# REPORT OF THE

# JOINT SUBCOMMITTEE STUDYING THE

# FEASIBILITY OF PRESERVING A

# REGIONAL HEALTH PLANNING MECHANISM

# TO

# THE GOVERNOR

# AND

# THE GENERAL ASSEMBLY OF VIRGINIA


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**Report of the**
**Joint Subcommittee Studying the**
**Feasibility of Preserving a**
**Regional Health Planning Mechanism**
**To**
**The Governor and the General Assembly of Virginia**
**Richmond, Virginia**
**January, 1983**

To: Honorable Charles S. Robb, Governor of Virginia
and
The General Assembly of Virginia

## I. Origin of the Study

During the 1982 Session of the General Assembly, House Joint Resolution No. 104 was passed which requested the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health to establish the Joint Subcommittee to Study the Feasibility of Preserving a Regional Health Planning Mechanism in the Commonwealth.

The rationale for this study was the apparent need to preserve regional health planning in Virginia in the face of drastic reductions or potential termination in federal financial support.

The Joint Subcommittee was composed of five legislative members, three members of the House Committee on Health, Welfare and Institutions and two members of the Senate Committee on Education and Health. Seven citizen members were included who were representatives of the State Department of Health, the health systems agencies, health insurers, physicians, hospital management, the business community and consumers. In addition, the Subcommittee agreed to appoint a representative of the Commonwealth's nurses to serve as an ex officio member.

The legislative members were: Delegate Warren G. Stambaugh, Chairman; Senator Edward M. Holland, Vice-Chairman; Senator Elmon T. Gray; Delegate Mary A. Marshall; and Delegate C. Jefferson Stafford. The citizen members were in the order of group representation: Raymond O. Perry, Assistant Commissioner, Department of Health; Thomas R. Bernier, Executive Director, Northwestern Virginia Health Systems Agency, Inc.; James L. Gore, Vice-President, Provider Relations, Blue Cross/Blue Shield, Richmond; George E. Broman, M. D., Culpeper; Carter T. Melton, Administrator, Rockingham Memorial Hospital; E. Wayne Titmus, Manager, Health Care Cost Unit, Reynolds Metals Corporation; Gillium M. Cobbs, Principal, Sandusky Middle School, Lynchburg; and Barbara S. Bolton, Executive Director, Virginia Nurses Association.

## II. Background of the Study

Government regulation of the development and expansion of health care facilities began with the Federal Hospital and Medical Facilities Construction Program (P.L. 79-225), better known as the Hill-Burton Act. This first involvement came shortly after World War II and was designed to fill a real need for hospital facilities in this country. Hill-Burton was a major influence in the health care industry for approximately 20 years.

In 1966, under the auspices of P.L. 89-749, the Comprehensive Health Planning Act, eight Comprehensive Health Planning Agencies and a Governor's Health Planning Council were established in Virginia. This early health planning mechanism was funded by federal and local money. No planning documents were produced by this early system. The Hill-Burton Act did, however, generate publications, which were the only health planning documents until the 1970's. The Comprehensive Health Planning Legislation was supplemented by P. L. 89-239, Regional Medical Programs, and P. L. 90-174, Experimental Health Delivery Systems. The concept of certificate of public need was first placed into law in the 1972 amendments to the Social Security Act. In this legislation, state approval was required in order to apply certain federal funds to construction costs of health care facilities. Virginia first enacted a certificate of public need law in 1973.

In 1974, Congress passed the National Health Planning and Resources Development Act (P. L. 93-641) as consolidated federal health planning legislation. This law includes requirements for

certificate of public need and health planning on the regional and state levels. Funding for this system has been almost exclusively federal, although some local funds have been contributed and recently, industry money has been allowed to support the system.

The regional health planning mechanism operated under the authority of the National Health Planning and Resources Development Act in Virginia consists of a State Health Planning and Development Agency (SHPDA), a Statewide Health Coordinating Council (SHCC) and six Health Systems Agencies. The six Health Systems Agencies are headquartered as follows: HSA I - Charlottesville; HSA II - Falls Church; HSA III - Blacksburg; HSA IV - Richmond; HSA V - Norfolk; and HSA VI - Tennessee (See Appendix A). Health Systems Agency VI includes the Counties of Scott and Washington and the City of Bristol with certain areas of Tennessee. Formal regional plans are produced by each of these agencies and are used as the bases for the State Health Plan.

The Statewide Health Coordinating Council was appointed and operating in Virginia in 1976; however, this body was not established in Virginia law until 1978 (See Appendix B, Title 32.1, Chapter 4, Article 4, § 32.1-117 et seq.). The first Virginia State Health Plan was produced in 1979 and was revised in 1980.

The recent federal impetus to return various responsibilities to states has included efforts to limit the federal role in health planning and the regulation of the health care industry and to stimulate competition in the delivery of services. These efforts have resulted in drastically reduced funding for the health planning mechanism and created speculation that the federal government will in the near future either eliminate or further reduce its participation in health planning.

The results of formal planning have been almost universally considered beneficial. With the costs of health care increasing alarmingly and drastic changes taking place in the industry, most experts feel that the continuation of formal health planning is essential to Virginia in order to avoid the mistakes of past. Some of the positive benefits of health planning are: increased public awareness of the costs of and issues in the health care industry, the establishment of open communication between the public, the business community and the health profession, the containment of costs through the certificate of need process and most importantly, the regional and state plans, which contain vital data for decision-making.

## III. Scope of the Committee Work

The Subcommittee reviewed the status of the National Health Planning and Resources Development Act (P.L. 93-641) of 1974. Funding for this law, which is commonly referred to as the National Health Planning Act, was due to expire on September 30, 1982, unless a continuing resolution was passed by Congress. The continuing resolution was passed, which included minimal funding for the Health Systems Agencies. This continuing resolution expired on December 17, 1982, at which time another resolution was passed. The continuing resolution of September 30, 1982, contained a proscription against the invoking of the penalties which are attached to the law for states' noncompliance with the revised federal certificate of public need requiements. This continuing resolution also required that future continuing resolutions contain similar language restricting the use of the penalties.

The penalties have been a matter of grave concern on the part of Virginia officials because the Virginia Certificate of Public Need law, passed during the 1982 Session of the General Assembly, has been designated as noncomplying by the Department of Health and Human Resources. Although this decision was appealed, some provisions of the Virginia law are still considered noncomplying by the federal officials.

The health planning legislation being considered by the Congress was also reviewed for the Subcommittee. There are two major bills presently before the Congress, S. 2720 and H.R. 7040. Both of these bills would significantly revise the health planning mechanism; however, the senate bill would result in greater changes. Senate Bill 2720 was introduced by Senators Quayle, Hatch and Hawkins. This proposal would eliminate the certificate of public need requirements and fund the health planning mechanism through a block grant. This proposal would require 25% matching funds from the states and would expire after one year. Funding would be provided for planning, competitive initiatives and the formation of business coalitions. No funding would be allowed for certificate of public need programs. House Resolution 7040, introduced by Representatives Waxman, Madigan, Shelby, Dingell and Broyhill, would create somewhat less drastic changes in the states'

health planning mechanisms. This proposal contains some changes in the certificate of public need requirement; however, states are required to conduct COPN programs if they accept funds. This proposal would be effective for two years and would fund both regional planning and state programs through a block grant. The big change in the law proposed by this bill is that the local agencies (HSA's) would not be allowed to participate in the certificate of public need process.

The Subcommittee reviewed the position papers on health planning of the State Board of Health and the Statewide Health Coordinating Council as well as the report on Health Planning in Virginia produced by the Statewide Health Coordinating Council in June of 1982. A condensed version of the recommendations of the State Board of Health was used by the Subcommittee as a working document as follows:

1. The Regional health planning system and State Level Council should be continued.

2. The Certificate of Public Need Law should be maintained until competition begins to become a reality.

3. Local involvement and public accountability should be enhanced through broadened participation and financial support.

4. Board composition should be revised to reflect more closely the state needs, but the consumer majority should be retained.

5. Formal planning should be continued both on the regional and state levels in order to provide bases for objective decision-making.

6. The Regional Planning agencies should be responsible for: (1) the regional health plans; (2) assisting in the implementation of the regional plan; and (3) review of COPN applications.

7. The State agency should continue to administer COPN, provide guidelines for regional health planning and staff the state level planning council.

8. That the funding of the planning system should be shared by the State and federal government and the private sectors. This would require increased state support and could include authority for increased license fees or the levy of a fee on COPN applications.

9. That Chapter 4, Articles 2 and 4 of Title 32.1 should be revised to reflect the policy changes.

The Subcommittee made some modifications and tentatively adopted eight of these recommendations for eliciting comment during a public hearing, which was held on November 10, 1982. Staff was directed to revise this material, incorporate the questions raised during the discussion and submit the revision to the Subcommittee for comment. After receiving and incorporating, as much as possible, the comments of the Subcommittee on the revised recommendations, staff was directed to prepare a press release with the materials enclosed and distribute these materials (See Appendix C). The Health Systems Agencies were asked to present a statement at the beginning of this public hearing on the fiscal status of their organizations.

## IV. TENTATIVE RECOMMENDATIONS FOR PRESERVING A REGIONAL HEALTH PLANNING SYSTEM IN THE COMMONWEALTH OF VIRGINIA

The following recommendations were adopted by the Subcommittee and used as basis for comment at the public hearing on November 10, 1983:

1. That a regional health planning system and state level coordination and guidance should be continued.

Rationale : Valuable planning data and cooperative relationships have been developed as a result of regional health planning and state and local collaboration. These data and relationships provide credible bases for local decision-making and cohesive state health planning.

Questions : Should the geographical boundaries of the present health systems agencies be maintained after making adjustments to recapture Bristol and the Counties of Scott and Washington? Do the demographic characteristics of the present health service areas provide viable data bases for planning in terms of population distribution? In terms of access to services? In terms of community mores and standards? In terms of availability of providers? If not, how should the regional units be apportioned? Should the scope of the responsibilities of the regional planning agencies be restricted? Should the participation in regional planning be on a voluntary basis? Should the regional facility plans be the bases for the state facility plan?

2. That the regional planning agencies should be responsible for: (a) the regional health plans; (b) facilitating the implementation of the regional plans; and (c) review of COPN applications.

Rationale : The primary functions of the present regional health planning agencies are to develop the regional health plans, to assist in implementing these plans and to review COPN applications. The expertise developed over the years in performing these activities is substantial; therefore, this knowledge and experience should be preserved and used to build a better health planning system.

Questions : Should the functions and responsibilities of the regional planning agencies be revised? Should the duties of these agencies be focused on planning rather than on regulating? Should the COPN review functions of the regional agencies be modified to include greater consumer, provider and planner involvement? Should the COPN review functions be eliminated? What functions presently performed by the HSA's are appropriate, beneficial and cost-effective? What functions presently performed by the HSA's are not appropriate, beneficial and cost-effective? What is the proper role of a regional planning agency?

3. That regional health plans should continue to be developed and used as the bases for the state health plan, which should be a reference for decision-making and provide a balance between uniformity and flexibility throughout the Commonwealth.

Rationale : Regional health plans have served as vehicles for the gathering of information that was not available before their existence. This information can be used to review the trends in the health care industry, a rapidly changing market. The valuable data also serves as the basis for local decisions, and a comprehensive state health plan, which provides state level decision-makers with the broad view of the status of the health care industry, its stresses and its excesses.

Questions : Should the state agency provide the regional health planning agencies with strict guidelines for development of their plans? Or should localities be given control of the development of these plans? If guidelines are not provided, will the data collected have any validity or value in developing a state health plan? Will it be possible to develop a credible state health plan at all unless guidelines are provided? If guidelines are provided, how detailed should they be? Should the state agency involvement be restricted to instances in which state involvement enhances, coordinates or is necessary to the planning process? If so, how can these instances be identified?

4. That the planning process should be more accountable to the public through effective local involvement and by broadening the base of financial support.

Rationale : Effective involvement of consumers, public officials, providers and elected officials in the health planning process should enhance its public accountability. Requiring or soliciting support of various segments of the health care industry such as provider associations, institutions, third-party

payors and state and local governments should also promote accountability.

Questions : How can local citizens be encouraged to become involved in health planning? What can be used to measure "effective involvement"? What mechanism should be used for broadening the financial support base? If the health planning mechanism, which is essentially a regulatory activity at present, is funded by those who are regulated, will conflicts of interests develop? What could be done to avoid this possibility?

5. That although a consumer majority should be retained, the composition of the planning agency boards should be revised to make them more responsive to regional and state realities.

Rationale : Maintaining a consumer majority on the planning agency boards provides another means for accountability. The federal law presently requires the board composition to conform with strict dictates. The composition of the boards would need to be revised to reflect more accurately the state needs and allow for more meaningful local authority and flexibility in program structure.

Questions : Would broader participation lead to greater public accountability? Or make decision-making more difficult? How should the boards be composed? What types of representation are essential other than consumers? How large should the boards be? On the regional level? On the state level? Should the composition of the regional boards be a matter for local decision? What authority should the regional boards have? How flexible should the program be? Should local health planning be a matter for the locality to develop autonomously?

6. That the Certificate of Public Need Law should be maintained until competition begins to become a reality.

Rationale : Many experts believe that it will take years to develop competition in the health care industry. However, the economic elements of competition are beginning to appear as reimbursement systems are restructured and alternative delivery systems developed. At present, the health care industry still does not resemble a competitive market; therefore, COPN is necessary to prevent redundant capitalization. When competition becomes a reality, most experts believe its effects will be obvious and that COPN will no longer be necessary to protect the consumer and the government from supporting unnecessary duplicative services and empty beds.

Questions : What are the outcomes of COPN? Is the expense to the providers of going through the COPN process justified by the results? Will maintaining COPN impede the development of competition? Will the transition from a cost reimbursement system to competition result in any reductions in services to the consumers? What precautions can be taken to avoid reductions in services? How will it be possible to recognize that competition has become a reality? What is competition in the health care industry?

7. That the state agency should continue to administer COPN, provide guidelines fo regional health planning and staff a state level planning council.

Rationale : Administration of COPN as a regulatory function is appropriately the Department of Health's responsibility. Also, without a central agency to pull together data and provide uniformity the value of health planning would be diminished.

Questions : Should the appeals process presently in the COPN law be revised to provide hearing officers who are *not* Department of Health officials? Should the COPN function of the Department be modified in any other way? Can the regulatory function of COPN be modified to include greater consumer, provider and local planner involvement? Should health planning on the local level be independent of the state agency? What is the proper relationship between the state department and the regional health planning agencies? What is the proper role of the State Department of Health in health planning?

8. That in the absence of adequate federal support, the funding of health planning should be a shared responsiblity.

Rationale : The federal administration has proposed that the responsibility for health planning be returned to the states. As a means of implementing this philosophy, the federal funding for health planning has been decreased and is expected to continue to decrease or even be eliminated. Federal

support for regional health planning in Virginia already borders on being inadequate; therefore, if Virginia is to maintain a viable regional health planning system, alternative funding sources will have to be developed.

Questions : Should the costs of health planning be shared by state and local governments and the private sector? Or should the costs be shared by only state and local governments? Or solely by the private sector? How should a shared cost arrangement work? How should the shares be prorated? Should one entity assume a larger share than the others? Should all entities share equally? Should the private sector be required to support regional health planning? Or encouraged to support it? If support is required, how should such a system work? Should the localities be required to support regional health planning? If so, should more control of this mechanism be given to local authorities?

V. Summary of the Testimony Presented at the Public Hearing on November 10, 1982

Mrs. Virginia Crockford, Executive Director of the Central Virginia Health Systems Agency, presented testimony on behalf of the executive directors of the Virginia Health Systems Agencies. Mrs. Crockford stated that the funding of the HSA's has fluctuated over the years. The original legislation required funding at 50¢ per capita, but this funding level was only received during one of the seven years of the HSA's operation. The functions of the HSA's have also been reduced. The current funding, even with stretching the money by using roll-forward funds left over from previous years, will only last until June, 1983 at most. The HSA's are determined to survive.

Mrs. Crockford pointed out that for every dollar spent on health planning in the last six years, $9.52 has been saved through the COPN review functions of the HSA's. The HSA's see their efforts to educate the consumer and establish a dialogue between the providers and the public as of great significance.

Mrs. Crockford further stated that the directors of the HSA's submitted the following recommendations:

(1) A state law should be passed which would provide for an official state agency and a minimum of five regional planning agencies. The five regional planning agencies would be funded by contract for the essential services. The sections of Virginia which are presently included in Tennessee should be recaptured in this regional planning mechanism.

(2) The health systems agencies should continue as nonprofit agencies with, if possible, the current boundaries.

(3) Regional plans should continue to be developed, incorporated into the state plan and used as the basis for COPN decisions.

(3) The majority of the boards should be consumers and business leaders with the providers and health insurance carriers also represented.

(4) The COPN process should be continued with an appeals panel to consist of a representative of the SCHH, a representative of regional planning and the Commissioner.

(5) Finally, a funding mechanism which provides 30¢ per capita, preferably by levying a licensure fee based on patient days, should be established.

Questions were asked concerning the cost shifting and increase in the cost of health care which might be caused by this fee. Several speakers indicated that there certainly would be some increase in the costs of health care; however, the cost savings which would result would outweigh the burden. Further, the hope was expressed that these costs would eventually be shifted to the third-party payors.

Mr. John Johnson, President of the Southwestern Virginia Health Systems Agency, then spoke on the unique problems encountered by the rural planning agencies. Without the offer of space by Blue Cross/Blue Shield at a reduced rate, this HSA would not be able to make it to June 30. Mr. Johnson enumerated the cost savings initiated by his HSA. He also described the development of the rural health centers and the emergency medical services network in the Southwestern area which was facilitated by the HSA.

Mr. Laurens Sartoris, Virginia Hospital Association, Mr. Thomas L. Robertson, Senior Vice President of Roanoke Memorial Hospital and Mr. John M. Simpson, President of Richmond Memorial Hospital were the next speakers. These three presentations were coordinated to provide the view of the Virginia Hospital Association.

Mr. Sartoris presented an outline of the history of health planning and regulation in the United States. He described the growth of the industry under the Hill-Burton program. The rationale of this stimulation of growth was, Mr. Sartoris stated, that if the facilities were constructd they would be "needed." Mr. Sartoris then detailed the growth of the Medicaid and Medicare programs in creating demand for the services which were made available through the Hill-Burton Program. Cost reimbursement, he said, was meant to stimulate provider expenditures and provide more and better services to more people.

During the 1970's, the attitude of government changed because the demand for services created by Medicaid, Medicare and the private third-party payors outstripped all of the original cost estimates and caused a desire to curtail costs. No one wanted to stifle the demand for health care; therefore, the certificate of public need concept was designed to curtail the supply.

Mr. Sartoris stated that health planning and certificate of need should not be thought of as synonymous. He said that health planning should not be a regulatory mechanism. He further stated that the success of certificate of need in controlling costs can be debated, because in spite of its controls, costs continue to rise.

Mr. Robertson spoke to the new health financing mechanisms and competition. He stated that the major elements of the reimbursement systems are changing much more rapidly than anyone thought they would. He said that competition is being initiated for three reasons:

1. Regulation did not contain health care costs;

2. Competition is a traditional American concept which should work in the health industry as it has elsewhere; and

3. Health care provider behavior is being modified by the changing financial incentives.

Mr. Robertson described some of the changes in the Medicaid reimbursement system which are affecting hospitals. He also commented on the changes taking place in the reimbursement systems of the Blue Cross/Blue Cross plans. He stated that all of these changes place the hospitals at risk for financial decisions. Some of these hospitals may not survive unless they modify their behavior. This, he stated, may cause a constriction in the industry which the regulatory process could never hope to accomplish.

Mr. Simpson addressed the elements of successful health planning and the future. He said that presently health planning in Virginia is government directed with its focus being certificate of public need. He believes that health planning can only be effective if it is independent of federal and state dictates. Health planning originated because of concern with allocation of scarce resources, Mr. Simpson said. Health planning should be rededicated to serve local needs. Planning, he said, is thinking before taking action, that is a prelude to action and an identifiction of alternatives. Planning is, in his opinion, always an advisory function. He felt that planning should be clearly distinquished from regulation, that it is not a political process and should be more than putting together a long planning document.

Mr. Simpson stated that primary responsibility for planning should be placed on the operating organizations who have the responsibility for making and implementing decisions about the resources they control. Mr. Simpson commented that health planning should be community based with input from many constituencies; that regional planning should be in the control of the local communities and not restricted by state guidelines; that planning activities and not regulatory functions should be emphasized; and that planning must become a major functions of the community.

Mr. Simpson further stated that the geographical boundaries should recognize patient origin and regional needs; that regional plans should be the basis of the state plan; community involvement should be encouraged; the membership of the boards should be limited and should consist of consumers, providers, business leaders and practitioners. He added that competition is being

developed; therefore, the certificate of public need process should be streamlined by implementing a review only for major expenditures involving patient care and clinically related projects and that the review process should involve three levels. These three levels would be the regional planning body, the SHCC or its equivalent and a three-member panel consisting of the Commissioner, a SHCC representative and a local regional planning representative. He stated that the capital review process (COPN) should cease once competition is firmly in place. Finally, he said that funding for regional health planning should be borne equally by the State and the localities.

The next speaker was Ms. Mary Schaefer, representing Northern Virginians for Health Planning. Ms. Schafer stated that her organization was an offshoot of the Health Systems Agency in Northern Virginia. She commented that NVHP would like to see regional planning continue on a mandatory basis with the local agencies responsible for the analysis of COPN applications, the development of health plans and the initiatives to implement these plans. She also stated that they are opposed to implementing health planning on a voluntary basis. The available funds are insufficient to support the system, she said. General revenues should fund this system in a manner similar to the funding of the Regional Planning District Commissions. She also noted that NVHP is in favor of the boards consisting of a majority of consumers.

Ms. Joan Gardner of Blue Cross/Blue Shield of Southwest Virginia was the next speaker. Ms. Gardner stated that health planning has been of assistance to the Commonwealth. She also stated that the Counties of Washington and Scott and the City of Bristol should be included in the Virginia health systems mechanism. She noted that COPN should be retained until competition becomes a reality. The funding, she said, should be a shared responsibiity from multiple sources with broad-based participation in the health planning process.

The next speaker was Dr. Ned Peple, Health Planning Coordinator for Blue Cross/Blue Shield. Dr. Peple stated that the factors motivating P. L. 93-641 (National Health Planning and Resources Development Act) were still present and that the federal funding should be continued because of the federal stake in health care costs through Medicaid and Medicare. He indicated that he thought the Virginia congressional delegation should be contacted to lobby for this continued funding. Dr. Peple also stated that COPN should be continued with some modifications until competition becomes apparent. He enumerated the involvement of Blue Cross/Blue Shield in health planning in Virginia. He commented that regional health planning should be continued to prevent unnecessary and duplicative services from developing.

The next speaker was Mr. Paul Boynton, Executive Director of the Eastern Virginia Health Systems Agency. Mr. Boynton described the objectives of health systems agencies under the federal law. He stated that the HSA's were not given the authority to achieve any of the goals; however, the participation of the HSA's in the certificate of need review process has been essential. He enumerated the savings this review process has brought to the state. He stated that the HSA'a should continue to participate in the COPN review process, that the regional agencies should be separate from the State Health Department, that the funding should come primarily from the State, and that the regional plans should be used as bases of the state plan. He presented a report which supports the success of the cost containment efforts of the HSA's. He stated that presently with the carryover funds the HSA's are operating with 27¢ per capita. A 30¢ per capita allocation would still be significantly lower than previous funding. He stated that without the carryover, the HSA's would have been funded at 19¢ per capita. He recommended that the state fund the HSA's at the level required to raise this funding to 30¢ per capita. With the assumption that the federal funding would be continued at the 19¢ per capita level next year, this amount would be 11¢ per capita.

Mr. Earl Willis, Administrator of Virginia Beach General Hospital, was the next speaker. Mr. Willis stated that the Eastern Virginia Health Systems Agency has been a valuable tool in the implementation of the Certificate of Need process. He said that the Eastern Virginia Health Systems Agency staff is more knowledgable of the needs of health care delivery and the institutions at the local level than it would be possible for a state agency to be. The analysis of the applications by this agency is always very thorough and factual. He stated his belief that this function should be retained. He stated his opinion that adequate funding and staffing for the planning agencies should be provided. He felt that the financial support should come from the state and local governments, providers and local business and industry. His rationale for this support was that the beneficiaries of the system should provide the support.

The next speaker was Mr. Ken Axtell, President of the Tidewater Hospital Council. Mr. Axtell

stated that regional planning was in his opinion the embodiment of local input. He said that a store house of information has been developed and should be maintained. The skills in this analysis have been developed at the local level and should not be lost. Mr. Axtell said further that rational guidelines which were agreed to by leading health planners should be used for the development of the plans. He stated that the regional planners could then develop meaningful plans which could serve as credible bases for the state plan. He believes that credibility could be only achieved if there is meaningful regional input. He stated that COPN should be maintained until a better system is in place. He said that COPN has reduced the number of projects and the scale of some projects and has forced the providers to plan projects better and to justify the expenditure of project funds. He enumerated the many roles of health planning, including facilitation of health care provider distribution and services to less populated areas. Planning also involves, he stated, screening, preventive services, reduction of exposure to hazards, fluoridation services and education.

Mr. Axtell felt that the system developed under the federal requirements has been cumbersome at times. However, he believes that health planning has served the citizens well.

He stated that he was adding five comments: (1) that the applications for COPN should be simplified; (2) the dollar thresholds should be raised to eliminate programs which have no significant impact on the system, and the applications should only be required for programs offering patient care and clinically related health care by all health care providers; (3) the final review level should be done by a panel, which should consist of the Commissioner, a representative of local planning and a member of the SHCC; (4) appeals should be in the courts in order to eliminate the administrative appeals process and remove the process from the political arena; and (5) funding should be a state responsibility with funding directly from the general funds.

The next speaker was Dorothy Healy, representing Howard Sparks of the Statewide Health Coordinating Council. Mrs. Healy is chairman of the SCHH. Mrs. Healy made five points: (1) health planning should be continued on a regional basis; (2) CON should be continued; (3) the planning process should be publicly accountable; (4) the consumer majority on the boards should be continued; and (5) the regional plans should be used as the bases for the state plan.

The next speaker was Dr. Betty Adelman from the Arlington County League of Women Voters. Dr. Adelman stated that regional planning agencies located where the affected citizens reside provide a convenient and appropriate opportunity for participation in the process of containing duplicative services. She stated further that the Northern Virginia HSA has promoted education, collected data and provided information for citizen groups. Strong health systems agencies are needed to implement the CON law and monitor the development and reallocation of health care resources. She said that her organization believes that a revised health planning law for the State should include assurances that adequate funding would be provided. She also said that the assurance of adequate funding is needed now if the HSA'a are to be able to maintain sufficient staff to analyze the CON applications. She noted that funding could be provided through a variety of sources such as community resources, health insurers, health care institutions, and local and state government.

The next speaker was Frank Mays, Executive Director of the Southwest Virginia Health Systems Agency. Mr. Mays stated that he had only one thing to add - a profile of local health planning. He used his HSA as an example to outline the participation. They have a subarea network with seven different subarea councils. Over 200 citizens are involved in this process ranging in occupation or profession as follows: 14 elected local government officials; 27 persons appointed directly by planning district commissions; 19 M.D.'s; 11 registered nurses; 9 dentists; and representatives from 4 primary care centers, 5 district health departments, 4 community service boards, 14 hospitals as well as representatives from commercial health insurance carriers and the Blue Cross/Blue Shield plans. The membership leans toward the consumer, e.g., community action agencies, agencies on aging, mental health advocacy groups, etc. The variety of this community input, he said, is evidence that the HSA's are in a position to accommodate wide community input. This structure, he stated, is in place and should be able to make the transition to a state health planning program.

The next and final speaker was Mr. Ray Blosse of Group Hospitalization, Inc., of Washington. Mr. Blosse explained the GHI serves thousands of Northern Virginians. He stated that GHI, which is the Blue Cross/Blue Shield agency of the northern area of the State, has been involved in health planning from its early days. He described the present situation in his area as being similar to the situation during the 1960's and 70's in which expansion of the health care industry outstripped the

population. He said that it took nearly a decade of health planning restraint to allow the population to catch up with this growth. He expressed the concern of GHI over the many applications for CON being filed and the fear that an expansion such as took place in the 1960's would occur which the insurance plan could ill-afford. He stated that the health planning system had been effective in retarding the growth of the industry in his locality. He commented that the HSA's should be continued as they are today, especially in regard to the CON activities. He advocated broad-based financial support with state and local contributions.

This concluded the public hearing portion of this meeting. The committee then discussed the course of action that should be followed. It was decided, in view of the uncertainty of the federal law and funding, that an alternative, interim funding mechanism should be designed and a continuing resolution should be requested to allow the Subcommittee to build on this year's work in designing a health planning mechanism in detail for the Commonwealth by 1984. Staff was directed to develop several alternative interim funding systems in order to support the HSA's until a permanent mechanism can be designed and directed to provide a report and a continuing resolution by the final meeting before the 1983 Session.

## VI. Conclusions and Recommendations

The Subcommittee has come to believe that the consensus in the health care industry and among the public is that regional health planning has been of benefit to the Commonwealth and should be preserved. However, the uncertain status of the federal law and funding has created a state of limbo in the development of a health planning mechanism tailored for Virginia. The next year should bring some resolution in this situation as several proposals are before Congress.

The Joint Subcommittee has developed a set of tentative general recommendations this year (see Section IV), which seem to be agreeable to all constituencies of the health planning system. However, conflicting testimony on the details of implementing a planning system for Virginia and the appropriate funding mechanism has convinced the Subcommittee that another year of intense study will be necessary to design this system and its funding mechanism. Therefore, a continuing resolution will be requested during the 1983 Session of the General Assembly (see Appendix E).

Because the federal funding has been drastically reduced, the future of this funding is in doubt, and the survival of the health planning agencies is in question, the Joint Subcommittee believes that an interim funding mechanism should be adopted by the Commonwealth (see Appendix D for charts describing the alternatives developed by staff). The Subcommittee recognizes that a funding mechanism for this interim which satisfies all constituencies cannot be designed. With this in mind and a desire to mediate the impact of any funding, but still preserve the regional planning mechanism, the majority of the Subcommittee agreed that alternative VIII be adopted and appropriate legislation be introduced for its implementation for one year (see Appendix E). The Subcommittee adopted the schedule of fees for certificate of need, which was devised by staff for funding alternative number VII, as follows: Applications proposing capital outlays of up to $1.5 million - $500; applications proposing capital outlays of $1.5 million to $5 million - $850; applications proposing capital outlays of over $5 million - $1200. The vote on this schedule was: 9-yes, 2-no and 1-abstain. The following surcharge schedule was adopted for professional licenses: nurses - $4; all professionals under the Board of Medicine except physical therapists and physical therapy assistants - $10; physical therapists and physical therapy assistants - $4; pharmacists - $5; dentists - $5; dental hygienists - $4; and optometrists - $5. The vote on the schedule for professional license surcharge fees was: 7-yes, 4-no. These two elements were estimated to be capable of raising $399,190. The remainder needed to raise $568,225 or 11¢ per capita would be $169,035 to be raised as a user's fee on beds. The vote on this element of the funding mechanism was: 7-yes and 4-no. [1]

The funding plan contained in this report is intended to be in place for one year and no longer. It represents an interim funding measure, which the majority of the Subcommittee feels is needed to sustain regional health planning throughout the State of Virginia until a more permanent and equitable arrangement can be developed.

It is the consensus of this Subcommittee that long-term funding for any regional health planning program should require that the costs be borne equitably by government, health care providers, and the private sector within each health planning region.

The joint subcommittee wishes to thank all of those who appeared before it or contributed data

for their assistance.

Respectfully submitted,

Warren G. Stambaugh, Chairman

Edward M. Holland, Vice-Chairman

Mary A. Marshall

C. Jefferson Stafford *

Thomas R. Bernier

Barbara S. Bolton

George E. Broman

Gillium M. Cobbs

James L. Gore *

Carter T. Melton *

Raymond O. Perry

E. Wayne Titmus *

* Dissenting In Part Opinions of C. Jefferson Stafford, James L. Gore, Carter T. Melton and E. Wayne Titmus are attached.

*Footnote:*

The vote on the schedule for CON fees was: yes - Stambaugh, Holland, Marshall, Bernier, Broman, Cobbs, Gore, Perry, Titmus; no - Stafford, Melton; abstain - Bolton.

The vote on the schedule of surcharge fees on professional licenses was: yes - Stambaugh, Holland, Bernier, Broman, Cobbs, Perry, Titmus; no - Marshall, Stafford, Gore, Melton.

The vote on the remainder of the 11¢ per capita being obtained from a user's fee on beds was: yes - Stambaugh, Holland, Marshall, Bernier, Broman, Cobbs, Perry; no - Stafford, Gore, Melton, Titmus.

## DISSENTING IN PART OPINION
## OF
## C. JEFFERSON STAFFORD

I dissent on the funding mechanism approved by the majority of the Subcommittee. Although the preservation of a Regional Health Planning Mechanism is desirable, I feel that funding should be through the general fund and be funded according to its priority. The mere fact that an increase of $4 in a license fee surcharge will net only $2 seems to me to be poor economics. Furthermore, I do not agree with the imposition of a user's fee on beds. The imposition of the fee on CON adds yet another burden to an already cumbersome and expensive process.

## DISSENTING IN PART OPINION
## OF
## JAMES L. GORE

This will give reasons for my dissenting vote on the last two funding sources at the recent meeting of the Committee. I voted negatively on both the use of licensure fees or assessments to support planning and also on the user's fee on beds.

My reasons for doing this are multiple. First, I object to the large amounts of money wasted through the collection process on the license surcharge issue. I also feel that the amount of money made available through the Federal and State governments should not be 30 cents, but should be something less than that, perhaps 24 or 25 cents. I, therefore, feel that the amount of money needed to bring it to this level could be raised through Certificate of Need fees only. The Health Systems Agencies should be required to go to their local areas for support of their needs beyond the 24 or 25 cents per capita.

I also feel that through using Certificate of Need fees, the hospitals are more likely to be able to receive reimbursement through the Federal programs and thereby be able to recover their costs which would be incurred through this process. It would also provide some small level of discouragement for requesting Certificates of Need which are not strongly needed.

## DISSENTING IN PART OPINION
## OF
## T. CARTER MELTON, JR.

I wish to express a dissenting opinion on that portion of this report which deals with the interim funding mechanisms for 1983. I wish to dissent for two reasons: (1) I believe that the appropriate approach to funding for regional health planning is through a partnership, whereby the State of Virginia participates in part of the funding, and there is a diversity of voluntary funding sources at the local and regional levels. The voluntary funding would come from such sources as the private sector, local governments and providers. This approach would not only demonstrate a commitment on the State's part, but would also demonstrate a commitment at the local level, and would require accountability as a planning body to their local constituencies; (2) the raising of monies through a licensure fee on institutions, a licensure fee on professionals and a filing fee on Certificate of Need applications, is really a form of taxation and should be addressed and handled as such by the General Assembly; and (3) although I have no reservations whatsoever about the intent of the recommending body, that this funding mechanism only be in place for one year, I have serious reservations about the precedential implications of establishing a special fund and a funding mechanism which may continue to be renewed on a continuous basis in future years.

The above comments in no way reflect opposition to the basic thrust of this report and my basic support in favor of the continuation of local health planning. I appreciate the opportunity to express this dissenting viewpoint.

## DISSENTING IN PART OPINION
## OF
## E. WAYNE TITMUS

As requested, I am submitting my rationale for the dissenting vote I cast against imposing a "user's fee on beds to collect remainder", listed under Funding Alternative Number VIII.

As a representative of the Virginia Manufacturers Association, I have to be constantly concerned with any additional expensives for hospitals that are going to be passed on to private payors for reimbursements. By imposing a user's fee on beds, hospitals would be forced to increase their, already high, charges even more. In turn, business and industry would be picking up a large portion of this increased expense. At a time when rising health care cost is already a critical issue, we should be searching for ways to control them, not increase them.

# 1982 REGULAR SESSION
# ENGROSSED

## HOUSE JOINT RESOLUTION NO. 104

House Amendments in [ ] - February 20, 1982

*Requesting the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health to establish a joint subcommittee to study the feasibility of preserving a regional health planning mechanism in the Commonwealth.*

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Patron–Glasscock, J. S.

---

Referred to the Committee on Health, Welfare and Institutions

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WHEREAS, the federal government is expected to reduce drastically or terminate in 1982 its financial support of the five health systems agencies that are responsible for health planning at the regional level in the Commonwealth; and

WHEREAS, it appears that a regional health planning mechanism in the Commonwealth is needed to preserve the quality of health care in the Commonwealth at a reasonable level of cost; and

WHEREAS, it appears that new funding sources must be developed if a regional health planning mechanism is to be retained; and

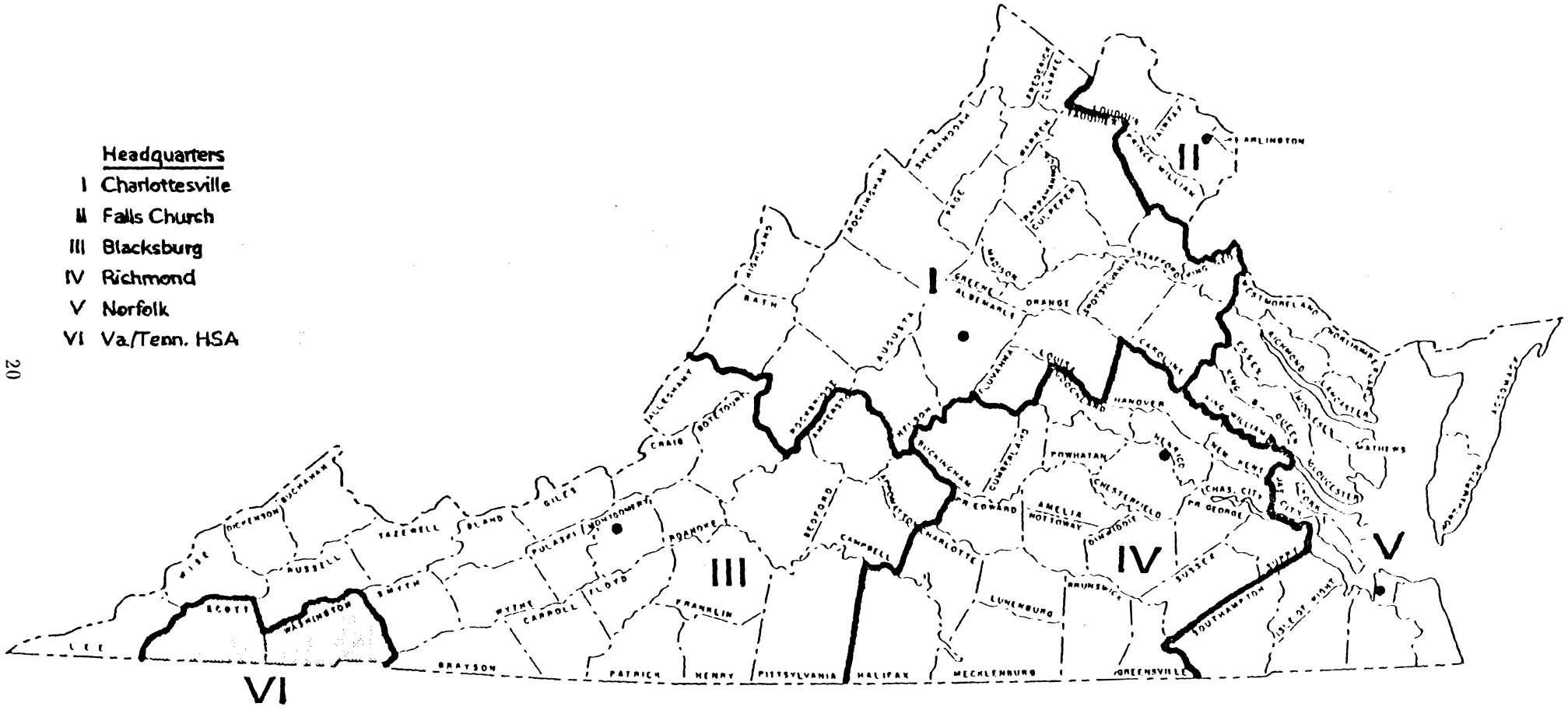
WHEREAS, representatives of health insurers, the health care professions and the business community have expressed an interest in helping to preserve a regional health planning mechanism in the Commownealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee of the House Committee on Health, Welfare and Insitutions and the Senate Committee on Education and Health is hereby requested to study the feasibility of preserving a regional health planning mechanism in the Commonwealth in anticipation of the reduction or termination of federal government funding of the Health Systems Agencies.

The joint subcommittee shall be composed of three members of the House Committee on Health, Welfare and Insitutions and two members of the Senate Committee on Education and Health to be appointed by the respective chairmen and [ ~~six~~ seven] ex officio members who are representatives of the State Department of Health, the health systems agencies, health insurers, [ ~~health care providers~~ physicians, hospital management], the business community and consumers of health care services in the Commonwealth to be appointed by the chairman of the subcommittee. The joint subcommittee shall consider the minimum staffing and funding levels necessary to preserve a regional health planning mechanism in the State, the implementation of one or more proposals for continued funding of a regional health planning mechanism in the State, the appropriate role of regional health planning agencies in the Commonwealth and such other issues as the subcommittee deems appropriate.

The joint subcommittee shall submit a report of its findings and recommendations to the Governor and the 1983 Session of the General Assembly. The cost of this study shall not exceed $8,500.

# Department of Health
# HEALTH SERVICE AREAS



## Appendix B

§ 32.1-117. Definitions. As used in this article:

1. "Consumer" means a person who is neither a direct provider nor indirect provider of health care services.

2. "Council" means the Virginia Statewide Health Coordinating Council.

3. "Health systems agency" means an entity organized and operated as provided in § 1512 of United States Public Law 93-641 and designated as a health systems agency pursuant to § 1515 of United States Public Law 93-641.

4. "Federal Act" means United States Public Law 93-641, the National Health Planning and Resources Development Act of 1974, and any amendments thereto.

5. "Provider" means a direct or indirect provider of health care services.

6. "Secretary" means the Secretary of the United States Department of Health, Education and Welfare.

§ 32.1-118. Statewide Health Coordinating Council; created; membership. A. There is hereby created in the executive branch of the State government the Virginia Statewide Health Coordinating Council.

B. The Council shall consist of not less than sixteen residents of the Commonwealth appointed by the Governor. The Governor shall appoint an equal number of members, but not less than two, from each health systems agency. Not less than one half of the members so appointed shall be consumers.

C. The Governor may appoint such other persons to serve on the Council as he deems appropriate except that (i) the number of such persons appointed pursuant to this subsection may not exceed forty per centum of the total membership of the Council and (ii) the majority of the persons appointed shall be consumers.

D. Not less than one third of the providers appointed to the Council shall be direct providers of health care.

E. In addition to the members appointed by the Governor, the Chief Medical Director of the Veterans Administration may designate a representative of the Veterans Administration facilities within the Commonwealth to serve as an ex officio member.

F. Members of the Council appointed by the Governor shall serve at the pleasure of the Governor.

§ 32.1-119. Same; bylaws; meetings. The Council shall adopt bylaws for its operation and for the election of its officers. It shall meet at least quarterly.

§ 32.1-120. Duties of Council. The Council is authorized and directed to:

1. Prepare, review and revise as necessary a State health plan which shall be made up of the health plans prepared by the health systems agencies, with due consideration and review of other plans relating to physical and mental health services provided by agencies of the Commonwealth.

2. Review annually the budgets and applications for designation and funding made by the health systems agencies to the Secretary and make recommendations to the Governor and the Secretary on its findings from these reviews.

3. Review annually and approve or disapprove any plan or application submitted by an agency of the Commonwealth for the receipt of any federal funds under the allotment made to the

Commonwealth under the United States Public Health Services Act, the Community Mental Health Centers Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act or the Drug Abuse Office and Treatment Act of 1972.

4. Inform the Board generally on the performance of the Council's responsibilities under the provisions of this article and the federal act.

5. Perform such other functions relating to the coordination of health planning as the Governor may request.

§ 32.1-121. Department of Health to act as designated agency; duties of Commissioner. The Department is hereby designated as the Health Planning and Development Agency of the Commonwealth for the performance of such functions as are designated by this article and the federal act. The Commissioner shall:

1. Conduct the health planning activities of the Commonwealth and, subject to the approval of the Board, implement those parts of the State health plan provided for in § 32.1-120 and the plans of the health systems agencies which relate to the government of the Commonwealth.

2. Prepare, review and revise as necessary a preliminary State health plan which shall be made up of the health plans prepared by the health systems agencies and submit such preliminary plan to the Council.

3. Provide staff and administrative services for the Council and assist the Council in the performance of its functions generally.

4. Administer § 1122 of the United States Social Security Act if the Commonwealth has made an agreement with the Secretary pursuant to such section.

5. After consideration and review of recommendations submitted by the health systems agencies regarding new institutional health services proposed to be offered within the Commonwealth, make findings as to the need for such services.

6. Review at least once every five years all institutional health services being offered in the Commonwealth and, after considering the recommendations submitted by the health systems agencies and the Council regarding such services and after review by the Board of Health, make public the findings.

7. Perform any other functions relating to health planning activities in the Commonwealth as may be requested by the Governor.

§ 32.1-122. Commissioner authorized to apply for, receive and expend federal funds. The Commissioner, with the approval of the Board, is authorized to make application for federal funding of the functions of the State Health Planning and Development Agency and to receive and expend such funds in accordance with State and federal regulations.

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

JOSEPH H. HOLLEMAN, JR.
CLERK OF THE HOUSE OF DELEGATES
AND
KEEPER OF THE ROLLS OF THE STATE
STATE CAPITOL
RICHMOND, VIRGINIA 23219

November 1, 1982

FOR IMMEDIATE RELEASE

Delegate Warren G. Stambaugh of Arlington, Chairman of the Joint Subcommittee studying the feasibility of preserving a regional health planning mechanism in the Commonwealth, announced today that the joint subcommittee will hold a public hearing in Richmond, Virginia on Wednesday, November 10, at 10:00 a.m. in House Room C of the General Assembly Building. Other legislative members of the subcommittee are: Senator Edward M. Holland, Vice-Chairman, of Arlington; Senator Elmon T. Gray of Waverly; Delegate Mary A. Marshall of Arlington; and Delegate C. Jefferson Stafford of Pearisburg. Citizen members of the joint subcommittee are: George E. Broman of Culpeper; Gillium M. Cobbs of Lynchburg; James L. Gore of Richmond; E. Wayne Titmus of Richmond; Raymond O. Perry of Richmond; Carter T. Melton of Harrisonburg; Thomas R. Bernier of Charlottesville;and Barbara Bolton of Richmond.

This subcommittee was established pursuant to House Joint Resolution 104 passed by the 1982 Session of the Virginia General Assembly and has been charged with studying the preservation of a regional health planning mechanism in anticipation of the reduction or termination of federal government funding of the health systems agencies and the Statewide Health Coordinating Council.

The joint subcommittee has reviewed the position papers of the State Board of Health and the Statewide Health Coordinating Council and has tentatively adopted recommendations for preserving a health planning mechanism and posed questions relating to this mechanism (see attached).

Anyone who wishes to speak to these recommendations and the many questions related to them may register in advance with Barbara Hanback, House of Delegates, (804) 786-7681, or Angi Cole, Division of Legislative Services, (804) 786-3591.

## RECOMMENDATIONS FOR PRESERVING

## A REGIONAL HEALTH PLANNING SYSTEM

## IN THE COMMONWEALTH OF VIRGINIA

The Joint Subcommittee to study the feasibility of preserving a regional health planning mechanism in the Commonwealth was established through House Joint Resolution No. 104 during the 1982 Session of the General Assembly. The Subcommittee was charged with studying the preservation of a regional health planning mechanism in anticipation of the reduction or termination of federal government funding of the health systems agencies and the Statewide Health Coordinating Council.

At this time, the status of the federal health planning law is uncertain and future reductions in funding are expected. Therefore, the Subcommittee believes that it is in the best interest of the Commonwealth to develop a proposal for preserving and funding a health planning mechanism in order to be prepared if the federal law should be repealed, or if the level of federal aid should become inadequate to support regional health planning in Virginia.

The Joint Subcommittee has reviewed the position papers of the State Board of Health and the Statewide Health Coordinating Council and has tentatively adopted recommendations for preserving a health planning mechanism and posed questions relating to this mechanism as follows:

1. That a regional health planning system and state level coordination and guidance should be continued.

*Rationale* : Valuable planning data and cooperative relationships have been developed as a result of regional health planning and state and local collaboration. These data and relationships provide credible bases for local decision-making and cohesive state health planning.

*Questions* : Should the geographical boundaries of the present health systems agencies be maintained after making adjustments to recapture Bristol and the Counties of Scott and Washington? Do the demographic characteristics of the present health service areas provide viable data bases for planning in terms of population distribution? In terms of access to services? In terms of community mores and standards? In terms of availability of providers? If not, how should the regional units be apportioned? Should the scope of the responsibilities of the regional planning agencies be restricted? Should the participation in regional planning be on a voluntary basis? Should the regional facility plans be the bases for the state facility plan?

2. That the regional planning agencies should be responsible for: (a) the regional health plans; (b) facilitating the implementation of the regional plans; and (c) review of COPN applications.

*Rationale* : The primary functions of the present regional health planning agencies are to develop the regional health plans, to assist in implementing these plans and to review COPN applications. The expertise developed over the years in performing these activities is substantial; therefore, this knowledge and experience should be preserved and used to build a better health planning system.

*Questions* : Should the functions and responsibilities of the regional planning agencies be revised? Should the duties of these agencies be focused on planning rather than on regulating? Should the COPN review functions of the regional agencies be modified to include greater consumer, provider and planner involvement? Should the COPN review functions be eliminated? What functions presently performed by the HSA's are appropriate, beneficial and cost-effective? What functions presently performed by the HSA's are not appropriate, beneficial and cost-effective? What is the proper role of a regional planning agency?

3. That regional health plans should continue to be developed and used as the bases for the state health plan, which should be a reference for decision-making and provide a balance between uniformity and flexibility throughout the Commonwealth.

*Rationale* : Regional health plans have served as vehicles for the gathering of information that was

not available before their existence. This information can be used to review the trends in the health care industry, a rapidly changing market. The valuable data also serves as the basis for local decisions, and a comprehensive state health plan, which provides state level decision-makers with the broad view of the status of the health care industry, its stresses and excesses.

*Questions* : Should the state agency provide the regional health planning agencies with strict guidelines for development of their plans? Or should localities be given control of the development of these plans? If guidelines are not provided, will the data collected have any validity or value in developing a state health plan? Will it be possible to develop a credible state health plan at all unless guidelines are provided? If guidelines are provided, how detailed should they be? Should the state agency involvement be restricted to instances in which state involvement enhances, coordinates or is necessary to the planning process? If so, how can these instances be identified?

4. That the planning process should be more accountable to the public through effective local involvement and by broadening the base of financial support.

*Rationale* : Effective involvement of consumers, public officials, providers and elected officials in the health planning process should enhance its public accountability. Requiring or soliciting support of various segments of the health care industry such as provider associations, institutions, third-party payors and state and local governments should also promote accountability.

*Questions* : How can local citizens be encouraged to become involved in health planning? What can be used to measure "effective involvement?" What mechanism should be used for broadening the financial support base? If the health planning mechanism, which is essentially a regulatory activity at present, is funded by those who are regulated, will conflicts of interest develop? What could be done to avoid this possibility?

5. That although a consumer majority should be retained, the composition of the planning agency boards should be revised to make them more responsive to regional and state realities.

*Rationale:* Maintaining a consumer majority on the planning agency boards provides another means for accountability. The federal law presently requires the board composition to conform with strict dictates. The composition of the boards would need to be revised to reflect more accurately the state needs, allow for more meaningful local authority and flexibility in program structure.

*Questions* : Would broader participation lead to greater public accountability? Or make decision-making more difficult? How should the boards be composed? What types of representation are essential other than consumers? How large should the boards be? On the regional level? On the state level? Should the composition of the regional boards be a matter for local decision? What authority should the regional boards have? How flexible should the program be? Should local health planning be a matter for the locality to develop autonomously?

6. That the Certificate of Public Need Law should be maintained until competition begins to become a reality.

*Rationale:* Many experts believe that it will take years to develop competition in the health care industry. However, the economic elements of competition are beginning to appear as reimbursement systems are restructured and alternative delivery systems developed. At present, the health care industry still does not resemble a competitive market; therefore, COPN is necessary to prevent redundant capitalization. When competition becomes a reality, most experts believe its effects will be obvious and that COPN will no longer be necessary to protect the consumer and the government from supporting unnecessary duplicative services and empty beds.

*Questions* : What are the outcomes of COPN? Is the expense to the providers of going through the COPN process justified by the results? Will maintaining COPN impede the development of competition? Will the transition from a cost reimbursement system to competition result in any reductions in services to the consumers? What precautions can be taken to avoid reductions in services? How will it be possible to recognize that competition has become a reality? What is competition in the health care industry?

7. That the state agency should continue to administer COPN, provide guidelines fo regional health planning and staff a state level planning council.

*Rationale* : Administration of COPN as a regulatory function is appropriately the Department of Health's responsibility. Also, without a central agency to pull together data and provide uniformity the value of health planning would be dimished.

*Questions* : Should the appeals process presently in the COPN law be revised to provide hearing officers who are *not* Department of Health officials? Should the COPN function of the Department be modified in any other way? Can the regulatory function of COPN be modified to include greater consumer, provider and local planner involvement? Should health planning on the local level be independent of the state agency? What is the proper relationship between the state department and the regional health planning agencies? What is the proper role of the State Department of Health in health planning?

8. That in the absence of adequate federal support, the funding of health planning should be shared responsiblity.

*Rationale* : The federal administration has proposed that the responsibility for health planning be returned to the states. As a means of implementing this philosophy, the federal funding for health planning has been decreased and is expected to continue to decrease or even be eliminated. Federal support for regional health planning in Virginia already borders on being inadequate; therefore, if Virginia is to maintain a viable regional health planning system, alternative funding sources will have to be developed.

*Questions* : Should the costs of health planning be shared by state and local governments and the private sector? Or should the costs be shared by only state and local governments? Or solely by the private sector? How should a shared cost arrangement work? How should the shares be prorated? Should one entity assume a larger share than the others? Should all entities share equally? Should the private sector be required to support regional health planning? Or encouraged to support it? If support is required, how should such a system work? Should the localities be required to support regional health planning? If so, should more control of this mechanism be given to local authorities?

## STATISTICS USED FOR CALCULATIONS

### I. Hospital Beds

17,758 - licensed and approved acute care beds
1,410 - pediatric beds
1,406 - obstetrical beds
2,476 - short and intermediate term psychiatric beds

23,050 TOTAL

### Nursing Home Beds

20,014 - licensed and approved, skilled and intermediate
1,546 - non-certified
1,385 - under construction

22,945 TOTAL

Source: 1981 Annual Survey of Virginia Hospitals
Certificate of Public Need Records
Division of Resource Development
Department of Health

### II. Population Figures:

HSA I - 695,768

HSA II - 1,015,714

HSA III - 1,159,681 (Does not include the Counties of Scott and Washington or the City of Bristol)

HSA IV - 960,110

HSA V - 1,334,409

Source: Federal Resigter, March 3, 1982 provided by the Bureau of Census as of April, 1980.

(Provided by Mr. Thomas R. Bernier)

## III. Health Systems Agencies Expenditures

### HSA I

| | Fiscal Years | | | | |
|---|---|---|---|---|---|
| | 1978 | 1979 | 1980 | 1981 | 1982 |
| Expenditures | $272,914 | $298,492 | $269,601 | $308,546 | $279,696 |
| Staff (FTE) | 8 | 8.2 | 10 | 10 | 8.7 |

Note: Fiscal year ends March 31st for HSA I.
Staff is Full Time Equivalent.
Expenditures are the actual amounts expended per year.

### HSA II

| | | | | | |
|---|---|---|---|---|---|
| Expenditures | $529,591 | $550,650 | $646,037 | $478,786 | $469,042 |
| Staff (FTE) | 18 | 20 | 19 | 15 | 9 |

### HSA III

| | | | | | |
|---|---|---|---|---|---|
| Expenditures | $520,713 | $592,992 | $597,074 | $645,337 | $458,206 |
| Staff (FTE) | 19 | 19 | 21 | 19 | 14.6 |

### HSA IV

| | | | | | |
|---|---|---|---|---|---|
| Expenditures | $490,933 | $503,196 | $503,143 | $438,925 | $376,948 |
| Staff (FTE) | 18 | 17 | 13 | 11 | 6.5 |

### HSA V

| | | | | | |
|---|---|---|---|---|---|
| Expenditures | $460,035 | $571,128 | $573,202 | $636,758 | $448,804 |
| Staff (FTE) | 19 | 24 | 22 | 24 | 16 |

Note: Fiscal year ends April 30th for HSA II, III, IV, V.
Staff is Full Time Equivalent.
Expenditures are the actual amounts expended per year.

# COMMONWEALTH of VIRGINIA

*Department of Health Regulatory Boards*

H. BRYAN TOMLINSON II
DIRECTOR

January 6, 1983

Ms. Norma Szakal
Division of Legislative Services
General Assembly Building
2nd Floor
910 Capitol Street
Richmond, Virginia

Dear Ms. Szakal:

In reference to our recent telephone conversation, I have attached a summary of current licensees of the Boards administered by the Virginia Department of Health Regulatory Boards. I have excluded the licensees of the Boards of Funeral Directors and Embalmers and Veterinary Medicine, respectively.

I hope this information will be useful to the Joint Sub-Committee Studying a Regional Health Planning Mechanism which is scheduled to meet on January 11, 1983. I will be available at that meeting to discuss those matters affecting health professional regulation.

Please let me know if you require further information on the health regulatory boards.

Sincerely,

H. Bryan Tomlinson, II
Director

HBT:pjg

Attachment

517 West Grace Street • Richmond, Virginia 23220 • 804-786-0015

Health Professionals Licensed by the
Virginia Department of Health Regulatory Boards

| Boards | Number of Licensees* |
|---|---|
| **Board of Nursing** | |
| RN | 40,925 |
| LPN | 25,224 |
| **Board of Medicine** | |
| Chiropractic | 299 |
| Clinical Psychologist | 524 |
| MD | 15,820 |
| Osteopath | 157 |
| Physical Therapist | 1,273 |
| Physical Therapist Assistant | 150 |
| Podiatrist | 337 |
| **Board of Pharmacy** | |
| Pharmacist | 4,599 |
| **Board of Dentistry** | |
| Dentist | 3,976 |
| Dental Hygienist | 1,714 |
| **Board of Optometry** | |
| Optometrist | 799 |
| Total | 95,797 |

*Licensed effective December 27, 1982.

# STATE DEPARTMENT OF HEALTH

Richmond, Virginia

## Inter-Office Correspondence

December 27, 1982

M E M O R A N D U M

TO: Raymond O. Perry, Assistant Health Commissioner
Office of Health Planning and Resources Development

FROM: Wendy Vanaver, Staff
Division of Resources Development

THROUGH: Marilyn H. West, Director
Division of Resources Development

SUBJECT: Certificate of Need project Review Data

As requested, we have compiled data on numbers and types of Certificate of Need projects considered by the Division of Resources Development. The time period includes January through November, 1982 during which 153 CON projects were reviewed:

| Capital Expenditure | Number of Projects |
|---|---|
| Over $5 Million | 9 |

In this class all of the projects reviewed were hospital related at a total capital cost of $104,146,487. Annualizing these figures, the Division will review approximately ten (10) projects per year at a total capital cost of $113.6 Million.

| Capital Expenditure | Number of Projects |
|---|---|
| Between $1.5 Million and $5 Million | 13 |

In this class, 13 projects were reviewed, 12 of which were hospital related, and one non-hospital related at a total capital cost of $38,678,912. Annualizing these amounts, the Division will review approximately 14 projects per year in this class at a total capital cost of approximately $42.2 Million.

| Capital Expenditure | No. of Projects |
|---|---|
| Less than $1.5 Million | 131 |

In this category 68 projects were hospital related, 7 were nursing home projects, 7 were significant changes and 49 were related to various other types of medical facilities. 45 of these projects required no (0) capital expense. Total capital expenditures for projects in this class were $36,703,765 for the eleven (11) month period. This would be approximately $40 Million annually if average capital expenditure per project is $427,000 excluding those projects that involve 0 capital expenditure.

MHW:ept

CHART I and CHART II

| | 1982 Expenditures (a) | Population | Per capita Expenditure for 1982 | Funding needed to provide 35¢ per capita (b) | Difference between present & projected (a-b) |
|---|---|---|---|---|---|
| HSA I | 279,696 | 695,768 | .40 | 243,519 | - 36,177 |
| HSA II | 469,042 | 1,015,714 | .46 | 355,500 | - 113,542 |
| HSA III | 458,206 | 1,159,681 | .40 | 405,888 | - 52,318 |
| HSA IV | 376,948 | 960,110 | .39 | 336,039 | - 40,909 |
| HSA V | 448,804 | 1,334,409 | .34 | 467,043 | + 18,239 |
| | 2,032,696 | 5,165,682 | 1.99* | 1,807,989 | - 224,707 |

* Average -.40

Note: All expenditures are operating costs. Approximately 65% of these expenditures represent personnel costs. Population figures do not include the Counties of Scott and Washington, and the City of Bristol

## FUNDING ALTERNATIVE NUMBER I

## USER'S FEE BASED ON NUMBER OF BEDS PER FACILITY

| Total funding* required to provide 35¢ per capita | Total number of beds: Hospital and nursing homes | Amount/year/bed | Amount/day/bed assuming 365 days/ year occupancy | Amount/day/bed assuming 75% occupancy for hospitals and 98% occupancy for nursing homes |
|---|---|---|---|---|
| $ 1,807,989 | 45,995 | $ 39.31 | .107 (.11) | .071 - hospital beds<br>.054 nursing home beds |



Calculations: The total number of beds was divided into the total funding required to provide 35¢ per capita ($39.31). Hospital beds represent 50.1% of the total; nursing home beds represent 49.9% of the total; therefore each segment would be responsible for 50% of the cost. $39.31 was then divided by 2 = $19.66. Each segment would be responsible for $19.66 per bed/per year. 75% occupancy represents 273.75 days/year. 98% occupancy represents 357.70 days/year. Therefore, $19.66 divided by 273.75 provides the cost per day per bed for hospitals (.071) and $19.66 divided by 273.75 provides the cost per day for nursing homes (.054).

(Pass through to third-party payors, i.e., Medicaid, Medicare, Blue Cross/Blue Shield and the commerical health insurance carriers, would be in excess of 80%, in other words, approximately $1,446,391.)

*This alternative would provide 5¢ per capita for the support of the SHPDA activities for a total of $258,284.

## FUNDING ALTERNATIVE NUMBER II - CERTIFICATE OF NEED FEES

| Total funding * required to provide 35¢ per capita | Approximate number of certificate of need applications (1980-81) | Total amount of capital outlays for which application was made (1980-81) | Percentage required to acquire funding at approximately 35¢ capita (1980-81) | Estimated funds collected if a .008% fee would have been applied to capital costs of CON applications |
|---|---|---|---|---|
| $ 1,807,989 | 203 | $ 214,509,553 | .008% | $ 1,716,076 |



Certain types of applications frequently do not require capital outlays, e.g., home health services. These applications should be assessed a flat fee for the sake of equity. The average cost to the facilities for the .008% fee would be $8,454. It is suggested, therefore, that a minimal fee be assessed because the operating costs of projects which do not involve capital outlays can impact the cost of health care significantly. No estimates can be made at this time of the revenues that would be generated by this fee. One effect of an application fee would be to discourage frivolous applications (if any are filed presently) and facilitate more careful estimates of the capital expenditures.

Fees on CON applications would be a fluctuating source of revenues. Fewer applications might be filed in the next few years, if competition reduces the incentives to build and expand. Further, such fees could be a burden on the providers unless factored into the allowable costs for reimbursement.

*This alternative would provide 5¢ per capita for the support of the SHPDA activities for a total of $258,284.

CHART III

| | 1982 Expenditures (a) | Population | Per capita Expenditure for 1982 | Funding needed to provide 30¢ per capita (b) | Difference between present & projected (a-b) |
|---|---|---|---|---|---|
| HSA I | 279,696 | 695,768 | .40 | 208,730.40 | - 70,965.60 |
| HSA II | 469,042 | 1,015,714 | .46 | 304,714.20 | - 164,327.80 |
| HSA III | 458,206 | 1,159,681 | .40 | 347,904.30 | - 110,301.70 |
| HSA IV | 376,948 | 960,110 | .39 | 288,033.00 | - 88,915.00 |
| HSA V | 448,804 | 1,334,409 | .34 | 400,322.70 | - 48,481.30 |
| | 2,032,696 | 5,165,682 | 1.99* | 1,549,704.60 | - 482,991.40 |

*Average - .40

Note: All expendutures are operating costs. Approximately 65% of these expendutures represent personnel costs. Population fugures do not include the Counties of Scott and Washington, and the City of Bristol.

FUNDING ALTERNATIVE NUMBER III
USER'S FEE BASED ON NUMBER OF PATIENT DAYS PER FACILITY

| Total funding * required to provide 30¢ per capita | Total number of estimated patient days: Hospital and nursing homes | Total amount/ Year/hospitals | Total amount/year nursing home | Amount/day/patient day assuming 75% occupancy for hospitals and 98% occupancy for nursing homes |
|---|---|---|---|---|
| $ 1,549,705 | 14,517,364 | 694,093.125 | 902,816.912 | .106 (.11) - hospital beds |
| | Hospitals: .50 | | | .106 (.11) - nursing home beds |
| | 6,309,937.50 (43.4%) | | | |
| | Nursing homes: | | | |
| | 8,207,426.50 (56.6%) | | | |
| | Assuming 98% occupancy | | | |

In order to find the estimated number of patient days per hospital, the number of beds was multipled by 365 (days in year) and 75% of this figure was then taken because hospitals are estimated to have a 75% occupancy rate: 23,050 beds x 365 x .75 = 6,309,937.50. The nursing home calculations were identical except that the assumed occupancy rate is 98%: 22,945 x 365 x .98 = 8,207,426.50. Hospitals would account for approximately 43.4% of the total patient days. Nursing homes would account for approximately 56.6% of the total patient days. The total sum was pro rated accordingly 43.4% = 672,571.97; 56.6% = 877,133.03. These sums were then divided by the total number of days for each kind of facility: 672,571.97 ÷ 6,309,937 = .106; 877,133.03 ÷ 8,207,426 = .106. The total amount of revenues per hospital or nursing home was calculated by multiplying .11 x the estimated patient days.

(Pass through to third-party payors, i.e., Medicaid, Medicare, Blue Cross/Blue Shield and the commerical health insurance carriers, would be in excess of 80%, in other words, approximately $1,277,528.)

*Total estimated revenues would be $1,596,910.04, thereby providing $47,205.04 for support of the SHPDA.

CHART IV

| | 1982 Expenditures (a) | Population | Per capita Expenditure for 1982 | Funding needed to provide 11¢ per capita (b) | Difference between present & projected (a-b) |
|---|---|---|---|---|---|
| HSA I | 279,696 | 695,768 | .40 | 76,534.48 | - 203,161,52 |
| HSA II | 469,042 | 1,015,714 | .46 | 111,728.54 | - 357,313.46 |
| HSA III | 458,206 | 1,159,681 | .40 | 127,564.91 | - 330,641.09 |
| HSA IV | 376,948 | 960,110 | .39 | 105,621.10 | - 271,326.90 |
| HSA V | 448,804 | 1,334,409 | .34 | 146,784.99 | - 302,019.01 |
| | 2,032,696 | 5,165,682 | 1.99* | 568,234.02 | -1,464,461.98 |

*Average - .40

Note: All expenditures are operating costs. Approximately 65% of these expenditures represent personnel costs. Population figures do not include the Counties of Scott and Washington and the City of Bristol.

FUNDING ALTERNATIVE NUMBER IV
USER'S FEE BASED ON NUMBER OF PATIENT DAYS PER FACILITY*

| Total funding** required to provide 11¢ per capita | Total number of patient days: hospital and nursing homes | Total amount/ year/hospitals | Total amount/ year/nursing homes | Amount/per patient day assuming 75% occupancy for hospitals and 98% occupancy for nursing homes |
|---|---|---|---|---|
| $ 568,225.02*** | 14,517,364 | $ 246,609.658 | $ 321,615.361 | .039 (.04) - hospitals<br>.039 (.04) - nursing homes |

Calculations: Methodology the same as for Alternative Number III

*Calculations based on 11¢ per capita - estimated amount needed in addition to federal funding to bring total amount up to 30¢ per capita this year.

**Total actual estimated revenues would be $580,694.56 (252,397.50 x 328,297.06), thereby providing $12,469.54 for support of the SHPDA

***Hospitals would account for approximately 43.4% of costs; nursing homes approximately 56.6%.

(Pass through to third-party payors, i.e., Medicaid, Medicare, Blue Cross/Blue Shield and the commercial health insurance carriers, would be in excess of 80%, in other words, approximately $464,555.648.)

CHART V

| | 1982 Expenditures (a) | Population | Per capita Expendutire for 1982 | Funding needed to provide 19¢** per capita (b) | Difference between present & projected (a-b) |
|---|---|---|---|---|---|
| HSA I | 279,696 | 695,768 | .40 | 132,195.92 | - 147,500.08 |
| HSA II | 469,042 | 1,015,714 | .46 | 192,985.66 | - 276,056.34 |
| HSA III | 458,206 | 1,159,681 | .40 | 220,339.39 | - 237,866.61 |
| HSA IV | 376,948 | 960,110 | .39 | 105,612.10 | - 271,335.90 |
| HSA V | 448,804 | 1,334,409 | .34 | 253,537.71 | - 195,266.29 |
| | 2,032,696 | 5,165,682 | 1.99* | 904,670.78 | -1,128,025.22 |

*Average - .40

**19¢ per capita = 1,000,000 ÷ 5,165,682.
$95,329.22 would be provided for support of the SHPDA.

Note: All expenditures are operating costs. Approximately 65% of these expendutures represent personnel costs. Population figures do not include the Counties of Scott and Washington, and the City of Bristol.

FUNDING ALTERNATIVE NUMBER V
A LIMITED USER FEE OF $1,000,000 BASED ON A FLAT CHARGE PER ADMISSION

| Funding level | Average Number of Admissions Per Year - 1980 | Suggested Fee** | Estimated Amount Generated |
|---|---|---|---|
| $ 1,000,000 | *Hospitals: 779,250 (99.8%)<br>Nursing homes: 1,276 (.2%) | 1.29 Admission | 1,006,878.54 |

Any user fee would have to be established by legislation and a mechanism for collection designed. The generated would also have to be dedicated funds. The limitation on the amount collected in any given year might make such a fee more palatable to the industry and the General Assembly. The HSA's should be encouraged to seek funding from other sources. This would also limit the pass through charges which would accrue to the state and the insurance companies.

*Does not include psychiatric hospitals.

** Suggested fee based on $1,000,000 divided by the total number of admissions (780,526) = $1.281.

CHART VI, VII & VIII

| | 1982 Expenditures (a) | Population | Per capita Expenditure for 1982 | Funding needed to provide 11¢ per capita (b) | Difference between present & projected (a-b) |
|---|---|---|---|---|---|
| HSA I | 279,696 | 695,768 | .40 | 76,534.48 | - 203,161,52 |
| HSA II | 469,042 | 1,015,714 | .46 | 111,728.54 | - 357,313.46 |
| HSA III | 458,206 | 1,159,681 | .40 | 127,564.91 | - 330,641.09 |
| HSA IV | 376,948 | 960,110 | .39 | 105,621.10 | - 271,326.90 |
| HSA V | 448,804 | 1,334,409 | .34 | 146,784.99 | - 302,019.01 |
| | 2,032,696 | 5,165,682 | 1.99* | 568,234.02 | -1,464,461.98 |

*Average - .40

Note: All expenditures are operating costs. Approximately 65% of these expenditures represent personnel costs. Population figures do not include the Counties of Scott and Washington and the City of Bristol.

## FUNDING ALTERNATIVE NUMBER VI

### CON fees/surcharge on licenses/user's fee on beds

| Total funding required to provide 11¢ per capita | License surcharge to collect $175,000 | CON fees (fee schedule*) | User's fee on beds to collect remainder | Amount/bed/year assuming 365 days/year occupancy |
|---|---|---|---|---|
| $568,225 | $175,000 ** collected through $4.00 surcharge from 97,485 professionals | $56,250* | $336,975*** | $7.33**** |

* $56,250 is the amount estimated to be collected from the following fee schedule: applications requiring capital outlays of 0 to $1.5 million - $250; applications requiring capital outlays of $1.5 million to $5 million - $750; applications requiring capital outlays of over $5 million - $1000. Between January through November, 1982, 153 applications for CON were reviewed by the Department of Health as follows: 131 applications ranging from 0 to $1.5 million in capital outlays; 13 applications ranging from $1.5 million to $5 million in capital outlays; 9 applications ranging above $5 million in capital outlays.

** Assuming a cost of at least $2.00 to process each request for payment of the surcharge and using the total number of professionals licensed by the regulatory Boards on December 27, 1982, the cost of processing these requests would be $194,970. When this amount is added to the amount to be collected, $175,000, the total minimum needed is $396,970. $396,970 was divided by the number of licensees (97,485) giving $ 3.795 as the pro rata share of each licensee. This figure was rounded up to $4.00. The number of licensees was multipled by $4.00, giving $389,940. It is proposed that the Boards keep the extra amount and that the fund receive 45% of the amount collected, which would equal $178,636.50 (assuming everyone paid).

*** $175,000 + $56,250 = $231,250. $568,225 - $231,250 = $336,975.

**** $336,975 ÷ 45,995 = $7.33.

## FUNDING ALTERNATIVE NUMBER VII

### CON fees/surcharge on licenses/user's fee on beds

| Total funding required to provide 11¢ per capita | License surcharge to collect $175,000 | CON fees (fee schedule)* | User's fee on beds to collect remainder | Amount/bed/year assuming 365 days/ year occupancy |
|---|---|---|---|---|
| $568,225 | $175,000** collected through $4.00 surcharge from 97,485 professionals | $95,400* | $297,825*** | $6.48**** |

* $95,400 is the amount estimated to be collected from the following fee schedule: applications requiring capital outlays of 0 to $1.5 million - $500; applications requiring capital outlays of $1.5 million to $5 million - $850; applications requiring capital outlays of over $5 million - $1200. Between January through November, 1982, 153 applications for CON were reviewed by the Department of Health as follows: 131 applications ranging from 0 to $1.5 million in capital outlays; 13 applications ranging from $1.5 million to $5 million in capital outlays; 9 applications ranging above $5 million in capital outlays.

** Assuming a cost of at least $2.00 to process each request for payment of the surcharge and using the total number of professionals licenses by the regulatory Boards on December 27, 1982, the cost of processing these requests would be $194,970. When this amount is added to the amount to be collected, $175,000, the total minimum needed is $396,970. $396,970 was divided by the number of licensees (97,485) giving $3.795 as the pro rata share of each licensee. This figure was rounded up to $4.00. The number of licensees was multipled by $4.00, giving $389,940. It is proposed that the Boards keep the extra amount and that the fund receive 45% of the amount collected, which would equal $178,636.50 (assuming everyone paid).

*** $175,000 + $95,400 = $270,400. $568,225 - $270,400 = $297,825.

**** $270,400 ÷ 45,995 = $6.48.

## FUNDING ALTERNATIVE NUMBER VIII

### CON fees/surcharge on licenses/user's fee on beds

| Total funding required to provide 11¢ per capita | License surcharge on health professionals (surcharge schedule*) | CON fees (fee schedule**) | User's fee on beds to collect remainder (calculation of remainder***) | Amount/bed/year assuming 365 days/ year occupancy (calculation****) |
|---|---|---|---|---|
| $568,225 | $303,790* | $95,400** | $169,035*** | $4.00($3.68)**** |

* License surcharge schedule was approved by the majority of the Subcommittee as follows: all nurses would be assessed $4.00; all chiropractors, clinical psychologists, podiatrists, medical doctors and osteopaths would be assessed $10.00; all physical therapists and physical therapy assistants would be assessed $4.00; all pharmacists would be assessed $5.00; all dentists would be assessed $5.00; all dental hygienists would be assessed $4.00 and all optometrists would be assessed $5.00 (see attached chart giving amounts to be collected from each profession). Two dollars of every fee would be kept by the Department of Health Regulatory Boards.

**$95,400 is the amount estimated to be collected from the following fee schedule: applications requiring capital outlays of 0 to $1.5 million - $500; applications requiring capital outlays of $1.5 million to $5 million - $850; applications requiring capital outlays of over $5 million - $1200. Between January through November, 1982, 153 applications for CON were reviewed by the Department of Health as follows: 131 applications ranging from 0 to $1.5 million in capital outlays; 13 applications ranging from $1.5 million to $5 million in capital outlays; 9 applications ranging above $5 million in capital outlays.

*** $303,790 from professional license surcharges + $95,400 = $399,190; $568,225 - $399,190 = $169,035.

**** $568,225 - $399,190 = $169,035 ÷ 45,995 (number of licensed beds) = $3.68 (rounded up to $4.00).

## SURCHARGE FEES ON PROFESSIONAL LICENSES

| | Number of professionals | | Fee | | Total amount generated | | Total amount retained by the Department of Health Regulatory Boards ($2.00/fee) | | Total amount generated for the Health Planning Fund through surcharge |
|---|---|---|---|---|---|---|---|---|---|
| Nurses: | 66,149 | X | $4.00 | = | $264,596 | - | $132,298 | = | $132,298 |
| Medical Professionals: | 17,137 | X | $10.00 | = | $171,370 | - | $ 34,274 | = | $137,096 |
| Physical Therapists: | 1,273 | X | $4.00 | = | $ 5,092 | - | $ 2,546 | = | $ 2,546 |
| Physical Therapy Assistants: | 150 | X | $4.00 | = | $ 600 | - | $ 300 | = | $ 300 |
| Pharmacists: | 4,599 | X | $5.00 | = | $ 22,995 | - | $ 9,198 | = | $ 13,797 |
| Dentists: | 3,976 | X | $5.00 | = | $ 19,880 | - | $ 7,952 | = | $ 11,928 |
| Dental Hygienists: | 1,714 | X | $4.00 | = | $ 6,856 | - | $ 3,428 | = | $ 3,428 |
| Optometrists: | 799 | X | $5.00 | = | $ 3,995 | - | $ 1,598 | = | $ 2,397 |
| | 95,797 | | | | $495,384 | - | $191,594 | = | $303,790 |

## Appendix E

## HOUSE BILL NO. 579

**Offered January 24, 1983**

*A BILL to provide an interim fund for health planning.*

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**Patrons–Stambaugh and Marshall**

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**Referred to the Committee on Appropriations**

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Be it enacted by the General Assembly of Virginia:

1. *§ 1. There is hereby established an interim fund for health planning for the purpose of ensuring the survival of the health systems agencies in the Commonwealth. The interim fund shall provide supplemental support of no more than eleven cents per capita for each health systems agency and shall be in addition to such funds as may be received from federal or private sources. This fund is predicated on raising an estimated $568,225, eleven cents per capita, for the support of the health systems agencies in the 1984-1985 fiscal year.*

*The fund shall be apportioned between the following sources: a schedule of fees on applications for certificates of public need, a user's fee on the beds in each hospital and nursing home licensed by the Department of Health to operate in the Commonwealth and a one-time special assessment surcharge on licenses for health professions. These fees shall be deposited by the Comptroller to this fund to be appropriated for this purpose to the Department of Health by the General Assembly as it deems necessary except that two dollars of each fee collected by the Department of Health Regulatory Boards shall be deposited by the Comptroller to that Department's account. The Board of Health shall promulgate such rules and regulations as may be necessary to administer this fund.*

*§ 2. A. The fee schedule on applications for certificates of public need shall be:*

*1. Applications for projects proposing capital outlays up to $1,500,000 shall be assessed a fee of $500;*

*2. Applications for projects proposing capital outlays of $1,500,000 to $5,000,000 shall be assessed a fee of $850; and*

*3. Applications for projects proposing capital outlays of $5,000,000 and over shall be assessed a fee of $1,200.*

*B. The user's fee on the beds in each hospital and nursing home licensed by the Department of Health shall be four dollars per bed per year in addition to the regular license fee and is predicated on there being 45,995 licensed beds in the Commonwealth with the average number of beds per facility being under 150.*

*C. The one-time special assessment surcharge on licenses of health professions shall be as follows:*

*1. The Board of Nursing shall assess a four dollar fee on all licensed nurses;*

*2. The Board of Medicine shall assess a ten dollar fee on all licensed medical doctors, clinical psychologists, chiropractors and osteopaths, a four dollar fee on all licensed physical therapists and physical therapy assistants;*

*3. The Board of Pharmacy shall assess a five dollar fee on all licensed pharmacists;*

*4. The Board of Dentistry shall assess a five dollar fee on all licensed dentists and a four dollar fee on all licensed dental hygienists; and*

*5. The Board of Optometry shall assess a five dollar fee on all licensed optometrists.*

*2. That this act shall expire on June 30, 1984.*

## HOUSE JOINT RESOLUTION NO. 45

**Offered January 20, 1983**

*Continuing the study of the Joint Subcommittee on the Feasibility of Preserving a Regional Health Planning Mechanism in the Commonwealth.*

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**Patron–Stambaugh**

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**Referred to the Committee on Rules**

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WHEREAS, the status of the National Health Planning and Resources Development Act, P.L. 93-641, is uncertain at this time; and

WHEREAS, the federal funding of regional health planning has diminished to the extent that the survival of the Health Systems Agencies is in question; and

WHEREAS, the Joint Subcommittee has prepared tentative recommendations on regional health planning which have met with general approval and submitted a report to the Governor and the 1983 General Assembly; and

WHEREAS, the Joint Subcommittee has developed an interim funding mechanism to assure the survival of health planning in Virginia and recommended the adoption of this temporary funding system to the General Assembly; and

WHEREAS, the Joint Subcommittee wishes to stress that this proposed interim funding mechanism, if enacted by the General Assembly, would expire at the end of one year; and

WHEREAS, the Joint Subcommittee has received much conflicting testimony on the appropriate implementation and funding of a Virginia health planning system; and

WHEREAS, in order to develop the details of health planning to meet Virginia's needs, the Joint Subcommittee must analyze the systems of other states and evaluate the various proposals received this year; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the work of the Joint Subcommittee on the Feasibility of Preserving a Regional Health Planning Mechanism in the Commonwealth shall be continued to accomplish the following:

1. To design a detailed system for health planning and regulation tailored to Virginia's unique needs; and

2. To develop a permanent funding mechanism for regional health planning in Virginia.

The Subcommittee shall complete its work in time to submit its recommendations to the 1984 Session of the General Assembly. The membership of the Joint Subcommittee shall remain the same.

The cost of this study shall not exceed $11,520.