

Certificate of Public Need (COPN) Work Group Minutes

**July 1st, 1:00-4:00 p.m.
General Assembly Building,
House Room C,
915 East Broad Street,
Richmond Virginia 23219**

In attendance: Virginia Department of Health Staff: Erik Bodin, Director of the Office of Licensure and Certification, Peter Boswell, Director of the Certificate of Public Need, Susan Puglisi, Policy Analyst, Joe Hilbert, Director of Governmental and Regulatory Affairs, and Doug Harris, Adjudication Officer Certificate of Public Need. Work Group Members: Dr. David Trump, Deborah Oswalt, C. Burke King, Dr. Richard Szucs, Dr. J. Abbott Byrd, Brian Keefe, Dr. Richard Hamrick, Jill Lobb, Karen Cameron, Dr. William Hazel, Eva Hardy, Mary Mannix, Pamela Sutton-Wallace, Laurie Kuiper, Douglas Suddreth, Carol Armstrong, and Robert Cramer. Non-voting advising member: Jamie Baskerville Martin. Members of the public also attended.

The Chair of the Work Group, Eva Hardy, called the meeting to order and requested all Work Group members to introduce themselves as well as all Virginia Department of Health (VDH) staff present.

Secretary Hazel gave some opening remarks regarding the expectations of the Work Group. He stated that it is the task of the Work Group to bring together providers, consumers, members of the business community, etc in order to assess the need for changes to the certificate of public need (COPN) program. Secretary Hazel is tasked with reporting the recommendations developed by the Work Group to the General Assembly by December 1, 2015. The Secretary noted that the group will be tasked with determining the answers to a number of questions: what the public good the Commonwealth is pursuing by utilizing the COPN program; how do we as a Commonwealth measure that public good: is the method the Commonwealth is using to pursue that public good working; why or why not; what needs to change?

Dr. Hazel presented the three aspects of the COPN program: the statute, the regulations and state plan, and the process and procedures. When reviewing the state plan the work group should consider if it is adequate. When reviewing the process and procedures the work group should consider if they are fair, open, transparent, equitable and cost effective. Dr. Hazel noted that COPN has been around for a long time and been studied before. However, a lot has changed in the health care environment since the last time Virginia's COPN program has been assessed. Specifically there has been expanded coverage through the federal exchange and other Affordable Care Act related changes. The Work Group will need to consider the repercussions for COPN should Medicaid expansion occur and also if it doesn't.

Next Secretary Hazel provided an abbreviated history of COPN. The first COPN statute was adopted by New York in 1964. Virginia enacted the COPN program in 1973. In 1974 a federal law was passed encouraging states to adopt COPN. Dr. Hazel noted that as early as 1983 there were questions as to whether COPN was working; in 1988 the federal requirement was allowed to expire. Virginia retained their COPN program. In 1996 the Joint Commission on Health Care

(JCHC) conducted a study. In 2000 the JCHC presented a report on COPN deregulation which was rejected by the 2001 General Assembly. Dr. Hazel noted that COPN laws vary around the US. Those states that do have COPN programs differ in the number of services that are regulated. Vermont has the highest number with 30, Virginia has 19 and there are states that regulate zero services.

Secretary Hazel then reviewed the Work Group's goals: 1) Review the COPN process in Virginia, exploring whether there is a need for change; 2) Consider the criteria used to make COPN decisions; 3) Evaluate how COPN process affects new health care services; 4) Examine the relationship between COPN and charity care, specifically how charity care is measured; 5) Examine how COPN effects medical education and teaching hospitals; and 6) Review the regional health planning agencies' role in COPN and determining whether the State Medical Facilities Plan needs to be updated.

Finally, Secretary Hazel presented the Work Group's timeline. He stated the next meeting is tentatively scheduled for September 28th. A final meeting will occur in late October and the final report of the Work Group shall be presented to the House Appropriations and Senate Finance Committees by December 1, 2015. Secretary Hazel stressed to the Work Group that they are members of a public body and therefore all meetings of members must be open to the public. Ms. Hardy the Work Group chair thanked Secretary Hazel for his opening remarks and stated that she hoped all members of the group have an open mind, that there are no preconceived notions about what the results of the group will be. Ms. Hardy stated that she hopes to hear a great deal of background and hear the issues so that the group can begin working towards the goals the Secretary mentioned.

Peter Boswell, Director of the COPN program was introduced and provided a presentation on the Certificate of Public Need in Virginia. Mr. Boswell explained that the COPN program is governed by the Code of Virginia, specifically §32.1-102.1 through §32.1-102.11, which requires the Board of Health to promulgate two sets of regulations: the Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations (12VAC5-220) and the State Medical Facilities Plan (12VAC5-230). The COPN regulations set forth the COPN review process and the State Medical Facilities Plan provides review standards specific to each type of project that requires COPN authorization.

Next, Mr. Boswell reviewed those projects which require COPN Authorization. He stated the types of projects that require COPN authorization are considered in review cycles that are separated into 7 different batch groups. The batch groups are as follows:

- A. General Hospitals, obstetrical services, neonatal special care services, general capital expenditures
- B. Open heart surgery cardiac catheterization, ambulatory surgery centers, operating room additions, transplant services
- C. Psychiatric facilities, substance abuse treatment, mental retardation facilities
- D. Diagnostic imaging facilities and services
- E. Medical rehabilitation beds and services

DRAFT – NOT APPROVED

- F. Radiation therapy, gamma knife surgery and linac based SRS, lithotripsy, diagnostic imaging equipment may be included in an application with radiation therapy
- G. Nursing home facilities and bed additions, nursing home capital expenditures

Mr. Boswell stated that there are two review cycles per year for each batch except Batch Group "G" which is reviewed every other month. For each of the project types the State Medical Facilities Plan provides service specific standards for evaluating the need for each type of project. Mr. Boswell noted that batching allows for the review of like or similar requests in the same planning area, which are considered to be competing applications. The state is divided into five planning regions and twenty two planning districts.

Mr. Boswell then moved on to the COPN Review Criteria and Standards. There are eight criteria listed in the Code that the Commissioner considers in determining need for a project. They are:

1. The extent to which the proposed service or facility will provide or increase access to needed services.
2. The extent to which the project will meet the needs of the residents of the area to be served, as demonstrated by each of the following:
 - a. The level of community support
 - b. The availability of reasonable alternatives
 - c. Any recommendation or report of the regional health planning agency
 - d. Any costs and benefits of the project
 - e. The financial accessibility of the project; and
 - f. Any other factors that may be relevant; which is at the discretion of the Commissioner.
3. The extent to which the application is consistent with the State Medical Facilities Plan (SMFP). Changes to the SMFP come about through the SMFP Task Force. The Code of Virginia requires that the SMFP Task Force meet once every two years, complete a review of the plan, and update or validate existing criteria once every four years. The SMFP was last updated in 2009. A Task Force met in 2013 and proposed changes to the standards for cardiac catheterization services and nursing homes which will be published soon. Another SMFP Task Force is scheduled to convene at the end of this month to consider improvements to the review standards for mental health services.
4. 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.
5. The relationship of the project to the existing health care system of the area, including the utilization and efficiency of existing services or facilities
6. The feasibility of the project.
7. The extent to which the project provides improvements or innovations in the financing and delivery of health care services
8. Any project which affects a teaching hospital association with a public institution of higher education or a medical school in the area to be served:
 - a. The unique research training and clinical mission of the teaching hospital or medical school, and

- b. 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.

Next, Mr. Boswell reviewed the specifics of the SMFP. He stated for each type of project the SMFP provides service specific standards when evaluating the need for a project. Of these specifics there are two that are applicable to ever review. They are travel time and the need for additional service capacity. Both of these elements aim to assure that access to needed services is adequate. To asses travel time and need for additional service capacity VDH uses outside data sources.

Next, Mr. Boswell reviewed the specifics of the application review process. He stated there are three basic phases in the review process: the pre-application phase, the review phase and the decision phase. Mr. Boswell clarified that the formal process starts 70 days prior to the start of the established batch review cycle with the applicant submitting a letter of intent. Applicants are due thirty days after the letter of intent is due.

At this point a Work Group member asked some clarifying questions regarding the SMFP. The member asked what were the two elements of the SMFP that the Task Force worked to update. Mr. Boswell stated that they were cardiac catheterization and nursing homes. The Work Group member then stated that the turnaround time for the updates has been two years and asked if that was typical. Mr. Boswell stated he would have to do some research to determine the typical time for SMFP updates. Another Work Group member asked how benefits are assessed? Mr. Boswell stated that he would need to research and get back to the Work Group. There were further questions regarding the SMFP. The Work Group Chair Ms. Hardy requested an update on the SMFP and a presentation explaining the SMFP in more detail at the next meeting.

Mr. Boswell then returned to his presentation. After an application is submitted the Division of COPN reviews the submission for completeness and submits any questions regarding completeness to the applicant and submits any questions regarding completeness to the applicant and submits any questions regarding completeness to the applicant in ten days. The applicant has 25 days to respond to the completeness questions and pay the filing fee. Mr. Boswell reviewed the cost of an application fee; he also stated that applicants frequently use consultants and attorneys in the development, presentation or defense of the COPN application, as well as staff time and other resources. He stated that those costs are not reported to VDH and therefore the Department cannot report on those costs. The Division of COPN has five days to review the completeness responses and either deem the application complete for the start of the review cycle and accept it for review or reject it as incomplete.

Next, Mr. Boswell went over the specifics of the review phase. If an application is accepted for review, the cycle starts on the 10th of the month. Next a public hearing is conducted. Mr. Boswell then reviewed the Decision phase, which is the series of steps leading from the recommendations of the reviewing agencies to the State Health Commissioner's decision and can last up to 120 days. Mr. Boswell then presented estimates of the time different elements of the decision process takes, based on data from 2011 the last time the review cycle was studied. Mr. Boswell noted that the Code of Virginia mandates that the review cycle cannot take more 190 days unless

extended by the applicant. Only the applicant has the authority to extend deadlines. In the event the Commissioner has not issued a decision by the 190th day of the review cycle and the decision schedule has not been extended by the applicant, the request is deemed to be approved. VDH classifies such an occurrence as a default, which has never occurred.

Mr. Boswell then reviewed the Request for Applications (RFA) process. Applicants to increase the number of nursing home beds in a planning district can only be accepted when filed in response to an RFA. The RFA process was designed to replace the moratorium on all new nursing home beds, which was in effect from 1988 to 1996, and to control the inventory of beds. The COPN program determines need for the RFA process by conducting an annual calculation by planning district. Age specific use rates are used which are derived from the statewide nursing home patient origin survey. From that information future need is projected. Need is determined to exist when the calculated bed need forecast exceeds the current inventory, the average annual occupancy for all existing and authorized Medicaid certified nursing facility beds was at least 93% and there are no authorized but unconstructed nursing facility beds in the planning district. The Department of Medical Assistance Services is consulted and must approve the RFA, certifying that funds are available.

Next Mr. Boswell reviewed conditions on COPNs. The State Health Commissioner has the authority to condition the issuance of a COPN on the applicant's agreement to certain conditions: 1) the provision of indigent care, 2) facilitation of the development and operation of primary care services and 3) accept patients requiring specialized care. Requiring the direct provision of health care services to the indigent is the most common condition recommended by the Division of COPN and imposed by the Commissioner. Mr. Boswell stated there is no regulatory guidance on the application of conditions; therefore the Commissioner can utilize all of the conditions or none of them, or anything in between. However conditions cannot be arbitrary or capricious. The Division of COPN recommends an indigent care condition to the regional average rate if: 1) The applicant is a new provider under COPN with no history of providing charity care or 2) the applicant is an existing COPN provider who failed to provide charity care at a rate equal to or above the regional average during the previously reported 12 months. The rate of required charity care percentage in a condition is calculated using the most recent data from Virginia Health Information (VHI). The rate is the total annual charges for the charity care provided by hospitals in the planning region divided by the total annual charges for all hospital services. Mr. Boswell noted the conditioned facility is required to provide charity care for the COPN-approved service each year as a percentage of the total charges by the conditions facility for that service for the same year. The facilitation of primary care is added to most conditions as an acceptable way to meet conditions by supporting safety net providers either with a check or in kind.

Mr. Boswell continued to review the conditioning of COPNs. He stated that the number of active conditions changes for a number of reasons, including: conditions expiring, certificates being surrendered, the project that the certificate permits is never built or completed, the certificate has been superseded by new COPNs or a condition has been rolled into a system wide condition at a higher percentage. Then Mr. Boswell reviewed the number of conditioned COPNs: there are 655 COPNs issued, 195 are active and 108 are not yet completed.

Next, Mr. Boswell reviewed the amount of care reported as provided in compliance with conditions. In 2013, the amount was \$1.34 billion with \$35.8 million in cash contributions to safety net providers. Mr. Boswell stated that many COPN holders would have provided some level of charity care without the conditions, therefore the entire \$1.34 billion cannot be ascribed entirely to COPN but it is believed that some portion of it is directly the result of COPN. However, the value of contributions to safety net providers is solely the result of COPN conditions, as only contributions made over and above the amount that an applicant had been making prior to COPN approval count toward satisfying the condition.

Mr. Burke King asked how the \$1.34 billion is valued. Mrs. Boswell stated that the care is provided to the indigent, those without insurance and therefore the care is valued at charges. A Work Group member asked what the process is if the provider fails to reach the conditioned requirement of the certificate. Mr. Boswell noted that should the provider fail to make the required percentage of care the provider can make up the difference by writing a check to a charity or safety net provider. Another Work Group member asked what the process is for ensuring compliance. Mr. Boswell noted that providers report to the Division of COPN annually and if they do not meet the levels of compliance the provider must create a plan of correction which requires a payment to a safety net provider. The payment to a safety net provider is not directed by the Division of COPN but rather provided directly to the clinic. Secretary Hazel noted that the process is self-reported, the Division of COPN does not have the resources to audit, however if compliance is not reported action is taken.

Deborah Oswalt asked how the term "safety net provider" is defined. Mr. Boswell stated that he would have to research that question and return with an answer. Secretary Hazel asked what the Division of COPN allows. Mr. Boswell stated that the Division of COPN has a Guidance Document which can be provided to the Work Group. Ms. Hardy noted that it would be helpful if the Division of COPN published this information on its website, that way the safety net providers could alert VDH if they did not receive the payment. Ms. Oswalt noted that the Healthcare Foundation has received some money when conditions are not met but it is nowhere near the amount of \$35.8 million. Work Group members asked further follow up questions regarding the cash contributions, the work group asked for more follow up information regarding this issue for the next meeting.

Mr. Brian Keefe asked how much indigent care is provided under a COPN which is conditioned versus one that is not, in other words, does conditioning make a difference? Mr. Boswell noted that there is evidence that the percentage of indigent care has grown over the years. Another member of the Work Group asked how it is determined whether to condition one certificate over another. Again Mr. Boswell reviewed the two circumstances in which the Division of COPN suggests conditioning a certificate as: 1) The applicant is a new provider under COPN with no history of providing charity care or 2) the applicant is an existing COPN provider who failed to provide charity care at a rate equal to or above the regional average during the previously reported 12 months.

Dr. Szucs asked where the determination of need for charity care comes from. Mr. Boswell stated that the determination of need is a process separate from the review process. Dr. Szucs asked for clarification regarding the Commissioner's authority regarding conditioning, whether

she could condition the color of the walls of a provider. Mr. Boswell stated no, that the Commissioner may only condition: 1) the provision of indigent care, 2) facilitation of the development and operation of primary care services and 3) accept patients requiring specialized care. Secretary Hazel asked whether Mr. Boswell has any information regarding the history of legislation around conditioning. Mr. Boswell stated that he would have to research to find that information and return to the Work Group.

Dr. Hazel then asked what the difference between the value of the service provided and the charges listed is. Dr. Hazel asked if VDH OLC has ever thought about utilizing Relative Value Units. Secretary Hazel stated that he believes charges incentivize providers to charge more, they seem irrelevant. He voiced concern that utilizing charges affects the transparency of the system, as the charge does not correlate with what the provider paid or what the provider is paid. Karen Cameron noted that charges are used because every provider charges differently, utilizing charges allows VDH to compare "apples to apples", if VDH utilizes costs individual providers may be able to "game" the numbers. Mr. King stated that charges are numbers on a piece of paper, and that true value is what Medicare or a commercial payer would pay. Ms. Oswalt stated that uninsured would have to pay the charge amount, especially if they are not aware to ask for a discount. Ms. Mary Mannix noted the Affordable Care Act now makes it against the law to charge at full price. Mr. Keefe asked how many non-conditioned COPNs are issued.

At this point Ms. Jamie Baskerville Martin summarized what the Work Group has asked for from OLC: the charity care guidance document, a sample of a MOU between OLC and a safety net provider, information regarding the levels of charity care provided to different safety net providers, research into whether the three conditions listed within the statute are the only conditions the Commissioner may impose on a certificate, and a list of all providers who have conditions on their certificates.

At that point Mr. Boswell returned to his presentation. He reviewed the program volume of COPN from 2010 -2014. COPN receives an average of 87 letters of intent per year, an average of 59 applications per year, an average of 16 applications are heard at 13 informal fact findings per year, an average of 52 decisions are made per year with 85.7 % approved and 14.3 % denied. Mr. Boswell stressed that the high approval rate should be regarded with the understanding that the existence of the COPN process itself culls out more speculative requests, resulting in only certain requests moving forward for consideration. Between 2010 and 2014 there was an average of \$434 million in approved projects and \$43 million in denied projects. Previously the COPN capital threshold, the dollar amount that at which and above which is defined as a project, is about \$18 million. That amount continues to be inflated annually.

Mr. Boswell then reviewed the program revenue in 2010 and 2015. He noted that with the decrease of program volume there has also been a decrease in revenue. Finally Mr. Boswell reviewed the program staffing, which has been adjusted from 7.5 full time equivalents (FTEs) to 5. The Director and Supervisor positions are now split between two programs. Mr. Boswell finished his presentation and asked the panel if they had any questions.

A panel member asked what the biggest reason for the denial of a COPN is. Mr. Boswell stated a request to build a new facility near a facility which is underutilized. Mr. Keefe asked what the

most common complaints from applicants are. Mr. Boswell noted he has not personally heard any complaints. Mr. Keefe asked if there are complaints from consumers or the public. Mr. Boswell stated that occasionally at public hearings members of the public will complain about the process or a determination of need; however Mr. Boswell was unable to recall specifics. Dr. J. Abbott Byrd asked for an explanation of the capital threshold requirement. Mr. Boswell noted that the capital threshold is currently 18 million dollars, which means that the facility wants to spend 18 million dollars or more to renovate. That concluded the panel's questions for Mr. Boswell.

Mr. Patrick W. Finnerty from PWF Consulting then introduced himself and began his presentation: A Review of the Joint Commission on Health Care's 2000 Certificate of Public Need Deregulation Plan. Mr. Finnerty began with a "roadmap" of his presentation, he stated he would begin with the legislative authority and directive, then turn to the process, the deregulation plan and finally the proposed legislation and the outcome of that legislation.

Senate Bill 337 (2000) as introduced would have repealed most of the COPN program. The approved legislation instead directed the Joint Commission on Health Care (JCHC) to develop a "transition plan" to eliminate the COPN program; the legislation would have allowed 3 years for such a plan. The key elements of the plan were to include meeting the health care needs of indigent and uninsured population, establishing licensure standards and providing adequate oversight for deregulated services, determining the effect of deregulation on academic health centers, long-term care facilities, and rural hospitals and monitoring the effect of deregulation during and after transition period. He stated the end game of the plan was to eliminate COPN.

Then Mr. Finnerty began reviewing the process. A COPN Subcommittee was formed chaired by Senator Bolling. The Subcommittee had 12 other members and met during the summer and fall of 2000. The Subcommittee assisted the JCHC in crafting a deregulation plan and involved stakeholders in addressing key issues during the development of the plan. The three key stakeholders were the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, and the Virginia Health Care Association. The meetings were very well attended and at least 40 meetings were held to develop the plan. There were four key areas that the Subcommittee focused on and workgroups were established to focus on these areas: access, quality, medical education, and fair payment/funding. There were five overall goals for Deregulation Plan adopted by the workgroups and JCHC: 1) offer more choices to patients; 2) ensure access especially to the indigent and uninsured; 3) quality protections; 4) financial support for medical education at academic medical facilities; and 5) ensure Commonwealth's financing programs pay market rates.

Mr. Finnerty then reviewed the three phases of the plan. The deregulation of each service was assigned to each of these phases based on cost impact on hospitals, complexity and risk. Phase I was MRI, CT, PET, Non-cardiac nuclear imaging and Lithotripsy. Phase II was cardiac catheterization, radiation therapy, and gamma knife surgery. Phase III was ambulatory surgery centers, OB services, neonatal special care, organ transplants, and open-heart surgery. The deregulation plan retained COPN requirements for certain facilities: nursing homes, hospital beds and mental health and substance use disorder facilities.

A key element of the plan was the consideration that paying patients who were receiving regulated services in a deregulated environment may go to other locations outside of the hospital, and that may have an effect on the hospital. Mr. Finnerty noted the intent of the plan was to cushion the impact of that effect.

There were specific actions that each phase depended on. Certain quality and data reporting provisions are applicable in all three phases. Mr. Finnerty noted that new licensure systems for each deregulated service were to be in place and applied equally across all care settings. Also providers of newly deregulated services would have been required to submit claims data, additional quality outcome information for selected high risk procedures and annual financial information on the level of indigent care. Mr. Finnerty then reviewed the specific action to be accomplished in each phase. Within Phase 1 the following actions were to take place: 1) the full funding of indigent care at academic health centers; 2) the improvement of adequacy of Medicaid hospital reimbursement; 3) the elimination of faculty-earned clinical revenues to fund core cost of undergraduate medical education; and 4) a JLARC study of Medicaid physician reimbursement. Within Phase 2 the following actions were to take place: 1) continued action to fully fund indigent care at academic health centers; 2) increasing Medicaid eligibility for caretaker adults; 3) increasing Medicaid eligibility for Aged Blind and Disabled individuals; 4) the improvement of adequacy of Medicaid hospital reimbursement; and 5) the continued elimination of faculty earned clinical revenues to fund core cost of undergraduate medical education. Finally in Phase III the following actions were to take place: 1) continued action to fully fund indigent care at academic health centers; 2) increasing Medicaid eligibility for caretaker adults; and 3) increasing Medicaid eligibility for ABDs.

Mr. Finnerty noted that the overall cost of the plan was \$135 million. He stated that 308 individuals and organizations generally supported the JCHC Deregulation Plan and that the JCHC did not hear clear opposition. House Bill 2155 and Senate Bill 1084 were introduced to implement the deregulation plan. The bills left their committees but were left in the House Appropriations and Senate Finance committees, respectively. Therefore the plan was not implemented.

Secretary Hazel thanked Mr. Finnerty for his presentation. He asked if Mr. Finnerty had any idea what the plan would cost today and whether he believes that Medicaid expansion would cover some of the cost. Mr. Finnerty stated he believed that Medicaid expansion would definitely solve part of the funding problem. Ms. Pamela Sutton-Wallace asked whether any consideration was given to the impact of non-listed services, specifically those services not covered under the three phases but where service revenue does not cover the hospital's cost of providing the service. Mr. Finnerty noted that the consensus for deregulation was a fragile one, he stated he is sure those specifics were discussed but he did not have any specific memory. Dr. Richard Hamrick stated that in 2000 Virginia was a dramatically different Commonwealth and the Work Group should be careful not to overstate what we can learn from 2000. With no further questions Mr. Finnerty concluded his presentation.

Ms. Susan Puglisi then introduced herself and began her presentation on COPN in other states. Ms. Puglisi began with an overview and history of COPN. She noted that in most other states Certificate of Public Need is commonly referred to simply as Certificate of Need (CON) and as

heard from other presenters CON laws were initially put into effect as part of the federal Health Planning Resources Development Act of 1974. Just six years later in 1980, 49 of 50 states had CON laws. Ms. Puglisi then showed a graphic of the 35 states including Virginia which have CON laws.

Ms. Puglisi provided an overview of all the categories of services regulated in each state. The most highly regulated service is nursing home or long-term care beds. There is a significant drop from the number of states regulating the next highly rated service: acute hospital beds. Virginia regulated each of the top-ten most regulated services. The most notable service Virginia does not regulate is home health agencies, 18 other states do regulate home health agencies and there are in excess of 900 home health agencies in the Commonwealth of Virginia.

Ms. Puglisi then noted the length of the CON review process across the country. The most common review period is 90 days. Of those states with CON programs Virginia has the longest review period of 190 days. Ms. Puglisi noted it is important to note certain caveats to the data which portray much shorter review periods in some other states. For example, Oklahoma has a review period of 45 days however that review period only begins after a CON hearing, none of the application process up until the hearing is considered as part of the review period. Likewise, Alabama has a review period of 50 days however that does not include the filing of the letter of intent, which must be submitted 30 days before filing an application.

Ms. Puglisi then reviewed the individuals or entities across the country that have the authority to issue a CON. In Virginia, the State Health Commissioner holds the authority to issue a COPN. The most common authority is the Department of Health with 7 states which provide the Department with this authority, followed by the Commissioner of Health which 6 states providing the Commissioner this authority. 5 states provide the authority to a "Review Board", 4 to an "Agency", 3 an "Office, and 3 a "Director." Secretary Hazel asked if these other entities hold similar authority that the Commissioner holds. Ms. Puglisi responded that although the legal authority may be placed with the Department, the Commissioner may make that decision. It is also possible that the Office, delegation and practice can't be determined from reading statute and regulations, interviews with each state would be required to know for sure.

Ms. Puglisi then moved on to the application fees charged across the country. She began with the maximum fee prescribed by law; the nationwide median maximum fee is \$45,000. Virginia's maximum fee is \$20,000. Secretary Hazel asked when the last time the fee within Virginia has changed. Mr. Bodin noted he believed the last time was in 1999 or 2000 but he would have staff look up the answer and report back to the Work Group. Secretary Hazel asked how much time and effort goes into a simple review versus a complex review. Mr. Bodin stated that fees are based on the estimated capital cost of the project, therefore there is not a good correlation between the fee and the amount of work goes into a review. Secretary Hazel asked if Virginia's review cycle was shortened would VDH OLC need more staff. Mr. Bodin stated yes. Secretary Hazel asked why there was a reduction in staff. Mr. Bodin noted that fee revenue has gone down and therefore the number of staff had to be cut. He noted that the number of applications has declined a bit, particularly for projects that would have been assessed the maximum fee. Therefore VDH OLC still has a relatively high number of reviews but a decrease in revenue.

Secretary Hazel noted that whatever the Work Group decides they need to ensure there is enough staff to be able to act on the decision.

Ms. Puglisi then continued her review by presenting the minimum application fee prescribed by law. She noted fewer states prescribe a minimum fee. Again, Virginia falls below the nationwide median minimum fee of \$2,000. Virginia's minimum fee is \$1,000. The most common minimum fee across the nation is \$1,000, with 3 other states also using \$1,000 as a minimum fee.

Ms. Puglisi then reviewed conditional certificates across the nation. A total of 24 states permit conditioning of CONs, Virginia is one of those states. Of those states which permit conditional certificates, Virginia is the most restrictive. The Code of Virginia in Section 32.1-102.2 states exactly what type of conditions that the Commissioner may put on a COPN. There are only 3: 1) provide a level of care at reduced rate to indigents; 2) provide care to persons with special needs; and 3) to facilitate the development of medical services in medically underserved areas. In contrast 11 states do not have any limitations set on what conditions can be placed on certificates. Those which do have limitations on conditions usually state simply that the conditions must be related to the specific project within the application, and the conditions must be related to the state's CON statute and regulations.

Next Ms. Puglisi reviewed moratoria which exist across the country in relation to CON. Seven states have a moratorium of some sort in place; several others have had moratoria over the years which have been lifted. Both New Jersey and Virginia require a call for applications before long term care applications can be submitted. A majority of the moratorium are related to long term care.

Ms. Puglisi then reviewed post-issuance monitoring. A majority of states require monitoring after a CON is issued. Twenty-one states require progress reports, which can be required on a quarterly basis or when a project reaches specific benchmarks such as when construction begins, when the foundation is laid, etc. Ten states, including Virginia, require annual reporting. Virginia requires annual progress reports until completion of the project for every COPN. Those certificates which are conditioned require an annual report regarding compliance with the condition(s). One state requires all CON regulated facilities to report annually in perpetuity.

Finally Ms. Puglisi reviewed those states which do not currently have a CON program. She again reviewed that the federal Health Planning Resources Development Act was passed in 1974 and by 1980, 49 states had some form of CON. In 1987, the federal government repealed the Health Resources Planning Development Act, and over the next few years states began repealing their CON program. By 1990, 12 states had repealed their programs. By 2000 an additional three had repealed their programs. Since 2000 Wisconsin is the only state to repeal its program Wisconsin repealed its program in 1987, reinstated it in 1993 and repealed it again in 2011. In addition, Indiana repealed its program in 1996, reinstated it in 1997 and repealed it again in 1999. With that Ms. Puglisi ended her presentation and asked if there were any questions.

A panel member asked if any states modified their program but did not repeal it. Ms. Puglisi stated she would look into that and return to the panel. Another panel member asked if other states have restrictions on the development of beds that are not called "CON" but something else.

Again Ms. Puglisi stated she would look into it. A panel member asked if there is any dedicated health planning staff at VDH. Mr. Bodin stated only the Division of COPN staff.

Secretary Hazel asked if we know anything about what happens in states after there has been deregulation, in terms of access, cost and private sector payment, as it would be instrumental in determining if we could achieve the same public good with a different method. Dr. Trump asked Secretary Hazel if he was directing his question to Ms. Puglisi or to the panel. Secretary Hazel clarified to the panel as a whole. Ms. Hardy thanked Ms. Puglisi for her presentation and stated that when looking at healthcare in the future it is important to look back to learn from lessons of the past but also to look forward and determine what is necessary to improve access, quality and costs.

At this point the Work Group had time for public comment. No members of the public came forward to speak. At that point, Ms. Hardy stated that the panel was open for discussion and closing statements which began with Ms. Oswald. She stated that there are several possible scenarios for which the future of health care could look like and there will need to be some systematic protections in place whether the coverage gap is improved or not. She stated she is particularly interested in focuses on access for the uninsured and care charity care obligations.

Mr. Keefe stated that in a post-Affordable Care Act world there are more patients seeking healthcare and he wondered whether CON prevents access to care. He noted he is still interested in hearing what complaints regarding the program exist. Finally Mr. Keefe noted that learning from other states is important and would like to hear what was learned from those states that repealed multiple times.

Mr. King stated that he wanted to ensure that the Work Group puts the purchaser and consumer at the forefront of the discussion and consideration, specifically how they are impacted by CON. He stated that consolidation of health care providers drives up costs significantly. He went on to stress that protecting the supply of services for the uninsured is important however the Work Group must understand the magnitude and impact of restricted competition on everyone.

Dr. Szucs stated there needs to be an obligation of everyone who is providing services to participate in providing charity care unless Medicaid expansion occurs. He noted that when there is an increase in facilities there is a rise in utilization, particularly with office-based imaging. He stated there will need to be a method to control runaway utilization.

Dr. Abbot Byrd stated that 2-3% of his organization's business is indigent care. He states it is necessary to have a cushion to spread those losses out. He went on to state that the Affordable Care Act has done a lot of good but has also increased co-payments for patients and COPN is also an anticompetitive measure which directly affects the patient. He stated more competition would drive prices down. He finished by stating if you review the data COPN restricts access and competition and does not add to quality; therefore he believes there is room for adjustment.

Dr. Richard Hamrick stated that he believes there will be increasing difficulty in the operating environment. He stated the patients are living longer and therefore cases are becoming more complex. He also stated that we have the technology to do more for patients now than we could

ever do in the past. He also stressed that the Work Group should recognize the shortage in mental health beds in Virginia.

Ms. Jill Lobb noted that as a representative of employers she believes she is coming from a different background from many of the other members on the Work Group. She stated she had a lot to learn about COPN. She noted that in terms of utilization her organization's workforce was utilizing emergency room services because many members of the workforce were unaware about primary care. She stressed the importance of educating patients. She stressed that she couldn't agree more that the Work Group should focus on cost competitiveness.

Ms. Karen Cameron noted that the consumers of healthcare include every resident of Virginia. She stated her biggest concern is the lack of health planning within Virginia. She assured other members of the Work Group that there are components of quality of healthcare that have been ensured by the COPN process and there are elements within the COPN that allow for competition such as the batching process. She finished by stating she wanted to ensure the public is represented within this process as she has concerns about indigent patients being left out stating "That which get paid gets provided."

Ms. Pamela Sutton- Wallace stated that there is a lot of conflicting data on the impact of COPN and it should be the task of the Work Group to sort through to the truth. She noted her concern for academic medical centers as removing COPN may leave them with the inability to cover services which are not profitable. She noted that the cost of certain services are not well reimbursed which can effect academic medical centers' ability to train the health care professionals of the future, which is alarming when the Commonwealth is already experiencing significant shortages in specialists and those supplying primary care.

Ms. Mary Mannix stated that this is a challenging time to evaluate COPN as it will be necessary to evaluate the program while considering both the possible circumstance of Medicaid expansion and the possibility expansion not occur. She noted that there is a real dynamic regarding competition for services that are reimbursed, and stated that some services will suffer. For example, providers are not going to "rush to the finish line" to open psychiatric beds. Ms. Mannix stressed the need to learn from other states that have deregulated such as Pennsylvania. She went on to argue competition is good as long as the Work Group addresses the inherent flaws and recognize that it will not be a free market economy if the group decides to repeal COPN. Also Ms. Mannix stated that in a lot of communities the hospitals are also the largest employer and lots of families depend on the strength of the hospital for both services and employment.

Mr. Douglas Suddreth stated that COPN's impact is different for different services. He stated that it is important to look at experiences of different states rather than getting tied up in ideology. He also stressed that healthcare is not a free market economy but rather the second most regulated industry. He stressed that no one wants a loved one within a nursing home that is losing money.

Carol Armstrong noted that she too is concerned about aging patients and is interested in how the Work Group can bring more value to purchasers and consumers.

Mr. Robert Cramer noted issues arise when competition is restrained. He asked if we are actually in a position of restrained competition. He noted that COPN is an elaborate process but a there is a mere 10% of "fall out". Therefore he noted the Work Group must look at what is really being rejected. He further stressed that when you add facilities you increase utilization. He stated there are many efforts to make consumers smarter and he hopes that should there be too many facilities consumer would chose the right one. He ended by noting that this is the first taskforce he has taken a part of that a real problem was not identified at the outset. He was surprised by that fact.

Ms. Jamie Baskerville Martin noted that as an advising member she does not have an opinion to present to the Work Group. She noted that she heard a number of questions and comments regarding the substance and process of the law. She stated that when it comes to COPN it is hard to separate the substance from the process. She stated there is a lot of literature regarding the effects of COPN on costs, access and quality however that literature does not fall 100% on either side of the argument.

Dr. David Trump noted that he is also on the Governor's Task Force on Prescription Drug and Heroin Abuse and members of that group recommended including methadone services within COPN.

Secretary Hazel noted that COPN has been a tool and the Work Group should determine if they think it's appropriate to recommend another better tool to achieve the same purpose. He asked if retaining COPN makes sense. He noted that we are in a period of unprecedented innovation and the Work Group must consider whether the COPN process can keep up, can it allow for innovation? He stressed that have the longest review process in the country is not good. He stated that the goal of the Work Group at a minimum would be to make the process faster, better and tighter. He noted that COPN is not the only tool out there.

Ms. Eva Hardy stated that the next Work Group meeting is set for September 28th. She stated additional information will be posted on the website and noted that Joe Hilbert will be the point of contact for the group should they have any information they wish to share or have posted. With that Ms. Hardy closed the meeting.