REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

A PLAN TO ELIMINATE THE CERTIFICATE OF PUBLIC NEED PROGRAM PURSUANT TO SENATE BILL 337

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND
DECEMBER 2000

JOINT COMMISSION ON HEALTH CARE

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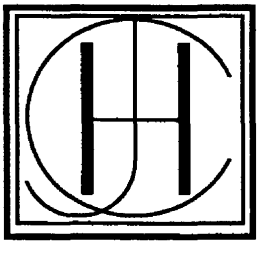

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I.
Authority For Report

Senate Bill 337 Of The 2000 Session Of The General Assembly Requires The Joint Commission on Health Care To Develop A Plan To Eliminate The Certificate of Public Need Program

The 2000 Session of the General Assembly passed Senate Bill (SB) 337 which calls for the elimination of the certificate of public need (COPN) program. The provisions of the bill require a transition period during which the program would be eliminated. The transition would begin on July 1, 2001, and would be completed by July 1, 2004. SB 337 further provides that the deregulation of the program would be in accordance with a plan to be developed by the Joint Commission on Health Care (JCHC). In developing the deregulation plan, the JCHC was directed to:

- work collaboratively with the Departments of Health, Medical Assistance Services, and Health Professions;
- seek input from all classes of health care consumers, providers, and representatives of health care facilities;
- include recommendations for legislative and administrative consideration to carry out the elimination of the COPN program; and
- submit the plan to the chairmen of the House Appropriations, Senate Finance, House Health, Welfare, and Institutions, and Senate Education and Health Committees on or before December 1, 2000 for review and approval by the 2001 Session of the General Assembly.

A copy of SB 337 is provided at Appendix A.

Organization of Report

This first section reviews the authority and legislative directive for the JCHC to develop a plan to eliminate the COPN program. Section II of the report discusses the key components that must be included in the deregulation plan, and describes the process used to develop the plan. Section III provides information regarding various aspects of Virginia's health care marketplace that form the basis for several of the recommendations included in the deregulation plan. Lastly, Section IV outlines the JCHC's recommended transition plan for eliminating the COPN program.

II.
Key Components To Be Included In Deregulation Plan; Process For Developing The Plan

The Commonwealth's COPN Program Is Authorized In Article 1.1, Chapter 4 Of Title 32.1 Of The *Code Of Virginia*

Section 32.1-102.1 et. seq. of the *Code of Virginia* establishes the Commonwealth's COPN program. The program requires that persons desiring to commence any project covered under the COPN program (e.g., hospital, nursing home, intermediate care facility, specialized center or clinic such as an ambulatory surgery center, and certain specialized equipment and services) must first obtain a COPN from the Commissioner of Health.

Over the last several years, numerous legislative proposals have been introduced to: (i) significantly limit the scope of the COPN program, (ii) eliminate certain projects from requiring a COPN, or (iii) eliminate the program altogether. As discussed in Section I of this report, SB 337 of the 2000 Session of the General Assembly directs the JCHC to develop a transition plan to eliminate the COPN program.

The Deregulation Plan To Be Completed By The JCHC Is Required To Include Several Key Components

SB 337 requires that the COPN deregulation plan developed by the JCHC address several health policy issues and concerns (see Figure 1).

Figure 1
Key Components To Be Included in the COPN Deregulation Plan As Required By SB 337

Section 32.1-102.13 of the Code of Virginia states that "The plan for deregulation to be developed by the Joint Commission on Health Care shall include, but need not be limited to, provisions for:"

- meeting the health care needs of the indigent citizens of the Commonwealth, including access to care and provision for all health care providers to share in meeting such needs;
- meeting the health care needs of the uninsured citizens of the Commonwealth, including access to care;
- establishing licensure standards for the various deregulated services, including whether nationally recognized accreditation standards may be adopted, to protect the public health and safety;
- providing for monitoring the effects of deregulation during the transition period and after full implementation of this section on the number and location of medical facilities and projects throughout the Commonwealth;
- determining the effect of deregulation of long-term care facilities and new hospitals with respect to the requirements for determination of need;
- determining the effect of deregulation on the unique mission of academic medical centers;
- determining the effect of deregulation on rural hospitals which are critical access hospitals;
- recommending a schedule for necessary statutory changes to implement the plan and for requiring, subject to approval of the General Assembly, that the appropriate regulatory boards promulgate regulations implementing the Commission's plan prior to any deregulation recommended in the plan; and
- considering the impact of deregulation on state-funded health care financing programs and examining the fiscal impact of such deregulation on the market rates paid by such financing programs.

Source: Senate Bill 337, 2000 Session of the General Assembly

The JCHC Formed a Subcommittee to Develop the COPN Deregulation Plan

Given the magnitude of the issues to be addressed in SB 337, the JCHC formed a subcommittee to develop the COPN deregulation plan. Figure 2 identifies the JCHC members who served on the COPN Subcommittee.

Figure 2

Members of JCHC Certificate of Public Need Subcommittee

Senator William T. Bolling (Chairman)
Senator J. Randy Forbes
Senator Benjamin J. Lambert, III
Senator Stephen H. Martin
Senator Linda T. Puller
Senator Kenneth W. Stolle

Delegate Robert H. Brink
Delegate L. Preston Bryant, Jr.
Delegate Jay W. DeBoer
Delegate Alan A. Diamonstein
Delegate Franklin P. Hall
Delegate Kenneth R. Melvin
Delegate Harvey B. Morgan

The Subcommittee held five meetings during the Summer and Fall to: (i) receive JCHC staff briefings on various issues regarding the deregulation process and plan; (ii) receive presentations from other state agencies and health care organizations on certain aspects of COPN deregulation; and (iii) decide on the specific provisions to be included in the deregulation plan. Figure 3 summarizes the activities of the COPN Subcommittee.

The COPN Subcommittee Established A Facilitation Process In Which Key Stakeholders And Other Interested Parties Worked To Reach Consensus On The Deregulation Plan

One of the critical activities of the Subcommittee was the establishment of a facilitation process in which key stakeholder groups and other interested parties were charged with trying to address and reach consensus on the provisions of the deregulation plan.

The principal objective of the facilitation process was to involve the parties affected by the deregulation of COPN in the development of the plan so that the final product not only would benefit from the expertise of each group, but also would be supported by each. Three "key stakeholders" were identified to participate in and provide support for the facilitation process: the Medical Society of Virginia (MSV), the Virginia Hospital & Healthcare Association (VHHA), and the Virginia Health Care

Figure 3

JCHC Certificate of Public Need Subcommittee Meetings And Activities

June 26 Meeting
- Overview of COPN legislative history *(JCHC staff presentation)*
- Description of current COPN program *(Presentation by Virginia Department of Health)*
- Views of key stakeholders on principles to be included in the plan *(Presentations by Virginia Hospital & Healthcare Association, Virginia Health Care Association, and Medical Society of Virginia)*

July 12 Meeting
- Public hearing *(Statements by interested parties)*
- Survey and analysis of COPN deregulation in other states *(JCHC staff presentation)*
- Analysis of indigent care burden and the uninsured population in Virginia *(JCHC staff presentation)*

September 13 Meeting
- Overview of Medicaid eligibility and provider payment levels *(JCHC staff presentation)*
- Impact of COPN deregulation on academic health centers *(Representatives of the Commonwealth's three academic health centers)*
- Impact of COPN deregulation on Medicaid nursing home budget *(Presentations by Virginia Health Care Association and DMAS)*

October 24 Meeting
- Presentation of proposed deregulation plan *(JCHC staff presentation)*

November 15 Meeting
- Summary of public comments on proposed deregulation plan *(JCHC staff presentation)*
- Subcommittee decisions on plan to be recommended to the full JCHC

Association (VHCA). Other health care organizations which participated in the facilitation included:

- Virginia Commonwealth University;
- University of Virginia;
- Virginia Chapter of the American College of Radiology;
- U.S. Oncology (Virginia Oncology Associates);

- Virginia Association of Health Plans;
- Virginia Poverty Law Center;
- Virginia Association of Regional Health Planning Agencies;
- Virginia Academy of Family Physicians; and
- Virginia Association of Nurse Anesthetists.

In addition to the health care organizations which participated in the facilitation process, the Virginia Department of Health (VDH) provided extensive staff support throughout the process. The Department of Medical Assistance Services, the Department of Health Professions, the State Council for Higher Education in Virginia, and the Office of the Attorney General attended some meetings.

The Process Was Directed By A Facilitator; Participating Groups Were Very Committed To The Process

The JCHC hired Barbara Hulburt of the McCammon Group (located in Richmond) to direct the facilitation process. The cost of the facilitator's services was shared by the JCHC and the key stakeholders (MSV, VHHA, and VHCA). All of the groups participating in the facilitation were very committed to the process, and devoted significant time and resources. Approximately 40 meetings were held between July 24th and October 17th to develop a consensus deregulation plan. The meetings were hosted by the three key stakeholder groups.

The overall approach taken during the facilitation was for the participating groups to identify all possible recommendations to be included in the deregulation plan with the understanding that the three key stakeholder groups would agree on a set of recommendations to include in the final plan presented to the COPN Subcommittee. As such, following approximately 35 meetings of the larger facilitation group, the key stakeholders met several times to review the recommendations and agree on a final deregulation proposal.

Several Workgroups Were Formed To Address Various Components Of The Deregulation Plan

As noted earlier in this section, SB 337 required that the deregulation plan include several components. Based on these requirements, four workgroups were formed among the facilitation participants: Access, Quality, Medical Education (Academic Health Centers), and Fair Payment/Funding. Figure 4 summarizes the key areas addressed by the facilitation workgroups.

Figure 4

Key Issues Addressed By Facilitation Workgroups

Access Workgroup
- Access to care for uninsured and indigent citizens
- All health care providers share in meeting the needs of indigent citizens

Quality Workgroup
- Licensure standards for deregulated services
- Adequate oversight of deregulated services to protect public health and safety

Medical Education (Academic Health Centers) Workgroup
- Impact of deregulation on academic health centers

Fair Payment/Funding Workgroup
- Impact of deregulation on state-funded health care financing programs
- Market rates paid by state-funded health care financing programs

Each of the workgroups met several times to develop recommendations in their respective areas to be included in the deregulation plan. The workgroups presented their respective recommendations to the full facilitation group in late September. As previously noted, following the meetings of the full facilitation group, the three key stakeholders then met on several occasions to determine which recommendations to include in the final plan. The key stakeholder groups included in the final plan presented to the COPN Subcommittee a significant majority of the recommendations made by the full facilitation group. However, some recommendations were not included in the final plan outlined in Section IV of this report. Among the workgroup recommendations not included in the final plan were: (i) increase Medicaid coverage for pregnant women from 133% of the federal poverty level (FPL) to 150% FPL; (ii) eliminate the deprivation requirement for Medicaid; (iii) study increasing the resource limit for Medicaid; (iv) increase state funding for the State and Local Hospitalization program; (v) provide $17.2 million towards graduate medical education; (vi) provide $10.8 million towards the cost of medical research; and (vii) increase

undergraduate medical education funding to the national average. The primary reason for not including many of these recommendations was the costs associated with the recommendation, and, consequently, the decreased likelihood of having the plan approved by the General Assembly. (The complete recommendations of the various workgroups are on file at the JCHC staff offices and are available for inspection by interested parties.)

The Deregulation Plan Proposed By The Facilitation Process Was Presented To The COPN Subcommittee; Public Comments Were Solicited On The Proposed Plan; Key Stakeholders, As Well As Many Other Groups Support The Consensus Deregulation Plan

The deregulation plan proposed by the facilitation process was presented to the COPN Subcommittee for its review. Following the presentation of the plan, public comments were solicited on the proposal. A total of 308 comments were received by JCHC staff. Most of the comments were generally supportive of the proposed plan. No one expressed clear opposition to the plan. However, various types of concerns were expressed by some respondents. Several of the hospitals/hospital systems commented that: (i) the funding provisions of the plan must be approved in order for the plan to be implemented, and (ii) the impact of each phase must be assessed before moving to the next phase. The regional health planning agencies expressed concern that the plan does not include several access improvements that had been recommended by the workgroups. A summary of all of the public comments is provided at Appendix B. (The original letters of comment are on file at the JCHC staff offices and are available for inspection by interested parties.)

The deregulation plan outlined in Section IV of this report is supported by the three key stakeholder groups (MSV, VHCA, and VHHA) as well as several other groups that participated in the facilitation process.

The COPN Subcommittee And The Joint Commission on Health Care Have Approved The Proposed Deregulation Plan; Legislation Will Be Introduced In The 2001 Session of the General Assembly To Implement The Plan

After receiving a summary of the public comments, the COPN Subcommittee approved the proposed deregulation plan on November 15, 2000. The full Joint Commission on Health Care then approved the plan at its meeting on November 21, 2000. Legislation and accompanying budget amendments will be introduced during the 2001 Session of the General Assembly to implement the plan.

III.
Key Aspects of Virginia's Health Care Marketplace That Are Reflected In The Deregulation Plan

Several Provisions Of The Deregulation Plan Were Included In Response To Certain Key Aspects Of Virginia's Health Care Marketplace

A significant portion of the facilitation process focused on what actions should be included in the plan to address access to health care for the state's indigent and uninsured residents, and whether the state's role as a purchaser of health care services needed to change in response to the elimination of COPN regulation. Issues regarding the indigent and uninsured included the number of uninsured Virginians, the amount of indigent care (also referred to as "charity" care) performed by health care providers, and how such care is accounted for. Issues regarding the state's role as a purchaser of health care services focused on the extent to which Virginia's Medicaid program pays "market rates" for the health care that it purchases on behalf of Medicaid recipients.

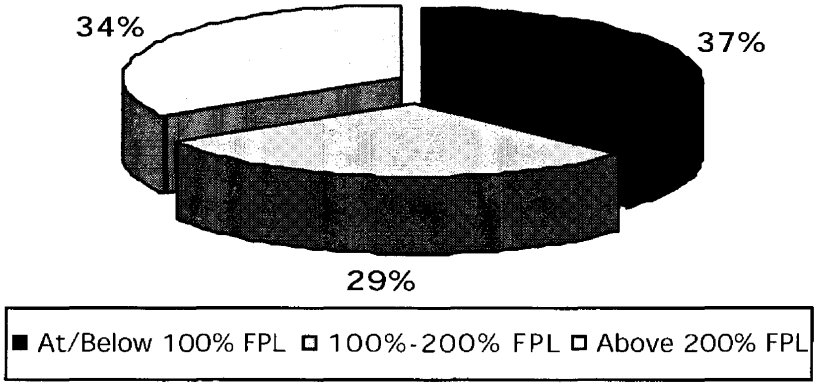
JCHC staff presented information concerning these issues to the JCHC's COPN Subcommittee at its July 12th and September 13th meetings. The information presented to the subcommittee was used extensively throughout the facilitation process. While the staff presentations included far more information than is presented here, this section presents a summary of the key findings that are reflected in the COPN deregulation plan.

The Number of Uninsured Virginians Has Remained Relatively Constant; Many of the Uninsured Are At Or Near the Federal Poverty Level

In 1996, the last year for which statewide data are available, there were 858,000 uninsured Virginians. This number was only slightly less than the 865,000 Virginians who were uninsured in 1993. As a percentage of population, 13% of the state's residents were uninsured in 1996 compared to 14% in 1993. Many of Virginia's uninsured residents in 1996 had incomes that were at or near the federal poverty level (FPL). As seen in Figure 5, over one-third (37%) of Virginia's uninsured population is at or below the FPL. Figure 6 illustrates the FPL guidelines for various family sizes. As discussed in Section IV of this report, the deregulation plan calls for a new statewide survey during 2001 in order to obtain

updated information concerning the number and characteristics of uninsured individuals in Virginia.

Figure 5
Virginia's Uninsured Population By Income



Source: JCHC staff analysis of 1996 Health Access Survey

Hospitals and Ambulatory Surgery Centers Report Indigent Care Data to Virginia Health Information (VHI); There is No Indigent Care Reporting Requirement for Physicians

In Virginia, hospitals and ambulatory surgery centers report to VHI the amount of "gross revenue" foregone to charity care. There is no such reporting requirement for physicians. Therefore, while many physicians provide charity care, there is no mechanism in place to quantify the amount of care that is provided statewide by physicians.

Pursuant to Virginia's health information data reporting regulations, charity care at 100% of poverty is defined as care for which no payment is received and that is provided to any person whose gross annual family income is equal to or less than 100% of the FPL. Similarly, charity care at 200% of poverty is defined as care for which no payment is received and that is provided to any person whose gross family income is greater than

Figure 6

2000 Federal Poverty Guidelines

Family Size	100% FPL	200%FPL
1	$8,350	$16,700
2	$11,250	$22,500
3	$14,150	$28,300
4	$17,050	$34,100
5	$19,950	$39,900

Source: Federal Register, Vol. 65, No. 31, February 2000.

100% but not greater than 200% of the FPL. Charity care information is reported separately for patients in each of these two income categories.

It is important to note that if a hospital or ambulatory surgery center receives just a small partial payment from a patient, the unpaid balance does not qualify as charity care for purposes of reporting to VHI. Rather, the unpaid portion of the bill most likely would be written off by the provider, and would be accounted for as "bad debt." In terms of definition and accounting, charity care is separate and distinct from bad debt.

Virginia Hospitals Provided $336 Million in "Gross" Charity Care (100% FPL) During 1998; Offsetting Payments from the State Resulted in Hospitals Providing $229 Million in "Net" Charity Care (100% FPL)

According to data reported to VHI, hospitals in Virginia provided a total of $336.1 million in "gross" charity care to individuals with family incomes at or below 100% FPL during 1998. (Gross charity care represents

the total amount of charges and does not reflect payment offsets received from enhanced disproportionate share hospital payments or payments from the Indigent Health Care Trust fund that are discussed later.) This amount reflects a substantial increase from the $294.2 million that was reported for 1994. Since 1995, however, the amount of gross charity care (at 100% FPL) reported by hospitals has remained relatively constant.

The gross amount of charity care provided by hospitals is offset, in part, by payments made by the state to hospitals for the purpose of supporting the provision of health care to the indigent. The state makes three different types of indigent care-related payments to hospitals: enhanced disproportionate share hospital (DSH) payments, payments from the Indigent Health Care Trust Fund (IHCTF), and payments from the State and Local Hospitalization (SLH) program. In 1998, a total of $123.5 million was paid to hospitals from these three sources. However, not all hospitals receive payments from each of these sources.

Only two hospitals (MCV and UVA) receive enhanced DSH payments. The enhanced DSH program is by far the largest source of state financial support to hospitals for the provision of indigent care. During 1998, of the $123.5 million in state payments, approximately $100 million was enhanced DSH payments to MCV and UVA. This represents approximately 81% of total state spending for indigent care.

The IHCTF includes $6 million in state general funds (GF) and $4 million in funds contributed by private hospitals. This amount ($10 million) is distributed among private hospitals whose charity care burden is greater than the statewide median. The IHCTF helps to "equalize" the financial burden of charity care among private hospitals. However, the amount of IHCTF monies that is distributed is quite small compared to the total amount of charity care provided by the hospitals.

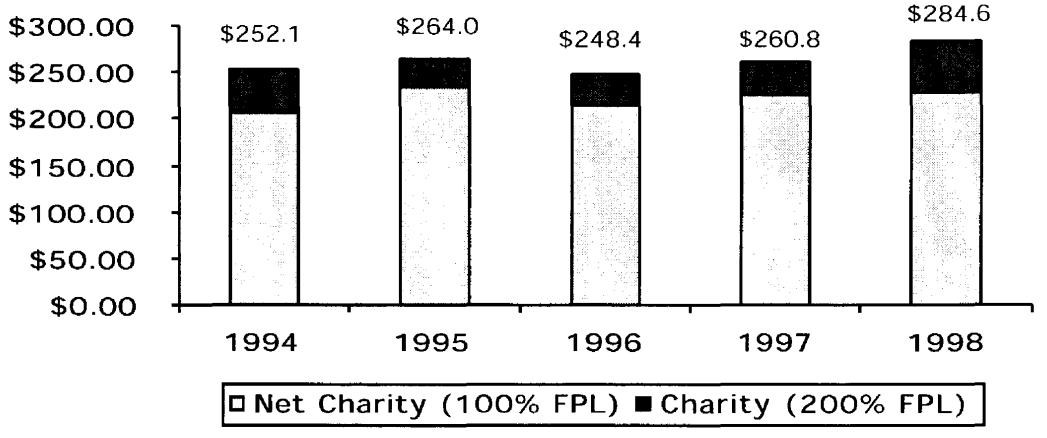
The SLH program provides a total of $13.3 million annually ($11 million state GF and $2.3 million in local funds) to pay for certain hospital inpatient and outpatient services for persons at or below 100% of FPL. Unlike the IHCTF, the SLH program is a "claims based" program that pays for the health care costs incurred by individuals who apply and qualify for the assistance. It is worth noting that the latter two, relatively small sources of indigent care payments (IHCTF and SLH) represent state and local government dollars and contributions from private hospitals, whereas the enhanced DSH payments include approximately a 50% match of federal dollars.

The Total Amount Of Unreimbursed Charity Care Provided By Hospitals Includes "Net" Charity Care (100% FPL) And Charity Care Provided To Persons With Incomes Between 101 - 200% of FPL

The total amount of unreimbursed charity care provided by Virginia hospitals includes (1) "net" charity care provided to individuals with family incomes up to and including 100% FPL which represents the gross amounts reported by hospitals adjusted for the enhanced DSH and IHCTF payments they receive; and (2) all charity care provided to individuals with family incomes between 101% and 200% FPL (there are no funds such as enhanced DSH or the IHCTF to offset charity care between 101-200% FPL). This total amount of unreimbursed charity care increased from $252 million in 1994 to $285 million in 1998. The vast majority of the total unreimbursed charity care is for those individuals with incomes at or below 100%FPL.

Figure 7 illustrates the total amount of unreimbursed charity care provided by Virginia hospitals from 1994 through 1998 to patients at or below 200% of the FPL.

Figure 7
Total Unreimbursed Charity Care Reported By Hospitals
(in millions)



Note: "Net" charity care reflects "gross" charity care at 100% FPL minus enhanced DSH to AHCs and IHCTF payments to private hospitals
Source: Virginia Health Information, 1994-1998 Annual Historical Filings

It should be noted that the above analyses of charity care provided by Virginia hospitals are based on "charges" and not "costs." Charge information is the standard unit of measurement in hospital reporting of this data due to the difficulty in assigning actual costs on a patient-by-patient basis. Overall, Virginia hospital data reflect a cost-to-charge ratio of approximately 61% (i.e., each $1.00 in charges represents about $.61 in costs).

The Virginia Medicaid Program's Expenditures for Health Care Services Are a Function of Policy Decisions Affecting Eligibility Requirements and Provider Payments

The Virginia Medicaid program is a major purchaser of health care services within the state. During FY 1999, Medicaid expenditures totaled $2.36 billion. This amount of expenditures made Virginia's Medicaid program, in terms of total payments to health care providers, the 23rd largest in the United States during FY99. However, on a per capita basis, the amount of Virginia's Medicaid expenditures was only 48th in the country in FY 1999. Several other aspects of Virginia's Medicaid program rank low, on a per capita basis, in comparison to other states:

- expenditure per Medicaid recipient – 36th,
- number of Medicaid recipients as a percent of population – 43rd, and
- Medicaid expenditures as a percentage of total state expenditures – 44th.

A key factor underlying Virginia's relatively low ranking in terms of per capita Medicaid recipients and expenditures is that Virginia has very restrictive policies for determining eligibility for the Medicaid program. The Virginia Medicaid program is particularly restrictive in terms of granting eligibility to adult parents with children. Figure 8 illustrates how Virginia's Medicaid eligibility level for adult parents, expressed as a percent of the FPL for a family of three, compares with other states and the national average.

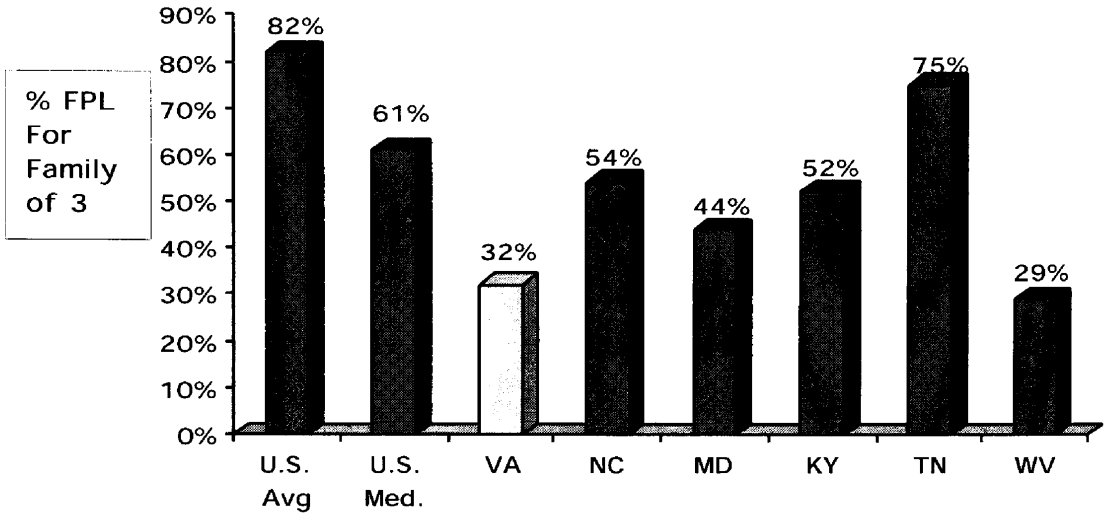
The Joint Legislative Audit and Review Commission (JLARC) Has Concluded that the Medicaid Program's Hospital Payment System Contains Elements Which Artificially Lower Payments to Hospitals

One of the specific issues to be addressed in the deregulation plan is whether the state's health care financing programs pay market rates for the services that are purchased. JLARC recently completed a review, as directed by the 2000 Appropriations Act, of Virginia Medicaid's

reimbursement system for inpatient hospital services. The Virginia Medicaid program reimburses hospitals using a prospective payment

Figure 8

Medicaid Eligibility Levels For Adult Parents: Virginia and Other States



Source: Families USA and Center on Budget and Policy Priorities

system. This system establishes inpatient rates based on the expected length of treatment associated with various diagnosis related groups (DRGs).

The results of JLARC's review were presented to the JCHC's COPN Subcommittee on November 15, 2000. The primary findings of JLARC's review are listed below.

- The rate-setting methodology implemented by the Virginia Department of Medical Assistance Services (DMAS), which includes a rebasing of all rates every three years, is generally sound and appropriate.

- However, the payment system contains an "adjustment factor" that artificially lowers payments to hospitals. Currently, the adjustment factor is reducing payments by 21%.

- The adjustment factor was established in 1996 as part of the settlement of litigation over the adequacy of the State's Medicaid payment system for inpatient care, and was intended to enable the new payment system to be "budget neutral."

- In 1996, it was intended that use of the adjustment factor would be revisited if there were demonstrable changes in several factors, including hospital efficiency.

- Based on trends in hospital costs (i.e., Medicaid allowable costs decreased by 2.18% from FY 1993 through FY 1998, while Medicaid allowable costs adjusted by patient days and patient mix increased by only 1.3%), this adjustment no longer appears justified as a component of the state's inpatient hospital reimbursement system.

- Virginia pays less for Medicaid inpatient hospital care than do other states with similar types of reimbursement systems.

- If the use of the adjustment factor is eliminated, operating payments by DMAS to hospitals will increase by $48 million ($24 million GF). (This amount reflects only the impact of eliminating the adjustment factor for acute care hospitals that are paid on a fee-for-service basis.)

JLARC recommended that, prior to February 1, 2001, DMAS should submit a plan to the House Appropriations and Senate Finance Committees outlining a strategy to phase out the rate adjustment factor by FY 2003. If this policy is eliminated, operating payments to hospitals will increase by $48 million ($24 million general funds).

Average Medicaid Reimbursement for Physician Services in Virginia is Less than the Average Medicare Fee, but Greater than the National Average Medicaid Fee

The Virginia Medicaid program pays for physician services on a fee-for-service basis. According to a study performed by the Urban Institute, Virginia's average Medicaid fee for physician services was 78% of the average Medicare fee for physician services in 1998. However, the national average Medicaid fee for physician services was only 64% of the average Medicare fee in 1998. Among Virginia's neighboring states, the average Medicaid fee as a percentage of the average Medicare fee was as follows:

- North Carolina – 85%,
- West Virginia – 84%,

- Kentucky – 77%, and
- Maryland – 64%.

In addition, Virginia's average Medicaid fee for physician services was nine percentage points greater than the national average Medicaid fee for physician services in 1998. Therefore, based on the Urban Institute analysis, Virginia's Medicaid physician reimbursement compared favorably with other states in 1998. However, a more in-depth analysis of Virginia Medicaid reimbursement for physician services, across all specialties, is warranted to determine if reimbursement for each specialty area reflects an appropriate market rate.

IV.
COPN Deregulation Plan

There Are Several Overall Goals Of The COPN Deregulation Plan

As provided in Senate Bill 337, under the deregulation plan recommended by the JCHC, state approval would no longer be required to purchase equipment or establish health care services and facilities that currently are subject to COPN regulation. In developing the transition plan to eliminate the COPN program, several overall goals were identified by the facilitation group and adopted by the JCHC. The overall goals of the deregulation plan are to:

- offer more choices to patients together with better information about the value of services in all care settings;
- ensure that access to essential health services for all Virginians, particularly the indigent and uninsured, is preserved, if not improved;
- provide strong quality protections that correspond to service intensity and/or patient risk, and that apply similarly across all settings;
- provide financial support for indigent care and medical education costs at the Commonwealth's academic health centers; and
- ensure that the Commonwealth's financing programs pay market rates and meet their responsibilities as a responsible business partner.

The Deregulation Plan Represents A "Fragile" Consensus Agreement Among The Key Stakeholder Groups; While Some "Fine-Tuning" Is Necessary, Substantial Changes Likely Would Fracture The Consensus

The deregulation plan outlined on the following pages represents a "fragile" consensus among the key stakeholder groups, the Medical Society of Virginia (MSV), the Virginia Hospital & Healthcare Association (VHHA), and the Virginia Health Care Association (VHCA). As noted in Section II of this report, a number of other groups participating in the facilitation process also support the plan. Given the volume and complexity of the issues involved in deregulating COPN, some "fine-tuning" of the provisions outlined in the proceeding pages will be necessary, particularly given the dynamic nature of some of the financial components of the plan. However, any substantial changes to the plan likely would fracture the fragile consensus among the stakeholders. That is not to say that there are no other means of eliminating COPN; however,

another plan that involves any significant variation from the proposal described herein likely would not have the support of all of the stakeholder groups.

The Impact Of An Expected Reduction In The Number Of "Paying" Patients Receiving Care In Hospitals Is Addressed In The Plan

Over the past several years, much of the debate in Virginia and across the nation over the elimination of COPN has focused on the degree to which "paying" patients who now receive care at hospitals will begin receiving care from the providers of newly deregulated services. A paying patient can be described as anyone with some financial means to pay for their care, whether it be self-pay or with third party insurance (e.g., private health insurance, Medicare, Medicaid, etc.). One of the protections that COPN provides to hospitals is the ability to "cost-shift" reimbursement received from paying patients to help offset the cost of providing care to persons who have no financial means (e.g., indigent and/or uninsured patients), and to subsidize the cost of certain services which generate relatively little revenue.

In a deregulated environment in which services that are currently provided primarily in hospital settings are now available from other providers outside of the hospital, the ability of hospitals to provide services for the indigent/uninsured is diminished in proportion to the number of paying patients who begin receiving these services from other providers. This scenario is particularly important to the academic health centers (AHCs) which provide substantial amounts of indigent care. However, the impact would be felt by all hospitals, especially certain small, rural hospitals.

This issue of cost-shifting to support certain services which are not self-supporting also pertains to funding the cost of undergraduate medical education at the Commonwealth's AHCs. Currently, a portion of the costs of undergraduate medical education at the AHCs is funded through faculty-earned clinical revenues. Similar to the impact on the provision of clinical services to indigent patients, as more patients begin to receive services from providers other than the AHCs, the ability to use faculty-earned clinical revenues to support the cost of undergraduate medical education will represent an increasingly difficult financial burden for the AHCs to absorb.

To address these issues, the deregulation plan includes several provisions to help cushion hospitals and the AHCs from the impact of being less able to cost-shift and subsidize indigent care, low revenue-generating services, and undergraduate medical education. These

provisions are implemented in the plan on an incremental basis in relation to the number and types of services being deregulated.

The Deregulation Plan Includes Provisions Related To Access, Quality, Medical Education, And Fair Payment/Funding

As discussed in Section II of this report, workgroups were formed during the facilitation process to address the major components of the deregulation plan: access, quality, medical education, and fair payment/funding. The provisions of the deregulation plan are best described using this same model. The following paragraphs identify the deregulation plan provisions according to these four major areas. Later in this Section, these same provisions are discussed in terms of a "phased-in" approach to eliminating COPN requirements.

The Deregulation Plan Includes Several "Access" Provisions Regarding Insurance Coverage Enhancements, Requirements For Providers Of Newly Deregulated Services, And Academic Health Centers

The deregulation plan includes a number of specific provisions related to improving access to care. These provisions are outlined below.

Access Provisions Related To *Insurance Coverage Enhancements*

The following access provisions included in the deregulation plan relate to improving insurance coverage for low-income, uninsured persons.

- continued emphasis on outreach and reducing barriers to enrolling children in the Children's Medical Security Insurance Plan (CMSIP) and the Family Access to Medical Insurance Security (FAMIS) plan being developed to replace CMSIP;
- a phased-in increase in Medicaid eligibility for low-income, uninsured adult parents whose income is at or below 100% of the federal poverty level (FPL) (currently, eligibility for this population is set at 32% FPL);
- a phased-in increase in Medicaid eligibility for aged and disabled persons whose income is at or below 100% of the federal poverty level (FPL) (currently, eligibility for this population is set at 75% FPL and is increasing to 80% in fiscal year 2002);
- a JCHC study on the feasibility of using a State Children's Health Insurance Program (SCHIP) waiver to provide coverage for low-income adult parents from 100-200% FPL; and
- a JCHC study on the costs and benefits of automatically extending Medicaid coverage to recipients of Supplemental Security Income (SSI) payments.

Access Provisions Related To *Providers Of Newly Deregulated Services* The deregulation plan requires that providers of newly deregulated services: (i) accept all patients regardless of ability to pay, and (ii) participate in Medicaid and CMSIP/FAMIS. In addition, the JCHC would design either a revised or new Indigent Health Care Trust Fund (IHCTF) to incorporate providers of newly deregulated services. (Currently, the IHCTF involves only private hospitals and state contributions.) The new or revised trust fund will define and track indigent care for all providers, including hospitals, at 200% FPL, and the rules governing this program will specify a minimum set of standards for reporting and valuing qualified charity care costs (e.g., by adopting current cost reporting principles). Because the revised IHCTF will be modeled after the current program in which the Commonwealth contributes monies to the trust fund, additional state dollars will have to be appropriated to supplement amounts contributed by providers of newly deregulated services.

Access Provisions Related To *Academic Health Centers* The deregulation plan calls for codifying a Commonwealth policy to fully fund the cost of indigent care at the Commonwealth's academic health centers (AHCs). The funding policy would be implemented in the Appropriations Act. In concert with this funding policy, the JCHC, the Department of Medical Assistance Services and the AHCs would specify the methodology for qualifying indigent care costs and monitor federal developments concerning the use of disproportionate share hospital (DSH) payments to fund these costs, with a particular focus on federal limits or "caps" on the availability of these funds. Use of Medicaid DSH payments to fulfill this obligation allows it to be met via shared federal and state funds, rather than relying on state-only sources.

Access Provisions Related To *Monitoring Access to Care* The deregulation plan includes the following other provisions related to monitoring certain access to care issues:

- the JCHC and the Virginia Department of Health (VDH) would study, track and report on access to care and changes over time as various equipment, services, and facilities are deregulated;
- the JCHC would arrange for a statewide survey of uninsured persons and would maintain information on the Commonwealth's indigent and uninsured populations (the last Virginia survey of the uninsured population in Virginia was conducted in 1996);
- the JCHC would define, monitor, and evaluate the level and availability of "community benefits" (e.g., uncompensated care other than "charity" care) provided by hospitals and providers of newly deregulated services; the study also would examine the issue

of not-for-profit status as it relates to community benefits and COPN deregulation; and

- the JCHC would conduct a study to determine the feasibility of establishing a state version of a critical access hospital program.

The Deregulation Plan Includes Several "Quality" Provisions Regarding Licensure of Newly-Deregulated Services, Data Reporting by Providers of Newly Deregulated Services, and Other Related Issues

The deregulation plan includes a number of specific provisions related to ensuring quality of care as equipment, services, and facilities are deregulated. These provisions are outlined below.

Quality Provisions Related To *Licensure of Newly-Deregulated Services* The deregulation plan includes the following provisions regarding licensure of deregulated services:

- licensure programs for each newly deregulated service must be in place prior to COPN deregulation; the licensing provisions would "grandfather" in existing providers for a limited period to allow these providers to meet the new licensing requirements;
- licensing programs would be modeled on established, nationally-recognized accreditation programs (e.g., American College of Radiology) for each service where applicable; the licensure programs also would allow for a "deemed status" option;
- licensure programs for highly complex services (i.e., organ transplant, neonatal special care, and open heart surgery) would include a process to assess the ability of service providers to meet minimum volume levels sufficient to provide quality care; and
- lithotripsy would require the same type of licensure as all other services deregulated in Phase I of the plan (the phased implementation of the plan is discussed later in this Section).

Quality Provisions Related To *Data Reporting by Providers of Newly Deregulated Services* The deregulation plan includes the following provisions regarding data to be reported by all providers of newly deregulated services:

- three levels of data reporting would be required of providers of newly deregulated services:
  1. claims data would be reported on deregulated services to provide summary performance information for consumers, medical management information for providers, and information for health policy makers to evaluate access changes;
  2. additional "quality" data would be reported on selected procedures provided in all settings that are judged to be of

concern (this data reporting requirement would be subject to periodic cost-benefit analysis and evaluation); and

3. the issue of "exceptions" reporting of defined events related to patient safety would be incorporated into ongoing studies being conducted by Virginia Health Information and others;

- a sunset provision on the above data reporting requirements would be enacted that would be consistent with the sunset date for provider data reporting required in Chapter 7.2, Title 32.1 of the *Code of Virginia.*

Other Quality Provisions The deregulation plan includes several other quality related provisions:

- the JCHC would monitor the activities of the Board of Medicine's office-based surgery initiative to ensure that the implementation of the COPN deregulation plan is consistent with any actions taken by the Board;
- the current restriction on capital investments relating to the establishment of newly deregulated services would be modified to allow such investments in advance of licensure requirements becoming effective; however, services could not be provided until the license is issued (this provision would apply only to those services that have been deregulated in statute); and
- relocation of beds within a hospital facility would be reported to VDH within 30 days, but otherwise would not be regulated under COPN.

The Deregulation Plan Includes Fair Payment/Funding Provisions

The deregulation plan includes several specific provisions related to fair payment/funding of state-sponsored health care financing programs. These provisions are outlined below.

- the Commonwealth would pay market rates for health care services provided to Medicaid recipients, and would operate as a responsible business partner;
- any increase in Medicaid fee-for-service payments would be recognized in the calculation of capitation rates for managed care plans;
- the Joint Legislative Audit and Review Commission (JLARC) would be requested to study Medicaid reimbursement for physicians; and
- as part of its ongoing monitoring of COPN deregulation, the JCHC would review aggregate pricing, unit costs, and utilization/volume issues.

The Deregulation Plan Includes Provisions Regarding Medical Education At The Academic Health Centers

The deregulation plan includes the following specific provisions related to medical education at the academic health centers (AHCs):

- the Commonwealth's policy for funding undergraduate medical education would not be predicated on having to fund a portion of educational costs out of faculty-earned clinical revenues;
- a study of the Commonwealth's policy for funding graduate medical education would be conducted by the AHCs and the State Council for Higher Education in Virginia (SCHEV); and
- a study would be conducted to review the current policies related to funding medical research at the AHCs.

The Deregulation Plan Would Be Implemented In Three Phases; The Equipment, Services And Facilities Included In Each Phase Were Determined On The Basis Of Cost Impact And Complexity/Risk

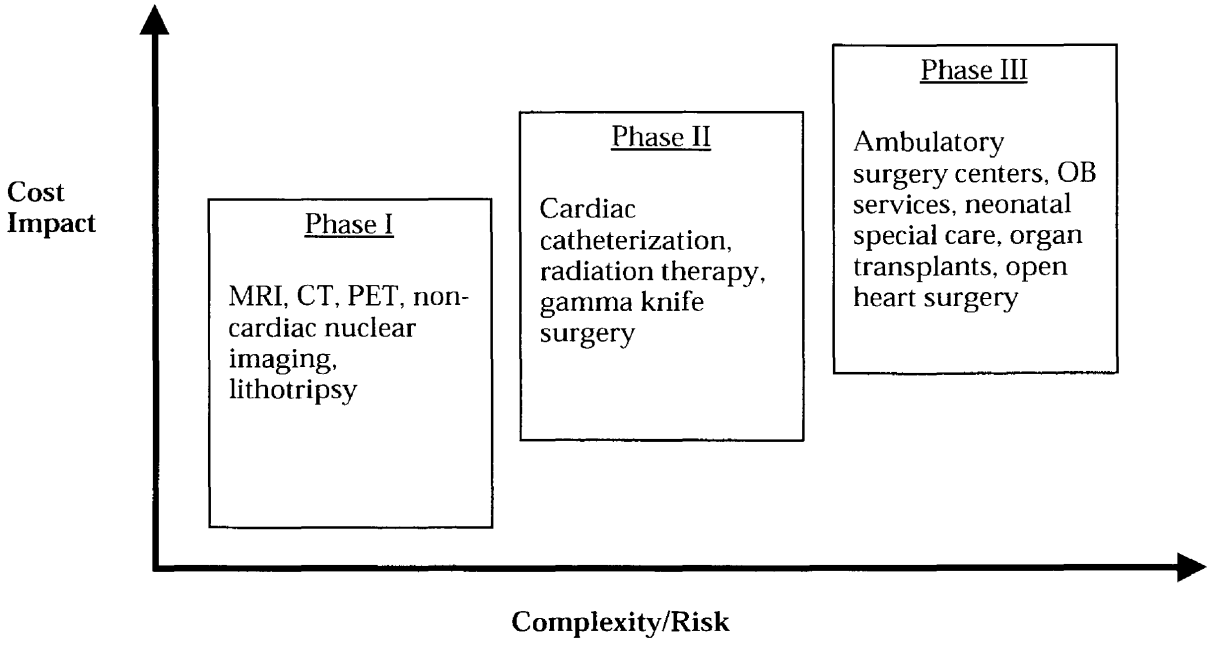
The deregulation of COPN would be accomplished in three phases under the JCHC plan. Decisions regarding which COPN projects to be included in each phase were based primarily on the cost impact on hospitals of deregulating the project, and the complexity/risk of the project. Those COPN projects with the least cost impact and complexity/risk were included in Phase I; projects with greater cost impact and complexity/risk were placed in Phase II; those with the greatest cost impact and complexity/risk were included in Phase III. Figure 9 illustrates the COPN projects to be deregulated in each phase.

Phase I: As noted in Figure 9, COPN regulation would be eliminated for: magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), non-cardiac nuclear imaging, and lithotripsy. In addition to these specific categories of COPN projects, capital expenditure thresholds, in and of themselves, would no longer be regulated under COPN beginning in Phase I. Also, the term "sanitarium" would be deleted from the *Code of Virginia* in this phase. (This is an outdated term that no longer has relevance to today's health care facilities.)

Phase II: COPN regulation would be eliminated for: cardiac catheterization, radiation therapy, and gamma knife surgery.

Figure 9

Equipment, Services, And Facilities To Be Deregulated In Each Of The Three Phases Of The COPN Deregulation Plan



Phase III: COPN regulation would be eliminated for: ambulatory surgery centers, obstetric services, neonatal special care, organ transplants, and open heart surgery.

The Deregulation Plan Retains COPN Regulation Of Certain Facilities

The deregulation plan described herein does not include elimination of COPN regulation for nursing homes, hospital beds, and mental health and substance abuse facilities. However, the JCHC will continue to monitor and evaluate continued COPN regulation of these facilities during the phased implementation of the deregulation plan, particularly as it relates to intermediate care facilities for the mentally retarded.

The Implementation Of Each Phase Of The Deregulation Plan Is Contingent Upon Specific Actions That Must Occur

A critical component of the JCHC's deregulation plan is that specific actions must occur in order for each of the respective phases to be implemented. For each phase, the requirement to receive a COPN for the equipment, services and/or facilities would be repealed only when new or revised licensure and data reporting requirements are in place. In addition, the deregulation that occurs in each phase is contingent upon the related funding provisions being included in the Appropriations Act. The various funding requirements are outlined below in the description of each Phase of the plan. (Appendix C provides a brief statement of how each of the cost estimates included in the plan were derived.)

The following paragraphs indicate in which phase the various provisions of the deregulation plan (identified earlier) would occur.

Certain Quality And Data Reporting Provisions Are Applicable In All Three Phases

While there are certain provisions in the plan that have specific application to one particular phase, there are several quality and data reporting provisions that apply to each phase. Rather than repeat these provisions in all three phases, they are presented below only once, but have application in all three phases.

- new licensure systems for each service are applied equally across all care settings; licensure provisions are based on existing, nationally recognized accreditation provisions, if applicable, and allow for "deemed status;" and
- providers of newly deregulated services are required to submit claims data, additional quality outcome information for selected high risk procedures (if applicable), and annual financial information on the level of indigent care (valued at "cost," using a standard methodology).

Provisions Of The Deregulation Plan Specific To Phase I Are Identified Below

Quality Related Provisions Specific To Phase I: The JCHC will evaluate data collection proposals developed by Virginia Health Information regarding additional "quality" information to be reported by providers on selected procedures and on the issue of "exceptions" reporting of defined adverse events. JCHC also will review and assess any regulatory changes initiated by the Board of Medicine concerning outpatient surgery. The JCHC will make recommendations as appropriate on these issues.

Access Improvements Specific To Phase I: The following provisions are included in Phase I to improve access to care:

- legislation would codify state policy to fully fund the indigent care costs at the academic health centers (AHCs), and the policy would be funded in the Appropriations Act along with language to ensure consistent cost accounting among the three AHCs;
  - *Cost: $22 million in general funds (GF) (VCU/MCV: $12.5 million; UVA: $2.3 million; and EVMS: $7.1 million)*
- the JCHC would conduct a study of a waiver under the State Children's Health Insurance Program (SCHIP) to cover low-income adult parents from 100-200% FPL;
- additional emphasis on outreach and enrollment of children in the CMSIP/FAMIS program;
- the JCHC would arrange for a statewide survey of the insurance status of Virginians;
- the JCHC would design a proposal for a new or revised Indigent Health Care Trust Fund to incorporate providers of newly deregulated services; and
- the JCHC would conduct a study to determine the feasibility of establishing a state version of a critical access hospital program.

Fair Payment/Funding Provisions Specific To Phase I: The following provisions, which relate to fair payment/funding, are included in Phase I:

- the initial phase of improving the adequacy of Medicaid hospital reimbursement pursuant to the 2000 JLARC study would be funded;
  - *Cost: $12 million GF*
- a JLARC study of Medicaid's physician reimbursement system would be conducted.

Medical Education Provisions Specific To Phase I: The initial phase of eliminating the use of faculty-earned clinical revenues to fund the core cost of undergraduate medical education would occur in Phase I. Appropriation Act language would require consistent accounting and reporting of medical education costs at each of the AHCs.

- *Cost: $6.5 million GF (VCU/MCV: $3.0 million; UVA: $2.5 million; and EVMS: $1 million)*

Provisions Of The Deregulation Plan Specific To Phase II Are Identified Below

Quality Related Provisions Specific To Phase II: The JCHC will assess and evaluate the appropriateness of revising the definition/criteria used in licensing ambulatory surgery centers.

Access Improvements Specific To Phase II: The following provisions are included in Phase II to continue improving access to care:

- continued policy/budget action to fully fund indigent care costs at the AHCs;
- initial phase of increasing Medicaid eligibility for adult parents to 100% FPL (in Phase II, eligibility would be increased from 32% FPL to 66% FPL);
  - *Additional Cost Above Phase I: $27 million GF*
- initial phase of increasing Medicaid eligibility for aged and disabled to 100% FPL (in Phase II, eligibility would be increased from 80% FPL to 90% FPL);
  - *Additional Cost Above Phase I: $11 million GF*
- implementation of revised Indigent Health Care Trust Fund to incorporate providers of newly deregulated services; state funds to match payments made by providers likely would be required;
  - *Additional Cost Above Phase I: unknown*
- JCHC studies of: (i) automatically extending Medicaid coverage to SSI recipients, (ii) community benefits and uncompensated care provided across all service delivery sites, and (iii) programs to provide insurance coverage for persons above 200% FPL; and
- JCHC/VDH monitoring of various aspects regarding access to care.

Fair Payment/Funding Provisions Specific To Phase II: The following provisions, which relate to fair payment/funding, are included in Phase II:

- the second phase of improving the adequacy of Medicaid hospital reimbursement pursuant to the 2000 JLARC study would be funded;
  - *Additional Cost Above Phase I: $12 million GF*
- initial action on Medicaid physician payment reform following JLARC study (if applicable)
  - *Additional Cost Above Phase I: unknown*

Medical Education Provisions Specific To Phase II: The second phase of funding the core cost of undergraduate medical education would occur in Phase II. *(Additional Cost Above Phase I: $6.5 million GF) (VCU/MCV: $3.0 million; UVA: $2.5 million; and EVMS: $1 million).* Also, the study regarding graduate medical education would be conducted by the AHCs and SCHEV.

Provisions Of The Deregulation Plan Specific To Phase III Are Identified Below

Quality Related Provisions Specific To Phase III: For high risk, highly complex services (open heart surgery, organ transplants, and neonatal special care), VDH's licensure review would evaluate the ability of applicants to reach minimum quality thresholds, including minimum volume for services in which there is an established link between volume and quality.

Data Reporting/Monitoring Provisions Specific To Phase III: In addition to the data reporting requirements that apply to all three phases, in Phase III, the Commissioner of Health would be authorized to collect more frequent volume and outcomes information from newly authorized providers of high risk/complex services, with annual reporting from established, high volume providers.

Access Improvements Specific To Phase III: The following provisions are included in Phase III to continue improving access to care:

- continued policy/budget action to fully fund indigent care costs at the AHCs;
- the phased-in increase in Medicaid eligibility for uninsured adult parents with incomes up to 100% FPL would be completed;
  - *Additional Cost Above Phases I & II: $27 million GF*
- the phased-in increase in Medicaid eligibility for aged and disabled persons with incomes up to 100% FPL would be completed;
  - *Additional Cost Above Phases I & II: $11 million GF*
- continued state match of additional indigent care cost payments from providers of newly deregulated services;
  - *Additional Cost Above Phases I & II: unknown*
- JCHC would continue to: (i) study programs to provide coverage for persons above 200% FPL, and (ii) monitor various access issues, including a review of aggregate pricing, unit cost and utilization/volume issues.

Fair Payment/Funding Provisions Specific To Phase III: The following provisions, which relate to fair payment/funding, are included in Phase III:

- continued action on physician payment reforms pursuant to JLARC study (if applicable);
  - *Additional Cost Above Phases I & II: unknown*
- JCHC would reassess the adequacy of Medicaid reimbursement of long-term care services.

Medical Education Provisions Specific To Phase III: Funding the core cost of undergraduate medical education would continue in Phase III. Also, recommendations arising out of the studies on graduate medical

education and state support of medical research at the AHCs would be reviewed.

The Deregulation Plan Has A Significant Fiscal Impact; However, The Funding Requirements Are Integral To Implementation Of The Plan

As discussed in the description of the plan's three Phases, there is a significant fiscal impact in implementing the deregulation plan. However, as noted previously, the funding requirements are integral to the plan. If the funding called for in a particular phase is not provided, the plan provides that the respective phase would not be implemented. Figure 10 summarizes the fiscal impact of the deregulation plan.

Figure 10

Summary of Fiscal Impact Of Deregulation Plan

	General Funds (millions) (Incremental Amounts)		
Funding Provision	**Phase I**	**Phase II**	**Phase III**
Indigent Care (AHCs)	$22.0	--	--
Medicaid (Adult Parents)	--	$27.0	$27.0
Medicaid (Aged, Disabled)	--	$11.0	$11.0
Undergrad. Medical Education	$6.5	$6.5	--
Medicaid Reimbursement: Hospitals	$12.0	$12.0	--
Medicaid Reimbursement: Physicians	--	unknown	unknown
State Match: Revised Indigent Health Care Trust Fund	--	unknown	unknown
TOTAL	**$40.5**	**$56.5**	**$38.0**

Throughout The Deregulation Process, The JCHC Would Monitor The Implementation Of Each Phase

As part of its responsibilities for conducting various studies throughout the deregulation process, the JCHC also would monitor the implementation of the plan. Part of this responsibility would be to ensure that the provisions of the plan are in place prior to the start of each of the three phases. The JCHC would make periodic reports to the General Assembly on the progress of the deregulation plan.

APPENDIX A:

Senate Bill 337, 2000 Session of the General Assembly

VIRGINIA ACTS OF ASSEMBLY -- 2000 SESSION
CHAPTER 894

An Act to amend the Code of Virginia by adding in Article 1.1 of Chapter 4 of Title 32.1 a section numbered 32.1-102.13, relating to certificate of public need.

[S 337]

Approved April 9, 2000

Be it enacted by the General Assembly of Virginia:
1. That the Code of Virginia is amended by adding in Article 1.1 of Chapter 4 of Title 32.1 a section numbered 32.1-102.13 as follows:
§ 32.1-102.13. Transition to elimination of medical care facilities certificate of public need.
A. Transition required. A transition for elimination of the requirements for determination of need pursuant to Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title shall begin on July 1, 2001, and shall be completed by July 1, 2004, as determined by the General Assembly.

B. Plan to be developed. The deregulation required by this section shall be accomplished in accordance with a plan to be developed by the Joint Commission on Health Care. The Joint Commission on Health Care shall work collaboratively with the Departments of Health, Medical Assistance Services, and Health Professions in conjunction with the implementation of the provisions of this section. The Departments of Health, Medical Assistance Services, and Health Professions shall provide technical assistance to the Joint Commission. All agencies of the Commonwealth shall provide assistance to the Joint Commission, upon request. The Joint Commission shall seek input from all classes of health care consumers, providers, and representatives of health care facilities in the performance of the duties of the Joint Commission hereunder. The plan shall include recommendations for legislative and administrative consideration to carry out, in accordance with subsection A of this section, the elimination of the requirements for determination of need. Such plan shall be submitted to the chairmen of the House Appropriations, Senate Finance, House Health, Welfare and Institutions, and Senate Education and Health Committees on or before December 1, 2000, for review and approval by the 2001 Session of the General Assembly.

C. Components of the plan. The plan for deregulation to be developed by the Joint Commission on Health Care shall include, but need not be limited to, provisions for (i) meeting the health care needs of the indigent citizens of the Commonwealth, including access to care and provision for all health care providers to share in meeting such needs; (ii) meeting the health care needs of the uninsured citizens of the Commonwealth, including access to care; (iii) establishing licensure standards for the various deregulated services, including whether nationally recognized accreditation standards may be adopted, to protect the public health and safety and to promote the quality of services provided by deregulated medical facilities and projects; (iv) providing adequate oversight of the various deregulated services to protect the public health and safety; (v) providing for monitoring the effects of deregulation during the transition period and after full implementation of this section on the number and location of medical facilities and projects throughout the Commonwealth; (vi) determining the effect of deregulation of long-term care facilities and new hospitals with respect to the requirements for determination of need; (vii) determining the effect of deregulation on the unique mission of academic medical centers; (viii) determining the effect of deregulation on rural hospitals which are critical access hospitals; (ix) recommending a schedule for necessary statutory changes to implement the plan and for requiring, subject to approval of the General Assembly, that the appropriate regulatory boards promulgate regulations implementing the Commission's plan prior to any deregulation recommended in the plan.

D. Fiscal impact. In developing the plan, the Commission shall also consider the impact of deregulation on state-funded health care financing programs and shall include an examination of the fiscal impact of such deregulation on the market rates paid by such financing programs for health care and long-term care services.

APPENDIX B:

Summary of Public Comments Received On COPN Deregulation Plan

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
Certificate of Public Need Facilitation Recommendations
(SB 337 of 2000 Session)

Organizations and Individuals Submitting Comments

A total of 308 individuals and organizations submitted comments in response to the Certificate of Public Need (COPN) facilitation recommendations:

- Virginia Hospital and Healthcare Association,
- Bon Secours Health System, Inc.,
- INOVA Health System,
- Sentara Healthcare,
- Carilion Health System,
- University of Virginia Medical Center,
- Virginia Association of Regional Health Planning Agencies,
- Central Virginia Health Planning Agency, Inc.,
- Northwestern Virginia Health Systems Agency, Inc.,
- Eastern Virginia Health Systems Agency, Inc.,
- S. Paul Klein,
- George W. McCall, III,
- Virginia Oncology Associates,
- Fairfax-Prince William Hematology-Oncology, P.C. (a total of seven letters were submitted),
- Mid-Atlantic Consultants in Hematology-Oncology,
- Oncology and Hematology Associates of Southwest Virginia, Inc.,
- Anita J. Harriotte,
- National Patient Advocate Foundation,
- Virginia Chapter, American College of Radiology,
- Fairfax Radiological Consultants, P.C.,
- The Virginia Poverty Law Center,
- Cardiac & Thoracic Surgical Associates,
- Paul J. Rubis, M.D.,
- Virginia Society of Opthamology,

- Virginia Association of Community Services Boards, Inc.,
- Mount Rogers Community Services Board,
- Department of Mental Health, Mental Retardation, and Substance Abuse Services,
- Virginia Association of Nurse Anesthetists,
- Physics Associates,
- Leslie P. Foldesi, M.S., CHP,
- County of Fairfax, and
- 271 form letters from cancer patients throughout the state.

Overall Summary of Comments

Most of the comments received were generally supportive of the proposed plan. No one expressed clear opposition to the plan. However, various types of concerns were expressed by some respondents.

The Virginia Hospital and Healthcare Association (VHHA) expressed support for the proposed plan. VHHA, as well as Bon Secours and INOVA, did raise potential issues concerning the timing with which actual implementation of the deregulation plan could or would occur. VHHA stated that the JCHC "should make further recommendations to the General Assembly on the timing and nature of each phase of this deregulation plan." Bon Secours Health System stated that "the effects of deregulation in each phase of the plan must be fully understood BEFORE deregulation occurs." INOVA Health System stated that "information needs to be made available to assess the impact on providers as each phase is fully implemented and before we move to the next phase." The comments of Sentara Health System emphasized the importance of fully funding the various plan provisions. Sentara endorsed a proposal that "no phase of this plan go forward unless funding is provided in the Governor's budget as introduced." Carilion emphasized the need to "assure funding commensurate with the level of deregulation."

The proposed plan received substantial support from physician oncologists and their patients throughout Virginia. While oncologists commented that they had hoped radiation therapy would have been included in Phase I, they, nonetheless, support the plan. The Virginia Chapter of the American College of Radiology also expressed support for the proposed plan.

The Virginia Association of Regional Health Planning Agencies (VARHPA) expressed several concerns about the proposed plan. VARHPA's concerns focused primarily on various types of health care access and quality provisions which it believed had been agreed to during

the facilitation process, but ultimately were not included in the proposed plan. VARHPA's comments were endorsed by the Northwestern Virginia Health Systems Agency and the Central Virginia Health Planning Agency. The Eastern Virginia Health Systems Agency stated that there must be a "substantial increase in State Health Department monitoring staff" in order for the plan to be appropriately implemented, and noted that the proposed plan contains no provision for additional health department staffing.

The Virginia Poverty Law Center urged the JCHC to implement expansion of Medicaid coverage for low-income parents earlier in the proposed plan, and that the proposed plan include specific provisions for improving enrollment in CMSIP/FAMIS. The County of Fairfax also commented that the plan needs to include more access improvements and that they should be implemented in Phase I. Dr. Paul Rubis, M.D., on the other hand, stated that the problem of the uninsured in Virginia does not appear to be severe enough to warrant the significant increase in Medicaid funding contained in the proposed plan.

The Virginia Society of Opthamology requested that facilities performing cataract surgery services be specifically included in Phase I of the proposed plan. The Virginia Association of Community Services Boards requested that Intermediate Care Facilities for the Mentally Retarded be specifically included in the proposed plan for deregulation in Phase I.

The Virginia Association of Nurse Anesthetists sought clarification of provisions of the proposed plan concerning ambulatory surgery centers as they relate to office-based surgery by physicians.

The 271 form letters from cancer patients indicated support for the proposed plan particularly as it relates to radiation therapy and diagnostic equipment used for cancer care. The letters stated that the proposal is a "reasonable and responsible plan."

Summary of Individual Comments

Virginia Hospital and Healthcare Association

Laurens Sartoris, President, expressed support for the proposed plan. Mr. Sartoris stated that, in implementing the plan, it will be essential to monitor health care quality, access and cost issues impacted by the deregulation plan; gauge the timeliness and effectiveness of related policy implementation; and make further recommendations to the General

Assembly on the timing and nature of each phase of the deregulation plan. According to Mr. Sartoris, "The JCHC is the best entity to perform these important tasks." Mr. Sartoris also stated that it is critical that the COPN deregulation plan:

- Remain comprehensive and inseparable in nature, and explicitly task the JCHC with the responsibility for monitoring progress on the deregulation plan and for making recommendations on subsequent steps.

- Avoid unintended consequences, and ensure that the General Assembly makes an informed decision about the timing of future COPN deregulation steps.

- Assure that the state's history of underfunding its Medicaid hospital payment is adequately addressed in Phase I. "VHHA's position is that substantial (preferably complete) progress must be made to bridge the gap between Medicaid hospital payment levels and costs as a required element in phase one of the plan."

Bon Secours Health System, Inc - Virginia Region

John T. Stone, Vice President - Advocacy, expressed support for the proposed plan "AS IS and contingent upon the required financial support from the State." Mr. Stone also stated that enforcement provisions must be developed to assure that all providers of deregulated services participate in meeting the indigent and charity care needs of Virginia. Mr. Stone stated that "it is essential that the final COPN deregulation plan be comprehensive and that the effects of deregulation in each phase be fully understood BEFORE deregulation occurs. In other words, sufficient time must be allowed to permit a reasonable assessment of the impact of Certificate of Public Need deregulation on specific services."

INOVA Health System

Donald F. Harris, Vice President, Governmental Relations, said that INOVA is "encouraged" by the results of the COPN facilitation process. INOVA strongly believes that should the proposed plan be adopted, there be no legislative "cherry picking" by organizations or individuals who would wish to have a particular service or program exempt from any phasing agreed to in the plan. Mr. Harris also stated that:

- "Implementation of the plan must avoid unintended consequences by providing mechanisms to monitor the effects of each phase before we proceed with future phases. We believe that information needs to be

made available to assess the impact on providers as each phase is fully implemented and before we move to the next phase."

- "The plan needs to provide for the additional regulatory personnel necessary to implement each phase."

Sentara Healthcare

David L. Bernd, Chief Executive Officer, said that Sentara can support the proposed plan "but only if the funding recommended by the COPN facilitation group is appropriated." Mr. Bernd said that the proposed plan "does not include everything we would like to see in such a plan particularly regarding uncompensated care...." Mr. Bernd also stated that:

- "If COPN is removed, the Commonwealth must provide fair payment for health care services while seeking to assure quality protections and access after the Certificate of Public Need phase-out begins. This is a very difficult goal to accomplish."

- Funding the proposed plan "should be a priority in the Governor's budget." "We endorse the proposal made by Delegate Hall that no phase of this plan go forward unless funding is provided in the Governor's budget as introduced."

- The proposed plan should "allow hospitals to redesignate beds within their facility."

Carilion Health System

Edward G. Murphy, M.D., Executive Vice President and Chief Operating Officer, commented that the plan seems to address most of the important issues, including quality of care and requirements for licensing and data reporting. Dr. Murphy did indicate concern about how dependent the plan is on new, uncertain funding by the General Assembly, and encouraged the JCHC to "carefully draft the proposed laws to assure funding commensurate with the level of deregulation." Dr. Murphy also noted that he hoped "more improvement to Medicaid reimbursement can be placed in Phase I." He also asked the Commission "to consider a provision in deregulation that allows existing hospitals to add to or re-designate some acute beds without a COPN." Lastly, Dr. Murphy indicated that "with adequate assurances that funding and deregulation will be inseparably linked and hopefully some changes in year one funding and on the issue of nursing home bed availability, Carilion can support the Joint Commission's recommendations and the process used for their development."

University of Virginia Medical Center

Larry Fitzgerald, Chief Financial Officer, described the proposed plan as "excellent." Mr. Fitzgerald strongly urges that there not be a "carve-out of any COPN for any service prior to the adoption of the entire comprehensive plan." Mr. Fitzgerald fully expects "the repeal of COPN to have many positive benefits, but this transition must be protected if we are to have a safety net for the uninsured, the indigent, and the training of the Commonwealth's doctors."

Virginia Association of Regional Health Planning Agencies (VARHPA)

Dean Montgomery of VARHPA expressed concern about the proposed COPN deregulation plan in that it is "substantially different from what was agreed to on September 27" at a meeting of the facilitation group. According to Mr. Montgomery, between September 27 and October 17, "there apparently were a number of closed door meetings involving staff from the medical care industry associations that substantially modified what had been accepted publicly (not objected to) on September 27." Mr. Montgomery also said that VARHPA "understood that there would be meetings of selected stakeholders to work on implementation of the September 27 package but that there would not be substantial modification to that set of recommendations."

VARHPA recommends that the JCHC COPN Subcommittee modify the facilitation recommendations "in ways that re-incorporate the more critical aspects of what was changed after the September 17 meeting." The recommended "crucial" changes are as follows:

- If the monies proposed are not all to be provided in Phase I, the plan should be implemented only as part of a biennial budget that incorporates monies for Phase I in the first year of the biennium and monies for Phase II in the second year of the biennium.

- The plan should fully cover the cost of indigent care with a combination of state (at least 50 percent) and provider monies through an expansion of the Indigent Health Care Trust Fund.

- All funding that would be implemented in phases should be initiated in Phase I.

- The Centers of Excellence voluntary designation system that was part of the September 27 package should be adopted in Phase I with regulations to specify the details.

- All of the September 27 proposals that would eliminate provisions that present higher barriers to receive medical coverage than cash assistance such as Temporary Assistance to Needy Families and Supplemental Security Income should be implemented in Phase I.

- Include in Phase II and Phase III the additional costs to Medicaid that will be incurred as a result of the increased use of services that followed the deregulation of Certificate of Public Need coverage in other states and the increased use experienced in Virginia following the partial de-regulation in 1989.

- Provide funding for graduate medical education and academic medical center research costs so that patient revenues do not have to be diverted to cover these expenses.

Central Virginia Health Planning Agency, Inc.

Karen Cameron, Executive Director/Chief Executive Officer, endorsed the comments of the Virginia Association of Regional Health Planning Agencies. Ms. Cameron expressed concern about the "lack of detail" in the proposed plan regarding (1) who would be responsible for oversight of quality of care and adequate funding for that oversight; (2) sanctions relative to non-compliance with licensure, indigent care and other requirements; (3) access to data and information by consumers and others about available services; and (4) the role of current primary care providers, such as local health departments, community health centers, rural health clinics, etc.

Northwestern Virginia Health Systems Agency, Inc.

Margaret P. King, Executive Director, endorsed the comments of the Virginia Association of Regional Health Planning Agencies.

Eastern Virginia Health Systems Agency, Inc.

Paul M. Boynton, Executive Director, stated that the proposed plan "can potentially result in a better health care system for all Virginians if it is implemented in its entirety." However, with regard to Phase I and the deregulation of MRI units, Mr. Boynton stated that there must be a "substantial increase in State Health Department monitoring staff to insure that all of the new services can be regularly inspected to assure that properly trained and credentialed professionals are operating the equipment safely and interpreting the scans correctly." Mr. Boynton noted that funds for expansion of this type of VDH monitoring activity are not included in the proposed plan.

S. Paul Klein (Consumer Representative, Valley Health Council)

Mr. Klein stated that he is "deeply concerned about the prospect of deregulation in Virginia." Mr. Klein commented that "we need assurance that a competitive health care system must guarantee quality of service." According to Mr. Klein, "Establishing standards, developing a repetitive test of those standards, and enforcement of the standards must be part of any attempt at deregulation."

George W. McCall, III (Executive Vice President, First Sentinel Bank)

Mr. McCall posed a series of questions concerning outpatient surgery and patient safety:

- What specific oversight measures are proposed to assure patient safety in the event outpatient surgery centers receive broader privileges to perform complicated procedures?

- What safeguards are proposed to assure non-exploitive patient care?

- What types of standards will be imposed on outpatient surgery centers, and how will their compliance with those standards be determined?

Virginia Oncology Associates

Dr. John Q.A. Mattern, II, President, expressed support for the proposed plan. Dr. Mattern did state that the proposed plan "is not all we had hoped it could be," due to the fact that radiation therapy services are in Phase II of the proposed plan rather than Phase I. Despite that, however, Dr. Mattern stated that the proposed plan is a "reasonable and responsible way to reform the health care market in Virginia."

Fairfax-Prince William Hematology-Oncology, P.C.

Arthur N. Kales, M.D., President, expressed support for the proposed plan. Dr. Kales did state that the proposed plan "is not all we had hoped it could be," due to the fact that radiation therapy services are in Phase II of the proposed plan rather than Phase I. Despite that, however, Dr. Kales stated that the proposed plan is a "reasonable and responsible way to reform the health care market in Virginia."

The following physicians with Fairfax-Prince William Hematology-Oncology, P.C. all submitted individual, identical comments in support of

the proposed plan: Alisan G. Kula, Anne M. Favret, Richard A. Binder, Nicholas J. Robert, Roy A. Beveridge, and Peter S. Francis.

Mid-Atlantic Consultants in Hematology Oncology

Robert L. Burger, M.D., F.A.C.P., President, expressed support for the proposed plan. Dr. Burger did state that the proposed plan "is not all we had hoped it could be," due to the fact that radiation therapy services are in Phase II of the proposed plan rather than Phase I. Despite that, however, Dr. Burger stated that the proposed plan is a "reasonable and responsible way to reform the health care market in Virginia."

Oncology and Hematology Associates of Southwest Virginia, Inc.

Gerald L. Schertz, M.D. expressed support for the proposed plan. Dr. Schertz did state that the proposed plan "is not all we had hoped it could be," due to the fact that radiation therapy services are in Phase II of the proposed plan rather than Phase I. Despite that, however, Dr. Burger stated that the proposed plan is a "reasonable and responsible way to reform the health care market in Virginia."

Anita J. Harriotte

Ms. Harriotte expressed support for the proposed plan. She stated that the proposed plan will allow for the development of integrated cancer care centers in Virginia.

National Patient Advocate Foundation

Nancy Davenport-Ennis, CEO and Founding Director, expressed support for the deregulation plan. She stated that "assuming that the phases proceed as planned, NPAF is pleased to join with the VHHA in support of this effort to allow integrated cancer care centers in Virginia." She went on to say that NPAF believes that the "plan to allow integrated cancer care centers as a part of a comprehensive health care reform package is a responsible and reasonable way to deregulate Virginia's health care market."

Virginia Chapter of the American College of Radiology (VCACR)

James A. Wassum, M.D., FACR, President, said that the proposed plan "is reasonable, workable and presents an opportunity to improve the delivery of health care services to all Virginians only if the plan's standards for ensuring quality of care and funding for improving access to health care are fully supported by the General Assembly and the Administration."

VCACR urges that (i) licensing standards for deregulated diagnostic services and providers in Phase I, and licensing standards for radiation therapy in Phase II, be implemented "by statute," and be based upon the accreditation standards of the American College of Radiology (ACR); and (ii) providers with ACR accreditation be deemed eligible for licensure. Dr. Wassum recommended that "COPN phase-out and expansion of funding for health care go hand-in-hand – or not at all."

Fairfax Radiological Consultants, P.C. (FRC)

William F. Allison, General Manager, stated that "FRC concurs with Phase I eliminating diagnostic radiology services as a good first step."

The Virginia Poverty Law Center

Jill A. Hanken, Staff Attorney, expressed support for all of the provisions of the proposed plan concerning access to care, but urges the JCHC to (1) revise the implementation time frames for Medicaid coverage of low income parents; and (2) outline specific actions for improving enrollment in children's health insurance.

Ms. Hanken stated that Phase I should include Medicaid coverage for low-income parents at 50% of the federal poverty line. Ms. Hanken stated that the JCHC should support specific actions for improving enrollment in CMSIP/FAMIS, including:

- eliminate the child support enforcement cooperation requirement,
- expand exceptions to the 12 month/6 month waiting period,
- allow adult caretakers to apply for the child's insurance,
- require continued use of a single application form for both Medicaid and CMSIP/FAMIS, and
- adopt 12-month eligibility for children in Medicaid and FAMIS.

Cardiac & Thoracic Surgical Associates

J. James Zocco, M.D., President, CTSA, directed his comments to Phase III of the deregulation plan involving organ transplants and open heart surgery programs. Dr. Zocco commented that "if the state is to license Cardiac Transplant and surgery programs, then we would like to see quantitative thresholds established in advance of final regulation." Dr. Zocco goes on to say that "Literature has shown that there is a correlation with volume and quality in high-risk services such as Cardiac Surgery and Organ Transplant." He also commented that they "would like to see the licensure requirement also consider the impact on existing high-risk

services." Dr. Zocco also inquired as to whether the data reporting and monitoring provisions of the plan would require programs to be "de-licensed" if they are not able to meet quality thresholds or volume requirements.

Paul J. Rubis, M.D.

Dr. Rubis urged the JCHC to recommend to the General Assembly that it proceed with implementation of the repeal of COPN. However, according to Dr. Rubis, there is one "central truth" that runs throughout the provisions of the proposed plan: "Virginia hospitals are fearful of increased competition." Dr. Rubis stated that, "In fact, it appears that they seek a substantial cash appropriation as their price for cooperation with the Legislature's decision to phase-out COPN."

While Dr. Rubis does not "minimize the problem of the uninsured, the problem does not appear to be severe enough to warrant the significant increase in Medicaid funding requested by Virginia hospitals." For example, based on statistics provided in JCHC's October 24th presentation of the COPN facilitation recommendations, total charity care provided by Virginia hospitals declined by more than 17 percent from 1994 to 1998, and still amounts to only 2.4% of gross patient revenues. Dr. Rubis attributes this "relatively small amount of charity care" to the fact that "we live in a prosperous state." Dr. Rubis also stated that (1) "the percentage of uninsured Virginians has actually declined slightly from 1993," and (2) "only seven other states have a lower percentage of Medicaid recipients to total population than Virginia." Dr. Rubis also stated that most Virginia hospitals are not-for-profit institutions, and do not have the tax obligations that the rest of the healthcare provider community faces. "The truth is that all healthcare providers offer charity care, and tax-exempt hospitals could stand to do more than they do."

Virginia Society of Opthamology

Dr. Garth Stevens, President, recommended that the draft plan be amended "to provide for the immediate deregulation of facilities performing cataract surgery." Dr. Stevens did acknowledge that, within the facilitation, "a procedure-by-procedure review would have been unworkable." Dr. Stevens also stated that "While we disagree with the link between deregulation and enhanced funding for Medicaid/Indigent care, we understand that this is a result of the facilitation process." Dr. Stevens stated that due to recent advancements, cataract surgery is a low cost and low risk procedure. Also, because Medicare provides reimbursement for a high number of the procedures, there would be little or no impact on Medicaid or indigent care. Dr. Stevens noted that, in light

of these considerations, deregulation of facilities performing cataract surgery in Phase I would be consistent with the intent of SB 337.

Virginia Association of Community Services Boards, Inc.

Mary Ann Bergeron, Executive Director, recommended that Intermediate Care Facilities for the Mentally Retarded (ICF-MR) be included in Phase I of the proposed plan. Ms. Bergeron stated that that would help "increase the level of community-based services to Virginians with mental retardation." As far as ICFs-MR are concerned, "COPN is unnecessary from a consumer protection perspective - consumers are well protected through other state and federal laws and regulations." According to Ms. Bergeron, while ICFs-MR can be large, better resident outcomes are derived in smaller facilities. Therefore, as part of the elimination of COPN for ICFs-MR, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) should be given the "statutory authority to limit the size of community-based ICFs-MR, based on current research and data on outcomes, through their licensure process."

Ms. Bergeron also stated that any additional data reporting required of public mental health, mental retardation, and substance abuse services (like community services boards), should take into account all current quality and outcome data reporting requirements imposed on them by DMHMRSAS. This consideration would help to minimize the data-reporting burden on these types of providers.

Ms. Bergeron also commented that, while some communities have a shortage of mental health and substance abuse facility beds, "there may be a number of beds that have a certificate of public need but are not open." This issue may be appropriate for further study.

Mount Rogers Community Mental Health and Mental Retardation Services Board

E.W. Cline, Jr., Executive Director, endorsed the comments and recommendations of the Virginia Association of Community Services Boards.

Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)

Richard E. Kellogg, Commissioner, stated that the DMHMRSAS strategic plan depends upon the expansion of community based programs which are currently regulated by COPN. DMHMRSAS wants to offer choices by expanding community alternatives for individuals who are currently in

state training centers but who could be served in smaller, community-based ICFs-MR.

Virginia Association of Nurse Anesthetists (VANA)

Leslie F. Herdegen, Legislative Coordinator, stated that VANA "is in agreement with the decision to eliminate COPN for ambulatory surgery centers." However, VANA believes that the proposed plan should be clarified in several respects, primarily as it relates to whether physician offices are considered ambulatory surgery centers.

Ms. Herdegen noted that since ambulatory surgery centers are not scheduled for deregulation until Phase III, VANA is hopeful that the Board of Medicine would be well into development of applicable regulations for office-based practice. According to Ms. Herdegen, should the new regulations be acceptable, "it may be that some office-based surgery no longer will be permitted without the office being licensed as an ambulatory surgery center. In that case, the Commission and the General Assembly could apply these [COPN deregulation plan] requirements to licensed ambulatory centers, but not to offices that are not required to hold that license."

Physics Associates

Lee S. Anthony, Ph.D., expressed support for the proposed plan and also suggested "the refinement of existing regulatory programs to protect public health and safety." Specifically, Dr. Anthony recommended that the Virginia Department of Health's Bureau of Radiological Health be allowed to promulgate an updated version of radiation protection regulations promulgated in 1988. Dr. Anthony also recommended that Virginia become a Nuclear Regulatory Commission (NRC) "Agreement State," which would allow Virginia to assume the regulation of medical and industrial radionuclide usage in the state. According to Dr. Anthony, "this has previously been approved by the General Assembly but has not been funded. Virginia has been working on this since 1964, and is now one of a small percentage of non-agreement states."

Leslie P. Foldesi, M.S., CHP

Mr. Foldesi commented on several provisions of the proposed plan which use the American College of Radiology's (ACR) various accreditation programs as the basis for a regulatory program to protect public health and safety. Mr. Foldesi stated that experience of the federal Mammography Quality Standards Act, which uses the ACR's mammography accreditation program and state inspectors conducting

field inspections of fully accredited facilities, has been very successful. However, "for those provisionally-accredited facilities where state inspectors do not conduct site visits, there have been documented abuses that include wire and health fraud." Mr. Foldesi stated that a licensure program designed to protect the public health and safety should have an adequate inspection and enforcement component.

Mr. Foldesi suggested that the state's radiation protection regulations be modified to address personnel qualifications, machine performance standards, and facility quality assurance standards for CT, nuclear medical imaging devices, lithotripters, MRI, and radiation therapy facilities using linear accelerators.

Finally, Mr. Foldesi explained that there is already a regulatory licensing program administered by the NRC that restricts the use of gamma knife equipment to qualified medical personnel. Mr. Foldesi stated that state licensure of gamma knife services may be duplicative of federal efforts, "unless the Commonwealth intends to enter into a agreement with the NRC for state regulation of this activity."

County of Fairfax

Katherine K. Hanley, Chairman of the Board of Supervisors, suggested the following changes to the proposed deregulation plan:

- Increase funding for indigent care – "we are concerned that the plan put forth does not contain additional general funding for either the Indigent Health Care Trust Fund or the State and Local Hospitalization Program, as was envisioned in the report adopted by the facilitation group."
- Expand Medicaid benefits more significantly, and begin in Phase I – "we are concerned that the expansion of the Medicaid program proposed is substantially less comprehensive than spelled out in the reports adopted by the facilitation group, and that no expansion is proposed in Phase I."
- Safeguard existing services for all residents – "the loss of revenues to local hospitals without full coverage of indigent care, without any Medicaid expansion in Phase I, and with only limited Medicaid expansion throughout the program concerns us. . ."
- Expand CMSIP/FAMIS benefits to include parents, as well as children – "we are pleased that the plan calls for a dedicated effort to enroll additional children and adults in CMSIP or FAMIS . . we strongly support this goal . . . we recognize, however, that implementing such a program will also be a time consuming process, and believe that this should be started prior to serious changes to the COPN process-not

after massive changes that may reduce access of the uninsured to services are underway."

- Deregulation must be contingent on the appropriation of the necessary resources – "we strongly support the comments of the COPN Subcommittee, at its October 24th meeting, that the implementation of any aspects of the plan MUST be contingent on the appropriation of the resources prior to its implementation."

Form Letter From 271 Cancer Patients

The form letter urges the Joint Commission to support the proposed deregulation plan, particularly as it relates to radiation therapy and diagnostic equipment used for cancer care. The letter states that "your support will allow integrated cancer care centers in Virginia that will be able to diagnose and treat cancer patients in a single location with a single team of dedicated cancer caregivers." The letter concludes by stating "This responsible and reasonable plan will help us all move forward in the war against cancer."

APPENDIX C:

Methodology for Estimating Costs Of Various Provisions Of Deregulation Plan

Data and Assumptions Used To Develop Cost Estimates of Certain Provisions Included in COPN Deregulation Plan

Funding of Indigent Care Costs at the Academic Health Centers

- The amounts used for VCU/MCV, UVA and EVMS were provided by the respective institutions and were based on Medicaid cost reports.

- The GF amounts requested for VCU/MCV and UVA would be used to draw down federal matching dollars through Medicaid enhanced disproportionate share hospital (DSH) payments. Because EVMS does not qualify for enhanced DSH payments, there would be no federal matching funds. The amount included in the plan for EVMS represents one-half of the unreimbursed indigent care at the institution.

Funding Core Costs of Undergraduate Medical Education At Academic Health Centers

- The GF amounts in the plan for funding the core costs of undergraduate medical education were provided by the respective institutions (VCU/MCV, UVA, and EVMS), and represent the current amount of faculty-earned clinical revenues that are used to support the cost of undergraduate medical education.

Increasing Medicaid Eligibility for Adult Parents to 100% FPL

- Data on uninsured persons were used from a Kaiser Foundation study (Kaiser Commission on Medicaid and the Uninsured) to arrive at an estimate of the number of uninsured adult parents in Virginia who are at or below 100% of FPL. Based on the Kaiser data, it was estimated that there are 76,513 uninsured adult parents at or below 100% FPL.
- Of this number (76,513), it was estimated that 75% of those eligible would actually enroll.
- The cost per person was the adult AFDC average expenditure per recipient for FY 1999 ($1,966) (Source: Department of Medical Assistance Services' Statistical Record)
- The calculation of costs was as follows:
    - 76,513 x .75 = 57,385
    - 57,385 x $1,966 = $112,818,910

- $112,818,418 x .4815 = $54,322,305 GF
- the total was rounded to $54 million and divided in half for the two-phase increase in eligibility to be $27 million GF in both Phase II and Phase III.

Increasing Eligibility for Aged, Disabled to 100% FPL

- Estimates calculated last year by the Department of Medical Assistance Services (DMAS) on this same issue were utilized.
- The DMAS estimate to increase eligibility to 100% of FPL for FY 2002 was $27.9 million GF. The DMAS estimate to increase eligibility to 80% FPL was $5.6 million GF.
- Since the 2000 Appropriation Act provides for an increase to 80% of FPL, the estimate for increasing eligibility to 100% FPL was calculated by subtracting the amount of funding needed to increase eligibility to 80% from the amount of funding needed to increase eligibility to 100% FPL which is $22.3 million GF.
- The amount was rounded to $22 million and then split it into equal halves for the two-phased increase in eligibility ($11 million GF in both Phase II and Phase III.)