



Office of the Chief Executive Officer of the Medical Center

Via email ([Joe.Hilbert@vdh.virginia.gov](mailto:Joe.Hilbert@vdh.virginia.gov)) and Regular Mail

October 14, 2015

Eva T. Hardy  
Chair, COPN Work Group  
c/o Joseph Hilbert  
Director of Governmental and Regulatory Affairs  
Virginia Department of Health  
109 Governor Street  
Richmond, VA 23219

Dear Ms. Hardy:

Thank you for the opportunity to serve on the Certificate of Public Need (“COPN”) Work Group. The Work Group’s meetings and discussions have been both informative and thought-provoking. As per your request, please consider the following comments regarding each of three scenarios contained in the document entitled “Framework of Potential Ideas for Recommendations.” With your indulgence, I am taking the liberty of discussing these scenarios out of the order presented in that document.

### **Potential Scenario 3: Eliminate COPN**

As UVA Medical Center’s Chief Executive Officer, I am strongly *opposed* to the elimination of COPN.

UVA Medical Center, as one of the two state-owned academic medical centers in Virginia, has a duty to provide care to all, regardless of ability to pay. Our duty to the Commonwealth is perhaps best expressed in our mission statement: “To provide excellence, innovation and superlative quality in the care of patients, the training of health professionals, and the creation and sharing of health knowledge within a culture that promotes equity, diversity and inclusiveness.”

Our mission as an academic medical center is further embedded in the language of the Code of Virginia Section 23-77.3 (“Operations of the Medical Center”) wherein the General Assembly recognized that “...*the ability of the University of Virginia to provide medical and health sciences education is dependent upon the maintenance of high quality teaching hospitals and related health care and health maintenance facilities....*”

In that same provision of the Code of Virginia, the General Assembly also recognized that in order for the Medical Center to achieve these purposes, it has to remain “*economically viable.*” We cannot provide patient care to all, teach health care professionals of the future, and create and share new knowledge through research without the economic viability to sustain the costs of our mission. COPN helps us to meet our financial burden.

COPN must be recognized for what it is: an essential, integrated part of Virginia's healthcare infrastructure. COPN has been deeply embedded in health care policy of Virginia since the 1970s. It plays an integral role in the planning and delivery of healthcare services, and has supported several important public policy objectives: access for the indigent and uninsured, the delivery of high quality care producing better outcomes, and financial support for medical education. Thus, contrary to the opinion of some, COPN is not an insular, "siloed" program, and it cannot be eliminated without significant adverse consequences to the delivery of healthcare in the Commonwealth. The consequences to academic medical centers would be among the most severe.

For example:

1. ***Elimination of COPN would jeopardize access to care for the most medically needy and financially vulnerable.*** UVA Medical Center, as a state institution, has particular concerns about our continued ability to provide critical services to all patients. UVA is a recipient of DSH support, but as a state hospital and quaternary care facility, we are also expected to offer services that other hospitals do not—poison control, burn care, and our recent role in Virginia's response to the Ebola crisis are but a few examples of the services UVA Medical Center is expected to—and does—provide. COPN helps us to care for all of our patients, regardless of their ability to pay, because it helps us subsidize the funding of critically necessary services and programs.
2. ***Elimination of COPN would lead to a decline in the quality of care delivered.*** The elimination of COPN would lead to the proliferation of highly profitable services, which would in turn result in the deterioration of the quality of care being provided. Areas of particular concern have included open heart surgery and NICU services, where COPN volume thresholds have helped to ensure that providers have the skills necessary for the best patient outcomes. However, the same arguments can be made for the deregulation of radiology services, where the resulting proliferation of low-cost imaging centers could lead to lower quality imaging, lower quality interpretation of results, and poorer patient outcomes.
3. ***Elimination of COPN would lead to a decline in the funding of undergraduate and graduate medical education.*** Academic medical centers like UVA play unique roles in the education and training of physicians, and Virginia has a vested interest in keeping physicians in the state once they have completed their training. 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 and clinical research activities, elimination of COPN would adversely impact these important initiatives.

UVA Medical Center is not opposed to competition, but to assert that the health care environment in which hospitals must operate is a true "free market" comparable to markets for other consumer goods and services ignores the realities of how healthcare is delivered. As my colleague Mary N. Mannix

(President and CEO of Augusta Health and Chair of the VHHA Board of Directors) so eloquently wrote in a recent (July 11, 2015) commentary in the *Richmond Times Dispatch*:

*“Competition is a good thing. It motivates hospitals to continually improve care for patients. It drives medical innovation, which has produced lifesaving technological advances. It also pushes health care providers to find operational efficiencies that improve care and lower costs. Hospitals welcome competition when all market competitors play by the same rules.*

*And therein lies the problem overlooked by those seeking hospital deregulation through the repeal of Virginia’s Certificate of Public Need law. Eliminating COPN would not be a health care panacea. It wouldn’t lead to new hospitals with new beds enabling patients to shop for less expensive care.*

*What it would produce instead is a situation where niche health care businesses swoop into communities and cherry pick profitable services to offer. Experience tells us those companies would not offer many of the services communities need, because not all are profitable...”*

For all of these reasons, I oppose the wholesale elimination of COPN. I could support a well-thought-out, carefully constructed, deregulation plan which includes phased implementation and a transition period. However, such plan must explicitly recognize and address the roles which COPN plays today in the fabric of Virginia’s public healthcare policy, particularly as that policy impacts the mission of academic medical centers. Our mission is too important to the citizens of Virginia to leave any gaps.

#### **Potential Scenario 1: Retain COPN As Is**

While I am opposed to the elimination of COPN without a well-thought-out, well-structured alternative that will support the mission of academic medical centers, I am convinced that the program needs meaningful reform (see my comments immediately below). Therefore I cannot support Potential Scenario 1.

#### **Potential Scenario 2: Retain COPN but with Modifications That Could Range from Minor to Significant**

Given the need for reform of the COPN program as it currently functions, I strongly support Potential Scenario 2, and I offer these specific recommendations below. I recognize that some of my proposals could require the commitment of additional staff and resources. However, if Virginia is serious about health planning, and wants COPN to have a role in the health planning process, then significant reform, and the resources necessary to support that reform, may well be required.

#### **Updating the State Medical Facilities Plan (SMFP)**

- 1. *The SMFP Task Force should be reconvened to consider how the SMFP might be restructured, updated, and otherwise revised.*** Despite current statutory requirements, we have learned that the State Medical Facilities Plan (SMFP) is not being reviewed and updated every four (4) years. Given the rapid increase in population and noted changes in population density in different areas of Virginia, the pace of technological change and

innovation, and other factors, an even shorter review and update cycle of every one (1) to two (2) years would seem to be more appropriate. It might also be appropriate to amend Section 32.1-102.21 of the Code (State Medical Facility Plan; task force) to specify that the Task Force include health planners from the Board of Health with appropriate training and experience. These individuals could act as advisors to the Task Force on such matters as sourcing of utilization data and the development of standards for review.

2. ***Once reconvened, the SMFP Task Force should re-examine the structure and content of the SMFP to determine how the document might better function as a health planning tool.*** Re-naming the SMFP as the “State Health Services Plan” would be reflective of a renewed intent to make the document function as a true health planning tool. Irrespective of what it is called, the SMFP must contain review standards that are objective, data-driven, and focused on quality; for example, data-driven criteria could include a more detailed specification of standards for such services as MRIs and CTs. The inclusion of quality of care standards and accreditation requirements for many services could also be beneficial, particularly where the proposed service is necessary to meet specific care guidelines.
3. ***An SMFP with more specific definitions and formulae for determining need, and one that relies upon verifiable, well sourced utilization data, would help to increase transparency.*** The amount of discretion that DCOPN and the Commissioner must now exercise in their decision-making is largely due to vague and plainly inadequate review standards. Such standards have further led to some of the frustration with the overall COPN process and confusion over the policy goals that the SMFP is intended to meet. Overall, an SMFP that is more proactive, more health planning focused, and generally more consistent with policy goals would help to alleviate some of the procedural challenges that are now so prevalent in the COPN program.
4. ***Simplify the SMFP approval process.*** Enabling the Board of Health to approve and re-issue the SMFP in a non-regulatory form as a “planning document adopted by the Board of Health” would simplify the current review process, which is viewed by many as needlessly difficult, cumbersome, and time consuming.

#### **Exemptions for Certain Facilities and Projects**

Exemptions for any facility or project must be carefully considered. As I have already mentioned, deregulation of certain services (e.g., NICU, open heart surgery, and radiology) can have profound impacts on the quality of patient care. Any deregulation must be considered in the context of overall health planning—what kinds of services are needed, and what will be the impact of deregulating them on the quality of care delivered? Will deregulation encourage or discourage the delivery of services to patients who need them the most, or those in medically underserved areas? What will be the impact of deregulation on the uninsured or underinsured?

### Improvements to Application Processing

1. **Improve public access to information.** The COPN program should increase the availability of online information through a dedicated portal maintained by VDH. Information such as monthly status reports should be updated and kept current. Letters of intent, project summaries, applications, hearing schedules, and ALJ decisions should be readily accessible online without the need for FOIA requests, which are expensive and time consuming for DCOPN and stakeholders alike.
2. **Eliminate public hearings.** Eliminating the requirement for a public hearing would reduce the amount of time and resources involved in the COPN review process for both applicants and the Commonwealth. Instead of conducting hearings, DCOPN could post public notice online through a dedicated portal or through existing electronic notice boards used by the Commonwealth, and solicit public comments by e-mail or letter directed to the project review analyst reviewing each project.
3. **Consider revising the application fee schedule.** Other states charge significantly higher fees for their Certificate of Need applications, and we need to consider whether the fees now being charged by VDH are adequate to cover the costs.
4. **All applications should have "expedited reviews."** The most significant differences today between expedited review and "regular" review are the absence of a public hearing and a shorter review timeline. Ideally, all application review could be expedited if all public hearings were eliminated and all review cycles could be shortened. In the absence of such widespread reforms, expedited review could be made available to additional categories of projects such as lithotripsy services, substance abuse treatment services, intermediate care facility/mental retardation services, and nuclear medicine.

### Revisions to COPN Conditioning

First and foremost, there must be a clear definition of what "charity care" means. While some might debate whether 200% or 400% of the FPL is an appropriate metric for determining a patient's indigency, the definition of charity care should focus upon a patient's ability to pay for services at the time the services are provided, and should not include bad debt or contractual allowances.

A more transparent methodology for setting charity conditions is also needed. One approach might be to require the COPN applicant to provide the same level of Medicaid service as the average in some defined area such as the planning district. For example, if the average Medicaid utilization in the Charlottesville planning district is four (4) percent then the Certificate holder would be required to provide four (4) percent Medicaid service. If the Certificate holder fails to meet that condition, it would be required to make a financial payment to a healthcare organization or the state indigent care fund.

Finally, meaningful reform is also necessary to create an infrastructure in DCOPN to implement and support a robust reporting process. Importantly, that would include the auditing of annual charity condition compliance reports.

#### **Post-COPN Approval Monitoring and Compliance**

There is clearly a need for better monitoring of compliance with charity conditions, as already noted. However, there is currently *no* mechanism in place to monitor how approved services are actually being delivered, potentially to the detriment of citizens of the Commonwealth. Other states, perhaps most notably Michigan, demonstrate their commitment to quality care by requiring annual reports from their providers on volumes and outcomes of certain services as a condition to continued authorization to continuing those services. Such post-COPN approval monitoring would require a significant commitment of resources. However, if COPN is to continue as an integral part of the healthcare landscape in Virginia, creation of post COPN approval monitoring should at least be considered.

#### **Promote Great Transparency**

Greater transparency would undoubtedly improve the COPN program, and please see my many other comments throughout this letter which have already addressed this point. DCOPN must make information much more readily available to both stakeholders and the public at large, and the thoughtful implementation of information technology systems would be a tremendous step in the right direction. DCOPN also needs improved access to data sources, so that it has the current, reliable information it needs to assist the Commissioner in making the fair and impartial decisions that all Virginians expect and deserve.

I hope that you find this input to be helpful. I would be happy to discuss this letter with you in further detail, and I thank you again for this opportunity to provide comments and recommendations.

Sincerely,



Pamela M. Sutton-Wallace  
Chief Executive Officer  
University of Virginia Medical Center

cc: William A. Hazel, Jr., MD, Secretary of Health & Human Services  
Commonwealth of Virginia  
Joseph Hilbert, Director of Governmental & Regulatory Affairs  
Virginia Department of Health