

## ***Virginia's COPN process should not be held as sacred – it is in need of streamlining***

- The current COPN process takes too long, is not efficient and is unpredictable. Reforms that reduce the application review timeline, put in place a real-time digitized records system are laudable but do little to improve the system when they lead to faster decisions that remain unpredictable and continue to restrict access to care and investment in infrastructure.
- The State Medical Facilities Plan (SMFP) assists in guiding the Commissioner and staff on decisions involving COPN. Notwithstanding the requirement that the plan be reviewed every four years, the current review process is less than thorough. Moreover, when there is a focus on updating a particular portion of the SMFP, that process can be as political as any hotly contested COPN application. e.g. highly subjective criteria that hinders the addition of open heart services “...without significantly reducing the utilization of existing open heart surgery rooms within two hours driving time one way” allows for manipulation of the system.
- The SMFP regulations governing neonatal insensitive care services (NICU) have not been substantially updated in 20 years. Medicine and the current standard of care have advanced dramatically in the last 20 years and what was considered “advanced” 20 years ago is considered “routine” today. However, COPN applications to add mid-level NICU services are reviewed against a 20 year old regulatory scheme.

## ***COPN reform can be accomplished without reducing charity care delivery***

- It is a myth that COPN is the only way to ensure adequate charity care. If COPN regulations are relaxed, charity care conditions can be written into statute and required for those services subject to fewer or no COPN regulations.

## ***Providers should be allowed flexibility to add or expand some services without permission from the state***

- Protection of patient volume by incumbent providers should not be the primary factor in determining whether to allow a new entrant to provide the same service in the immediate service area.
- Many opponents of reform indicate that COPN is needed to ensure that certain facilities maintain a certain volume of patients to sustain proficiency in certain services and that without COPN quality of care would plummet at existing facilities and the new facilities would be substandard. This argument is often used in the discussion of NICU and Open Heart services. However, Vivian Ho, the chair in health economics at Rice University's Baker Institute for Public Policy and a professor of medicine at BCM [authored a study](#) that found that states that removed COPN regulations experienced a 4% decrease in the average cost of patient care and also for open-heart surgery experienced no change in patient mortality.
- Providers should have the flexibility to deploy their capital in a timely fashion in the way they desire. A healthcare provider is not going to invest in offering a new service without meeting all the applicable clinical and licensing standards. To do otherwise, would open the provider to being sued for negligence – a risk the provider will do everything it reasonably can to minimize.
- Moreover, a provider is not going to invest millions of dollars in a facility or a service without confidence the market demand supports the investment. The provider will know whether the market can support the new service offering and if it does not, economics will eventually require the service to be discontinued.

## **Conclusion**

Even if the Secretary's Workgroup cannot come to consensus on specific recommendations, the workgroup's report should acknowledge that:

- Virginia's COPN process should not be held as sacred – it is decades old and in need of streamlining and substantive reform
- COPN reform can be accomplished without reducing charity care delivery
- Providers should be allowed flexibility to add or expand some services without seeking permission from the state