criteria tacitly acknowledge the historic relationship between the COPN program and state support for the missions of academic medical centers and medical schools in the Commonwealth.

This historic relationship has also been a central consideration in plans by the General Assembly to deregulate the COPN law in the past. The JCHC Deregulation Plan highlights the relationship of the COPN law to academic medical centers in the Commonwealth:

*[T]he ability to provide services for the indigent/uninsured is diminished in proportion to the number of paying patients who begin receiving these services from other providers. This scenario is particularly important to the academic health centers (AHCs) which provide substantial amounts of indigent care.*

*This issue of cost-shifting to support certain services which are not self supporting also pertains to funding the cost of undergraduate medical education at the Commonwealth’s AHCs. Currently, a portion of the costs of undergraduate medical education at the AHCs is funded through faculty-earned clinical revenues. Similar to the impact on the provision of clinical services to indigent patients, as more patients begin to receive services from providers other than AHCs, the ability to use faculty-earned clinical revenues to support the cost of undergraduate medical education will represent an increasingly difficult financial burden for the AHCs to absorb.*

*To address these issues, the deregulation plan includes several provisions to help cushion hospitals and the AHCs from the impact of being less able to cost-shift and subsidize indigent care, low revenue-generating services, and undergraduate medical education.*

Report of the Joint Commission on Health Care, A Plan to Eliminate the Certificate of Public Need Program Pursuant to Senate Bill 337 (December 2000). The JCHC Deregulation Plan acknowledges that if COPN laws were to be repealed, academic medical centers would be less able to subsidize this indigent care and the costs of undergraduate and graduate medical education. Accordingly, the JCHC Deregulation Plan called for codifying a policy to fully fund the costs of indigent care at the Commonwealth’s academic medical centers, to offset losses of faculty earned clinical revenues by funding the core cost of undergraduate medical education, and to study the effects on the ability of academic medical centers to meet funding obligations related to graduate medical education and on state support of medical research.

This discussion highlights the critical role of the COPN law in supporting medical schools and graduate medical education in Virginia. In short, the COPN law acts as an indirect

financial subsidy that helps to address funding shortfalls of public institutions and associated private teaching hospitals. Without the COPN law and absent some alternative funding source, the gaps in funding needed to support medical schools and graduate medical education would become even wider.

**ii. *Lack of Adequate State Funding Combined with Virginia's Health Workforce Shortage Underscore the Role of Need for COPN in Advancing Policy Goals***

There is broad consensus among policymakers that Virginia faces current and projected maldistributions and shortages of physicians and other advanced practice professionals in Virginia.<sup>21</sup> Workforce shortages are most acute in the area of primary care services, particularly in more remote or rural areas of the state. VHHA's Healthcare Workforce Task Force found that Virginia's current healthcare workforce system is not sustainable and significant change will be needed to meet the needs of patients in the coming decades, especially considering a disproportionate over reliance on an aging healthcare workforce at a time when our patient population is both growing and aging.

Consistent with the JCHC Deregulation Plan, in the absence of a policy to fully fund the costs of undergraduate medical education and ensure adequate resources to support graduate medical education, the COPN law, including provisions that take into consideration the effects on academic medical centers, plays an important role in addressing the workforce shortage.

**iii. *Private Teaching Hospitals Play an Important Role in Advancing Policy Goals***

Many private hospitals in Virginia have established relationships with public institutions and medical schools and serve as training sites for medical and graduate medical education. Private teaching hospitals also serve as training sites for nursing schools and allied health professionals and many sponsor their own nurse and allied health professional training programs. Additionally, private teaching hospitals are partners in clinical research with public institutions. In short, private teaching hospitals play an increasingly important role in medical education, addressing healthcare workforce needs, and other policy goals associated with the COPN program. As a result, the same policy rationale behind utilizing the COPN law as a mechanism to indirectly subsidize funding for medical schools and graduate medical education extends to private teaching hospitals as well.

**iv. *Public Institutions and Private Teaching Hospitals Contribute Financial Resources to Increase Capacity for Residencies and Clinical Training Opportunities***

Due in large part to significant population growth since the 1996 federal freeze on residency slots, Virginia has fewer resident and fellow positions for medical school graduates compared to the national average at a time when we are increasing our medical school capacity faster than the

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<sup>21</sup> See e.g., Report of the Joint Commission on Health Care, Update on the Virginia Physician Workforce Shortage, House Document No. 2 (2014).

national rate. Virginia also has a shortage of clinical training slots for other health professionals, notably nursing.

Virginia has increased the capacity of its educational programs significantly since 2001. Medical School graduation has increased at a rate of two times the national average increase. Advanced practice education has seen similar increases. However, neither federal nor state-funded programs have increased the number of funded residency or clinical training opportunities at the same pace.

The Balanced Budget Act of 1997 placed caps on the number of residents for which each teaching hospital is eligible to receive federal graduate medical education reimbursement and these caps have remained in place with very limited increases since that time. Similarly at the state level, Virginia's Medicaid program has not rebased the underlying graduate medical education rate for community teaching hospitals in more than 15 years. As a result of this funding inequity, Virginia is exporting medical school graduates to other states. A majority of Virginia-educated graduates must leave the Commonwealth in order to find training opportunities.

In an effort to mitigate the effects of inadequate state funding, public institutions and private teaching hospitals are underwriting the costs of accredited residency slots on their own despite the significant costs of the programs. A 2012 survey of VHHA members showed that 504 residency slots were funded directly by public institutions and private teaching hospitals at a cost of over \$52 million. These facts help to illustrate the need to continue to include provisions in the COPN law that take into consideration the unique roles of public institutions and their academic medical centers and medical schools, and the private teaching hospitals that are associated with them.

***v. Public Institutions and Private Teaching Hospitals Subsidize the Costs of High Complexity Services***

Academic medical centers and private teaching hospitals are home to high complexity, specialized services that are not available in other settings. Quaternary and tertiary services offered by academic medical centers and private teaching hospitals in Virginia include Level I trauma, burn care, and organ transplant services. These services have significant fixed costs that are cross-subsidized by other more profitable services offered by the institution. In addition, the financial sustainability of these programs hinges on policy and planning decisions to direct resources to centralized or regionalized providers within the state or nationally. This further highlights the value of the COPN program in supporting public institutions and private teaching hospitals as they strive to meet the needs of the Commonwealth's most acutely ill patients. It also highlights the need to continue to include provisions in the COPN law that take into consideration the unique roles of public institutions, their academic medical centers and medical schools, and the private teaching hospitals that are associated with them.

**vi. *Public Institutions and Private Teaching Hospitals Conduct Research and Promote Advances in Treatment and Medical Technology***

Training and research at academic medical centers and teaching hospitals frequently leads to advances in treatment and medical technology. The ability to conduct this research and obtain funding from public and private sources requires academic medical centers and teaching hospitals to demonstrate advanced capabilities including a sufficient number of high-acuity patients that could benefit from technological applications and practitioners with highly specialized training and credentials. This illustrates the value of the COPN program to the advancement of medicine in the Commonwealth, and further highlights the need to continue to include provisions in the COPN law that take into consideration the unique roles of public institutions, their academic medical centers and medical schools, and private teaching hospitals that are associated with them.

**vii. *Public Institutions and Private Teaching Hospitals Require Minimum Volumes of Procedures and Specialized Services in Order To Adequately Train Health Professionals***

The American College of Graduate Medical Education establishes minimum case-load requirements for physician residencies. For example, a resident in radiation oncology must treat a minimum of 450 patients with external beam radiation therapy and a minimum of 5 interstitial and 15 intracavity brachytherapy procedures. These case load requirements are necessary to ensure that residents have an adequate number of patients for proper training.

In order to ensure the quality of care of services provided by the COPN applicant, the SMFP establishes minimum proficiency volumes for regulated services. For example, the SMFP includes a minimum volume proficiency standard required to establish need for a new radiation therapy machine based upon utilization by any existing and the new radiation therapy machine.<sup>22</sup> While required for different purposes, the SMFP minimum proficiency standards complement minimum case load requirements and are another way that the COPN law, albeit indirectly, supports medical education. Minimum utilization requirements help prevent case-loads from being eroded and hindering the ability of academic medical centers and private teaching hospitals to provide the level of training needed to educate health professionals.

**c. Recommendations**

**i. *Reinforce the Importance of COPN in Supporting Policy Goals Related to Medical Education and Workforce Shortages***

In response to the consideration at Va. Code Ann. § 32.1-102.3(B)(8), applicants for a COPN often provide information to support reasons why the project involves a unique research, training, or clinical component and describe possible contributions to the delivery, innovation, and improvement of health care, including the indigent or underserved. These responses are frequently

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<sup>22</sup> 12 Va. Admin. Code § 5-230-290.

identified in DCOPN recommendations and Commissioner decisions to approve a COPN application. Private teaching hospitals play an increasingly important role in supporting policy goals related to medical education and workforce shortages. To the extent that public institutions and private teaching hospitals continue to fund additional residency slots, doing so is also consistent with the JCHC Deregulation Plan, which recognized that COPN is necessary in the absence of a policy to fully fund the costs of undergraduate medical education and ensure adequate resources to support graduate medical education. In light of the clear connection established between COPN and the state's ability to advance policy goals of supporting public institutions for higher education, caring for the indigent, and addressing health care workforce needs, application of this consideration should remain solidly intact.

As discussed here, the COPN process has been used by the state as a surrogate for the partial funding of medical education and graduate medical education in lieu of directly addressing funding needs. Because the COPN process enables teaching hospitals and medical schools to cross-subsidize health care workforce training programs, changes to the process could adversely impact these programs. Any reduction in graduate medical education exacerbates the health care workforce shortage at a time when improving access to health care services is critical.

## **VIII. Efficacy and Role of RHPAs and Possible Barriers to Continuation (Subgroup 5)**

### **a. Overview**

Virginia Code Section 32.1-122.05 establishes the authority of the Board of Health to designate RHPAs for the purpose of representing the interests of health planning regions and performing health planning activities at the regional level. Prior to 2009, each of Virginia's five health planning regions had a RHPA. In 2009, four of the five RHPAs suspended operations and dissolved. The Health Systems Agency of Northern Virginia ("HSANV"), the RHPA for Northern Virginia (Planning District 8) is currently the only remaining health planning region with a RHPA.

The COPN study legislation directs the Secretary to evaluate the efficacy of RHPAs, the role of RHPAs in the certificate of need process, and barriers to the continued role of RHPAs in the COPN process. This area was assigned to Subgroup 5, which was composed of representatives from VHHA members who routinely work with the Northern Virginia RHPA and individuals from other regions of the state who had experience working with the RHPA in that region. Following completion of tasks and review, analysis, and discussion of related information, Subgroup 5 produced the following findings and recommendations:

### **b. Findings**

#### ***i. Some Subgroup Members Report RHPAs Provide In-Depth and Region-Specific Analysis***

Some subgroup members report that a RHPA brings a stronger understanding of the unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care to the

COPN review process because RHPA staff and board members reside and work in that region. Using region-specific information and local expertise and input, RHPAs are able to better interpret available evidence to understand traffic patterns, public perception, and need. Some subgroup members also report that DCOPN is not able to provide the same level of analysis as a RHPA due to resource constraints and because it does not have designated project analysts with local knowledge and experience for each region. This may lead to variation in COPN process across the state.

**ii. *Some Subgroup Members Report RHPAs Encourage Local Input in the COPN Process***

A RHPA is required to be governed by a board composed of residents of the region. Virginia Code Section 32.1-122.05 sets forth who shall be included on the board, including consumers and providers. This statutory requirement ensures members of the local public are involved in the COPN process.

HSANV's public hearings are conducted by the Project Review Committee, a subset of the full board, and committee members are able to question the applicants about their projects. Additionally, HSANV's public hearings are held in the evenings when more members of the public can attend, whereas DCOPN conducts its hearing during working hours.

DCOPN's public hearings are conducted by a DCOPN staff member who is not always the project analyst for the project being presented and DCOPN does not question applicants as part of the public hearing. Thus, in regions without a RHPA, DCOPN is the only reviewer and the only party to question an applicant. Subgroup members report that there is often more dialogue and discussion among applicants and HSANV board members when a RHPA is part of the COPN process.

**iii. *Some Subgroup Members Report the COPN Process is More Resource Intensive and Time-Consuming When a RHPA is Involved***

There are additional steps in the COPN process when the RHPA is involved. Some subgroup members report these additional steps and involvement of an additional party can cause applicants to expend more time and resources during the COPN process. For example, the RHPA may submit completeness questions separate and apart from DCOPN's completeness questions. To the extent that DCOPN and RHPA questions are redundant or inconsistent with each other, the applicant must expend additional time and resources to duplicate efforts or prepare additional responses.

Other parts of the COPN process that could include additional time and resources because of a RHPA include pre-letter of intent discussions, which may be separate and apart from similar discussions with DCOPN, preparation for and attendance at the Project Review Committee public hearing, which could involve questioning of the applicant, attendance at the RHPA board meeting, and IFFC preparation, participation and response. One subgroup member that operates within the jurisdiction of HSANV as well as within other regions reports the COPN process with a RHPA

requires significant additional staff time to complete compared to the COPN process without a RHPA.

**iv. *Because RHPAs are not Present in All Regions, the Existence of HSANV Creates Differences in the COPN Process Across the State***

The COPN process does not include a RHPA review for applicants in four of the five health planning regions. These applicants file a letter of intent and an application with DCOPN, respond to DCOPN's completeness questions, attend a DCOPN-conducted public hearing, receive a DCOPN recommendation and attend an IFFC, if DCOPN recommends denial, prior to receiving a decision from the Commissioner. In contrast, applicants in the Northern Virginia Health Planning Region must file a LOI and application with DCOPN and HSANV, respond to HSANV's and DCOPN's completeness questions, attend a HSANV-conducted public hearing, attend a HSANV board meeting, receive a HSANV recommendation, receive a DCOPN recommendation and attend an IFFC, which occurs if either HSANV or DCOPN recommend denial of the project, prior to receiving a decision from the Commissioner. Thus, the COPN process is different depending on a project's location and applicants must be aware of these differences when applying for a COPN. Additionally, there are times when the HSANV's recommendation is inconsistent with DCOPN's recommendation and/or with the Commissioner's decision. Such variation would inevitably exist within any region having a RHPA; however, the presence of only one RHPA could result in variation of outcomes in regions across the state. This may make it more difficult for applicants to rely on COPN decisions as helpful precedent that might guide them in preparing future COPN applications and generally increases the level of uncertainty in the COPN process.

**v. *RHPAs Require Local Funding in Order to Sustain Operations***

Prior to 2009, RHPAs received funding through General Assembly appropriations and residual COPN fees provided by the Department of Health. The General Assembly ceased appropriating funds for RHPAs in 2007 and the amount of residual COPN fees dwindled over time until there were not enough funds to support the RHPAs. Four of the five RHPAs suspended operations and dissolved in 2009 due to elimination of state funding and an inability to obtain adequate funding from other sources. The current budget specifies that special funds from COPN application fees in excess of those required to operate the COPN program are to be used to provide supplemental funding to RHPAs, subject to DCOPN retaining a special fund balance to meet any revenue shortfalls.<sup>23</sup> However, it is unclear whether any such special funds are available or are being distributed to HSANV at this time.

HSANV historically received funding from alternative sources, which it was able to use to remain in operation once state funding was no longer available. HSANV currently receives funding from the counties of Arlington, Fairfax and Prince William and the cities of Alexandria, Fairfax, Falls Church and Manassas. In 2013, it reported \$179,067 in total funding from these localities. HSANV has continually received funding from these localities in the past. Such funding is not guaranteed in

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<sup>23</sup> 2015 Acts of Assembly, Ch. 665, Item 278.

perpetuity, but there is no indication to suggest that the funding is at risk of being curtailed or eliminated at this time.

**c. Recommendations**

**i. *Address Differences in the COPN Process Across Regions in the State***

RHPAs can provide region-specific analysis and encourage local input in the COPN process, but having only one health planning region with a RHPA creates differences in the COPN process across regions within the state. The Secretary's Work Group or other body identified or appointed by the General Assembly should identify possible measures for eliminating differences in the COPN review process from one region to another including evaluating possible funding mechanisms to support RHPAs (*e.g.*, funding by localities, foundation grants, and private donations) and developing mechanisms to include region-specific analysis and encourage more local input in the COPN review process for all regions.

**IX. Frequency with which the State Medical Facilities Plan is Updated and Whether Such Plan Should Be Updated More Frequently (Subgroup 6)**

**a. Overview**

Virginia Code Section 32.1-102.2:1 requires the Board of Health to appoint and convene a task force to meet at least once every two years and complete a review of the SMFP, updating or validating existing criteria in the SMFP at least every four years. The SMFP is the state's planning document used to make medical care facilities and services needs decisions.

The VHHA Board principles for regulation of COPN establish that changes to COPN regulation should require similar quality of care standards and accountability for all providers delivering similar services in all practice settings. This principle recognizes the relationship between the SMFP utilization requirements and expansion thresholds and quality of care standards. Accordingly, any changes to the COPN law or regulation, including the SMFP, could have an adverse impact on the quality of care provided in Virginia and should be carefully considered to avoid any unintended consequences.

The COPN study legislation directs the Secretary to evaluate the frequency with which the State Medical Facilities Plan is updated and whether such plan should be updated more frequently. This area was assigned to Subgroup 6, which was composed of subject matter experts, including individuals who participated in the SMFP Task Force and have been routinely involved in revisions to the SMFP in the past. Following completion of tasks and review, analysis, and discussion of related information, Subgroup 6 produced the following findings and recommendations:

## **b. Findings**

### **i. *The State Medical Facilities Plan was Last Amended in 2009***

The SMFP was last amended in 2009.<sup>24</sup> Pursuant to Virginia Code Section 32.1-102.2:1, the SMFP was due for an update or validation in 2013. The SMFP Task Force met on June 18, 2013, and established three subcommittees to further study and provide recommendations. The three subcommittees were (i) radiation therapy, (ii) cardiac catheterization, and (iii) long-term care/nursing homes. The work of the SMFP Task Force involves review of existing provisions of the SMFP to determine whether revisions are necessary to address changes in technology, emerging technology utilization and occupancy standards, population data, travel times, and other factors affecting COPN review.

The SMFP Task Force last met on October 30, 2013. Subgroup members that participated in the SMFP Task Force reported that they were provided with little direction and clarity regarding the review process, schedule and expectations, and that generally there was no apparent systematic approach to the review.

### **ii. *Virginia Reviews its State Medical Facilities Plan Less Frequently than Other States***

Compared to other states with similar certificate of need laws, Virginia has a longer review cycle. Alabama requires the State Board of Health to prepare, review, and revise a Medical Facilities Plan, at least annually, with such interim revisions as may become necessary.<sup>25</sup> Kentucky requires the cabinet to promulgate an administrative regulation, updated annually, to establish the State Health Plan.<sup>26</sup> Mississippi authorizes the Department of Health to prepare, review at least triennially, and revise as necessary, a State Health Plan, which shall be submitted to the Governor for approval before it becomes effective.<sup>27</sup> North Carolina regulations require the State Medical Facilities Plan to be published annually using up-to-date data provided by licensed entities in their annual licensure renewal applications (or registration forms for medical equipment).<sup>28</sup> South Carolina regulations request that the State Health Plan be submitted to the Board of Health at least once every two years for final revision and adoption.<sup>29</sup> Tennessee requires the Planning Division of the Office of Health Planning to create a state health plan that is evaluated and updated at least annually.<sup>30</sup>

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<sup>24</sup> See Virginia Register of Regulations, March 2, 2009, Volume: 25, Issue: 13.

<sup>25</sup> See Ala. Code § 22-4-13.

<sup>26</sup> See Ky. Rev. Stat. Ann. § 216B.040(2)(a)2.a.

<sup>27</sup> See Miss. Code Ann. § 41-7-185(g).

<sup>28</sup> See N.C.G.S. §131E-177.

<sup>29</sup> See S.C. Code Ann. § 61-15-106.

<sup>30</sup> See Tenn. Code Ann. § 68-11-1625(d)(3).

**iii. *Lack of Regular State Medical Facilities Plan Reviews and Revisions Have a Negative Impact on the COPN Process and Applicants***

The lack of regular reviews and revisions to the SMFP dilutes the SMFP's relevance and undermines the effectiveness of the COPN law. If the SMFP provisions are outdated and not in line with current practice, then project analysts, the Hearing Officer and the Commissioner cannot rely on them when making their COPN recommendations and decisions. This leads to greater discretion and variation in decision making and can lead to less consistency in decisions overall.

**c. Recommendations**

**i. *Enforce Statutory Review Requirements and Amend Statute to Require Review Every Year and Updates Every Two Years***

The Board of Health should ensure the SMFP Task Force that it appoints and convenes complies with Virginia Code Section 32.1-102.2:1 (the "SMFP Task Force Statute") that requires periodic review and updating of the SMFP. It could require the SMFP Task Force to provide status updates on a quarterly or biannual basis. Additionally, the SMFP Task Force Statute should be amended to require the SMFP Task Force to review the SMFP every year and update or validate existing criteria at least every two years. The current requirement states the SMFP must be updated or validated at least every four years which is not often enough to stay abreast of changes in medical care facilities and services. The SMFP Task Force Statute could also be amended to require the SMFP Task Force meet a certain number of times each year (*e.g.* quarterly) in order to ensure work on the SMFP progresses.

**ii. *Appoint a Third Party to Lead SMFP Task Force***

The SMFP Task Force has traditionally been led by a DCOPN staff member. Given the small size of DCOPN's staff and DCOPN's current duties and responsibilities it is apparent that additional resources are required. Additionally, accountability for timely review and updates to the SMFP would be improved if the SMFP Task Force was to be led by an individual or group of individuals outside of DCOPN. Accordingly, responsibility for review and updates to the SMFP should be assigned to a third party appointed by the Board of Health. The third party should be an individual or group of individuals with policy and health planning experience familiar with Virginia's COPN law and regulations. Such third party could develop a process, schedule, and expectations for completion of the SMFP review, with support provided by DCOPN staff. Possible appointments could include individuals within the Virginia Department of Health (outside of DCOPN) or Office of the Secretary of Health and Human Resources. Alternatively, the Board of Health could contract a private consulting or professional services firm with health services planning expertise to perform reviews and updates to the SMFP, subject to approval by the Board of Health or other third party appointed by the Board of Health.

**iii. *Integrate Facilities Planning with Department of Health's Plan for Population Health***

The State Health Commissioner is currently drafting a state plan for population health. This plan includes objectives and measures related to health planning, but does not include the concept of facilities planning. Facilities, health care services, and medical equipment planning, which is the purpose of the SMFP, should be part of any statewide health plan. Similarly, the SMFP should be integrated with, or at least take into consideration, the state plan for population health. By understanding how facilities, health care services, and medical equipment planning fits into the Commissioner's overall plan, hospitals and other medical care facilities can better plan for changes and updates to their individual facility plans.

**iv. *Create a Robust SMFP that is More Objective and Data-Driven***

The structure and content of the SMFP should be revised to make it more robust, objective, and data-driven. A SMFP with more specific definitions and formulas for determining need, utilization data, and service expansion requirements would help to minimize the amount of discretion required in DCOPN and Hearing Officer recommendations and Commissioner decisions. The current SMFP leaves room for interpretation and thus greater discretion and variation in the COPN review and decision making process.

**X. Summary and Conclusion**

VHHA continues to support reforms and improvements to the COPN process, which are essential to ensure that this program effectively advances state policy goals underlying the COPN law. The COPN study legislation and the findings and recommendations in this report provide a roadmap for the Secretary and the General Assembly to identify measures to streamline and make meaningful improvements to the COPN process.