VIRGINIA DEPARTMENT OF HEALTH

Office of Licensure and Certification

Division of Certificate of Public Need

Staff Analysis

October 19, 2020

COPN Request No. VA-8520
Bon Secours Maryview Hospital LLC, d/b/a Bon Secours Maryview Medical Center and Bon Secours-DePaul Medical Center LLC
Suffolk, Virginia
Introduce intermediate level neonatal services, intensive care services with up to eight beds, and expand medical/surgical bed capacity by up to 16 medical/surgical beds.

Applicant

Bon Secours Hampton Roads Health System, Inc. (BSHR) is the sole corporate member of Maryview Hospital d/b/a Maryview Medical Center (Maryview). BSHR and Maryview are both 501(c)(3) not-for-profit, non-stock corporations in Virginia. Maryview currently provides services on its campus in downtown Portsmouth and on its campus in northern Suffolk, Bon Secours Harbour View. Both of Maryview's campuses are in Health Planning Region (HPR) V, Planning District (PD) 20.

On its Harbour View campus in Suffolk, Maryview provides: imaging services (including CT, MRI and mobile Pet/CT), lithotripsy services, endoscopy services, an anorectal physiology center, emergency services at a freestanding emergency department (stroke accredited and chest pain center), laboratory services, a women's imaging center (with 3-D mammography, stereotactic breast biopsy, ultrasound and bone densitometry), a cardiac imaging center (including echocardiography and holter monitoring), a non-invasive vascular laboratory, outpatient physical medicine and rehabilitation, sports performance training, radiation therapy services (including stereotactic radiosurgery and stereotactic body radio therapy services), chemotherapy and infusion services, support services for bariatric surgery patients, and several primary and specialty care practices.

Pursuant to COPN No. VA-04631, in October 2018 the State Health Commissioner (Commissioner) approved Maryview's request to construct a small, short-stay surgical hospital on its Harbour View campus in Suffolk with 18 acute care beds and four general-purpose operating rooms, relocated from Maryview's Portsmouth campus. In March 2020, BSHR submitted a significant change request seeking authorization to transfer the beds and general-purpose operating rooms from Bon Secours DePaul Medical Center (DePaul), rather than from Maryview. Furthermore, BSHR advised that upon completion and opening of Harbour View, DePaul would delicense and relinquish 36 beds and four general-purpose operating rooms.

Background

Medical/Surgical Bed Inventory in PD 20

Division of Certificate of Public Need (DCOPN) notes that nearly all acute care hospital beds in Virginia are licensed as "medical/surgical" beds, with the exception of psychiatric, substance abuse treatment, and rehabilitation beds, which are licensed separately. As long as the total licensed bed complement is not exceeded, hospitals may configure and use "medical/surgical" beds as circumstances require. For this reason, DCOPN has included obstetric, pediatric, and intensive care beds in the total count of licensed medical-surgical beds (**Table 1**).

According to Virginia Health Information (VHI) data for 2018, the most recent year for which such data is available, and as demonstrated by **Table 1** below, the medical/surgical bed inventory of PD 20 consists of 2,463 beds. For 2018, the PD 20 medical/surgical bed inventory operated at a collective occupancy of 64.7%.[1]

Table 1. Medical/Surgical Bed Inventory[2] in PD 20: 2018

Facility	Licensed Beds	Staffed Beds	Available Days	Patient Days	Occupancy %
Bon Secours DePaul Medical Center	180	120	65,700	24,528	37.3%
Bon Secours Maryview Medical Center	267	173	97,455	40,399	41.5%
Chesapeake Regional Medical Center	310	213	113,150	64,234	56.8%
Children's Hospital of The King's Daughters	198	188	72,270	44,228	61.2%
Hospital for Extended Recovery	35	35	12,775	5,972	46.7%
Lake Taylor Transitional Care Hospital	104	104	37,960	26,974	71.1%
Sentara Leigh Hospital	247	247	90,155	75,480	83.7%
Sentara Norfolk General Hospital	469	446	171,185	141,018	82.4%

[1] DCOPN notes that the number of available patient days reported by Virginia Health Information for medical/surgical beds in PD 20 in 2018 appears to be in error. DCOPN has calculated occupancy based on a corrected number of available patient days, derived by multiplying the number of licensed medical/surgical, obstetric, pediatric, and intensive care beds by 365.

[2] The Adjudication Officer's case decision for COPN No. VA-04682 held that DCOPN was in error by including obstetric, intensive care and pediatric patient days in its calculations for medical-surgical bed need, despite those beds being fungible and accordingly, able to convert to medical-surgical beds without COPN authorization. However, because obstetric, intensive care and pediatric beds can be easily converted to medical-surgical beds, thereby changing the medical-surgical inventory without first obtaining COPN authorization, DCOPN maintains that obstetric, intensive care and pediatric beds should be included in the medical-surgical inventory and the corresponding patient days used for medical-surgical bed need calculations.

Facility	Licensed Beds	Staffed Beds	Available Days	Patient Days	Occupancy %
Sentara Obici Hospital	158	158	57,670	39,243	68.0%
Sentara Princess Anne Hospital	174	174	63,510	50,848	80.1%
Sentara Virginia Beach General Hospital	241	217	87,965	65,294	74.2%
Southampton Memorial Hospital	80	80	29,200	3,768	12.9%
Total/Average	**2,463**	**2,155**	**898,995**	**581,986**	**64.7%**

Source: VHI (2018) and DCOPN Records

ICU Bed Inventory in PD 20

According to VHI data for 2018, the most recent year for which such data is available and as demonstrated by **Table 2** below, the ICU bed inventory of PD 20 consists of 343 licensed beds. For 2018, the PD 20 ICU inventory operated at a collective occupancy of 76.2%[3].

Table 2. Intensive Care Bed Inventory in PD 20: 2018

Facility	Licensed Beds	Staffed Beds	Available Days	Patient Days	Occupancy %
Bon Secours DePaul Medical Center	24	23	8,760	4,845	55.3%
Bon Secours Maryview Medical Center	26	22	9,490	5,660	59.6%
Chesapeake Regional Medical Center	28	24	10,220	8,864	86.7%
Children's Hospital of The King's Daughters	95	95	34,675	27,201	78.4%
Sentara Leigh Hospital	20	20	7,300	5,683	77.8%
Sentara Norfolk General Hospital	90	85	32,850	28,543	86.9%
Sentara Obici Hospital	12	12	4,380	3,619	82.6%
Sentara Princess Anne Hospital	16	16	5,840	4,620	79.1%
Sentara Virginia Beach General Hospital	24	24	8,760	5,926	67.6%
Southampton Memorial Hospital	8	8	2,920	448	15.3%
Total/Average	**343**	**329**	**125,195**	**95,409**	**76.2%**

Source: VHI (2018) and DCOPN Records

[3] DCOPN notes that the number of available patient days reported by Virginia Health Information for PD 20 ICU beds in 2018 appears to be in error. DCOPN has calculated occupancy based on a corrected number of available patient days, derived by multiplying the number of licensed intensive care beds by 365.

Neonatal Intensive Care Unit Services in PD 20

As **Table 3** demonstrates, within HPR V, there are 11 neonatal special care providers with services ranging from intermediate to sub-specialty levels of care. In total, these service providers have a current inventory of 120 bassinets[4] (**Table 3**). DCOPN notes that bassinets within certificate of public need (COPN) approved special care nurseries may be utilized interchangeably at their approved level or at a lower level, but not at a higher level than approved within that facility. For example, specialty level nurseries may be used to provide intermediate level care. Furthermore, bassinets are not licensed beds, and authorized facilities can change the number of bassinets at will. DCOPN further notes that intermediate level neonatal special care services and obstetric services at DePaul and Maryview were suspended in March 2020 and June 2019, respectively.

As may be observed in **Table 3**, special care nursery utilization has been consistently high at Sentara Norfolk General Hospital, Sentara Leigh Hospital and Riverside Regional Medical Center, moderate at Sentara Obici and Bon Secours Mary Immaculate Hospital, but has been low at the other facilities in HPR V. The overall average utilization for the special care nursery facilities in HPR V from 2014-2018 was 57.3%.

[4] DCOPN notes that the number of available patient days reported by Virginia Health Information for PD 20 bassinets in some years appears to be in error. DCOPN has calculated occupancy based on a corrected number of available patient days, derived by multiplying the number of bassinets by 365.

Table 3. Special Care Nursery Inventory and Utilization in HPR V 2014-2018[5]

Facility (COPN Approved Bassinet Level)	Staffed Bassinets	2014	2015	2016	2017	2018	Facility Average
Bon Secours DePaul Medical Center (Intermediate)*	6	35.27%	34.11%	39.55%	29.93%	17.63%	31.30%
Bon Secours Mary Immaculate Hospital (Specialty)	7	44.03%	47.44%	42.12%	48.96%	63.52%	49.21%
Bon Secours Maryview Medical Center (Intermediate)**	4	40.55%	27.08%	22.33%	27.67%	17.33%	26.99%
Chesapeake Regional Medical Center (Specialty)	8	6.85%	6.30%	3.35%	49.42%	55.45%	24.27%
Riverside Regional Medical Center (Specialty)	12	127.05%	92.19%	96.99%	97.53%	96.64%	102.08%
Sentara Careplex Hospital (Intermediate)	3	N/A	N/A	N/A	N/A	8.13%	8.13%
Sentara Leigh Hospital (Intermediate)	4	49.52%	52.53%	62.98%	66.23%	59.86%	58.23%
Sentara Norfolk General Hospital (Specialty)	48	69.67%	77.89%	80.75%	77.91%	74.72%	76.19%
Sentara Obici Hospital (Intermediate)	4	51.99%	54.79%	56.35%	29.59%	26.03%	43.75%
Sentara Princess Anne Hospital (Specialty)	20	33.93%	27.77%	34.17%	36.99%	33.95%	33.36%
Sentara Williamsburg Regional Medical Center (Intermediate)	4	13.01%	12.33%	11.54%	11.64%	17.74%	13.25%
Total/Average	**120[6]**	**54.50%**	**55.20%**	**58.33%**	**60.74%**	**57.73%**	**57.30%**

Source: VHI Data (2018)
*Service suspended in March 2020
**Service suspended in June 2019

[5] DCOPN notes that the number of available patient days reported by Virginia Health Information for PD 20 bassinets in some years appears to be in error. DCOPN has calculated occupancy based on a corrected number of available patient days, derived by multiplying the number of bassinets by 365
[6] DCOPN notes that NICU care stations at Children's Hospital of the King's Daughters (CHKD) are not broken out specifically in CHKD's reporting to VHI and are not included in Table 3.

Table 4. HPR V Live Births: 2014-2018

Facility	PD	2014	2015	2016	2017	2018	Facility Average
Sentara Norfolk General Hospital	20	2,214	2,918	2,932	2,970	3,040	2,815
Sentara Princess Anne Hospital	20	2,003	2,775	2,580	2,489	2,273	2,424
Riverside Regional Medical Center	21	2,008	2,482	2,637	2,180	2,005	2,262
Chesapeake Regional Medical Center	20	615	2,399	2,256	2,359	2,850	2,096
Sentara Leigh Hospital	20	1,416	1,982	2,106	2,207	2,065	1,955
Bon Secours Mary Immaculate Hospital	21	644	1,586	1,506	1,708	1,468	1,382
Sentara Obici Hospital	20	987	1,353	1,451	1,408	1,369	1,314
Bon Secours DePaul Medical Center*	20	476	1,413	1,393	1,320	1,265	1,173
Sentara Williamsburg Regional Medical Center	21	722	949	966	912	873	884
Bon Secours Maryview Medical Center**	20	415	1,029	821	675	396	667
Sentara Careplex Hospital	21	N/A	N/A	N/A	N/A	360	360
Riverside Shore Memorial Hospital	22	318	354	340	364	304	336
Southampton Memorial Hospital	20	154	144	138	32	N/A	117
Total		**11,972**	**19,384**	**19,126**	**18,624**	**18,268**	**17,475**
Average		**998**	**1,615**	**1,594**	**1,552**	**1,552**	

Source: VHI Data 2014-2018
*Service suspended in March 2020
**Service suspended in June 2019

Proposed Project

As discussed above, COPN No. VA-04631 authorized Maryview's request to construct a small, short-stay surgical hospital on its Harbour View campus with 18 acute care beds and four general purpose operating rooms, relocated from DePaul and to delicense and relinquish 36 beds and four general purpose operating rooms from DePaul. Pursuant to this current COPN request, Harbour View seeks authorization to expand its original request to include general and intermediate level neonatal services, intensive care services with up to eight beds, and up to an additional 16 medical/surgical and Obstetrical beds.

The projected capital costs of the proposed project are $115,666,890 approximately 65% of which are attributed to direct construction costs (**Table 5**). The total capital costs of $115,666,890 include $77,075,738 approved pursuant to COPN No. VA-04631. In a change from the information provided in the application for COPN No. VA-04631, capital costs will now be funded through the accumulated reserves of Bon Secours Mercy Health (BSMH) and have been reduced by $6,372,845. The applicant expects to begin construction in December 2020, and for the project to be completed in February 2023. The applicant anticipates a target date of opening of March 2023.

Table 5. Harbour View Hospital's Projected Capital Costs

Direct Construction Costs	$74,998,569
Equipment Not Included in Construction Contract	$30,193,770
Site Preparation Costs	$5,299,551
Architectural and Engineering Fees	$4,925,000
Other Consultant Fees	$250,000
Total Capital Costs	**$115,666,890**

Source: COPN Request No. VA-8520

Project Definitions

§32.1-102.1:3 of the Code of Virginia defines a project, in part, as "An increase in the total number of beds…in an existing medical care facility..." and "Relocation of beds from an existing medical care facility described in subsection A to another existing medical care facility described in subsection A…" and "Introduction into an existing medical care facility described in subsection A of any… neonatal special care…."

§32.1-123 defines a medical care facility as "Any facility licensed as a hospital."

In its application, submitted July 2, 2020, the applicant proposed to establish obstetrical services at Harbour View. DCOPN notes that the addition of obstetrical services is no longer subject to COPN review.

Required Considerations -- § 32.1-102.3, of the Code of Virginia

In determining whether a public need exists for a proposed project, the following factors shall be taken into account when applicable.

1. **The extent to which the proposed project will provide or increase access to health care services for people in the area to be served, and the effects that the proposed project will have on access to health care services in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to health care;**

Geographically, Maryview will be located at the intersection of Bon Secours Drive and Harbour Towne Parkway, Suffolk, Virginia. Both Bon Secours Drive and Harbour Towne Parkway intersect with Harbour View Boulevard and are in close proximity to Harbour View Boulevard and College Drive, a major shopping and entertainment thoroughfare in northern Suffolk. The site is located near the intersection of US Route 17 and Interstate I-664, allowing access from both east and west directions. As will be discussed in greater detail later in this staff analysis report, inpatient bed services are generally available within a 30-minute drive for a least 95% of the population of PD 20 and approval of the proposed project would not improve geographic access to inpatient bed services. With regard to neonatal special care services, as will be discussed in greater detail later in this staff analysis report, introduction of these services at Harbour View Hospital will not increase geographic access to neonatal special care services for people in the area to be served.

Population plays a major role in determining the need for inpatient and neonatal special care services in a planning district. **Table 6** shows projected population growth in PD 20 through 2030.

Table 6. Population Projections for PD 20, 2010-2030

Locality	2010	2020	% Change 2010-2020	Avg Ann % Change 2010-2020	2030	% Change 2020-2030	Avg Ann % Change 2020-2030
Isle of Wight	35,270	38,060	7.91%	0.75%	41,823	9.89%	0.95%
Southampton	18,570	17,739	-4.47%	-0.45%	17,711	-0.16%	-0.02%
Chesapeake	222,209	249,244	12.17%	1.13%	270,506	8.53%	0.82%
Franklin	8,582	8,268	-3.66%	-0.36%	8,140	-1.55%	-0.16%
Norfolk	242,803	246,881	1.68%	0.16%	249,889	1.22%	0.12%
Portsmouth	95,535	95,027	-0.53%	-0.05%	90,715	-4.54%	-0.46%
Suffolk	84,585	94,733	12.00%	1.11%	109,424	15.51%	1.45%
Virginia Beach	437,994	457,699	4.50%	0.43%	467,187	2.07%	0.21%
Total PD 20	**1,145,548**	**1,207,652**	**5.42%**	**0.52%**	**1,255,394**	**3.95%**	**0.39%**
PD 20 65+	**124,196**	**167,891**	**35.18%**	**2.98%**	**222,845**	**32.73%**	**2.87%**
Virginia	8,001,024	8,655,021	9.30%	0.77%	9,331,666	7.82%	0.76%
Virginia 65+	976,937	1,352,448	38.44%	3.22%	1,723,382	27.43%	2.45%

Source: U.S. Census, Weldon Cooper Center Projections (June 2019) and DCOPN (interpolations)

As depicted in **Table 6** at an average annual growth rate of 0.52%, PD 20's population growth rate is slightly below the state's average annual growth rate of 0.77%. Overall, the planning district is projected to add an estimated 62,104 people in the 10-year period ending in 2020 – an average increase of 6,210 people annually and 47,742 in the 10-year period ending 2030 – an average increase of 4,774 people annually. DCOPN notes that Suffolk, the location of the proposed project, is expected to grow at a rate of 1.45% from 2020 to 2030, much higher than any other locality in PD 20.

Regarding socioeconomic barriers to access to the applicant's services, according to regional and statewide data regularly collected by VHI, for 2018, the most recent year for which such data is available, the average amount of charity care provided by HPR V facilities was 5.1% of all reported total gross patient revenues (**Table 7**). Recent changes to § 32.1-102.4B of the Code of Virginia now require DCOPN to place a charity care condition on every applicant seeking a COPN. DCOPN notes that, if approved, the proposed project should be subject to the 4.0% Bon Secours Hampton Roads Health System system-wide charity care condition established in March 2017 pursuant to COPN No. VA-04237, in addition to any new requirements as found in the revised § 32.1-102.4B of the Code of Virginia.

Table 7. HPR V Charity Care Contributions: 2018

2018 Charity Care Contributions at or below 200% of Federal Poverty Level			
Hospital	**Gross Patient Revenues**	**Adjusted Charity Care Contribution**	**% of Gross Patient Revenue**
Bon Secours DePaul Medical Center	$698,996,618	$53,230,518	7.62%
Sentara Careplex Hospital	$889,460,665	$64,660,889	7.27%
Riverside Tappahannock Hospital	$162,491,011	$11,307,825	6.96%
Riverside Regional Medical Center	$1,861,151,990	$126,769,911	6.81%
Bon Secours Maryview Medical Center	$1,273,955,832	$85,038,667	6.68%
Sentara Obici Hospital	$825,126,790	$54,851,619	6.65%
Riverside Walter Reed Hospital	$252,673,741	$16,571,599	6.56%
Sentara Virginia Beach General Hospital	$1,210,282,480	$67,107,518	5.54%
Riverside Doctors' Hospital Williamsburg	$124,258,743	$6,791,596	5.47%
Sentara Norfolk General Hospital	$3,313,578,465	$168,093,514	5.07%
Riverside Shore Memorial Hospital	$235,708,877	$11,934,270	5.06%
Sentara Leigh Hospital	$1,182,257,169	$55,810,160	4.72%
Bon Secours Mary Immaculate Hospital	$675,071,989	$29,896,497	4.43%
Sentara Princess Anne Hospital	$967,617,447	$38,069,270	3.93%
Sentara Williamsburg Regional Medical Center	$659,049,590	$24,789,255	3.76%
Chesapeake Regional Medical Center	$900,598,911	$15,330,992	1.70%
Hampton Roads Specialty Hospital	$25,627,019	$433,771	1.69%
Southampton Memorial Hospital	$209,949,572	$3,282,979	1.56%
Bon Secours Rappahannock General Hospital	$71,220,177	$1,107,592	1.56%
Children's Hospital of the King's Daughters	$1,009,437,096	$6,094,726	0.60%
Lake Taylor Transitional Care Hospital	$46,761,019	$0	0.00%
Hospital For Extended Recovery	$25,515,975	-$252,369	-0.99%
Total Facilities Reporting			22
Median			4.9%
Total $ & Mean %	**$16,620,791,176**	**$840,920,799**	**5.1%**

Source: VHI (2018)

DCOPN did not identify any other unique geographic, socioeconomic, cultural, transportation, or other barriers to care in the planning district.

2. The extent to which the proposed project will meet the needs of people in the area to be served, as demonstrated by each of the following:

(i) the level of community support for the proposed project demonstrated by people, businesses, and governmental leaders representing the area to be served;

DCOPN received over 600 letters of support and 189 signatures on a petition in support of the proposed project from members of the medical community, citizens of Suffolk and patients of BSMH. Collectively, these letters articulate numerous benefits of the project, including:

- The expanding population of the city of Suffolk and the need for increased capacity to better accommodate growing inpatient demand;
- BSHR's commitment to the community and excellence as a community partner;
- The importance of the availability of obstetric and neonatal services for patients seeking to have a "Bon Secours baby";
- The expansion will offer Bon Secours patients access to inpatient care located close to their other health care providers practice; and
- The inconvenience and potential risk of having to travel across bridges, tunnels and heavy traffic for obstetric care.

DCOPN also received one letter of opposition from Sentara Hospitals d/b/a Sentara Obici Hospital (Sentara Obici) and one letter of concern from Chesapeake Regional Medical Center (CRMC).

The Sentara Obici letter documented the following concerns:

- Bon Secours' current proposal represents a drastic turnabout that is inconsistent with claims made in the 2018 application. Instead of establishing an innovative short-stay hospital, Bon Secours seeks to build the very type of broader-scope general-purpose acute care hospital for which DCOPN found no need in 2018. Specifically, instead of 18 inpatient beds, Bon Secours proposes a facility with 54 beds, ICU services, OB services and an intermediate level nursery.
- The Commissioner's approval in 2018 noted the innovative nature of the proposed short-stay hospital, and DCOPN recognized Maryview's assertion that the establishment of Harbour View Hospital would improve the financial stability of Maryview's downtown Portsmouth campus in furtherance of its long-range plan.
- Patient demand and utilization patterns indicate lack of public need for Bon Secours' current proposal. Other acute care hospitals within 10-20 miles of Harbour View have capacity to meet the inpatient needs of residents of PD 20.

- Bon Secours' acquisition of Southampton [Memorial Hospital] is inconsequential to an assessment of public need for Bon Secours' current proposal, as is the claim that Maryview's planned tertiary role necessitates a new hospital. Historically, residents of Southampton's service area have not relied heavily on Maryview for inpatient care.

- Bon Secours' failure to invest in DePaul does not create a public need for Harbour View Hospital. Reallocating resources, including significant staffing resources, from an existing hospital that serves a large, aging, and more financially challenged population – and thus a population more likely to need inpatient care – to a new hospital that will serve a less populous area comprised of younger residents disrupts the geographical distribution of inpatient care resources in PD 20.

- Bon Secours' proposal will have a significant adverse impact on existing inpatient care resources, including at Sentara Obici.

The CRMC letter included the following concerns:

- There is a surplus of 345 medical/surgical beds and 75 ICU beds in PD 20, and thus, no public need for the additional beds at Harbour View Hospital;

- There is no inpatient experience at Harbour View, and therefore no proof that it will need beds in addition to those beds that were previously approved;

- Relocation of the requested beds will remove services from an economically disadvantaged area and move them to one of the highest socioeconomic areas in PD 20;

- Bon Secours has not shown any subarea need for the addition of ICU services at Harbour View Hospital;

- Existing special care nursery services are operating well below the SMFP utilization threshold of 85%;

BSHR responded to Sentara's letter of opposition and CRMC's letter of concern. BSHR's response outlined the following:

- Approval of the proposed project will improve access to, and utilization of, existing resources that for years have been substantially underutilized.

- Even as expanded, Harbour View Hospital will continue to achieve a 7% reduction in the number of medical/surgical beds in PD 20.

- Sentara's hospitals' inpatient discharges account for a substantial majority (64.9%) or all PD 20 inpatient discharges.

- The population in the immediate DePaul area is not seeking inpatient care at DePaul and it is appropriate to relocate the beds to western PD 20 where there is a greater need.

- In response to the COVID-19 pandemic, all Bon Secours entities, including Maryview, suspended construction projects.

Public Hearing
Section 32.1-102.6 B of the Code of Virginia directs DCOPN to hold one public hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city in the case of competing applications; or in response to a written request by an elected local government representative, a member of the General Assembly, the Commissioner, the applicant, or a member of the public. COPN Request No. VA-8520 is not competing with another project in this batch cycle. DCOPN did not receive a request to conduct a public hearing.

(ii) the availability of reasonable alternatives to the proposed project that would meet the needs of the people in the area to be served in a less costly, more efficient, or more effective manner;

The status quo is a viable alternative to the proposed project. As demonstrated by **Table 1**, medical/surgical beds in PD 20 operated at a collective utilization of 64.7% in 2018, well below the 80% SMFP threshold for expansion. As demonstrated by **Table 2**, the ICU beds in PD 20 operated at a collective utilization of 76.2% in 2018, above the 65% SMFP threshold for expansion. However, as will be discussed in greater detail later in this staff analysis report, DCOPN finds that the addition of ICU beds at the to-be-constructed Harbour View is premature at this time. Furthermore, these additions are inconsistent with the original scope of the Harbour View project as approved by COPN Request No. VA-04631.

The State Medical Facilities Plan (SMFP) advises that intermediate level neonatal special care services should be located within 30 minutes driving time one way under normal driving conditions of hospitals providing general level newborn services. As demonstrated in **Table 8**, CRMC, Sentara Leigh Hospital, Sentara Norfolk General Hospital and Sentara Obici Hospital are each within 30 minutes driving time of Harbour View. Consequently, it can be argued that the status quo suffices as an alternative to the proposed project.

DCOPN notes that intermediate level neonatal special care services and obstetric services at DePaul and Maryview were suspended in March 2020 and June 2019, respectively.

Table 8. Travel Time and Distance from Harbour View

Facility (COPN Approved Bassinet Level)	Travel Time (Minutes)	Travel Distance (Miles)
Bon Secours DePaul Medical Center (Intermediate)*	22	13.2
Bon Secours Maryview Medical Center (Intermediate)**	13	8.1
Chesapeake Regional Medical Center (Specialty)	24	20.4
Sentara Leigh Hospital (Intermediate)	24	18.8
Sentara Norfolk General Hospital (Specialty)	14	10
Sentara Obici Hospital (Intermediate)	22	18.9
Sentara Princess Sentara Princess Anne Hospital (Specialty)	34	25.8
Average	21.9	16.5

Source: Google Maps

(iii) any recommendation or report of the regional health planning agency regarding an application for a certificate that is required to be submitted to the Commissioner pursuant to subsection B of § 32.1-102.6;

Currently there is no organization in HPR V designated by the Virginia Department of Health to serve as the Health Planning Agency for PD 20. Therefore, this consideration is not applicable to the review of the proposed project.

(iv) any costs and benefits of the proposed project;

As demonstrated by **Table 5**, the projected capital costs of the proposed project are $115,666,890, approximately 65% of which are attributed to direct construction costs. The total capital costs of $115,666,890 include $77,075,738 approved pursuant to COPN No. VA-04631. In a change from the original request, capital costs will now be funded through the accumulated reserves of BSMH and are reduced by $6,372,845. Accordingly, there are no financing costs associated with this project. DCOPN concludes that when compared to similar projects these costs are reasonable. For example, COPN No. VA-04602 issued to Valley Health System – Warren Memorial Hospital to build a replacement hospital including 36 inpatient beds is anticipated to cost approximately $97,700,000.

The applicant identified numerous benefits of the proposed project, including:

- Improving access to a broader scope of services;
- Maintain availability of significantly more care in the local communities historically served by Maryview and Harbour View;
- Complement the modalities and ancillary services already operational on the Harbour View campus or nearby;
- Access to obstetrical and neonatal services for those in PD 20 who want to experience a faith-based delivery at a Bon Secours facility;
- Inclusion of intensive care services as part of the expected complement of care at a hospital;
- Offering a new choice of provider for inpatient services in the city of Suffolk; and

- Inventory neutral relocation of capacity from DePaul.

(v) the financial accessibility of the proposed project to the people in the area to be served, including indigent people; and

The Pro Forma Income Statement provided by the applicant includes the provision of charity care in the amount of 3.9% (**Table 9**). DCOPN notes that, according to VHI data from 2018, the most recent year for which such data is available, the average amount of charity care provided by HPR V facilities was 5.1% of all reported total gross patient revenues (**Table 7**). As previously discussed, recent changes to § 32.1-102.4B of the Code of Virginia now require DCOPN to place a charity care condition on every applicant seeking a COPN. DCOPN notes that, if approved, the proposed project should be subject to the 4.0% Bon Secours Hampton Roads Health System system-wide charity care condition established in March 2017 pursuant to COPN No. VA-04237, in addition to any new requirements as found in the revised § 32.1-102.4B of the Code of Virginia.

Table 9. Harbour View Hospital's Pro Forma Income Statement

	Year 1 (2023)	**Year 2 (2024)**
Inpatient Gross Revenue	$82,931,128	$89,237,099
Outpatient Gross Revenue	$178,598,000	$184,156,000
Total Gross Revenue	**$261,529,128**	**$273,393,099**
Charity Care	($10,199,636)	($10,662,331)
Contractuals/All Other	($183,070,390)	($191,375,169
Net Patient Services Revenue	**$68,259,102**	**$71,355,599**
Total Operating Expenses	$60,029,336	$62,353,529
Income from Operations	**$8,229,766**	**$9,002,070**

Source: COPN Request No. VA-8520

(vi) at the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a proposed project;

As previously discussed, the Commissioner approved Maryview's request to construct a small, short-stay surgical hospital on its Harbour View campus in Suffolk with 18 acute care beds and four general purpose operating rooms. BSHR planned to transfer these beds and operating rooms from DePaul and would delicense and relinquish 36 beds and four general-purpose operating rooms. In support of this request, Maryview identified numerous benefits, including:

- Keeping up with population growth in the service area of more than 3.0%, and significantly faster growth of those patients most likely to need elective surgical procedures - seniors, whose population is expected to grow nearly six (6) times faster than the overall population;

- Maintaining other services and more chronic, intensive care for the selected service lines at Maryview, minimizing the need to duplicate selected services (and incur additional capital costs) across campuses;

- Services with shorter inpatient stays and more frequently scheduled are expected to support a more efficient operating model that minimizes duplication of services;

- Shifting the locus of the elective surgical services from the following services lines from Maryview to the new Bon Secours Harbour View Hospital made logical sense because they already have a significant footprint presence on the existing Harbour View campus:

    - orthopaedics and spine
    - general surgery (including bariatric surgery and minor surgical oncology such as breast surgery, etc.)
    - gynecology and gynecology oncology
    - plastic and reconstructive surgery
    - urology
    - otolaryngology
    - endocrinology

Maryview explained "the target procedures were narrowed down to short, elective inpatient stay and outpatient surgical cases" and "co-locating a hospital focusing on those selected service lines is an increased convenience for patients, families, and physicians."

In his approval of COPN No. VA-04631, the Commissioner recognized the unique and innovative nature of a short stay surgical hospital and the public need for it in Suffolk. DCOPN observes that the proposed expansion to a full, acute care hospital appears to be inconsistent with the Commissioner's approval of COPN No. VA-04631.

DCOPN also notes that the Commissioner should give consideration to the issue of newborn safety and the difficulties faced by NICU providers operating with a limited average daily census. For example, the American Academy of Pediatrics has articulated some degree of correlation between patient volume and the quality of care as such:

> In addition to level of care, patient volume in the NICU seems to influence outcome. However, it must be acknowledged that the relationship between volume and outcome tends to be true on the average, and considerable variability exists among individual hospitals and physicians. In a study of hospitals in California in 1990, risk-adjusted neonatal mortality based on linked birth and death certificate data were significantly lower for births that occurred in hospitals with level III NICUs that had an average daily census of at least 15 patients, compared with lower-volume centers. In another study using linked birth and death certificate data in California for 1992 and 1993, the effect on mortality of the level of care provided at the hospital of birth was examined for low birth weight infants. Compared with birth in a hospital with a regional NICU, risk-adjusted mortality for infants with birth weight less than 2000 g was significantly higher at a hospital with no NICU, an intermediate NICU, or a community NICU with an average census less than 15 patients. [7]

[7] American Academy of Pediatrics, "Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children", PEDIATRICS Volume 114, November 5, 2004.

Harbour View has projected a volume of 529 patient days by Year 1, and a volume of 571 patient days by Year 2 for the six requested intermediate level bassinets. With respect to the average daily census, this amounts to an average of 1.45 and 1.56 NICU patients per day. This projection falls considerably short of the 15 patient average daily census threshold cited by the American Academy of Pediatrics.

3. The extent to which the application is consistent with the State Health Services Plan;

Section 32.1-102.2:1 of the Code of Virginia calls for the State Health Services Plan Task Force to develop, by November 1, 2022, recommendations for a comprehensive State Health Services Plan (SHSP). In the interim, these regulations provide the best available criteria and DCOPN will consider the consistency of the proposed project with the predecessor of the SHSP, the State Medical Facilities Plan (SMFP).

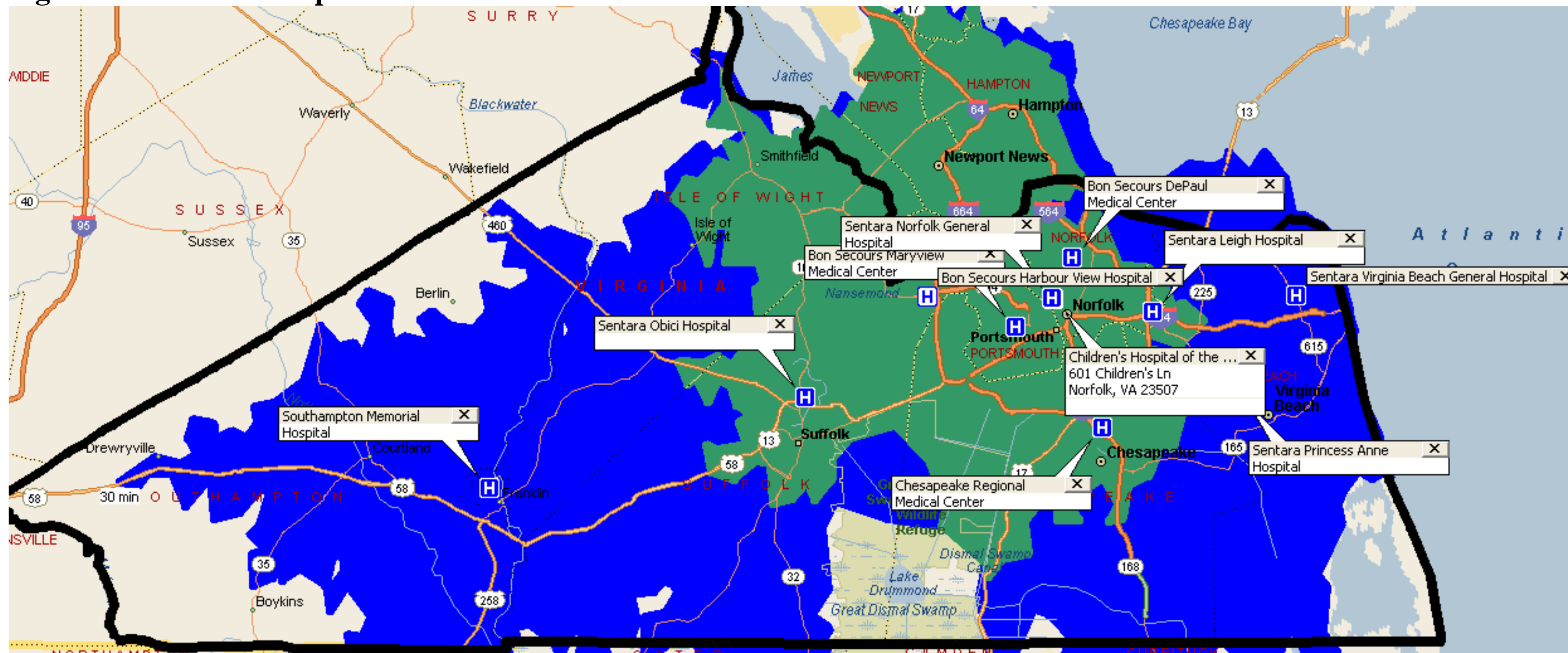
The SMFP contains criteria/standards for the addition of medical/surgical beds. They are as follows:

Part VI
Inpatient Bed Requirements

12VAC5-230-520. Travel Time.
Inpatient beds should be available within 30 minutes driving time one way under normal conditions of 95% of the population of a health planning district using mapping software as determined by the commissioner.

The heavy black line in **Figure 1** represents the boundary of PD 20. The white "H" symbol marks the proposed location of Harbour View Hospital. The blue "H" symbols mark the locations of all other existing inpatient bed services in PD 20. The blue shaded area represents the area of PD 20 that is within 30 minutes' drive time of existing inpatient bed services. The green shading represents the area within 30 minutes' drive time of the proposed project. Given the amount of shaded area, it is evident that inpatient bed services currently exist within a 30-minute drive for a least 95% of the population of PD 20. Accordingly, DCOPN concludes that approval of the proposed project would not improve geographical access to inpatient bed services for persons in PD 20 in any meaningful way.

Figure 1: Acute Care Inpatient Beds in PD 20



12VAC5-230-530. Need for New Service.

No new inpatient beds should be approved in any health planning district unless:

1. **The resulting number of beds for each bed category contained in this article does not exceed the number of beds to be needed for that health planning district for the fifth planning horizon year; and**
2. **The average annual occupancy based on the number of beds in the health planning district for the relevant reporting period is:**
   a. **80% at midnight census for medical-surgical and pediatric beds;**
   b. **65% at midnight census for intensive care beds.**

B. For proposals to convert under-utilized beds that require a capital expenditure of $15 million or more, consideration may be given to such proposals if:

1. **There is a projected need in the applicable category of inpatient beds; and**
2. **The applicant can demonstrate that the average annual occupancy of the converted beds would meet the utilization standard for the applicable bed category by the first year of operation.**

For purposes of this part, "utilization" means less than 80% average annual occupancy for medical-surgical or pediatric beds, when the relocation involves such beds and less than 65% average annual occupancy for intensive care beds when the relocation involves such beds.

C. The capital expenditure threshold referenced in subsection B of this section shall be adjusted annually using the percentage increase listed in the Consumer Price Index for All Urban Consumers (CPI-U) for the most recent year as follows:

$$A \times (1 + B)$$

Where:

A = the capital expenditure threshold amount for the previous year; and
B = the percent increase for the expense category "Medical Care" listed in the most recent year available of the CPI-U of the U.S. Bureau of Labor Statistics.

The calculation below demonstrates that there is a projected surplus of 1,347 medical/surgical beds in PD 20 for the five-year planning horizon. According to VHI data (**Table 10**), the average occupancy for PD 20 inpatient medical/surgical beds from 2014-2018 was 63.1%. This is well below the SMFP standard of 80% required for the establishment of new inpatient beds. Although the applicant proposes to transfer the requested medical/surgical beds from DePaul, and thus will not add to this surplus, because Harbour View hospital has not yet been constructed, there is no discernible way to confirm that Harbour View is in need of the additional medical/surgical beds and DCOPN considers this request to be premature.

12VAC5-230-540. Need for Medical-surgical Beds.
The number of medical-surgical beds projected to be needed in a health planning district shall be computed as follows:

1. **Determine the use rate for medical-surgical beds for the health planning district using the formula:**

BUR = (IPD/PoP)

Where:
BUR = the bed use rate for the health planning district.
IPD = the sum of the total inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported to VHI; and
PoP= the sum of the total population 18 years of age and older in the health planning district for the same five years used to determine IPD as reported by a demographic program as determined by the commissioner.

Step 1. PD 20 – SMFP Medical/Surgical Bed Use Rate

IPD 2014-2018 Sum Patient Days Last 5 Years	PoP 2014-2018 Sum Population Age 15+ Last 5 Years	BUR 2014-2018 Bed Use Rate
2,861,673	2,002,776	1.4289

Table 10: PD 20 Medical/Surgical Inpatient Beds Occupancy (2014-2018)

Year	Licensed Beds	Staffed Beds	Available Days	Patient Days	Occupancy Rate
2014	2,461	2,393	898,265	561,721	62.5%
2015	2,565	2,410	936,225	571,380	61.0%
2016	2,465	2,418	902,190	571,112	63.3%
2017	2,465	2,418	899725	575,474	64.0%
2018	2463	2155	898995	581986	64.7%
Total and Average	12,419	11,794	4,535,400	2,861,673	63.1%

Source: VHI data (2014-2018)
* DCOPN notes that the number of available patient days reported by Virginia Health Information for medical/surgical beds in PD 20 for some years appears to be in error. DCOPN has calculated occupancy based on a corrected number of available patient days, derived by multiplying the number of licensed medical/surgical, obstetric, pediatric, and intensive care beds by 365.

Table 11. PD 20 Historical and Projected Population (Ages 18+)

	2014	2015	2016	2017	2018	TOTAL 2014-2018	2025 (Projected)
Population	520,119	451,679	392,524	341,363	297,091	2,002,776	228,091

Source: Weldon Cooper
Note: While the SMFP requires population data for ages 18+, Weldon Cooper data is broken into age groups by 5-year increments. As such, the calculations above include data for persons aged 15-17 years of age.

The medical-surgical bed use rate for 2014-2018 in PD 20 was 1.4289 per capita for the population age 15[8] and over.

2. **Determine the total number of medical-surgical beds needed for the health planning district in five years from the current year using the formula:**

$$\textbf{ProBed} = \frac{\textbf{((BUR x ProPop) / 365}}{\textbf{0.80}}$$

Where:
ProBed = the projected number of medical-surgical beds needed in the health planning district for five years from the current year.
BUR = the bed use rate for the health planning district determined in subdivision 1 of this section.
ProPop = the projected population 18 years of age and older of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

$$\text{ProBed} = \frac{((1.4289 \times 228{,}091) / 365)}{0.80}$$

ProBed = 1,116.1

At a medical-surgical average utilization of 80%, there is a need for 1,116.1 (1,117) medical-surgical beds in PD 20 for five years from the current year.

3. **Determine the number of medical-surgical beds that are needed in the health planning district for the five year planning horizon year as follows:**

NewBed = ProBed – CurrentBed

Where:
NewBed = the number of new medical-surgical beds that can be established in a Health planning district, if the number is positive. If NewBed is negative, No additional medical-surgical beds should be authorized in the health Planning district.
ProBed = the projected number of medical-surgical beds needed in the health Planning district for five years from the current year as determined in

[8] The Weldon Cooper Center for Public Service projects Virginia population on an annual basis by county/city broken down by age in 5-year increments. As such, the calculations above include data for those persons aged 15 - 17.

Subdivision 2 of this section.
CurrentBed = the current inventory of licensed and authorized medical-surgical Beds in the health planning district.

New Bed = 1,116.1 – 2,463
New Bed = (1,346.9)

At a medical-surgical average utilization of 80%, there is a current calculated surplus of 1,346.9 (1,347) medical-surgical beds in PD 20.

12VAC5-230-550. Need for Pediatric Beds.

In the interest of brevity, this calculation has been omitted from this DCOPN staff analysis report as the applicant is not proposing to add pediatric beds.

12VAC5-230-560. Need for Intensive Care Beds.
The projected need for intensive care beds in a health planning district shall be computed as follows:

1. **Determine the use rate for ICU beds for the health planning district using the formula:**

ICUBUR = (ICUPD/Pop)

Where:

ICUBUR = The ICU bed use rate for the health planning district.

ICUPD = The sum of total ICU inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported by VHI; and

Pop = The sum of population 18 years of age or older for adults or under 18 for pediatric patients in the health planning district for the same five years used to determine ICUPD as reported by a demographic program as determined by the commissioner.

Step 1. PD 20—SMFP ICU Use Rate

ICUPD 2014-2018 Sum of Patient Days Last 5 Years	Pop 2014-2018 Sum Population Age 15+ Last 5 Years	ICUBUR 2014-2018 Bed Use Rate
441,480	2,002,776	0.2204

Note: While the SMFP requires population data for ages 18+, Weldon Cooper data is broken into age groups by 5-year increments. As such, the calculations above include data for persons aged 15-17 years of age.

Table 12: PD 20 ICU Beds Occupancy (2014-2018)

Year	Licensed Beds	Staffed Beds	Available Days	Patient Days	Occupancy Rate
2014	321	318	117,165	82,863	70.72%
2015	321	318	117,165	83,560	71.32%
2016	329	326	120,414	85,255	70.80%
2017	340	340	124,100	94,393	76.06%
2018	343	329	125,195	95,409	76.2%
Total and Average	**1,654**	**1,631**	**604,039**	**441,480**	**73.09%**

Source: VHI data (2014-2018)
* DCOPN notes that the number of available patient days reported by Virginia Health Information for ICU beds in PD 20 for some years appears to be in error. DCOPN has calculated occupancy based on a corrected number of available patient days, derived by multiplying the number of intensive care beds by 365.

The ICU bed use rate for 2014-2018 in PD 20 was 0.2204 per capita for the population age 15 and over.[9]

2. **Determine the total number of ICU beds needed for the health planning district, including bed availability for unscheduled admissions, five years from the current year using the formula:**

ProICUBed = ((ICUBUR x ProPop)/365)/0.65

Where:

ProICUBed = The projected number of ICU beds needed in the health planning district for five years from the current year;

ICUBUR = The ICU bed use rate for the health planning district as determine in subdivision 1 of this section;

ProPop = The projected population 18 years of age or older for adults or under 18 for pediatric patients of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

$$\text{ProICUBed} = \frac{((0.2204\text{x } 228{,}091) / 365)}{0.65}$$

ProICUBed = 211.9

At an ICU average utilization of 65%, there is a need for 211.9 ICU beds in PD 20 for five years from the current year.

[9] The Weldon Cooper Center for Public Service projects Virginia population on an annual basis by county/city broken down by five-year increments. As such, the calculations above include data for those persons aged 15-17.

3. **Determine the number of ICU beds that may be established or relocated within the health planning district for the fifth planning horizon planning year as follows:**

NewICUB = ProICUBed – CurrentICUBed

Where:

NewICUBed = The number of new ICU beds that can be established in a health planning district, if the number is positive. If NewICUBed is a negative number, no additional ICU beds should be authorized for the health planning district.

ProICUBed = The projected number of ICU beds needed in the health planning district for five years from the current year as determined in subdivision 2 of this section.

CurrentICUBed = The current inventory of licensed and authorized ICU beds in the health planning district.

NewICUBed = 211.9-343
NewICUBed = (131.1)

At an ICU average utilization of 65%, there is a calculated surplus of 131.1 (132) ICU beds in PD 20.

Within the application, the applicant asserts the "introduction of intensive care services at [Harbour View] is responsive to hospital preparedness and pandemic readiness efforts." The approach of approving and staffing beds for a highly uncommon worst-case scenario is inconsistent with several of the guiding principles of SMFP expressed in 12VAC5-230-30. The first principle listed in this section states that "[t]he COPN program is based on the understanding that excess capacity or underutilization of medical facilities are detrimental to both cost effectiveness and quality of medical services in Virginia." Moreover, the final principle listed in this section states the "[t]he COPN program discourages the proliferation of services that would undermine the ability of essential community providers to maintain their financial viability." Maintaining and staffing beds in anticipation of another health emergency that may never come is directly contradictory to both of these principles.

Furthermore, using the possible resurgence of COVID-19 or another health emergency to justify making permanent beds that could be temporarily approved under Executive Order (EO) 52 sets a dangerous precedent that DCOPN strongly rejects. The Governor, by limiting the approval of these beds contingent on the duration of EO 52, clearly did not intended these temporarily approved beds to exist past EO 52's expiration. As such, use of a potential resurgence to justify approval would run contrary to the clear intent of the Governor's Executive Order creating these beds. Approval of the request for ICU beds must not be based on the COVID-19 crisis and should be based solely on the clear need within the planning district. DCOPN notes that under the EO 52 process 1,204 beds were temporarily added, including 527 ICU beds in PD 20 (63 [49 ICU] at Maryview, 83 [24 ICU] at DePaul and 80 [34 ICU] at Obici).

12VAC5-230-570. Expansion or Relocation of Services.

A. Proposals to relocate beds to a location not contiguous to the existing site should be approved only when:
   1. **Off-site replacement is necessary to correct life safety or building code deficiencies;**
   2. **The population currently served by the beds to be moved will have reasonable access to the beds at the new site, or to neighboring inpatient facilities;**
   3. **The number of beds to be moved off-site is taken out of service at the existing facility;**
   4. **The off-site replacement of beds results in:**
      a. **A decrease in the licensed bed capacity;**
      b. **A substantial cost savings; cost avoidance, or consolidation of underutilized facilities; or**
      c. **Generally improved efficiency in the applicant's facility or facilities; and**
   5. **The relocation results in improved distribution of existing resources to meet community needs.**

B. Proposals to relocate beds within a health planning district where underutilized beds are within 30 minutes driving time one way under normal conditions of the proposed relocation should be approved only when the applicant can demonstrate that the proposed relocation will not materially harm existing providers.

As previously discussed, although the applicant proposes to transfer the requested medical/surgical beds from DePaul, and thus will not add to PD 20's surplus, because Harbour View hospital has not yet been constructed, there is no discernible way to confirm that Harbour View is in need of the additional beds and DCOPN considers this request to be premature.

12VAC5-230-580. Long-Term Acute Care Hospitals (LTACHs)

In the interest of brevity, this standard has been omitted from this DCOPN staff analysis report, as the applicant is not proposing to add LTACH beds or to convert existing beds to LTACH beds.

12VAC5-230-590. Staffing.
Inpatient beds should be under the direction of one or more qualified physicians.

The applicant is an established provider of inpatient care beds and services and the applicant provided assurances that the existing and proposed inpatient beds will be under the direction of one or more qualified physicians.

The SMFP contains criteria/standards for the addition of Neonatal Special Care Services. They are as follows:

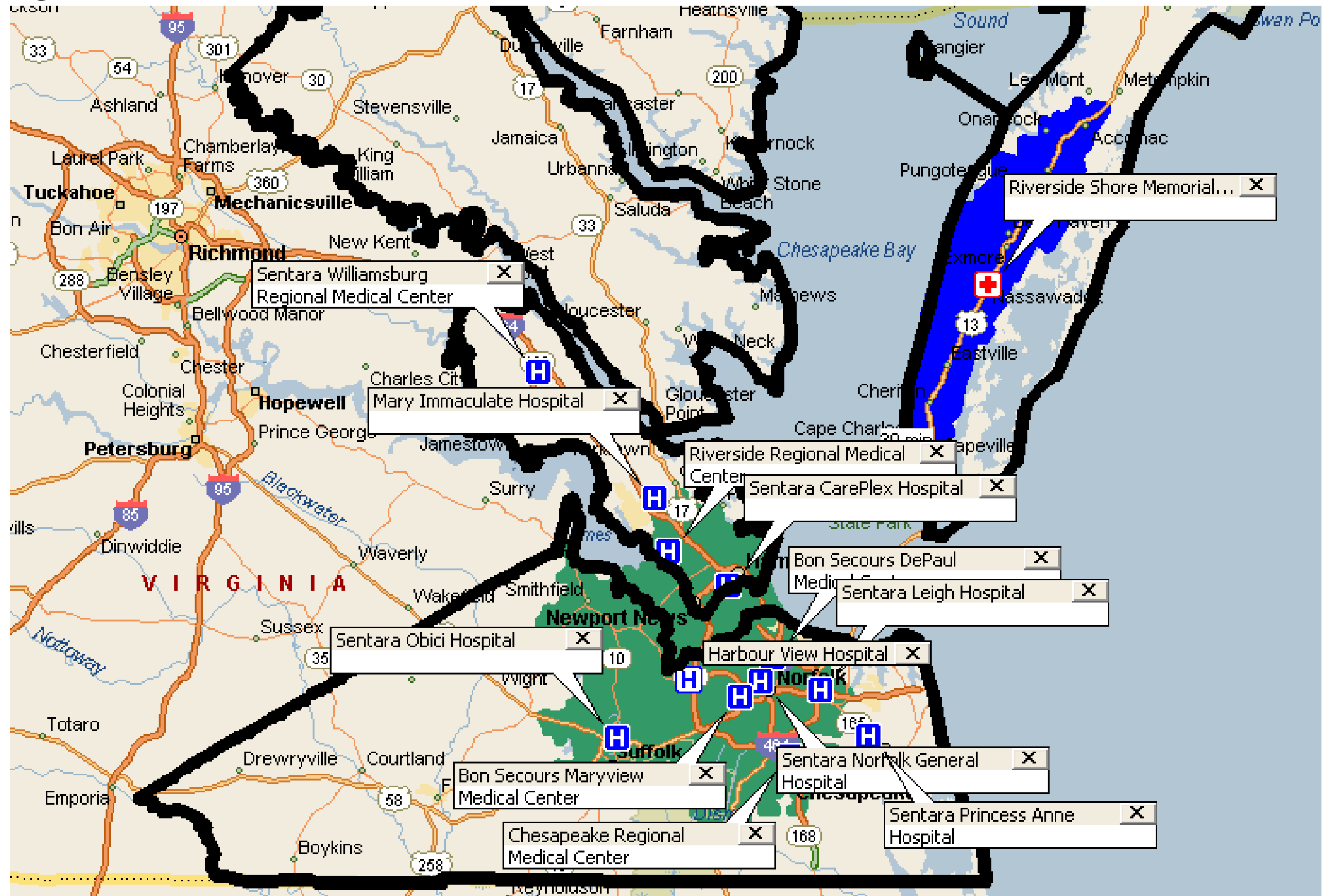
Part XIII
Perinatal and Obstetrical Services
Article 2
Neonatal Special Care Services

12VAC5-230-940. Travel time.

A. Intermediate level neonatal special care services should be located within 30 minutes driving time one way under normal driving conditions of hospitals providing general level newborn services using mapping software as determined by the commissioner.

The heavy dark line in **Figure 2** is the boundary of HPR V. The white "H" symbol marks the proposed location of Harbour View Hospital. The blue "H" symbols mark the locations of all other hospitals providing neonatal special care services. DCOPN notes that there is only one facility in HPR V, which provides obstetrical services but does not also provide neonatal special care services, Riverside Shore Memorial (marked by a red cross). The blue shaded area represents the area that is within 30 minutes driving time one-way under normal driving conditions from Riverside Shore Memorial. DCOPN further notes that there is no neonatal special care service within 30 minutes driving time of Riverside Shore Memorial Hospital. The green shaded area represents the area that is within a 30-minute drive time one-way from the proposed location of Harbour View Hospital. From the green shading, it is clear that this area is already well served by existing providers and introduction of neonatal special care services at Harbour View Hospital would not significantly increase access for obstetrical patients at Riverside Shore Memorial Hospital or patients at other facilities providing obstetrical services in HPR V.

Figure 2



B. Specialty and subspecialty neonatal special care services should be located within 90 minutes driving time under normal conditions of hospitals providing general or intermediate level newborn services using mapping software as determined by the commissioner.

Not applicable. The applicant is not requesting to introduce specialty or subspecialty level special care services.

12VAC5-230-950. Need for new service.
No new level of neonatal service shall be offered by a hospital unless by a hospital unless that hospital has first obtained a COPN granting approval to provide each level of service.

It is the express intent of the COPN Request to obtain COPN approval for the proposed project.

12VAC5-230-960. Intermediate level newborn services.

A. Existing intermediate level newborn services as designated in 12VAC5-410-443 should achieve 85% average annual occupancy before new intermediate level newborn services can be added to the health region.

The definition of "bed" in the SMFP excludes bassinets and, regardless of the service level, bassinets are neither COPN approved nor licensed as to the number of bassinets. COPN authorization and licensing relate *only to the level* of neonatal special care, i.e. intermediate level, specialty level and subspecialty level. Therefore, the available number of such bassinets, either in total or at any specific level, is not a fixed number for any period of time. Because hospitals may increase or decrease the number of bassinets without COPN authorization or notice, the availability and occupancy of existing bassinets reported to VHI by hospitals with special care nursery services may often be arbitrary.

Additionally, in the adjudication officer's good cause standing report for COPN Request No. VA-7283 (Bon Secours St. Francis Medical Center's request to introduce specialty level nursery services) in which Chippenham and Johnston-Willis Hospitals, Inc., were found to have good cause standing, the adjudication officer reached the conclusion that this standard is "meaningless" and "unworkable."

However, DCOPN notes that the utilization of intermediate and specialty level nurseries (which may also be used to provide intermediate level care) in HPR V in 2018, was far below 85% at only 57.73% (**Table 3**).

B. Intermediate level newborn services as designated in 12VAC5-410-443 should contain a minimum of six bassinets.

The proposed intermediate level neonatal service will include six bassinets.

C. No more than four bassinets for intermediate level newborn services as designated in 12VAC5-410-443 per 1,000 live births should be established in each health planning region.

Again, because bassinets are neither COPN-approved nor licensed and hospitals may increase or decrease the number of bassinets without COPN authorization or notice, the availability and occupancy of existing bassinets reported to VHI by special care nursery hospitals may often be arbitrary thus this standard considered to be "meaningless" and "unworkable" by DCOPN.

However, DCOPN notes that according to VHI data for 2018, the most recent year for which such data is available, there were 18,268 live births in HPR V (**Table 4**), representing a maximum of 73 intermediate level bassinets in HPR V. DCOPN notes that there are 29 bassinets that are approved for a maximum care level of intermediate. However, as previously discussed, bassinets within COPN approved special care nurseries may be utilized interchangeably at their approved level or at a lower level, but not at a higher level than approved within that facility. Therefore, the specialty level nurseries in HPR V may be used to provide intermediate level care, and thus it can be argued that there is a surplus of bassinets in HPR V.

12VAC5-230-970. Specialty level newborn services.

A. Existing specialty level newborn services as designated in 12VAC5-410-443 should achieve 85% average annual occupancy before any new specialty level newborn services can be added to the health planning region.

Not applicable. The applicant is not requesting to introduce specialty level newborn services.

B. Specialty level newborn services as designated in 12VAC5-410-443 should contain a minimum of 18 bassinets.

Not applicable. The applicant is not requesting to introduce specialty level newborn services.

C. No more than four bassinets for specialty level newborn services as designated in 12VAC5-410-443 per 1,000 live births should be established in each health planning region.

Not applicable. The applicant is not requesting to introduce specialty level newborn services.

D. Proposals to establish specialty level services as designated in 12VAC5-410-443 shall demonstrate that service volumes of existing specialty level newborn service providers located within the travel time listed in 12VAC5-230-940 will not be significantly reduced.

Not applicable. The applicant is not requesting to introduce specialty level newborn services.

12VAC5-230-980. Subspecialty level newborn services.

A. Existing subspecialty level newborn services as designated in 12VAC5-410-443 should achieve 85% average annual occupancy before any new subspecialty level newborn services can be added to the health planning region.

Not applicable. The applicant is not requesting to introduce subspecialty level newborn services.

B. Subspecialty level newborn bassinets as designated in 12VAC5-410-443 should contain a minimum of 18 bassinets.

Not applicable. The applicant is not requesting to introduce subspecialty level newborn services.

C. No more than four bassinets for subspecialty level newborn services as designated in 12VAC50410-443 per 1,000 live births should be established in each health planning region.

Not applicable. The applicant is not requesting to introduce subspecialty level newborn services.

D. Proposals to establish subspecialty level newborn services as designated in 12VAC5-410-443 shall demonstrate that service volumes of existing subspecialty level newborn providers located within the travel times listed in 12VAC5-230-940 will not be significantly reduced.

Not applicable. The applicant is not proposing to introduce subspecialty level newborn services.

12VAC5-230-990. Neonatal services.

The application shall identify the service area and the levels of service of all the hospitals to be served by the proposed service.

The applicant identified the service area and the levels of service of all hospitals to be served by the proposed service. The applicant indicates that the primary service area encompasses the city of Portsmouth and portions of Chesapeake and Suffolk. The secondary service area encompasses the remainder of Suffolk and portions of Isle of Wight County.

12VAC5-230-1000. Staffing.
All levels of neonatal special care services should be under the direction or supervision of one or more qualified physicians as described in 12VAC5-410-443.

The applicant has provided assurances that the neonatal special care services provided at Harbour View will be under the direction and supervision of qualified physicians.

Required Considerations Continued

4. The extent to which the proposed project fosters institutional competition that benefits the area to be served while improving access to essential health care services for all people in the area to be served;

BSHR facilities are licensed to operate 527 medical/surgical beds in PD 20, (not including those temporarily authorized under Executive Order 52 in response to the pandemic), at three sites, representing approximately 21% of the inpatient medical/surgical inventory in the planning district. In contrast, Sentara facilities are licensed to operate 1,289 medical/surgical beds in PD 20 at five sites, representing approximately 52% of the medical/surgical inventory in the planning district. Therefore, DCOPN concludes that approval of the proposed project would introduce institutional competition with regard to inpatient bed services.

5. The relationship of the proposed project to the existing health care system of the area to be served, including the utilization and efficiency of existing services or facilities;

Table 1, as well as the calculated surplus, demonstrates that there is arguably ample capacity within the existing PD 20 medical-surgical inventory to provide care for PD 20 patients.

With regard to neonatal care, as previously discussed, the proposed project will not increase access to neonatal care services but is likely to reduce utilization at other intermediate level nurseries in PD 20.

6. The feasibility of the proposed project, including the financial benefits of the proposed project to the applicant, the cost of construction, the availability of financial and human resources, and the cost of capital;

As already discussed, DCOPN contends that the projected costs for the proposed project are reasonable when compared to previously authorized projects similar in scope. Furthermore, the Pro Forma Income Statement provided by the applicant projects a net profit of $8,229,766 from in the first year of operation and of $9,002,070 in the second year of operation. DCOPN notes that this represents a drastic increase from the projected profits provided in the application for COPN No. VA-04631, which were $3,545,000 in Year 1 and $3,653,000 in Year 2. The applicant will fund the proposed project through the accumulated reserves of members of BSMH. Accordingly, there are no financing costs associated with this project.

With regard to staffing, in its application the applicant anticipates the need to hire a total of 369.8 full time employees (FTEs) to staff the Harbour View Hospital. DCOPN notes that of those 369.8 FTEs, 129.1 were accounted for in the request for COPN No. VA-04631. Furthermore, an additional 45 current staff members in the existing Harbour View Emergency Department on the Harbour View campus will relocate to the Harbour View Hospital. Therefore, the applicant anticipates the need to hire 195.7 FTEs to staff *this* request pursuant to COPN Request No. VA-8520. DCOPN notes that the applicant is an established provider with a robust employee retention plan. Accordingly, DCOPN does not anticipate that the applicant would have difficulty staffing the proposed project, or that doing so will have a significant negative impact on existing facilities. With regard to this standard, the applicant provided the following:

> A large portion of the needed personnel at [Harbor View] will transfer from Maryview, DePaul or the Bon Secours Health Center at Harbour View. As a result, the expansion project anticipates a limited need for recruitment of additional FTEs. Selected new personnel required that are not anticipated to relocate from Maryview or DePaul include environmental services, maintenance, IT, security staff and mother/baby services. When recruitment is necessary, [BSMH] and its affiliates across the Commonwealth and nation utilize comprehensive recruitment methods, including advertisements in area newspapers, employment fairs at local health education schools and colleges, professional publications and journals, recruiting firms, etc. Recruitment efforts take place locally, regionally, statewide, and nationally as necessary. Recruitment is also available through the www.bonsecours.com website.
>
> In addition, [BSMH] and its entities operate a school of nursing health professions, and collaborate with colleges, universities, and established allied health schools and programs to facilitate training of new health care professionals at [BSMH] facilities throughout the Commonwealth. These relationships have assisted [BSMH] facilities to recruit new staff into the area. Bon Secours also maintains a system-wide "job board" so that [BSMH] employees nationwide can be made aware of opportunities throughout the enterprise.

Based on the financial benefits of the project to the applicant, the cost of construction, the availability of financial and human resources, and the cost of capital DCOPN concludes the inpatient bed services portion of the proposed project is feasible.

With regard to the neonatal special care services, DCOPN notes some concern with the applicant's ability to appropriately staff the requested intermediate level NICU. As previously discussed, BSHR closed its obstetrical and NICU services at DePaul and Maryview after the departures of large OB groups, one to CRMC. In response to a request to provide more information on its plan to staff the requested OB and NICU services at Harbour View, the applicant provided the following:

> Bon Secours expects that a portion of the obstetric and nursery personnel needed to staff the obstetrical and nursery programs at the Bon Secours Harbour View Hospital will come from other Bon Secours facilities or from Bon Secours associates who want to advance their nursing career. When the programs at Maryview and DePaul closed, many associates accepted different positions within Bon Secours. Since then, many such affected associates have shared their support and enthusiasm for the services at Harbour View and expressed an interest in being part of the new obstetrical and nursery programs if approved. In addition, obstetrical clinicians locally and across the state have shared an interest in being part of the proposed program at the brand new hospital. Also attached to this correspondence is a letter of support from Dr. Jeffrey Morrison, a practicing OB/GYN.

7. The extent to which the proposed project provides improvements or innovations in the financing and delivery of health care services, as demonstrated by; (i) the introduction of new technology that promotes quality, cost effectiveness, or both in the delivery of health care services; (ii) the potential for provision of health care services on an outpatient basis; (iii) any cooperative efforts to meet regional health care needs; and (iv) at the discretion of the Commissioner, any other factors as may be appropriate; and

The proposal would introduce no new technology that would promote quality or cost effectiveness in the delivery of inpatient acute care or neonatal special care services. Nor does it increase the potential for provision of services on an outpatient basis.

In its application, submitted July 2, 2020, the applicant proposed to establish obstetrical services at Harbour View. DCOPN notes that the addition of obstetrical services is no longer subject to COPN review.

8. In the case of a project 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, (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.

Bon Secours and its entities operate a school of nursing health professions and collaborate with colleges, universities, and established allied health schools and programs to facilitate trainings of new health care professionals at Bon Secours' facilities throughout the Commonwealth.

DCOPN Findings and Conclusions

DCOPN finds that the proposed project to add intermediate level neonatal services, intensive care services with up to eight beds and up to an additional 16 medical/surgical beds is generally inconsistent with the applicable criteria and standards of the SMFP and the Eight Required Considerations of the Code of Virginia.

DCOPN finds that the total projected capital cost of $115,666,890 are reasonable when compared to previously approved projects similar in scope and that the project would introduce beneficial competition among the Bon Secours and Sentara facilities, which hold the market share of inpatient services in the planning district. However, DCOPN further finds that the status quo is preferable to the proposed project and the proposed project is an unnecessary duplication of existing services in PD 20.

Furthermore, because Harbour View hospital has not yet been constructed, there is no discernible way to confirm that Harbour View is in need of the additional medical/surgical beds and DCOPN considers this request to be premature. Additionally, in his approval of COPN No. VA-04631, the Commissioner recognized the unique and innovative nature of a short stay surgical hospital and the public need for it in Suffolk. DCOPN observes that the proposed expansion to a full, acute care hospital is inconsistent with the Commissioner's approval of COPN No. VA-04631.

Finally, with regard to neonatal special care services, HPR V is already well served by existing providers and introduction of neonatal special care services at Harbour View Hospital would not significantly increase access for obstetrical patients in HPR V.

DCOPN Staff Recommendation

The Division of Certificate of Public Need recommends **denial** of Bon Secours Maryview Hospital LLC, d/b/a Bon Secours Maryview Medical Center and Bon Secours-DePaul Medical Center LLC's request to introduce intermediate level neonatal services, establish intensive care services with up to eight beds, and expand medical/surgical bed capacity by up to 16 medical/surgical beds.

1. The proposed project is not consistent with the applicable criteria and standards of the State Medical Facilities Plan and the Eight Required Considerations of the Code of Virginia.

2. Maintenance of the status quo is more advantageous than the proposed project.

3. The proposed project unnecessarily duplicates existing services already available in surplus in PD 20.

4. Neonatal special care services are already sufficiently available in HPR V.

5. The expanded request is premature and is inconsistent with the Commissioner's approval of COPN No. VA-04631.