REPORT OF THE
DEPARTMENT OF HEALTH

ANNUAL REPORT ON THE STATUS OF VIRGINIA'S MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED PROGRAM

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 57

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

COMMONWEALTH of VIRGINIA

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December 14, 1999

TO: The Honorable James S. Gilmore, III

and

The General Assembly of Virginia

The report contained herein is pursuant to Section 32.1-102.12 of the Code of Virginia.

This report constitutes the response of the Virginia Department of Health (VDH) to annually report on the status of Virginia's Certificate of Public Need Program.

The cost to VDH to prepare this report was $4,750. The report involved 75 staff hours of time.

Respectfully Submitted,

E. Anne Peterson, M.D., M.P.H.
State Health Commissioner

EXECUTIVE SUMMARY

This third annual report to the Governor and the General Assembly of Virginia on the status of Virginia's Medical Care Facilities Certificate of Public Need (COPN) Program has been developed pursuant to § 32.1-101.12 of the Code of Virginia of 1950, as amended.

The COPN Program is a regulatory program administered by the Virginia Department of Health (VDH). It regulates certain categories of capital investment by and/or for certain categories of medical care facilities and services. Capital projects regulated within the COPN Program must be authorized by the State Health Commissioner prior to implementation.

The State Health Commissioner issued 79 certificate of public need decisions in FY 1999, authorizing or conditionally authorizing 49 projects at a total capital expenditure of $252,426,976 and denying 30 requests with proposed capital expenditures totaling $113,617,556. Eighteen COPN requests, proposing projects with estimated capital expenditures totaling $48,559,262, were filed and deemed complete for review but subsequently withdrawn during the fiscal year.

VDH has established a five-year schedule (1997-2001) for analysis of all project categories within the scope of COPN regulation as it existed in 1997. The schedule provides for analysis of at least three project categories per year. This report considers the appropriateness of COPN regulation of long-term hospitals, nursing facilities, medical rehabilitation facilities and mental retardation facilities. It also addresses health care market reform, the accessibility of regulated medical care facilities by the indigent, and the quality of medical care in regulated facilities within the context of COPN regulation.

In this year's report, alternate policy options were developed for each of the four categories of facilities under review. Based on the review of their appropriateness for COPN regulation, VDH recommends deregulation as a viable option for three of the four categories reviewed and defers to the Department of Mental Health, Mental Retardation, and Substance Abuse Services on the fourth.

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Preface

This third annual report to the Governor and the General Assembly of Virginia on the status of Virginia's Medical Care Facilities Certificate of Public Need (COPN) Program has been developed pursuant to § 32.1-102.12 of the Code of Virginia of 1950, as amended. This section of the Code is reproduced in Appendix A.

The COPN Program is a regulatory program administered by the Virginia Department of Health (VDH). It regulates certain categories of capital investment by and/or for certain categories of medical care facilities and services. The current regulatory scope of the program, as defined in Virginia law, is shown in Appendix B. Capital projects regulated within the COPN Program must be authorized by the State Health Commissioner prior to implementation. The statute establishing Virginia's COPN program is in § 32.1-102.1 et seq. of the Code.

SUMMARY OF THE STATE HEALTH COMMISSIONER'S ACTIONS AND OTHER COPN PROGRAM ACTIVITY DURING FISCAL YEAR 1999

Project Review

In fiscal year 1999 (FY99), the State Health Commissioner (the Commissioner) issued 79 decisions on requests to establish new medical care facilities or modify existing medical care facilities. Forty-nine (49) of these requests were approved or conditionally approved, at a total authorized capital expenditure of $252,426,976. Thirty (30) requests were denied. These 30 projects had proposed total capital expenditures of $113,617,556. COPN decisions in FY99 are profiled in Appendix C.

During FY99, the Division of Certificate of Public Need (DCOPN) of VDH, which assists the Commissioner in administration of the COPN program, received 113 letters of intent to submit COPN requests and 73 applications for COPNs. Letters of intent are required of all persons intending to become applicants for COPNs and provide sufficient information on a proposed project so that VDH can batch the project in an appropriate review cycle and provide the applicant with the appropriate COPN application package for the proposed project. Four (4) letters of intent and 18 COPN applications were withdrawn by applicants during the year. The withdrawn applications had a total proposed capital cost of $48,559,262. Most of the application withdrawals occurred following the issuance of negative recommendations by the regional health planning agency and/or DCOPN.

Virginia's five regional health planning agencies are not-for-profit corporations which receive state funding to conduct regional health planning and to assist VDH in the review of COPN requests by conducting public hearings and making recommendations to the Commissioner concerning the public's need for proposed projects in their respective regions. The five health planning regions in Virginia are shown on the map in Appendix D.

There were 15 informal fact-finding conferences (IFFCs) on COPN applications convened in FY99. These conferences are usually held for the purpose of reconsidering a negative recommendation on a project by a regional health planning agency and/or the DCOPN. They are also convened if a person opposed to a project wishes to have his/her opposition considered by the Commissioner on a par with the recommendations of the regional health planning agency, the DCOPN, and the VDH adjudicator presiding at the IFFC. Such persons must demonstrate good cause, as defined in the COPN law. The IFFC is the central feature of an adjudication process that serves as an administrative appeal prior to final decisions on projects by the Commissioner.

One (1) COPN for replacement of cardiac catheterization equipment was surrendered or returned in FY99.

The Commissioner reviewed 3 requests for significant changes in authorized projects. All three were authorized. One involved an expansion of the range of surgical facilities performed at an existing outpatient surgical hospital. The second involved authorization for clinical provision of a service previously authorized only for research purposes. The third involved a change in the site of an authorized outpatient surgical hospital and an increase in the authorized cost of that facility ($536,000, an increase of approximately 16%).

The Commissioner reviewed no requests for waiver of COPN requirements for medical equipment replacement projects.

Monitoring of Progress in Project Implementation and Extension of Certificates
DCOPN reviewed and approved 42 requests for extension of the validity of COPNs.

Registration of Capital Expenditures By or On Behalf of Existing Medical Care Facilities
Thirteen (13) capital expenditures of one million dollars or more, but less than five million dollars, by or on behalf of medical care facilities, were registered with VDH in FY99. These registered expenditures totaled $32,766,251. All but one were registered by general hospitals. The single nursing facility capital expenditure registered in FY00 totaled $1,500,000.

Registration of Equipment Replacements
Two (2) equipment replacement registrations were filed with VDH in FY99, under the provisions of amendments to the COPN law effective March 29, 1999 which eliminated all COPN regulation of the replacement of medical equipment. These equipment replacements involved total capital expenditures of $3,116,712. They are profiled below:

Registration of Equipment Replacements - FY99

Facility	Equipment	Cost	Procedure Volume/Year
Martha Jefferson Hospital Charlottesville	Computed Tomography	$1,476,629	5,376/1998
Medical College of Virginia Hospitals Richmond	Cardiac Catheterization	$1,640,083	2,422/1998

Competitive Nursing Home Review

Effective July 1, 1996, a general prohibition on the issuance of COPNs that would increase the supply of nursing home beds in the Commonwealth, commonly known as the "nursing home bed moratorium," which had been in place in Virginia statute since 1988, was replaced with an amended process governing COPN regulation of increases in nursing home bed supply (Va. Code § 32.1-102.3:2). The new process requires the Commissioner to issue, at least annually, in collaboration with Virginia's Medicaid Program, a Request for Applications, which will target geographic areas for consideration of increased bed supply and establish competitive review cycles for the submission of applications. In FY97, VDH promulgated amendments to the Virginia Medical Care Facilities COPN Rules and Regulations (12 VAC 5-220-10) and the Virginia State Medical Facilities Plan (12 VAC 5-360-10) to implement this new process. These regulatory amendments became effective in January 1997.

The Commissioner issued the first Request for Applications for nursing home bed projects on August 20, 1997. It established competitive review cycles for eight planning districts in Virginia considered to have the greatest need for increased nursing home bed supply based on projections of historically observed bed use rates, high recent Medicaid-certified bed occupancy, and the absence of unconstructed bed authorizations. A total of 1,080 additional beds were allocated for these eight planning districts. Review cycles for these eight planning districts began in FY98 and final decisions on seven of the eight districts were completed in FY99. Final decisions on the eighth and final district targeted in 1997 were issued on August 20, 1999. A total of 48 COPN requests were filed and completed in response to this first general RFA.

In May 1998, the Commissioner issued the second RFA for nursing home bed projects. This RFA was requested by the Department of Medical Assistance Services and was limited to projects which would increase the number of specialized pediatric nursing facility beds. Five planning districts were eligible and only one specialized unit with a maximum of 15 beds could be authorized per planning district, under the terms of this RFA. Review cycles for projects proposed in response to this RFA began in FY99. One new pediatric nursing unit, located in Richmond, was authorized through this RFA. A second unit, proposed for development in Lynchburg, was not recommended for authorization by the regional health planning agency or DCOPN and is currently in adjudication.

A second general RFA for nursing facility beds was issued in November, 1998. It targeted three planning districts for a total of 360 beds. Eleven COPN requests were filed and completed from two planning districts in response to this second general RFA. No completed applications were submitted from third planning district. A final decision authorizing 90 additional beds for one of the planning districts, Planning District 1 (LENOWISCO) was issued on July 7, 1999. Nine competing projects in the second planning district, Planning District 5, are currently in adjudication and final decisions will be issued in Fiscal Year 2000 (FY00).

DCOPN has recommended that a general RFA which targets planning districts for additional beds not be issued in FY00, given the decline in nursing facility bed population use rates and the recent general decline in actual levels of nursing facility bed utilization. The analysis upon which this recommendation is based has been distributed for review and comment to interested persons and was published in the Virginia Register on August 30, 1999. The Board of Health will consider comments and the issuance of a final RFA at its November 1999 meeting. The exception is an RFA for 30 beds in planning district 4 that is in response to specific COPN legislation resulting from SB 2080.

Legislation

Three bills affecting the COPN program were passed during the 1999 General Assembly Session and signed by the Governor. These bills: 1) amended the scope of COPN regulation by eliminating all requirements for COPN authorization of projects for the replacement of medical equipment; 2) specified certain aspects of the COPN application review process, including timeframes for final decisions on COPN requests which, if not met, result in "deemed approval" of such requests and refunds of portions of the COPN applicaton fee; 3) amend the required considerations in COPN project review to include specific consideration of unique needs of rural areas and require the development of regulations which also specifically address rural area concerns, and; 4) require that the Commissioner qualify planning districts for additional nursing facility beds without regard to the existence of certain authorized but unconstructed beds in these planning districts, if the districts meet all of the other criteria for inclusion in a RFA. The first change in the law was effective March 29, 1999. The changes in the review process will become effective on October 1, 1999. The latter two changes became effective on July 1, 1999.

DCOPN Recommendations issued in FY 1999 – Summary Statistics

Reports Issued in	**1999**	**YTD 2000**
Total Reports Issued	58	29
Reports Issued by Due Date	5	15
Percentages of Reports Issued by Due dates	9%	52%
Average Number of Days Late (Total)	35	3
Median Number of Days Late (Total)	30	2
Average Number of Days late – (Standard Cycle, No complicating Issues)	31	3
Median Number of Days late (Standard Cycle, No complicating Issues)	27	2

Final Decisions Issued for Projects for which a DCOPN Report was Issued	1999	YTD 2000
Total Decisions	34	11
Decisions Issued by Due date	13	9
Percentage of Decisions issued by Due Date	38%	82%
Average Number of Days late (Total)	41	N/A
Median Number of Days late (Total)	17	N/A
Average Number of Days Late (Standard Cycle, No Complicating Issues)	40	
Median Number of Days Late (Standard Cycle, No Complicating Issues)	9	
Average Number of Days Late – Non-adjudicated Projects	21	
Median Number of Days Late – Non-adjudicated Projects	7	
Average Number of Days late – Adjudicated Issues	156	
Median Number of Days Late – Adjudicated Projects	209	

Regulation

The promulgation of emergency regulations was authorized by two of the three COPN-related bills passed by the 1999 General Assembly Session. Development of these emergency amendments to existing regulations began in FY99 and will be completed in FY00.

Timeliness of COPN Application Review

DCOPN issued 58 recommendations on COPN requests in FY99. Forty-eight (48) of these requests were reviewed within the standard review cycle. The average number of days between the beginning of the review cycle and the issuance of a DCOPN recommendation for these 48 standard review cycle requests was 99 days, 29 days longer than the regulatory standard of 70 days. The median number of days between the beginning of the review cycle and the issuance of a DCOPN recommendation was 98 days, 28 days longer than the regulatory standard of 70 days.

Of the 48 standard review cycle requests for which DCOPN made recommendations in FY99, 22 required adjudication. Of these 22 adjudicated COPN requests, final decisions have been made on eight (8). The average number of days between the beginning of the review cycle and the issuance of a final decision for these 8 COPN requests was 340 days, 220 days longer than the regulatory standard of 120 days. The median number of days between the beginning of the review cycle and the issuance of a final decision for these 8 COPN requests was 360 days. Of the remaining 14 adjudicated projects, 1 had an IFFC convened in FY99 but no final decision has been issued to date, 6 have IFFCs scheduled in the first quarter of FY00, and 7 have not scheduled an IFFC to date.

Twenty-nine (29) COPN requests were recommended for authorization or conditional authorization by DCOPN in FY99 which were not adjudicated and for which final decisions were issued. The average number of days between the beginning of the review cycle and the issuance of a final decision for these 29 COPN requests was 141 days, 21 days longer than the regulatory standard of 120 days. The median number of days between the beginning of the review cycle and the issuance of a final decision for these 29 COPN requests was 127 days, 7 days longer than the regulatory standard of 120 days.

The backlog of adjudication cases in calendar 1999 was eliminated by September. At the beginning of this calendar year, there were 47 adjudicated COPN cases pending final decisions. By July 1, three of the 47 cases remained undecided and 12 additional cases were on the docket or had been decided. As of September, the adjudication case backlog had been cleared; 59 COPN adjudicated cases had been decided, and no current case decisions had extended beyond the 120-day deadline.

Since September 1, sixteen (16) cases have been adjudicated, seven case decisions have been made and nine cases are pending decisions. None of these case decisions have extended beyond the allowable time frame. Fourteen cases are currently scheduled for hearing before the end of this year.

Appendix E profiles the timeliness of COPN requests considered within a standard review cycle for which recommendations were issued in FY99.

Other

DCOPN expended $637,593 in FY99 in the administration of the COPN program. COPN application fees (net of refunds) and miscellaneous administrative fee revenue received by the DCOPN in FY99 totaled $834,971.

DCOPN does not receive a general fund appropriation and, thus, must rely on COPN application fees to fund its expenses. Excess COPN application fee revenue, with the exception of carry-over equivalent to one month of expenditures for DCOPN, is distributed to Virginia's regional health planning agencies, pursuant to provisions of the Appropriations Act. The amount of $144,245 was distributed to the five health systems agencies in FY99.

FIVE-YEAR SCHEDULE FOR ANNUAL PROJECT CATEGORY ANALYSIS

VDH has established a five-year schedule (1997-2001) for analysis of all project categories within the current scope of COPN regulation which provides for analysis of at least three project categories per year. It is attached to this report as Appendix F.

On the basis of this schedule, this Annual Report on the Status of Virginia's COPN Program will consider the appropriateness of COPN regulation of medical rehabilitation, long-term care hospital services, nursing home or nursing facility services, and mental retardation facilities.

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PROJECT CATEGORY ANALYSIS

Overview

For purposes of understanding the pattern of change in the supply of many types of medical care facilities and services in Virginia since 1973, the year of the COPN program's inception, it is useful to understand that the program's 25 years can be segmented into three distinct periods, which can be characterized as regulatory, non-regulatory, and a return to regulation. Those periods are: 1) 1973 to 1986, a period of relatively consistent regulation; 2) 1986 to 1992, a period of dramatic deregulation; and 3) 1992 to the present, a period in which Virginia revived COPN regulation but also began, in 1996, a process of review and consideration of the scope of the new regulatory environment.

Between 1973 and the mid-1980s, there was an effort, with mixed results, to ground COPN decision-making in established plans and standards of community need based on an assumption that controlling the supply of medical care facilities and equipment is a viable strategy for aiding in the containment of medical care costs. Increases in the supply of medical care facilities in Virginia during this period were, in most cases, gradual and tended to be in balance with population growth, aging of the population, and increases in the population's use of emerging technological advances in medical diagnosis and treatment.

Beginning around 1986 and through 1992, there was a period of "de facto" (1986 to mid-1989) and formal (mid-1989 to mid-1992) deregulation. Few proposed non-nursing home projects were denied during this period, followed by the actual deregulation of most non-nursing home project categories. There was a growth of most specialized diagnostic and treatment facilities and services that were deregulated.

On July 1, 1992, Virginia "re-regulated" in response to the perceived excesses of the preceding years of deregulation, bringing back the scope of COPN regulation of non-nursing home facilities and services to a level similar to that in place prior to 1989, updating and tightening its project review standards, and taking a more rigorous approach to controlling growth in the supply of new medical care facilities and the proliferation of specialized services.

In recent years, VDH has taken an incremental approach to reviewing COPN regulation, by de-emphasizing regulation of replacement and smaller, non-clinically related expenditures, and focusing COPN regulation on new facilities development, new services development, and expansion of service capacity.

ANALYSIS OF THE APPROPRIATENESS OF COPN REGULATION

Four types of regulated medical care facilities are considered in this report: long-term hospitals, nursing facilities, medical rehabilitation facilities, and mental retardation facilities.

Long-term hospitals are hospitals with an average length of stay of 25 days or longer which are exempt from the Medicare prospective payment system (PPS) created during the 1980s. The

Medicare PPS reimburses most hospitals, i.e., general hospitals with average lengths of stay less than 25 days, on the basis of the diagnostic classification of the hospitalized patient. Long-term care hospitals, which predominantly serve Medicare and Medicaid patients, are paid on the basis of Medicare reasonable costs per case, limited by a hospital specific target amount per discharge. Each hospital has a separate payment limit or target amount which was calculated based on the hospital's cost per discharge in a base year. The base year target amount is adjusted annually by an update factor. Hospitals whose costs are below their target amount are entitled to bonus payments equal to half of the difference between costs and the target amount, up to a maximum of five percent of the target amount. Medicare also makes additional payments to hospitals whose costs exceed their target amounts. For these hospitals, Medicare pays bonus payments equal to half of the amount by which the hospitals exceed the target amount up to 10 percent of the target amount. Hospitals that experience significant increase in patient acuity may also apply for additional Medicare exceptions payments. Medicare limits payment to a maximum of 150 days.

Medicaid reimbursement for long-term hospitals is also prospective cost-based but is annually "rebased" on the basis of cost reports. There is no length-of-stay limitation.

Thus, the designation of long-term hospital is one which primarily derives from the context of Medicare reimbursement. In theory, such hospitals fill a niche between acute general hospital care and the care provided by nursing facilities. There are three long term hospitals in Virginia. Two of these facilities are operated by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) and are oriented toward the elderly population with mental illness or disability. Facilities owned and operated by DMHMRSAS are exempt from COPN regulation.

Nursing facilities are those facilities or distinct components within other facilities licensed by the Department of Health to provide long-term nursing care. Most nursing facility care is provided in Virginia's 266 licensed nursing homes. There are 28 general hospitals that operate nursing facility units and there are also 4 facilities owned and operated by DMHMRSAS which provide nursing facility care. These latter facilities are exempt from COPN regulation.

Medicaid is the dominant payor for nursing facility care and, as with long-term hospitals, Medicaid reimbursement is prospective subjective to per-diem ceiling and without length-of-stay limitations. Medicare pays for limited amounts of nursing facility care following discharge from a hospital. Until recently, Medicare reimbursement for nursing facility care was cost-based but a transition to reimbursement based on the "resource use" profile of Medicare patients served by the nursing facility is currently underway and should be completed by 2002.

Medical rehabilitation facilities are those hospital facilities or distinct components within general hospital facilities that provide services to individuals who are primarily physically disabled with the objective of restoring normal function after injury or illness. Medical rehabilitation services do not include services provided to individuals whose primary disability is psychiatric illness or substance abuse. As in the case of long-term hospitals, Medicare reimbursement is the dominant

consideration in classification of these facilities. Medical rehabilitation facilities that meet certain criteria with respect to the patient population they serve are exempt from PPS and are reimbursed by Medicare using the cost-based method outlined above for long-term hospitals. Medicare is the dominant payor for medical rehabilitation facilities. VDH has incorporated PPS-exempt status into its definition of medical rehabilitation facility and, thus, limits COPN regulation to such medical rehabilitation facilities. There are 5 medical rehabilitation hospitals and 17 medical rehabilitation units within general hospitals in Virginia.

Mental retardation facilities are facilities which provide services to mentally retarded individuals. By regulation, COPN regulation is limited to a specialized category of nursing facilities defined by federal regulation, the intermediate care facility/mentally retarded (ICF/MR). The bulk of ICF/MR services are provided by DMHMRSAS in five large facilities, which are exempt from COPN regulation. There are 12 "group home" style ICF/MRs (average size: 11 beds) in Virginia. Medicaid is the predominant payor for care provided by ICF/MRs.

Establishing facilities for the provision of these services requires COPN authorization as does introducing these services into an existing medical care facility or expanding the capacity of an existing medical care facility to provide these services through the addition of new beds.

Long-Term Hospitals

Medicare recognized in the early 1980s that there was a group of hospitals in the United States serving a patient population that did not match the conventional, general acute care hospital patient population. It was this latter patient population which served as a model for the Diagnostic-Related Group (DRG) classification scheme chosen by Medicare as the basis for shifting from retrospective, cost-based reimbursement to prospective payment, based solely on patient diagnosis. Thus, Medicare carved out an exemption from PPS for these facilities, using average length of stay as the defining criteria, and continued to reimburse these hospitals on the basis of reported cost.

This decision provided a strong financial incentive for the development of long-term hospitals and the number of such hospitals has increased substantially in the years since implementation of Medicare PPS, particularly in states without certificate of need style regulation. General hospitals operating within PPS must seek to discharge Medicare patients to their homes or to alternative care settings as quickly as possible and the long-term hospital provided an alternative setting. This has had the effect of increasing Medicare expenditures, through the substitution of general acute hospital services, for which Medicare cost exposure is limited, with long-term hospital services and through the substitution of long-term hospital services for less costly complex long-term care provided in nursing facilities.

Virginia has avoided the inflationary impact of long-term hospital development. COPN regulations discourage applicants who have broached development plans with VDH and regional health planning agency (RHPA) staff. This is supposed to be a factor in controlling health care cost inflation. Only two COPN requests for establishment of long-term hospitals have been filed and completed for review since 1992. The first, from northern Virginia, was recommended for

denial by the regional health planning agency and DCOPN. The adjudication process has not proceeded because of outstanding litigation on another matter between the applicant and the Commonwealth. The second, from eastern Virginia's Tidewater area, was denied. Approximately six other potential applicants have met with DCOPN and/or RHPA staff but have been discouraged from applying. Virginia has only one regulated long-term hospital, Lake Taylor Hospital in Norfolk, which pre-dates the implementation of Medicare PPS and, from the standpoint of cost, patient acuity, payor mix and length of stay, much more closely mirrors the operation of a nursing facility than the higher cost, Medicare-oriented model of long-term hospital developed in other states since the early 1980s and proposed for development in Virginia. Lake Taylor Hospital's current Medicare payment limit (per discharge) is $7,900 and the hospital's current Medicaid per diem reimbursement is $373. Approximately 85% of its patients are Medicaid or Medicare patients. The chart below shows occupancy and length of stay for this facility.

Lake Taylor Hospital, Norfolk
Long-Term Hospital

	1996	1997	1998
Beds	104	104	104
Patient Days	18,158	19,628	21,024
Average Annual Occupancy Rate	47.7%	51.7%	55.4%
Average Length of Stay (Days)	109	134	117

Medicare announced plans in 1997 to move long-term hospital reimbursement in the direction of a DRG or resource utilization group system of payment but no specific methodology has been finalized and no timetable for the transition to a new payment model has been established. Such a change may weaken the financial incentives for development of these types of hospitals. VDH anticipates receiving at least one proposal for development of a long-term hospital in FY00, based on pre-application discussions with potential applicants.

Options: The following options are available for consideration with their resultant impact:

No Change: This option would likely be supported by nursing facility providers. Hospitals may take no position since many already have nursing facility beds and would want to protect their status; however other hospitals may see this as an opportunity to convert unused beds for a new service which is not under PPS.

Minimal Change: DCOPN could issue a RFA for additional beds based on a collaborative review with affected parties to determine need and location of additional beds.

Deregulation: The deregulation of these services could potentially have an adverse effect on general hospitals and nursing facilities if LTC facilities substitute for hospitals or nursing facility placement. Nursing facilities and general hospitals with LTC beds might see a reduction in current occupancy due to increased beds. However some general hospitals may welcome the opportunity to develop a new service to replace unused beds. The incentive to initiate a service that is reimbursed on a cost basis versus PPS would be attractive to providers if indeed there is a

true need for additional beds. There may also be an increase in Medicare expenditure for the more costly hospitalization that is not reimbursed under PPS.

Discussion of Recommendation: Virginia's historic emphasis on the development of long-term care facilities at the lower end of the acuity and cost spectrum has translated into lower levels of Medicare and Medicaid expenditure without jeopardizing the viability of the state's acute care hospitals. Allowing deregulation of these facilities could potentially have an adverse effect on general hospitals and nursing facilities, though experience in other states has not shown adverse effects.

RECOMMENDATION: Virginia could continue to regulate the establishment of long-term hospitals, but deregulation is a viable option for discussion among involved parties.

Nursing Homes and Nursing Facilities

The establishment and expansion of nursing facilities has been subject to COPN regulation since the program's inception in 1973. This was approximately 8 years after the establishment of the Medicare and Medicaid programs. These public programs, created in the mid-1960s, especially with regard to Medicaid, made the development of today's nursing home industry possible.

Medicaid is the largest single payor for nursing facility care, paying for approximately 66 percent of the nursing facility patient days in Virginia. Medicaid pays for an unlimited number of nursing facility patient days for indigent patients requiring such care. Nursing facility care consumed 17.5% of Medicaid expenditures in FY1998, approximately $410 million.

Medicare reimbursement for nursing facility services is more limited, in terms of types of care and days of payment. Medicare accounts for less than 10 percent of nursing facility patient days in Virginia although some facilities which orient themselves to serving the Medicare market may have a much larger proportion of such patients.

Medicaid pays for nursing facility care on the basis of reported costs and Medicaid reimbursement is, in most cases, substantially lower than the market prices that nursing facilities can command from the limited private payment segment of the market. Limiting bed supply is supposed to result in higher average bed occupancy rates which result in lower per day costs than the lower bed occupancy rates that would occur in an unregulated environment. In addition, because of the reimbursement differential between Medicaid and the private payor, lower bed occupancy is likely to result in more intensive competition for the private paying patient. Such competition may have a pricing dimension, which would force nursing home operators to seek cost efficiencies. Bed oversupply may also tend to create a higher level of "tiering" of nursing facilities within a locality or region, in which some facilities dominate the private paying market segment and the balance of facilities exclusively serve or nearly exclusively serve the Medicaid population. However, a recent study of states that have deregulated nursing homes has not shown an increase in beds or costs.

Virginia has been relatively successful in maintaining high levels of nursing facility bed occupancy although a measure of this success has been due to two legislatively-imposed moratoria on the issuance of COPNs that increase nursing facility bed supply. Virginia has higher average annual bed occupancy, lower levels of Medicaid expenditure, and a richer supply of non-nursing facility long-term care residential alternatives than most states. High occupancy does also mean decreased flexibility in finding space for patients when nursing homes close for financial reasons or are terminated for quality care problems.

Nursing Facility Utilization - Virginia 1980-1998

	1980	1985	1990	1995	1996	1997	1998
Beds	19,459	22,584	26,647	30,816	30,913	31,174	31,383
Patient Days	6,666,186	7,946,406	9,084,229	10,574,271	10,585,228	10,486,866	10,428,140
Avg. Annual Occupancy Rate	93.6%	96.4%	93.4%	94.0%	93.6%	92.2%	91.0%

The population of Virginia has been decreasing its use of nursing facilities in recent years. A variety of reasons have been put forth for this decline in per capita demand. The better general health of the state's elderly population, which would tend to decrease or delay use of nursing facilities and the rise of alternative long-term care facilities, such as adult care residences, are cited by most observers as the primary factor in falling use rates. Until the latter half of this decade, this decline in use rates had merely slowed growth in nursing facility bed utilization. In the last two years, it has resulted in actual declines in the volume of nursing facility patient days demanded. (See above table.) As the baby boom generation enters the age of high nursing facility use in the next century, it seems unlikely that this recent trend in declining real demand for nursing facility patient days will continue long term, even if population use rates continue to decline.

Medicare reimbursement for nursing facility care is in a process of reform which began in 1997 and will eventually eliminate all vestiges of cost-based reimbursement. These changes are creating concerns for many nursing facilities that specialized in the care of Medicare patients, such as general hospital nursing facility units and other providers of nursing facility care with a rehabilitative or specialized service orientation.

Medicaid reimbursement reform could have the effect of eliminating or decreasing the program's cost exposure to lower levels of bed occupancy. However, such payment reform is unlikely to eliminate all concerns with respect to bed supply. Even if Medicaid changes to pay nursing facilities on some prospectively determined basis, bed oversupply will result in higher nursing facility cost for providers. Given Medicaid's dominant position as a payor for nursing facility care, investors will not want to overbuild these facilities.

Options: The following options are available for consideration with their resultant impact:

No Change: This option would likely be supported by nursing homes and facilities. A recent study demonstrates that there is no projected need for additional nursing home beds in 2001 except in PD 4 directly in response to SB 2080. The RFA process recently approved an additional 1440 nursing facility beds throughout the state based on a determined need. Nursing homes have experienced a decreasing occupancy with the ACR industry attracting or reducing the need for nursing home placement. The hospital industry may take no position due to differing views of their constituency.

Minimal Change: DCOPN could issue a RFA for targeted areas that do not show need in 2001, but would receive special attention due to rural considerations.

Deregulation: The Virginia Health Care Association would vehemently oppose this option stating that a surplus of beds would increase Medicaid costs and further weaken their profitability. The Virginia Association of Nonprofit Homes for Adults has voiced support for deregulation. Advocates may welcome this option because it would provide more choice for consumers and the free market would promote quality services. The explosion of Adult Care Residences is defacto competition. These changing factors for nursing homes have changed the impact of potential deregulation. As the recent study has shown deregulation has not increased beds or costs.

RECOMMENDATION: Virginia should consider discussions of deregulation in light of recent changes in the nursing home industry and studies of the effect deregulation in other states.

Medical Rehabilitation

As in the case of long-term hospitals, the establishment of Medicare PPS in the 1980's, created a strong financial incentive for the development of medical rehabilitation hospitals and medical rehabilitation units of general hospitals. By exempting medical rehabilitation from prospective payment and continuing to reimburse for this type of care on a cost basis, Medicare encouraged hospitals to substitute medical rehabilitation for general acute care and nursing facility care, which can also be used as a setting for rehabilitative therapy but is usually less lucrative for the hospital and may be less desirable in the view of the patient and physician.

The power of this incentive was recognized by the Virginia General Assembly when it retained COPN regulatory coverage of the introduction of medical rehabilitation services in the 1989 amendments to the COPN law, amendments that deregulated almost every other specific category of clinical service in the state. However, this statutory mandate was largely ignored from 1989 to 1991 and several PPS-exempt medical rehabilitation units were allowed to develop without COPN authorization.

Unlike the case of long-term hospital services, Virginia has not escaped the explosive growth in medical rehabilitation use and bed capacity. In the past twelve years, seven new medical rehabilitation hospitals or hospital units have been created in Virginia, an increase of 64%. The number of medical rehabilitation beds has increased by 204 during the same period, an increase of 44%. As shown in the following chart, in 1998, the state's medical rehabilitation beds were utilized at an average annual occupancy rate of 67.5%.

Medical Rehabilitation Facilities - Virginia - 1998

Health Planning Region	Planning District	Facility	Beds	Patient Discharges	Patient Days	AAOR	ALOS (Days)
I	6	Augusta Medical Center Augusta County	8	84	1,523	52.2%	16.7
	7	Winchester Rehabilitation Center Winchester	30	496	6,772	61.8%	13.1
	10	University of Virginia/HealthSouth Rehabilitation Hospital Charlottesville	50	485	10,283	56.3%	20.2
	10	University of Virginia Kluge Childrens Rehabilitation Center Charlottesville	26	89	2,664	28.1%	31.2
II	8	Inova Mount Vernon Hospital Fairfax County	59	NR	17,272	80.2%	NR
	8	Pentagon City Hospital Arlington County	50	431	5,361	29.4%	12.4
III	1	Lee County Community Hospital Lee County	5	NR	NR	NR	NR
	2	Clinch Valley Medical Center Tazewell County	20	188	2.401	32.9%	12.8
	5	Lewis-Gale Hospital Salem	35	600	12,163	95.2%	20.3
	5	Carilion Roanoke Memorial Hospital Roanoke	28	NR	7,829	76.6%	NR
	11	Virginia Baptist Hospital Lynchburg	20	279	5,398	73.9%	NR

Medical Rehabilitation Facilities – Virginia – 1998

Health Planning Region	Planning District	Facility	Beds	Patient Discharges	Patient Days	AAOR	ALOS (Days)
	12	Danville Regional Medical Center Danville	10	187	2,245	61.5%	NR
IV	15	Children's Hospital Richmond	16	70	1,077	18.4%	15.0
	15	Cumberland Hospital New Kent County	52	132	14,492	76.4%	119.2
	15	HealthSouth Medical Center Henrico County	36	582	7,998	60.9%	13.5
	15	HealthSouth Rehabilitation Hospital of Virginia Henrico County	40	NR	12,066	82.6%	NR
	15	Johnston-Willis Hospital Chesterfield County	34	677	11,368	91.6%	17.2
	15	Medical College of Virginia Hospitals Richmond	46	729	12,371	73.7%	17.3
	15	Sheltering Arms Hospital Hanover County	40	1,041	12,540	85.9%	12.1
V	18	Riverside Tappahannock Hospital Essex County	6	43	286	13.1%	NR
	20	Bon Secours DePaul Medical Center Norfolk	14	260	4,176	81.7%	16.1
	20	Bon Secours Portsmouth General Hospital Portsmouth	25	422	6,629	72.6%	16.2
	20	Sentara Norfolk General Hospital Norfolk	36	534	9,864	75.1%	18.4
	21	Riverside Rehabilitation Institute Newport News	75	1,016	17,121	62.5%	17.2
Virginia			**751**	**8,345**	**183,899**	**67.5%**	**17.9**

Next year, Medicare plans to begin phasing in a prospective payment system for medical rehabilitation based on the average cost of a course of rehabilitative hospitalization for particular categories of patients and assessments of the case mix of individual hospitals or distinct-part units of hospitals.

Options: The following options are available for consideration with their resultant impact:

No Change: The hospital industry would support this option because the state's medical rehabilitation beds were utilized at an average annual occupancy rate of 67.5% and additional beds would serve to further depress the occupancy.

Minimal Change: In collaboration with the hospital industry, consumers and advocates, DCOPN could study projected need and perhaps target specific planning districts for a limited number of beds, issuing a RFA.

Deregulation: The financial incentive to initiate these services is being reduced with Medicare plans to begin phasing in a PPS for medical rehabilitation based on the average cost of a course of rehabilitative hospitalization. Therefore deregulation may have no impact since the removal of attractive reimbursement for these services is being removed. However, those hospitals with existing services would be threatened at the prospect of reduced reimbursement and further competition to maintain occupancy at 67.5%. Deregulation is not likely to create a significant increase in new beds if the services are not demanded. The market is a better indicator of the need to expand beds and services. The total Medicaid expenditures for institutional rehabilitation services in 1997 were $12 million. There are a limited number of Medicaid recipients who require these services. There must be approval for these services as "medically necessary." Therefore, simply building more facilities will not increase Medicaid expenditures. If beds are increased, expenditures will simply be spread among participating providers.

RECOMMENDATION: Virginia could continue to regulate the establishment of medical rehabilitation hospitals, the introduction of medical rehabilitation units in general hospitals, and the expansion of existing medical rehabilitation units. Again, deregulation appears to be a more viable option than in the past and could be discussed.

Mental Retardation Facilities

The use of COPN regulation of the supply of ICF/MRs and ICF/MR beds has supported a DMHMRSAS policy that discourages the development of ICF/MRs generally on the basis that this facility model will unnecessarily increase the cost of appropriately housing and training mentally retarded persons in need of a supervised living environment. VDH has adopted regulatory standards which only allow for development of small (four or fewer beds) ICF/MRs.

Since 1992, establishment of only one new ICF/MR has been authorized and expansion of two existing facilities has also been approved. No proposed ICF/MRs have been denied although several proposed projects not consistent with the review standards have been filed and subsequently withdrawn after negative preliminary reviews by DCOPN and DMHMRSAS staff.

Options: The following options are available for consideration with their resultant impact:

No Change: The DMHMRSAS would support this position. Their policy has been to discourage the development of ICF/MRs. Advocates may state consumers need more choices

and flexibility that additional beds would provide. The trend to de-institutionalize mental health facilities supports restriction of new facilities that would generate additional costs.

Minimal Change: Place granting of ICF/MRs COPNs under the RFA process. The DCOPN in collaboration with DMHMRSAS could review need and target specific locations to issue a RFA for additional beds.

Deregulation: Advocates may welcome this option to provide greater choices to consumers.

Discussion: VDH defers to DMHMRSAS with respect to appropriate statewide policy on the supply of ICF/MR facilities. VDH is working with DMHMRSAS policy of ICF/MRs. Currently there is an adequate supply and diminishing demand for additional beds. COPN regulations could be retained to ensure this. Conversely diminished demand could also be seen as obviating the need for COPN regulations.

RECOMMENDATION: Virginia could continue to regulate the establishment and expansion of ICF/MRs.

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HEALTH CARE MARKET REFORM

"Managed care" organizations have become the organizational framework of the U.S. health care system in the past ten years. The emergence of payment reforms which would control utilization and reduce investment in capital resources was viewed in Virginia in the late 1980s as a basis for eliminating COPN regulation. Studies undertaken in 1987 led to legislation in 1988 and 1989 that eliminated most controls on capital spending and "sunset" all non-nursing facility COPN regulation within two years. This deregulatory initiative was aborted in 1992.

Using 1986 as a benchmark, the year before the policy studies which indicated no further need for COPN regulation, it can be seen, as illustrated in the table that follows, that the managed care "revolution" of the past 12 years has not, for the most part, had the effect of reducing demand for the expensive forms of medical care regulated under the COPN program. This suggests that managed care, in its current form, is unlikely to address the single most important factor in medical cost inflation. Recent developments in the managed care field, including substantially higher rate increases, financial losses among managed care plans, and the retreat from Medicare risk contracts, and the legislative and regulatory backlash on the utilization controls that have been implemented, bolster this outlook.

Selected Facility and Service Utilization and Use Rates
Virginia - 1986-1998

	1986	1998
Hospital beds/1,000 population	4.1	3.0
Hospital patient days/1,000 population	1,039	570
Average annual occupancy rate of hospital beds	69.5%	52.2%
Neonatal special care units (NSCU)/100,000 population	.48	.75
Level 4 NSCU/100,000 population	.17	.09
Level 2 and 3 NSCU/100,000 population	.31	.66
Medical rehabilitation programs/100,000 population	.2	.4
Medical rehabilitation patient days/1,000 population	15.1	26.9
Average annual occupancy rate of medical rehabilitation beds	52.1%	67.5%
Cardiac catheterization laboratories/100,000 population	.5	1.2
Cardiac catheterization procedures/1,000 population	3.3	9.4
Cardiac catheterization procedures/laboratory	714	815
Open-heart surgery programs/100,000 population	.2	.3
Open-heart surgery procedures/1,000 population	.8	1.4
Open-heart surgery procedures/program	224	521
Megavoltage radiation therapy units (MRT)/100,000 population	.6	.7
MRT procedures/1,000 population	33.6	43.7
MRT procedures/unit	5,953	5,850
Extracorporeal shock-wave lithotripsy (ESWL) units/100,000 population	.1	.2
ESWL procedures/100,000 population	40.4	69.5
ESWL procedures/unit	337	339
Computed tomography (CT) units/100,000 population	1.2	2.1
CT procedures/1,000 population	36.6	90.5
CT procedures/unit	3,104	4,405*
Magnetic resonance imaging (MRI) units/100,000 population	.3	1.3
MRI procedures/1,000 population	1.8**	41.0
MRI procedures/unit	691**	3,147*

Medical Rehabilitation Facilities - Virginia - 1998

	1986	1998
Operating rooms /100,000 population	11.3	13.4
Operating room visits (ORV)/1,000 population	86.4	104.5
ORV/operating room	733	780
Nursing facility beds/1,000 population	4.1	4.6
Nursing facility patient days/1,000 population	1,442	1,527
Average annual occupancy rate of nursing facility beds	95.6%	91.0%

*Hospital-based

**Estimate based on partial data

Since 1995, VDH has supported changes in the scope of COPN regulation that focus the program on new facility and service development or expansions of service capacity while reducing regulation of replacements and renovations.

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ACCESSIBILITY BY THE INDIGENT TO CARE PROVIDED BY REGULATED MEDICAL CARE FACILITIES

COPN regulation can limit the development of medical care facilities that siphon off the most profitable segments of a hospital's market. Such action can be viewed in two contrasting ways; as unhealthy protectionism, allowing hospitals to grow unresponsive to the discipline imposed by the competitive marketplace or, in the alternative, as a socially responsible mechanism for rationally allocating limited resources which has the positive side-effect of assisting hospitals in maintaining their ability to fund uncompensated care to the indigent.

In practice, VDH has tended toward the latter view in its administration of the COPN program. This is a defensible position for reasons other than concern for the poor or for the health and wealth of hospitals. Evidence from international comparisons of medical care organization and spending in the United States and other developed countries strongly suggest that the higher level of investment in sophisticated medical care facilities and services that has occurred in the U.S. is a major factor in the unparalleled level of medical care spending in this country.

Hospitals represent a source of charitable medical care for the indigent who lack third party payor coverage and other persons who may have difficulty in obtaining care from other sources. It is prudent to consider the impact that altered market conditions may have on competitive behavior and the levels of cooperation among providers in meeting community needs. Virginia, like most states, has not succeeded in using COPN-style regulation to substantially control facilities development and expansion or the proliferation of medical technology. In the end, differences in the pattern of medical facilities development among states with and without COPN-style regulation are fairly marginal.

From 1993 to July, 1999, 64 certificates have been conditioned on the provision of a minimal level of charity care. The projected dollar value of the charity care to be provided by these conditioned certificate holders and their reported compliance with these conditions is profiled in Appendix G.

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QUALITY OF CARE IN REGULATED MEDICAL CARE FACILITIES

Previous studies of the COPN program found that it played a role in promoting better care outcomes by stressing the necessity for certain service programs established by medical care facilities, such as open-heart surgery, to have sufficient patient and service volume.

More broadly, COPN can be viewed as promoting quality of medical care in the following ways:

- Regulating the distribution of medical care facilities can assure appropriate access to care;
- Regulating the number of certain types of facilities or programs can assure that those programs will achieve service volumes necessary for competent and technically proficient delivery of the service;
- Regulating the characteristics of a proposed facility or program can assure that it is appropriately designed and staffed;
- By acting as a competitive mechanism for the awarding of medical facility franchises (when such franchising is considered to be in the public interest), it can assure that the prospective franchise holders have an acceptable track record in the provision of quality of care.

The utility of COPN is limited with respect to ongoing evaluation of care process, care outcomes, and patient satisfaction.

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RECOMMENDATION SUMMARY

- VDH does recommend recognizing the many changes in health care utilization and financing as well as recent studies showing no increase in beds or cost in states that have deregulated COPN.
- Virginia could continue to regulate the establishment of long-term hospitals, but deregulation is a viable option for discussion among involved parties.
- Virginia should consider discussions of deregulation in light of recent changes in the nursing home industry and studies of the effect deregulation in other states.
- Virginia could continue to regulate the establishment of medical rehabilitation hospitals, the introduction of medical rehabilitation units in general hospitals, and the expansion of existing medical rehabilitation units. Again, deregulation appears to be a more viable option than in the past and could be discussed.
- Virginia could continue to regulate the establishment and expansion of ICF/MRs.

APPENDIX A

§ 32.1-102.12. Report Required.

The Commissioner shall annually report to the Governor and the General Assembly on the status of Virginia's certificate of public need program. The report shall be issued by October 1 of each year and shall include, but need not be limited to:

1. A summary of the Commissioner's actions during the previous fiscal year pursuant to this article;

2. A five-year schedule for analysis of all project categories which provides for analysis of at least three project categories per year;

3. An analysis of the appropriateness of continuing the certificate of public need program for at least three project categories in accordance with the five year schedule fo analysis of all project categories;

4. An analysis of the effectiveness of the application review procedures used by the health systems agencies and the Department required by § 32.1-102.6 which details the review time required during the past year for various project categories, the number of contested or opposed applications and the project categories of these contested or opposed projects, the number of applications upon which the health systems agencies have failed to act in accordance with the timelines of § 32.1-102.6 B, and the number of deemed approvals from the Department because of their failure to comply with the timelines required by § 32.1-102.6 E, and any other data determined by the Commissioner to be relevant to the efficient operations of the program;

5. An analysis of health care market reform in the Commonwealth and the extent, if any, to which such reform obviates the need for the certificate of public need program;

6. An analysis of the accessibility by the indigent to care provided by the medical care facilities regulated pursuant to this article and the relevance of this article to such access; and

7. An analysis of the relevance of this article to the quality of care provided by medical care facilities regulated pursuant to this article; and

8. An analysis of equipment registrations required pursuant to § 32.1-102.1:1, including the type of equipment, whether an addition or replacement, and the equipment costs.

APPENDIX B

SCOPE OF COPN REGULATION EFFECTIVE OCTOBER 1, 1999 (Va. Code § 32.1-102.1)

"Project" means:

1. Establishment of a medical care facility;
2. An increase in the total number of beds or operating rooms in an existing medical care facility;
3. Relocation at the same site of ten beds or ten percent of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of ten percent of its beds as nursing home beds as provided in § 32.1-132;
4. Introduction into an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided;
5. Introduction into an existing medical care facility of any new cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), medical rehabilitation, neonatal special care, obstetrical, open heart surgery, positron emission tomographic (PET) scanning, psychiatric, organ or tissue transplant service, radiation therapy, nuclear medicine imaging, substance abuse treatment, or such other specialty clinical services as may be designated by the Board by regulation, which the facility has never provided or has not provided in the previous twelve months;
6. Conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds;
7. The addition by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, or other specialized service designated by the Board by regulation. Replacement of existing equipment shall not require a certificate of public need; or
8. Any capital expenditure of five million dollars or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. However, capital expenditures between one and five million dollars shall be registered with the Commissioner pursuant to regulations developed by the Board.

APPENDIX C

COPN DECISIONS FY1999

Project Category	*Capital Expenditure*	
ESTABLISHMENT OF MEDICAL FACILITIES		
27 TOTAL DECISIONS		
10 APPROVALS		
8 NURSING FACILITIES	$37,437,980	
2 COMPUTED TOMOGRAPHY (CT) FACILITIES	$2,124,477	
Subtotal		$39,562,457
17 DENIALS		
12 NURSING FACILITIES	$61,780,140	
3 OUTPATIENT SURGICAL HOSPITALS	$6,747,402	
1 RADIATION THERAPY FACILITY	$2,821,298	
1 MAGNETIC RESONANCE IMAGING (MRI) FACILITY	$1,709,059	
Subtotal		$73,057,899
ADDITION OF BEDS TO AN EXISTING FACILITY		
24 TOTAL DECISIONS		
14 APPROVALS		
628 NURSING FACILITY BEDS	$47,441,511	
Subtotal		$47,441,511
10 DENIALS		
633 NURSING FACILITY BEDS	$35,580,996	
Subtotal		$35,580,996
ADDITION OF OPERATING ROOMS TO AN EXISTING FACILITY		
2 TOTAL DECISIONS		
2 APPROVALS	$6,100,710	
Subtotal		$6,100,710

INTRODUCTION OF NEW SERVICES BY AN EXISTING FACILITY

6 TOTAL DECISIONS

4 APPROVALS		
NURSING FACILITY SERVICES (2)	$924,076	
STEREOTACTIC RADIOSURGERY	$317,710	
MRI	$2,355,949	
Subtotal		$3,597,735
2 DENIALS		
RADIATION THERAPY	$3,180,982	
CARDIAC CATHETERIZATION	$0	
Subtotal		$3,180,982

ADDITION OF MEDICAL EQUIPMENT BY AN EXISTING FACILITY

7 TOTAL DECISIONS

6 APPROVALS		
CARDIAC CATHETERIZATION (2)	$2,020,763	
CT (2)	$937,000	
MRI	$1,246,653	
RADIATION THERAPY	$2,007,963	
Subtotal		$6,212,379
1 DENIAL		
MRI	$1,797,750	
Subtotal		$1,797,679

REPLACEMENT OF MEDICAL EQUIPMENT BY AN EXISTING FACILITY

8 TOTAL DECISIONS

8 APPROVALS		
CT (3)	$2,002,261	
CARDIAC CATHETERIZATION (3)	$3,007,690	
RADIATION THERAPY (2)	$3,885,318	
Subtotal		$8,895,269

MISCELLANEOUS CAPITAL EXPENDITURES BY EXISTING FACILITIES

5 TOTAL DECISIONS

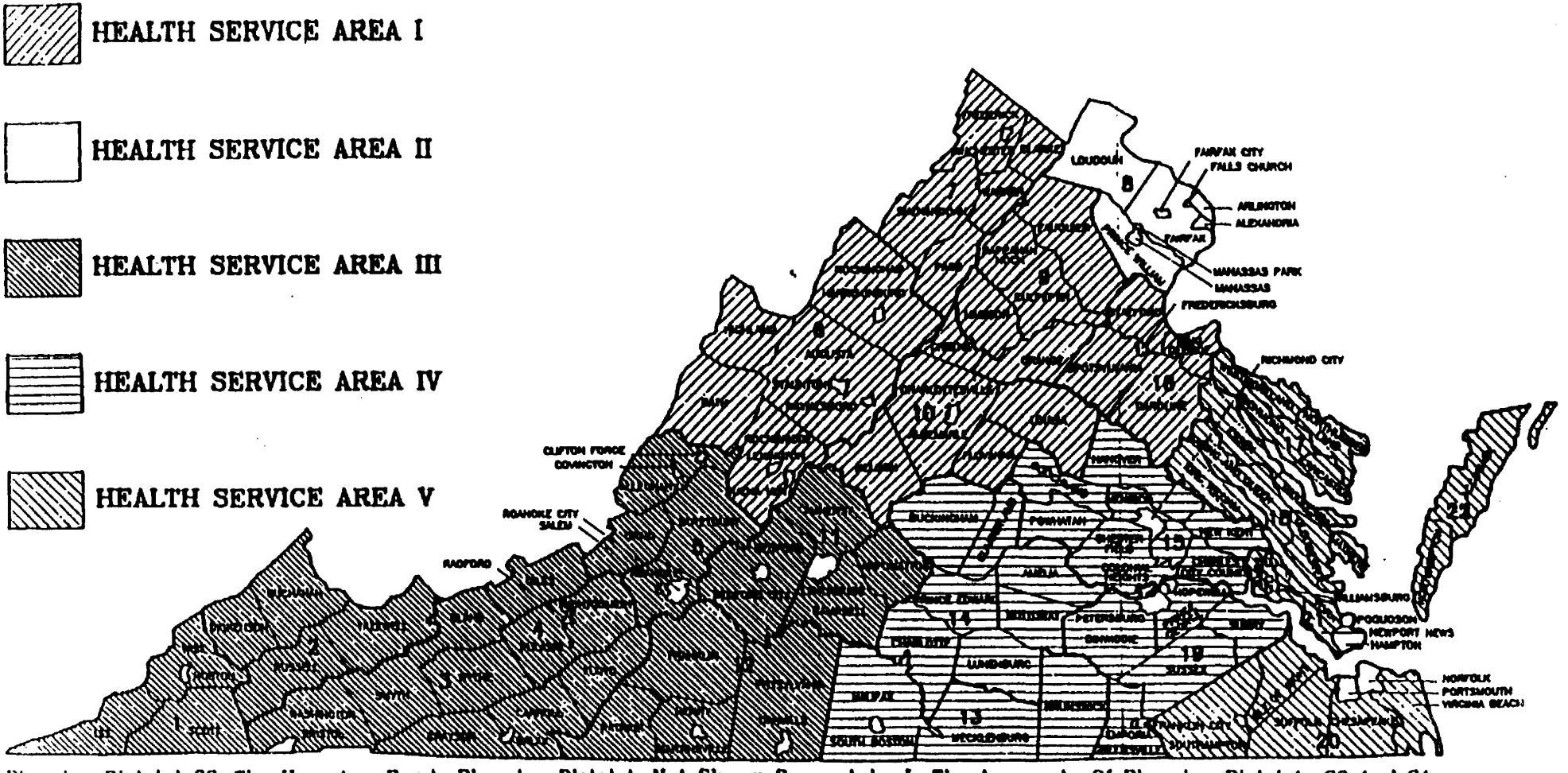
5 APPROVALS

HOSPITAL INFORMATION SYSTEMS (2)	$87,800,000	
HOSPITAL EXPANSION/RENOVATION (2)	$43,464,319	
HOSPITAL PARKING	$9,352,576	
Subtotal		$140,616,895

SUMMARY

79 DECISIONS	**$366,044,532**
49 APPROVALS OR CONDITIONAL APPROVALS	**$252,426,976**
30 DENIALS	**$113,617,556**

COMMONWEALTH OF VIRGINIA
PLANNING DISTRICTS AND
HEALTH SERVICE AREAS



Planning District 23, The Hampton Roads Planning District, Not Shown Separately, Is The Aggregate Of Planning Districts 20 And 21.

SOURCE: Virginia Center For Health Statistics

APPENDIX E
DCOPN Recommendations Issued in Fiscal Year 1999
for Projects Considered within the Standard Review Cycle (120 days)

Request No.	Project Description	Due Date for DCOPN Report	Date DCOPN Report Issued	No. of Days Late	Date of IFFC	Date of Final Decision	No. of Days Late
6181	Establish an outpatient surgical hospital	05/19/98	07/07/98	49	10/28/98	08/17/99	405
6168	Add an operating room (mobile)	06/13/98	07/09/98	26	08/13/98	07/08/99	271
6140	Add radiation therapy equipment	03/21/98	07/13/98	114	NA	08/03/98	85
6079	Replace cardiac catheterization equipment	05/19/98	07/21/98	63	NA	09/11/98	65
6203	Establish an outpatient surgical hospital	05/19/98	07/22/98	64	TBA		
6220	Add CT equipment	07/19/98	07/23/98	4	NA	08/06/98	0
6226	Replace CT equipment	07/19/98	07/23/98	4	NA	08/31/98	0
6097	Add MRI equipment	07/19/98	09/02/98	45	NA	09/14/98	7
6222	Establish a specialized center for MRI	07/19/98	09/02/98	45	11/20/98	07/08/99	304
6232	Establish a specialized center for CT	07/19/98	09/02/98	45	NA	11/06/98	60
6182	Replace cardiac catheterization equipment	05/19/98	09/02/98	76	10/22/98	02/02/99	209
6233	Establish a nursing facility	07/19/98	09/03/98	46	NA	09/30/98	23
6221	Establish a specialized center for MRI	07/19/98	09/08/98	51	12/16/98	04/06/99	211
6230	Add MRI equipment	07/19/98	09/09/98	52	NA	09/14/98	7
6234	Replace radiation therapy equipment	09/19/98	09/25/98	6	NA	10/07/98	0
6092	Establish a specialized center for CT	07/19/98	09/25/98	55	NA	09/17/98	10
6227	Introduce nursing facility services	07/19/98	10/19/98	92	01/26/99	06/02/99	268
6215	Establish a nursing facility	11/19/98	11/19/98	0	NA	11/23/98	0
6245	Establish a general hospital	10/19/98	11/19/98	31	TBA		
6240	Replace radiation therapy equipment	09/19/98	11/19/98	61	NA	12/07/98	30
6207	Add cardiac catheterization equipment	11/19/98	11/20/98	1	NA	12/07/98	0
6236	Add nursing facility beds	11/19/98	11/23/98	4	NA	12/04/98	0
6243	Expand/renovate a general hospital	10/19/98	11/23/98	35	NA	12/01/98	0
6072	Establish an outpatient surgical hospital	11/19/98	11/25/98	6	01/25/99	02/22/99	45
6205	Add operating rooms	11/19/98	11/25/98	6	01/25/99	02/22/99	45
6212	Add nursing facility beds	11/19/98	12/02/98	14	NA	12/23/98	0
6260	Intro open-hrt surgery & add operatng rms	11/19/98	12/15/98	27	TBA		
6253	Introduce open-heart surgery	11/19/98	12/15/98	27	TBA		

DCOPN Recommendations Issued in Fiscal Year 1999 *Page 2*

Request No.	Project Description	Due Date for DCOPN Report	Date DCOPN Report Issued	No. of Days Late	Date of IFFC	Date of Final Decision	No. of Days Late
6254	Add cardiac catheterization equipment	11/19/98	12/15/98	27	TBA		
6261	Add operating rooms	11/19/98	12/15/98	27	TBA		
6250	Add operating rooms	11/19/98	12/16/98	28	NA	02/02/99	25
6251	Replace cardiac catheterization equipment	11/19/98	01/12/99	55	NA	Withdrawn	NA
6277	Add CT equipment	01/19/99	02/04/99	16	NA	04/08/99	29
6265	Introduce nursing facility services	01/19/99	02/19/99	31	NA	03/09/99	0
6264	Add nursing facility beds	01/19/99	02/22/99	34	05/03/99	No final	
6274	Establish a specialized center for MRI	01/19/99	02/23/99	35	TBA		
6288	Introduce nursing facility services	02/19/99	03/22/99	31	NA	Withdrawn	NA
6290	Add nursing facility beds	03/21/99	03/23/99	2	NA	05/21/99	11
6285	Add lithotripsy equipment	03/21/99	04/01/99	11	09/08/99		
6297	Computer system - general hospital	04/21/99	04/02/99	0	NA	04/07/99	0
6298	Computer system - general hospital	04/21/99	04/07/99	0	NA	04/23/99	0
6289	Add nursing facility beds	05/19/99	05/19/99	0	NA	05/28/99	0
6252	Introduce lithotripsy services	04/17/99	05/19/99	32	08/06/99	No final	
6305	Establish an outpatient surgical hospital	05/19/99	05/24/99	5	08/30/99		
6306	Establish an outpatient surgical hospital	05/19/99	05/24/99	5	08/30/99		
6303	Introduce liver transplantation services	05/19/99	06/01/99	12	09/28/99		
6299	Expand & renovate a general hospital	05/19/99	06/02/99	13	07/06/99	No final	
6318	Establish a nursing facility	06/19/99	06/16/99	0	NA	07/07/99	0

APPENDIX F

FIVE YEAR PROJECT CATEGORY GROUPING FOR ANNUAL REPORTS ON THE STATUS OF CERTIFICATE OF PUBLIC NEED

First Annual Report - 1997

Group 1 General hospitals, general surgery, specialized cardiac services and organ and tissue transplantation

- Establishment of a general hospital
- Establishment of an outpatient surgical hospital or specialized center or clinic or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery
- An increase in the number of operating rooms in an existing medical care facility
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of cardiac catheterization
- Introduction into an existing medical care facility of any new cardiac catheterization service
- Addition or replacement by an existing medical care facility of equipment for the provision of cardiac catheterization
- Introduction into an existing medical care facility of any new open heart surgery service
- Addition or replacement by an existing medical care facility of equipment for the provision of open heart surgery
- Introduction into an existing medical care facility of any new organ or tissue transplantation service

Second Annual Report - 1998

Group 2 Diagnostic Imaging

- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of computed tomography (CT)
- Introduction by an existing medical care facility of any new CT service
- Addition or replacement by an existing medical care facility of CT equipment
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of magnetic resonance imaging (MRI)
- Introduction by an existing medical care facility of any new MRI service
- Addition or replacement by an existing medical care facility of MRI equipment
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of magnetic source imaging (MSI)
- Introduction by an existing medical care facility of any new MSI service
- Addition or replacement by an existing medical care facility of MSI equipment
- Establishment of a specialized center or clinic or that portion of a physician's office

developed for the provision of nuclear medicine imaging

- Introduction by an existing medical care facility of any new nuclear medicine imaging service
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of positron emission tomography (PET)
- Introduction by an existing medical care facility of any new PET service
- Addition or replacement by an existing medical care facility of PET equipment

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Group 3 Medical rehabilitation, long-term care hospital services, nursing home services and mental retardation facilities

- Establishment of a medical rehabilitation hospital
- Introduction by an existing medical care facility of any new medical rehabilitation service
- Conversion of beds in an existing medical care facility to medical rehabilitation beds
- Establishment of a long-term care hospital
- Establishment of a nursing home
- Establishment of an intermediate care facility
- Establishment of an extended care facility
- Introduction by an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided
- Establishment of a mental retardation facility

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Group 4 Radiation therapy, lithotripsy, obstetrical services and neonatal special care

- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of radiation therapy, including gamma knife surgery
- Introduction into an existing medical care facility of any new radiation therapy, including gamma knife surgery, service
- Addition or replacement by an existing medical care facility of equipment for the provision of radiation therapy, including gamma knife surgery
- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of lithotripsy
- Introduction into an existing medical care facility of any new lithotripsy service
- Addition or replacement by an existing medical care facility of equipment for the provision of lithotripsy
- Establishment of an outpatient maternity hospital (non-general hospital birthing center)
- Introduction into an existing medical care facility of any new obstetrical service
- Introduction into an existing medical care facility of any new neonatal special care service

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Group 5 Psychiatric services, substance abuse treatment services and miscellaneous capital expenditures

- Establishment of a sanitarium
- Establishment of a mental hospital
- Establishment of a psychiatric hospital
- Establishment of an intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts
- Introduction by an existing medical care facility of any new psychiatric service
- Introduction by an existing medical care facility of any new substance abuse treatment service
- Conversion of beds in an existing medical care facility to psychiatric beds
- Any capital expenditure of five million dollars or more, not defined as reviewable in subdivisions 1 through 7 of the definition of "project," by or in behalf of a medical care facility

APPENDIX G

CERTIFICATES OF PUBLIC NEED WITH CONDITIONS INVOLVING THE PROVISION OF FREE OR REDUCED RATE SERVICES TO THE INDIGENT (CHARITY CARE)

APPENDIX G

Updated: 8/25/99

COPNO		Applicant	Service	Project Complete	Report Filed Year 1	Report Filed Year 2	Report Filed Year 3	Free Care Required (% of Total Revenue)	Revenue Year 1	Value of Free Care Provided Year 1	Free Care as % of Revenue	Revenue Year 2	Value of Free Care Provided Year 2	Free Care as % of Revenue	Revenue Year 3	Value of Free Care Provided Year 3	Free Care as % of Revenue	Most Recent Action	Compliance Full	Compliance Part
3098	1	Retreat (Hanover)	Amb. Surgery	Jan-94	Yes	Yes	Yes	2.0%	$2,512,892	$5,465	0.2%	$3,188,002	$1,131	0.0%	$3,558,184	$1,294	0.0%	Noncompliance Notice 6/15		
3099	1	Urosurgery Hse.	Amb. Surgery	Feb '94	Yes	Yes	Yes	2.0%	$750,272	$9,361	3.9%	$640,060	$11,384	1.8%	$1,596,289	$22,366	1.4%	Note #1		
3175	1	Russell Co.Med.Ctr.	Obstetrical Srvs	June '95	Yes	Yes	Yes	Unspecified	$393,952	$0	0.0%	$563,551	$12,763	3.5%	$107,746	$0	0.0%	Noncompliance Notice 8/5		a
3176	1	Riverside Tapp.	Lithotripsy	June '95	Yes	Yes	Yes	2.0%											b	
3184	1	Lewis-Gale	CT	Aug '95	Yes	Yes	Yes	1.3%	$5,988,034	$29,024	0.5%	$7,319,982	$39,722	0.5%	$8,225,575	$18,304	0.2%	Noncompliance notice sent 7/1		
3185	1	Surgicare, Wash.	Amb. Surgery	Aug '95	Yes	Yes	Yes	0.7%	$4,534,975	$72,965	1.6%	$5,306,586	$104,826	2.0%	$5,880,144	$98,160	1.7%		a	
3195	1	Russell Co. MC	CT	July '95	Yes	Yes	No	1.3%	$1,141,281	$11,613	1.0%	$1,245,732	$19,782	1.6%				Condtn req See letter of 8/5		a
3197	1	Stonegate Jackson	CT	Nov '95	Yes	Yes	Yes	1.4%	$533,699	$7,210	1.4%	$563,052	$8,496	1.5%	$701,748	$10,006	1.4%		a	
3221	1	Culpeper Mem.	MRI	May '96	Yes*	Yes*	NA	1.8%	Not Reported	$1,001,983		Not Reported	$1,320,082					Noncompliance Notice 8/5		
3227	1	SMT Mobile	MRI	April '96	Yes*	No	NA	$10,000	Not Reported	$10,000								Noncompliance Notice DUE		
3230	1	Page Memorial	CT	Nov '96	Yes	Yes	Yes	1.6%	$540,950	$2,711	0.5%	$679,982	$30,271	4.5%	$711,654	$11,992	1.7%		a	
3245	1	Lewis-Gale	Rad. Therapy	Oct '96	Yes	Yes	NA	1.8%	$3,652,230	$19,131	0.5%	$4,188,417	$29,672	0.7%				Noncompliance notice sent 7/1		
3247	1	The Heart Cntr No. VA	Non. Medicine	Oct '96	Yes	Yes	Yes	2.0%	$333,069	$6,883	2.1%	$329,666	$14,494	4.4%	$493,310	$21,034	4.3%		a	
3252	1	Alliance @ Retreat	MRI	Nov '96	Yes*	No	NA	1.2%	Not Reported	$1,950								Noncompliance Notice DUE		
3253	1	Alliance Mobile	MRI	Nov '96	Yes*	No	NA	1.6%	Not Reported	$1,646								Noncompliance Notice DUE		
3271	1	SMT Greenville	MRI	April '96	Yes	Yes	NA	1.2%	$64,500	$641	1.0%	$77,795	$1,097	1.4%				Noncompliance Notice DUE		a
3272	1	SMT Southampton	MRI	April '96	Yes	Yes	NA	2.0%	$272,609	$4,314	1.6%	$292,403	$6,262	2.1%				Noncompliance Notice DUE		a
3274	1	SMT Community	MRI	April '96	Yes	Yes	NA	1.2%	$326,416	$3,152	0.9%	$363,804	$4,498	1.2%				Noncompliance Notice DUE		a
3275	1	SMT Martinsville	MRI	May '97	Yes	Yes	NA	1.8%	$760,696	$12,681	1.7%	$1,004,169	$19,719	2.0%				Noncompliance Notice DUE		a
3276	1	SMT Halifax	MRI	April '96	Yes	Yes	NA	1.2%	$327,734	$3,516	1.0%	$439,066	$6,084	1.4%					a	
3277	1	Retreat	CT	April-97	Yes	Yes	NA	1.2%	$1,840,816	$10,121	0.5%	$2,698,123	$7,045	0.3%				Noncompliance Notice 6/15		
3279	1	Johnston-Willis	Med. Rehab.	May '97	Yes	NA	NA	qus hsd	NA	NA	NA								a	
3280	1	McGuire Med. Grp.	CT	June '97	No	NA	NA	1.0%										Noncompliance Notice DUE		
3305	1	Comm. Mem.	ESWL	Sept '97	No	NA	NA	None										Noncompliance Notice DUE		
3309	1	St. Mary's Richmond	Cardiac Cath.	Oct '97	Yes*	NA	NA	1.7%	Not Reported	$324,929								Noncompliance Notice DUE		
3310	1	Russell Co.	ESWL	Nov '97	Yes	Yes	NA	1.8%	$64,674	$7,186	11.1%	$24,950	$14,970	60.0%				Ref. CON 3192 & letter of 8/5	a	
3313	1	St. Mary's Richmond	Non. Medicine	Dec '97	Yes*	NA	NA	1.7%	Not Reported	$21,393								Noncompliance Notice DUE		
3323	1	John Randolph	Non. Medicine	Jan '98	No	NA	NA	1.7%										NCN & AO Referral 6/29		
3324	1	John Randolph	MRI	Jan '98	No	NA	NA	1.7%										NCN & AO Referral 6/29		
3331	1	Ctr. For Hrt.	Non. Medicine	May '98	No	NA	NA	2.0%										Noncompliance Notice DUE		
3334	1	Lewis-Gale	Non. Medicine	April '98	NA	NA	NA	1.8%												
3353	1	HEALTHSOUTH	CT	April '98	NA	NA	NA	1.7%												

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3341	1	Sent. Cty. CV	Amb. Surgery	Feb '98	Yes	NA	NA	1.0%	$1,145,450	$15,282	1.3%							Noncompliance Notice 7/26		
3342	1	Western Leigh	MRI	June '98	NA	NA	NA	2.0%												
3345	1	SMT @ Hanover	MRI	April '97	Yes	NA	NA	1.2%	$122,331	$1,564	1.3%									
3346	1	SMT @ Allegheny	MRI	Aug '96	Yes	Yes	NA	1.9%	$290,300	$12,112	4.2%	$341,230	$14,830	4.3%						
3346	1	SMT @ Pulaski	MRI	Aug '98	NA	NA	NA	1.9%												
3334	1	Chester. CHCC	Amb. Surgery	Aug '98	NA	NA	NA	2.3%												
3336	1	First Meridian	MRI	Sept '98	NA	NA	NA	2.0%												
3337	1	Culpeper Mem.	CT	Sept '98	NA	NA	NA	2.9%												
3360	1	Henrico Doctors	CT	Sept '98	NA	NA	NA	1.7%												
3367	1	Buchanan Gen.	CT	Nov '98	NA	NA	NA	1.9%												
3369	1	Lee Co. Comm.	Psych.	Nov '98	NA	NA	NA	365days												
3373	1	Lewis-Gale	Cardiac Cath.	Jan '99	NA	NA	NA	1.9%												
3378	1	Sentara Leigh	Cardiac Cath.	Feb '99	NA	NA	NA	1.7%												
3388	1	No. Va. Imaging	MRI	June '99	NA	NA	NA	2.0%												
3389	1	Children's/KD	MRI	April '99	NA	NA	NA	1.7%												
3395	1	Va. Baptist	Rad. Therapy	June '99	NA	NA	NA	2.0%												
3400	1	Rockingham Mem.	MRI	June '99	NA	NA	NA	1.8%												
3402	1	Augusta MC	CT	Aug '99	NA	NA	NA	1.8%												
3403	1	Patrick Comm.	CT	Aug '99	NA	NA	NA	2.0%												
3408	1	SMT Mobile	MRI	Sept '99	NA	NA	NA	2.0%												
3409	1	Central Va. Imaging	CT	Sept '99	NA	NA	NA	2.0%												
3421	1	Williamsburg Comm.	CT	Jan'00	NA	NA	NA	1.2%												
3422	1	John Randolph	Cardiac Cath.	Jan '00	NA	NA	NA	1.7%												
3424	1	St. Mary's Rich.	General Surg.	Feb '00	NA	NA	NA	1.0%												
3426	1	Kaiser Permanente	Amb. Surgery	Feb '00	NA	NA	NA	0.8%												
3428	1	Southside Reg.	MRI	Mar '00	NA	NA	NA	1.7%												
3437	1	Rich Hme for Ladies	Nursing Home	April '00	NA	NA	NA	$230,000												
3382	1	Rockingham Mem.	Rad. Therapy	July '98	No	NA	NA	1.8%										Noncompliance Notice DUE		
3454	1	Surgi-Ctr., Central VA	Add OR	July '00	NA	NA	NA	2.0%												
3455	1	Snowden Services, Inc.	Amb. Surgery	July '00	NA	NA	NA	2.0%										Noncompliance Notice 7/30		
3348	1	Greenville Mem.	CT	Nov '97	No	NA	NA	2.4%										Noncompliance Notice DUE		
3436	1	IMI, Arlington, Inc.	MRI	Aug '00	NA	NA	NA	1.9%												
3458	1	Prince William Hospital	CT	Aug '00	NA	NA	NA	1.9%												

*Partial

Note #1: Virginia Urology Center reports compliance with the charity care condition in FY97 (2.8% of

CERTIFICATES OF PUBLIC NEED WITH CONDITIONS INVOLVING THE PROVISION OF FREE OR REDUCED RATE SERVICES TO THE INDIGENT (CHARITY CARE)

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OFR) and FY98 (6.3% of OFR), using internally generated reporting systems and the corporate audit files. The years shown above are FY94 thru FY96. On June 2, 1999, VUC was instructed to begin reporting facility-specific information on revenue and charity care to Virginia Health Information, consistent with its condition, beginning with the current fiscal year. VHI has also given them this instruction, at DCOPN's request.