REPORT OF THE
VIRGINIA DEPARTMENT OF HEALTH

Annual Report on the Status of Virginia's Medical Care Facilities Certificate of Public Need Program

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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TO: The Honorable James S. Gilmore, III

and

The General Assembly of Virginia

The report attached hereto is submitted in satisfaction of § 32.1-102.12 of the Code of Virginia.

This report constitutes the annual report of the Virginia Department of Health on the status of Virginia's medical care facilities Certificate of Public Need (COPN) Program. In addition to providing a summary of COPN activity for fiscal years 2000 and 2001 and addressing timeliness of COPN application review, legislation and regulation, health care market reform, accessibility to care, quality of care within the context of COPN and equipment registration, the report focuses on specific categories of regulated projects: radiation therapy, lithotripsy, obstetrical services, neonatal special care, psychiatric services, substance abuse treatment services and miscellaneous capital expenditures.

Respectfully Submitted,

Robert B. Stroube, M.D., M.P.H.
Acting State Health Commissioner

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EXECUTIVE SUMMARY

This annual report to the Governor and the General Assembly of Virginia on the status of Virginia's Certificate of Public Need (COPN) program has been developed pursuant to § 32.1-102.12 of the Code of Virginia. The report is required to address the activities of the program in the previous fiscal year, review the appropriateness of continued regulation, at least three specific project categories, the issues of access to care by the indigent, quality of care within the context of the program, and health care market reform. A copy of the enabling Code section is reproduced at Appendix A. This report includes data for the most recent fiscal year (FY) (2001) as well as FY (2000). Administrative turnover precluded the Virginia Department of Health (VDH) from completing the FY 2000 Annual Report. In addition, staff effort was directed toward providing technical assistance to the Joint Commission on Health Care's study committee developing a plan to eliminate COPN as a result of the passage of Senate Bill 337 in 2000. Had the FY2000 report been completed, it might have conflicted with the study committee's recommendations. Thus, the most recent data from FY2001 will be presented first, followed by the FY2000 data.

For the years covered in this report, the State Health Commissioner issued 158 decisions, authorizing 140 projects at a total expenditure of $1,151,398,205 and denied 18 projects with proposed capital expenditures totaling $44,539,428. (See Appendix C for a summary of these decisions.) Additional program activities are described in the "Summary of the State Health Commissioner's Actions" beginning on page 2.

The project category analyses for FY 2000 and 2001 contained in this report include radiation therapy, lithotripsy, obstetrical services, neonatal special care, psychiatric services, substance abuse services, and miscellaneous capital expenditures. The section addresses the history of COPN regulation for these project categories, the current relationship between supply and demand for these facilities and services, the perceived benefits and costs of continuing regulation in these specific categories, and the likely consequences of eliminating or modifying COPN regulation in those areas. Recommendations concerning the selected project categories are:

1. Issue a Request for Applications (RFA) for additional radiation therapy services based on a collaborative review with affected parties to determine the need for and location of additional services. Though this would require a legislative change, it would meet the planned need for new services in appropriate planning districts in a market competitive manner and improve access;
2. Support efforts to deregulate COPN for lithotripsy. Regulation and restriction of this relatively low cost service provides little benefit to the public;

3. Support efforts to deregulate COPN for obstetrical services. The urban and suburban market appears to be well served with regards to obstetrical care. There has been little interest in the further development of obstetrical services in rural areas, which is where, if at all, the service remains in short supply;
4. Issue a Request for Applications (RFA) for additional neonatal special care services based on a collaborative review with affected parties to determine the need for and location of additional services, therefore assuring access where needed. Though this would require a legislative change, it would meet the planned need for new services in appropriate planning districts in a market competitive manner and improve access;
5. Support efforts to deregulate psychiatric services. There are typically few to no requests for psychiatric services and the service falls under the auspices of the DMHMRSAS, which favors deregulation of their services from COPN;
6. Support efforts to deregulate substance abuse services. There are typically no requests for substance abuse services and the service falls under the auspices of the DMHMRSAS, which favors deregulation of their services from COPN; and
7. Continue to review all capital expenditures of $5 million or more to assure appropriate use of limited health care dollars, with the exception of expenditures for parking structures and road improvements.

Compliance with the conditions to provide charity care remains relatively poor. A detailed chart of charity care provided through 1999 by hospitals within each planning district can be found in Appendix G. However, this is the first year that compliance with the conditions of COPN will be considered during the annual licensure renewal of hospitals and nursing homes.

Preface

This 2001 annual report to the Governor and the General Assembly of Virginia on the status of Virginia's Certificate of Public Need (COPN) program has been developed pursuant to § 32.1-102.12 of the Code of Virginia. It includes data for the most recent fiscal year (2001) as well as the previous one (2000); administrative turnover precluded the Virginia Department of Health (VDH) from completing the fiscal year (FY) 2000 study and staff effort was directed toward providing technical assistance to a legislative study committee developing a plan to eliminate COPN. Additionally, had the FY2000 report been completed, it might have conflicted with a legislative study written by the Joint Commission on Health Care on COPN. Thus, the most recent data from FY2001 will be presented first, and the FY2000 data will follow it. A copy of the enabling Code section is reproduced at Appendix A.

The COPN Program is a regulatory program administered by the Virginia Department of Health (VDH). The program was established in 1973. The preamble of the legislation states the objectives of the program are: (i) promoting comprehensive health planning to meet the needs of the public; (ii) promoting the highest quality of care at the lowest possible cost; (iii) avoiding unnecessary duplication of medical care facilities; and (iv) providing an orderly procedure for resolving questions concerning the need to construct or modify medical care facilities. In essence, the program seeks to contain health care costs while ensuring financial and geographic access to quality health care for Virginia citizens at a reasonable cost. The current regulatory scope of the program, as defined in Virginia law, is shown in Appendix B.

The statute establishing Virginia's COPN program is found in § 32.1-102.1 et seq. of the Code. The State Health Commissioner (Commissioner) must authorize capital projects regulated within the COPN Program prior to implementation. The Commissioner must be satisfied that the proposed project meets public need criteria. The Code specifies 20 factors that must be considered in the determination of public need.

SUMMARY OF THE STATE HEALTH COMMISSIONER'S ACTIONS AND OTHER COPN PROGRAM ACTIVITY DURING FISCAL YEARS 2001 AND 2000

Project Review

Decisions

Fiscal Year 2001

During FY01, the Division of Certificate of Public Need (DCOPN) of VDH, which assists the Commissioner in administering the COPN program, received 100 letters of intent to submit COPN requests and 68 applications for COPNs. There were 32 letters of intent or applications withdrawn by applicants or which lapsed during the year. Letters of intent are required of all persons intending to become applicants for COPNs. These letters describe the proposed project in enough detail to enable VDH to batch the project in an appropriate review cycle based on the information, and provide the applicant with the appropriate COPN application package for the

proposed project. A letter of intent will lapse if a COPN application is not submitted within a year of the time the letter of intent was submitted. The date in which a letter of intent will lapse may occur in different fiscal years.

In FY2001 the Commissioner issued 68 decisions on requests to establish new medical care facilities or modify existing medical care facilities. Sixty-two (62) of these requests were approved or conditionally approved, at a total authorized capital expenditure of $585,591,415. Six (6) requests were denied. These six denied projects had proposed total capital expenditures of $16,446,767. COPN decisions in FY01 are profiled in Appendix C.

Fiscal Year 2000

In FY2000 there were 93 letters of intent and 90 COPN decisions rendered by the Commissioner. Thus, three letters of intent lapsed or were withdrawn. Seventy-eight of these requests were ultimately approved, resulting in a total capital expenditure of $565,806,790. Twelve requests were denied. Had they been approved, the 12 denied projects would have had a total capital expenditure of $28,092,661. COPN decisions in FY00 are also profiled in Appendix C.

Table 1. COPN Activity Summary

Fiscal Year	Total COPN Applications	Approvals	Denials
2000	90	78	12
2001	68	62	6

The DCOPN not only assists the Commissioner in the administration of the COPN program by providing technical support such as historical financial data and other information, but it provides written recommendations addressing the merits of approval or denial of COPN applications. The DCOPN provides advisory reports on all completed applications that are not subsequently withdrawn.

COPN advisory reports are also provided to the Commissioner by the health planning agencies. The health planning agencies are not-for-profit corporations that receive state funding to conduct regional health planning and to provide an independent recommendation to assist the Commissioner in the COPN decision process. The regional health planning agencies conduct public hearings and make recommendations to the Commissioner concerning the public's need for proposed projects in their respective regions. The five health planning regions in Virginia are shown on the map in Appendix D.

Adjudication

If the DCOPN or one of the regional health planning agencies recommends denial of a COPN project, or if requested by any person seeking to demonstrate good cause an informal fact-finding conference (IFFC) is held. These conferences, conducted in accordance with the

Administrative Process Act, are usually held for the purpose of providing the applicant with the opportunity to submit information and testimony in support of a project application. An IFFC is also held when two or more requests are considered to be competing to provide the same or similar services in the same jurisdiction and one or more of the requests are denied. Another purpose for IFFCs is to permit persons opposed to a project, who have shown good cause, to voice their concerns.

During the IFFC, the applicant or other interested party provides testimony that he hopes will be persuasive to the VDH Adjudication Officer presiding at the IFFC, in making his recommendation to the Commissioner. The IFFC is the central feature of an informal adjudication process that serves as an administrative appeal prior to final decisions on projects by the Commissioner.

There were 30 COPN applications warranting IFFCs convened in FY2001 and 44 in FY2000[1]. This difference can largely be attributed to the number of nursing home IFFCs in FY2000.

The number of COPNs warranting an IFFC that were ultimately approved in FY2001 was 21. Six were denied. In one instance the adjudication officer decided the project did not warrant a COPN. Two projects heard at IFFC in FY2001 still have decisions pending and will be resolved in the Fall of 2001. In FY2000 the number of IFFC projects that were successful in gaining Commissioner approval totaled 19. Twenty-five were denied.

In FY2001, there were 20 individual hearings, while there were 31 such hearings in FY2000. An individual hearing means the project under consideration was not a project competing with another similar project. Six applications in both FY2000 and FY2001 were competing ones.

The COPNs requesting MRI, CT, and PET services can be further categorized into diagnostic imaging equipment. Thus, in FY2001 there were 15 IFFCs for diagnostic imaging equipment, representing 75% of the total IFFCs for that fiscal year. In FY2000, there were only 6 IFFCs for diagnostic imaging equipment, which represents 14% of all diagnostic imaging requests in FY2000.

Table 2 illustrates the types of projects that were forwarded to an IFFC in FY00 and FY01.

[1] Although these COPNs were forwarded to an IFFC in their respective fiscal year, the year in which the COPN application was submitted may have occurred in an earlier fiscal year.

Table 2 IFFC Projects in FY 00 and FY01

Project Type	FY00	FY01
Nursing Home	17	0
Outpatient Surgery Hospitals	10	6
Lithotripsy	5	1
Magnetic Resonance Imaging	4	5
CT Services	2	6
Expand/Renovate Hospital	2	0
Radiation Therapy	1	0
Relocate/Replace Hospital	1	0
Med. Rehab. Services	1	0
Add Operating Rooms	1	2
Trauma Services	0	1
Add Hospital Beds	0	3
PET services	0	4
Add OB/GYN Services	0	1
Add Psych Services	0	1
TOTAL	44	30

Section 32.1-102.12 of the Code requires this report to consider three COPN project categories. For FY 2001, the project categories are:

- psychiatric services
- substance abuse treatment services
- miscellaneous capital expenditure

The one IFFC in this area concerned an application to establish a 32-bed psychiatric and substance abuse treatment unit in Richmond. The application was ultimately approved by the Commissioner.

The project categories for FY2000 include:

- radiation therapy
- lithotripsy
- obstetrical services
- neonatal special care

In FY2000, there was one IFFC held concerning a COPN seeking to establish radiation therapy, five for the provision of lithotripsy services, and none for obstetrical services or neonatal care.

The one FY2000 radiation therapy COPN was approved in the amount of $4,677,510.

The five lithotripsy COPNs that went to IFFC met with mixed results. Two were approved and three were denied. The approved projects resulted in capital expenditures of $600,000. This amount represents the total amount of one of the projects as the other had no costs involved. Had the denied projects been approved, the total capital expenditures would have totaled $2,971,921.

In summary, there were a greater number of COPNs warranting an IFFC for FY2000 than there were in FY2001. Some of the difference can be attributed to the competing responses to the

nursing home request for applications (RFA). There were 44 COPN projects warranting an IFFC in FY2000 as opposed to 30 in FY2001. In FY2001, 21 COPN requests that went to IFFC were approved, and 6 were denied. In FY2000, 19 COPN requests warranting an IFFC were approved while 25 were denied. However, the number of individual IFFCs did not vary appreciably between the 2 years. There were 30 IFFCs in FY2001 and 31 in FY2000. (Note that some IFFCs are for multiple competing requests being heard concurrently).

Judicial Review

FYs 2000 and 2001

COPN decision challenges are not limited to administrative appeals. Once an applicant has exhausted his administrative remedies, he can take his claim to state court for judicial review. Four applicants availed themselves of this remedy in FY01.

Chippenham & Johnston-Willis Hospitals sought to appeal the Commissioner's decision to deny Chippenham & Johnston-Willis Hospitals' (Chippenham) petition to participate as a good cause party in the COPN application of the Bon Secours Health System to build a replacement facility for the Bon Secours Stuart Circle Hospital. By filing its good cause petition, Chippenham sought to participate as a party to the COPN review process, oppose the application, and challenge the approval recommendation of the regional health planning agency. The circuit court of appeals upheld the Commissioner's decision to deny Chippenham's petition to participate as a good cause party. Chippenham has submitted an appeal from the circuit court of appeals to the Supreme Court of Virginia.

The second judicial review resulted from the denial of a request for the development of an outpatient surgical hospital submitted by a podiatrist. The circuit court has upheld the Commissioner's decision in this case as well. There are no known appeals.

Sentara Health System challenged the Commissioner's November 3, 1997 decision that there was no public need for Sentara to establish the Commonwealth's fourth liver transplant service. The challenge resulted in the third judicial review in FY 2001. Sentara contended that the Commissioner's decision was unsupported by the record. The Circuit Court of the City of Norfolk upheld the Commissioner's decision while the Court of Appeals did not. The Supreme Court has reversed the Court of Appeals in this case.

The final instance of judicial review resulted from the denial of Georgetown University's request to establish a dedicated linear accelerator to provide stereotactic radiosurgery in Georgetown's Fairfax Radiation Center. Although the original denial resulted from a 1997 application, the Circuit Court of Arlington County decided the case in support of the Commissioner's denial.

There is a request for appeal on behalf of the Urosurgical Center of Richmond regarding the denial of its request for the establishment of computed tomography services in the greater Richmond area. The Commissioner based her denial on, among other reasons given, that there

was no demonstrated public need for additional CT imaging services in PD 15 that could not be met through the use of existing CT imaging capacity. There has been no final judicial determination on this issue.

Certificate Surrenders
FY2001

Infrequently, an applicant awarded a COPN may have reasons to surrender it. A typical reason would be the inability to proceed with the project. In FY2001, there was only one certificate surrender. Riverside Health System surrendered a COPN to establish computed tomography services authorized under COPN No. VA-03506. The total authorized capital cost of the project was $306,824. The certificate was surrendered because the information and circumstances that lead to its approval changed. Rather than acquire an existing CT scanner and relocating it, as was proposed in the COPN, Riverside sought to purchase a new CT scanner for the same location. Riverside revised the information set forth in the surrendered certificate when it applied for COPN VA-06496, which was granted. The total authorized capital cost of the revised project was $ 912, 427.

FY2000

There were no surrenders of COPN certificates in FY2000.

Significant Changes

FY2001

A significant change results when there has been any alteration, modification, or adjustment to a reviewable project for which a COPN approval has been issued. To be considered a significant change that alteration, modification, or adjustment must change the site, increase the authorized capital expenditure by 10% or more, change the service proposed to be offered, or extend the schedule for completion of the project beyond three years (36 months) from the date of certificate issuance or beyond the time period approved by the Commissioner at the date of certificate issuance.

The Commissioner reviewed five requests for significant changes in FY2001. Four of the significant changes were authorized and the fifth required a resubmission of a COPN request. Three of those significant changes authorized involved an increase of authorized capital expenditure by 10% or more. The first involved an increase in capital costs from $2.01 million to $2.41 million for a project to add beds to a nursing home. The second increased the approved capital cost amount from $6.01 million to $6.76 million for the addition of operating rooms. The last of the authorized significant changes requested an increase in capital costs from $129.2 million to $151.4 million for a major hospital renovation and building project. The fourth approved significant change was for a change of site of a CT scanner.

The fifth request for a significant change requested an increase in the total authorized capital cost of more than 20% higher. Because the proposed change entailed a significant dollar variance of more than 20% above the authorized project capital cost, it was outside the scope of the Commissioner's authority to authorize. The applicant was required to either submit an entirely new COPN application or reduce the cost of the project to a level that was approvable by the Commissioner. The applicant reduced the scope of the project to reduce the capital cost to a level that the Commissioner could authorize and resubmitted the significant change request, which was subsequently authorized.

There were more significant changes requested in FY2001 than in FY 2000, but more importantly the dollar value represented by the FY2001 requests was substantially larger. The 3 approved FY 2001 significant change requests involving an increase in capital costs had a value of $23,350,000 versus the 2 requests for increased capital costs in FY2000 that had a value of $ 10,347,168. The significant change requests in FY2001 dealt with substantial cost estimating errors on the part of the applicant's architect and inflationary cost increases resulting in long delays in the process then in effect for COPN review. In addition to delays resulting from missing review deadlines several delays resulted from the request for applications (RFA) process and litigation that followed the Commissioner's decision.

FY2000

In FY2000 there were three requests for significant changes in authorized projects. Two involved an increase in capital funds and the third concerned changing the site of a proposed project. The first significant change requested an increase in capital costs from $673,700 to $748,395 for the change of a site for a transitional care unit. The second significant change request also involved a capital expenditure increase, from $74,677,527 to $84,950,000, for a replacement hospital. The third requested a change of site for a nursing home in Lee County. All 3 requests were authorized.

Competitive Nursing Home Review

Effective July 1, 1996, a general prohibition on the issuance of COPNs that would increase the supply of nursing home beds in the Commonwealth, commonly known as the "nursing home bed moratorium," which had been in place in Virginia statute since 1988, was replaced with an amended process governing COPN regulation of increases in nursing home bed supply (Va. Code §32.1-102.3:2). The new process requires the Commissioner to issue, at least annually, in collaboration with Virginia's Medicaid Program, a Request for Applications (RFA), which will target geographic areas for consideration of increased bed supply and establish competitive review cycles for the submission of applications. In FY 97, VDH promulgated amendments to the Virginia State Medical Facilities Plan (12 VAC 5-360-10) to implement this new process. These regulatory amendments became effective in January 1997.

On March 24, 2000 an RFA was issued for the addition of 17 nursing home facility beds in PD 15. The beds were to be specific to patients with irreversible physical disabilities. A single

applicant, the Virginia Home, responded to the RFA and subsequently was issued COPN authorizing the addition of 17 beds.

A RFA for the year 2001 is currently being developed and is expected to be issued prior to the end of the calendar year.

TIMELINESS OF COPN APPLICATION REVIEW

During the 1999 General Assembly session, two bills, House Bill (HB) 2369 and Senate Bill (SB) 1282 were passed. They specified certain timelines for the COPN application review process. The 2000 session of the General Assembly passed additional modifications to the COPN review schedule to correct conflicts created in the 1999 session between the regulations governing the COPN review process and the timelines put forth by the Administrative Process Act. A flow chart illustrating COPN timelines as a result of these and other bills can be found at Appendix E. The flow chart identifies the time periods within which VDH is to perform certain COPN functions.

As a result of these legislative changes, all COPN recommendations by DCOPN must be completed by the 70th day of the review cycle. Review cycles begin on the 10th day of each month. FY2001 data demonstrate DCOPN's success in meeting the timelines specified for COPN review. All 68 COPN applications from FY2001 were reviewed within the statutory limit. All 90 of the FY 2000 application reviews were also completed on time in accordance with the statutory time limits.

The Code also specifies the time frame in which the Commissioner must render a decision. Decisions must be rendered within 190 days of the start of a review cycle. In FY2001, all of the Commissioner's decisions were rendered within this time period. These facts demonstrate a marked improvement by VDH in the timeliness of COPN application review.

Although the timeliness for COPN application review represents a success, there remain opportunities for improvement in the timeliness of action on project registrations and extensions of certificates as well as in VDH's response time to significant change requests.

The requirement for registration of equipment replacement, medical care facility acquisitions and capital expenditures between one and five million dollars was placed in the statute in 1999. There are no FY2000 data available. However, there is no statutory time frame in which VDH must respond to such registrations. In FY2001, there were 54 registrations submitted. VDH has sent a letter to the registrants acknowledging receipt of and extending 19 of these 54 registrations. Another 35 of them still require a letter to be written. Of the 35 outstanding letters, 21 are to respond to registrations that are in excess of 6 months old. The delays in addressing the extensions has resulted from the DCOPN staff's priority shift to meeting the statutory timelines applied to project review.

VDH is required to respond to requests for extensions of current certificates within 30 days. In FY2001 there were 90 requests for such extensions. Fifty-six of these requests have been

acted upon within the 30-day time period. Of the 34 requiring action, all were submitted to VDH more than 90 days ago.

LEGISLATION

2000

In the 2000 session of the General Assembly there were 8 Senate bills and 12 House bills that called for the deregulation of some or all services and equipment regulated by COPN. They ranged in scope from complete deregulation of all services (SB 337, Martin) to less comprehensive bills that would have deregulated just specialized centers for outpatient surgery (HB 730, Griffith). Three of these bills were passed by the General Assembly, SB 337, in a compromised version, HB 326 and HB 1270. The passed version of SB 337 established the process by which the Joint Commission on Health Care would develop a plan for the phased deregulation of COPN.

Delegate Black introduced HB 326 that exempted a continuing care retirement community for retired military officers from a condition placed on their COPN. This bill was passed and the exemption has been implemented.

Delegate Rust sponsored HB 1270 that reconciled the timelines mandated for the COPN review process with the Administrative Process Act to correct discrepancies made in changes enacted in the 1999 session. This bill, too, passed.

2001

Four bills affecting the COPN program were introduced during the 2001 session of the General Assembly. Two bills (HB2155/SB1084) arose from the work conducted by a special task force of interested stakeholders that was convened by the Joint Commission on Health Care. The special task force was mandated by SB337 (2000 Session). Senate Bill 337 required the establishment of a schedule to eliminate COPN. The 2001 bill described a three-phased plan addressing particular specialty services and included separate enactment clauses allowing for implementation of the plan, as funding for Virginia's indigent health care programs, (i.e., Medicaid, the Academic Medical Center indigent care, and the Indigent Care Trust fund), becomes available. Both bills died in their respective finance committees as the associated funding amount ($157 million) could not be accommodated within the Governor's proposed budget and legislators were unable to find the needed funding from other sources. In addition, a faction of the legislature that supports the elimination of the COPN program introduced two bills (HB2800 and SB1390) in response to HB2155 and SB1084. These bills mirrored HB2155 and SB1084 although they provided no funding for indigent health care. HB2800 did not survive its committee assignment. SB 1390 was referred to the Finance Committee, where no action was taken.

The Joint Commission on Health Care has announced it will be reviewing the proposed funding amounts during one of its fall meetings with the intent of decreasing, if possible, the amount needed to fully fund their proposal to eliminate the COPN program.

REGULATION

Legislation from the 1999 and 2000 sessions of the General Assembly directly impacted selected sections of the COPN and State Medical Facilities Plan (SMFP) regulations. Amendments to the regulations included: (i) reduction in the scope of the program, (ii) modification of the criteria for the annual report on program activities, (iii) simplification of the fee schedule, (iv) modification of the response time on disputed projects, and (v) including the requirement to address the special needs of rural localities when making COPN decisions. The essence of the amendments reduced the burden imposed by the COPN program on persons subject to the regulation. In addition, a provision of the SMFP regarding liver transplantation services was found to be outdated, inadequate and otherwise inapplicable and in need of revision. The current volume standard of 12 for liver transplantation procedures to ensure a successful liver transplantation program is far below the nationally recommended number of 20 procedures. This provision was included in emergency regulations that expired in January 2001 but which are in the promulgation process now.

FIVE-YEAR SCHEDULE FOR ANNUAL PROJECT CATEGORY ANALYSIS

Overview

For purposes of understanding the pattern of change in supply of many types of medical care facilities and services in Virginia since 1973, the year of the COPN program's inception, it is useful to understand that the program's 28 years can be segmented into three distinct periods, which can be characterized as regulatory, non-regulatory, and return to regulation. Those periods are: 1) 1973 to 1986, a period of relatively consistent regulation; 2) 1986 to 1992, a period of dramatic deregulation; and 3) 1992 to the present, a period in which Virginia revived COPN regulation but also began, in 1996, a process of review and consideration of the scope of the new regulatory environment.

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

Beginning around 1986 and through 1992, there was a period of "de facto" (1986 to mid-1989) and formal (mid-1989 to mid-1992) deregulation. Few proposed non-nursing home projects were denied during this period, followed by the actual deregulation of most non-nursing

home project categories. There was a growth of most specialized diagnostic and treatment facilities and services that were deregulated.

On July 1, 1992, Virginia "re-regulated" in response to the perceived excesses of the preceding years of deregulation, however no process had been set up to evaluate whether there were actually any service capacity excesses. Re-regulation brought the scope of COPN regulation on non-nursing home facilities and services to a level similar to that in place prior to 1989. This updated and tightened project review standards and took a more rigorous approach to controlling growth in the supply of new medical care facilities and the proliferation of specialized services.

In recent years, VDH has taken an incremental approach to reviewing COPN regulation in response to legislative initiatives, by de-emphasizing regulation of replacement and smaller, non-clinically related expenditures, and focusing COPN regulation on new facilities development, new services development, and expansion of service capacity. As a result of legislation passed during the 2000 session of the General Assembly a plan was developed by the Joint Commission on Health Care for the phased deregulation of COPN in a manner that preserves the perceived positive aspects of the program. Due to the high cost of implementing the plan it failed to gain General Assembly support in the 2001 session and was not enacted.

In accordance with section 32.1-102.12 of the Code, VDH has established a five-year schedule for analysis of all project categories within the current scope of COPN regulation that provides for analysis of at least three project categories per year. It is attached to this report as Appendix F.

In calendar year 2000 DCOPN focused its reporting efforts in support of the Joint Commission on Health Care development of a plan for deregulating COPN in response to SB 337. Therefore the annual report was not completed in 2000. The three project categories that would have been discussed in the 2000 report will be included in this report along with the FY2001 project categories. Thus, this annual report considers the appropriateness of COPN regulation of FY 2000's project categories, which include radiation therapy, lithotripsy, obstetrical services and neonatal special care and FY 2001's project categories of psychiatric services, substance abuse services and miscellaneous capital expenditures.

PROJECT CATEGORY ANALYSES

Section 32.1-102.12 of the Code provides guidance concerning the content of the project analysis. It requires the report to consider the appropriateness of continuing the certificate of public need program for each of the project categories. It also mandates that, in reviewing the project categories, the report address:

- the review time required during the past year for various project categories;
- the number of contested or opposed applications and the project categories of these proposed project categories;

- the number of applications upon which the health systems agencies (regional health planning agencies) have failed to act in accordance with the timeliness of section 32.1-102.B of the Code, and the number of deemed approvals from the Department because of their failure to comply with the timelines required by statute; and
- any other data determined by the Commissioner to be relevant to the efficient operations of the program.

As stated above, FY 2000's project categories include radiation therapy, lithotripsy, obstetrical services and neonatal special care.

In FY200 there were 5 COPN applications for the introduction of radiation therapy equipment, 3 for mobile lithotripters and 1 for the introduction of obstetrical care. There were no COPN requests for neonatal specialty care. The total capital expenditure of these nine requested projects totaled $11,048,211. Because two were not approved, the total capital expenditure of the approved projects was $9,612,711.

Radiation Therapy

The SMFP defines radiation therapy as a "clinical specialty in which ionizing radiation is used for treatment of cancer, often in conjunction with surgery or chemotherapy or both of these treatment methods. The predominant form of radiation therapy involves an external source of radiation whose energy is focused on the diseased area." It includes megavoltage radiation therapy, stereotactic radiosurgery, as well as gamma knife procedures.

In FY2000 there were 5 requests for radiation therapy services COPNs. The Commissioner approved all 5 COPN requests. The resultant capital expenditure amount for radiation therapy services COPNs in FY2000 was $7,071,487.

The following radiation therapy COPNs were authorized in FY2000:

- The introduction of stereotactic radiosurgery at an existing facility in northern Virginia. It was the first of two COPNs requested for stereotactic radiosurgery during this time period. Stereotactic radiosurgery means, according to the SMFP, "a noninvasive therapeutic procedure in which narrow beams of radiant energy are directed at the treatment target in the head so as to produce tissue destruction, using computerized tomography (CT), radiography, magnetic resonance imaging (MRI), and angiography for localization." The Commissioner approved the COPN request, basing her opinion on, among other factors, an earlier project review by the regional health planning agency that concluded stereotactic radiosurgery services were best located in major medical centers. The applicant was a major provider of radiation oncology with a demonstrated appropriate patient population and, thus, she concluded, a logical site for introduction of the service.

- The addition of radiation therapy equipment for use in an existing hospital radiation oncology department to serve the Tidewater area. The project involved the construction

of a 2,535 gross square foot vault to house a second linear accelerator. Linear accelerators are machines used to generate intense radiation for therapeutic purposes. The Commissioner approved the project noting that it was generally consistent with the SMFP standards for the addition of radiation therapy equipment and that it was not expected to have an adverse impact on the utilization, costs or charges of any other provider of radiation therapy services in the health planning region.

- The introduction of radiation therapy services at an existing medical care facility on the Eastern Shore of Virginia. It entailed the establishment of a radiation therapy facility, and was the most expensive of all FY2000 COPN requests for radiation therapy services. The Commissioner likewise approved this project. One of the reasons cited for approval included the project's proposed ability to improve access to radiation therapy services for residents of the Virginia Eastern Shore, a predominantly rural and geographically isolated locality with an extremely high poverty rate.

- The introduction of stereotactic radiosurgery in western Virginia. The Commissioner approved this COPN request for reasons consistent with the earlier stereotactic radiosurgery request approval, i.e. the applicant, as a major provider of radiation oncology services with a demonstrated appropriate patient population, would be a logical site for the introduction of stereotactic radiosurgery.

- The introduction of radiation therapy services in Bedford County. There were no capital costs associated with the project because it was a revival of a discontinued service. The applicant requested authorization to revive the service in response to increased demand for, and heightened physician interest in, providing the service. The Commissioner approved the project, noting it would improve access to radiation therapy services and that there was no cost associated with the improved access.

Appropriateness of Continuing COPN for Radiation Therapy

The FY2000 COPN experience concerning radiation therapy supports a contention that the program is appropriate for these services. As mentioned earlier, one of the goals of the COPN program is the promotion of comprehensive health planning to meet the needs of the public. Although the Commissioner approved all of the radiation therapy COPNs, they were all approved for reasons that further comprehensive health planning goals. All of the applicants were successful in satisfying the COPN criteria concerning their respective project's ability to improve access to the service. The continuation of the COPN program for radiation therapy is appropriate. However, there are alternatives to consider.

Options:

No Change: Continue applying the COPN program to radiation therapy services as currently outlined. Ongoing efforts to review, and where appropriate, update the SMFP will address necessary changes to the review criteria. This option would likely be supported by everyone except oncology physicians and the Medical Society of Virginia (MSV). Individual physicians and the MSV have come before the General Assembly several times in support of legislation to

deregulate radiation therapy services under the theory that deregulation will improve access to treatment resulting from a proliferation of free-standing radiation therapy treatment centers.

Minimal Change: In collaboration with the hospital industry, physicians, consumers and advocates, VDH could produce a comprehensive assessment of the State's needs for radiation therapy services and by way of a targeted RFA publicize the locations where a demonstrated need for new or additional radiation therapy services existed as a means of stimulating interest in requesting authorization for development of the service.

Deregulation: Support efforts outside the comprehensive Joint Commission on Health Care's plan to deregulate just radiation therapy services. The physicians and other advocates will welcome this option but hospitals and other existing providers of the service will oppose it.

RECOMMENDATION: DCOPN could issue a Request for Applications (RFA) for additional services based on a collaborative review with affected parties to determine the need for and location of additional radiation therapy services. This would meet the planned need for new services in appropriate planning districts in a market competitive manner and improve access.

Lithotripsy

Lithotripsy is a short-hand term for extracorporeal shock wave lithotripsy. It is defined in the SMFP as a "noninvasive procedure that uses shock waves produced outside the body to fragment matter, such as stones that occur in the kidney or upper urinary tract (renal stones)."

In FY2000 there were 3 requests for COPNs to provide lithotripsy services. Had the three applications been approved, the resultant capital expenditures would have totaled $1,435,500. However, because two requests were denied and the final approved proposal had no capital expenditures associated with it, there were no capital expenditures for lithotripsy services in FY2000. Equally important, the Commissioner determined the approved project would not have a negative impact on the utilization, costs, or charges of any other provider in the planning district.

Decisions were made for the following lithotripsy COPN requests in FY2000:

- Request to establish mobile lithotripsy services for a group of member hospitals by the introduction of a portable lithotripter. The Commissioner denied the request primarily because the use of existing lithotripsy services in Planning Districts 8 and 9 had not been maximized and the applicant was unable to put forth data that would demonstrate a public need existed.

- The second and third requests were competing applications. The second COPN request for lithotripsy services entailed the relocation of an existing mobile lithotripsy unit from a hospital in Portsmouth to one in Suffolk. Thus, there were no costs associated with the project. The Commissioner approved the project, citing its ability to enable to applicant to continue to provide the services in an efficient manner. She also noted the proposed project would not have a negative impact on the utilization, costs, or charges of any other provider in the planning district.

- The competing request for the addition of a second mobile lithotripsy unit to serve the applicant's three contracted facilities in eastern Virginia. The Commissioner denied the application because the applicant did not demonstrate a need for additional lithotripsy equipment capacity. She found the existing lithotripter to be underused and with no demonstrated public need to expand its capacity. She also found there was a reasonable and less costly alternative to the proposed project.

Appropriateness of Continuing COPN for Lithotripsy

The FY2000 COPN experience concerning lithotripsy supports, even more strongly than the radiation therapy information, the contention that the COPN program is appropriate for certain services. As noted above, had the three COPN applications for lithotripsy been approved, the resultant capital expenditures would have totaled $1,435,500. In addition, absent the COPN program, lithotripsy services would have been added to planning districts where such services had not been maximized. Thus, the COPN program prevented unnecessary capital expenditure as well as duplication of services.

However, as the cost of lithotripsy equipment has come down substantially over the last 10 years the actual capital cost impact of growth in the availability of the service is relatively minor. The dilution of utilization of existing providers would occur with the introduction of additional capacity in areas that have yet to maximize the efficient utilization of their existing services. Again, the financial impact of this would be relatively minor. For these reasons the Joint Commission on Health Care enjoyed unanimous support from participating parties when developing a plan for the overall deregulation of the COPN program for the early and unconditional deregulation of lithotripsy services.

Options:
No Change: Continue the applying the COPN program to lithotripsy services as currently outlined. Ongoing efforts to review, and where appropriate, update the SMFP will address necessary changes to the review criteria.

Minimal Change: In collaboration with the hospital industry, physicians, consumers and advocates, VDH could produce a comprehensive assessment of the State's needs for lithotripsy services and by way of a targeted RFA publicize the locations where a demonstrated need for new or additional lithotripsy services existed as a means of stimulating interest in requesting authorization for development of the service.

Deregulation: Support efforts outside the comprehensive Joint Commission on Health Care's plan to deregulate just lithotripsy services. Everyone except perhaps current providers of the service will support this option.

RECOMMENDATION: Support efforts to deregulate COPN for lithotripsy. Regulation and restriction of this relatively low cost service provides little benefit to the public.

Obstetrical

There was only one COPN for obstetrical services in FY2000. The services are termed "basic obstetrical services" in the SMFP and are defined as "the distinct, organized inpatient facilities, equipment and care related to pregnancy and the delivery of newborns." The one COPN for obstetrical services projected capital expenditures at $2,541,224. Because it was the only COPN application submitted for the provision of obstetrical services (OB), and it was approved, this amount represents the total capital expenditures for COPNs requesting OB services in FY2000.

The applicant proposed introducing OB services through the renovation of existing space within its hospital. The total bed complement would be reduced because of the renovation. The Commissioner approved the project because it allowed for improved access to obstetric care in a rural medically and perinatally underserved area.

Appropriateness of Continuing COPN for Obstetrics

Options:
No Change: Continue the applying the COPN program to obstetric services as currently outlined. Ongoing efforts to review, and where appropriate, update the SMFP will address necessary changes to the review criteria.

Minimal Change: In collaboration with the hospital industry, physicians, consumers and advocates, VDH could produce a comprehensive assessment of the State's needs for obstetric services and publicize the locations where a demonstrated need for new or additional obstetric services existed as a means of stimulating interest in requesting authorization for development of the service.

Deregulation: Support efforts outside the comprehensive Joint Commission on Health Care's plan to deregulate just obstetric services.

RECOMMENDATION: Support efforts to deregulate COPN as it applies to obstetrical services. The urban and suburban market appears to be well served with regards to obstetrical care. There has been little interest in the further development of obstetrical services in rural areas, which is where, if anywhere, the service remains in short supply.

Neonatal Special Care Services

Neonatal special care is defined in the SMFP as "care for infants in one or more of the eight patient categories identified by the Perinatal Services Advisory Board in its 'Guidelines for Neonatal Special Care.' " No requests for neonatal special care were reviewed in FY 2000. It has been some time since a request for a COPN has been received for this service.

Neonatal special care is a service that has typically been established as a regional service, recognizing that with effective maternal and neonatal transport programs not every facility providing obstetric services needs the expense of a capital and labor intensive neonatal special care unit. Additionally, a well-trained and experienced staff is critical to the success of these programs. Regionalization of this service concentrates patients at the most appropriate sites, which in turn creates the most experienced staff.

Options:
No Change: Continue the applying the COPN program to neonatal special care services as currently outlined. Ongoing efforts to review, and where appropriate, update the SMFP will address necessary changes to the review criteria.

Minimal Change: In collaboration with the hospital industry, physicians, consumers and advocates, VDH could produce a comprehensive assessment of the State's needs for neonatal special care services and by way of a targeted RFA publicize the locations where a demonstrated need for new or additional neonatal special care services existed as a means of stimulating interest in requesting authorization for development of the service.

Deregulation: Support efforts outside the comprehensive Joint Commission on Health Care's plan to deregulate just neonatal special care services.

RECOMMENDATION: DCOPN could issue a Request for Applications (RFA) for additional services based on a collaborative review with affected parties to determine the need for and location of additional neonatal special care services, therefore assuring access where needed. This would meet the planned need for new services in appropriate planning districts in a market competitive manner and improve access.

Effectiveness of the COPN Application Review Procedures for FY2000 Project Categories

The statute defining the contents of this study requires an analysis of the effectiveness of the application review procedures used by the regional health planning agencies and VDH. An analysis of effectiveness must detail the review time required during the past year for various project categories. To ensure consistency, the project categories for purposes of this document are the same project categories that were selected for review during FY2000- namely, radiation therapy, lithotripsy, and obstetrical services and neonatal special care. The statute also dictates that this report address the number of contested or opposed applications and the project categories of these contested or opposed projects. Information concerning all contested or opposed COPNs for FY2000 can be found under the section entitled "Judicial Review" as well as the section labeled "Adjudication". Finally, the statute requires the report to identify the number of projects automatically approved from the regional health planning agencies because of their failure to comply with the statutory timelines.

The application review process for FY2000 was completed in a timely manner as dictated by the Code. At no time did delays occur in receipt of a recommendation from a regional health planning agency such that there was an impact in DCOPN's ability to make a recommendation or

in the Commissioner's ability to make a decision. The number of requests automatically considered as recommended for approval from the regional health planning agency or DCOPN due to their failure to act in accordance with statutory timelines was zero in FY2000.

Where appropriate projects were authorized, but perhaps more importantly projects were denied and prevented from proceeding when there was no demonstrable need for the project. This avoided duplication of services and costs without adversely impacting access to care.

FY2001 Project Analyses

Psychiatric services, substance abuse treatment services and miscellaneous capital expenditures are the three project areas to be addressed in terms of their activity in FY2001.

Psychiatric Services

Psychiatric services for the purposes of COPN review are:

- the establishment of a medical care facility for psychiatric services
  - a psychiatric medical care facility subject to COPN review excludes "any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)"
- the conversion of beds in an existing medial care facility to psychiatric beds.
- the introduction into an existing medical care facility of any new psychiatric service that the facility has never provided or not provided in the previous 12 months.
- any capital expenditures of $5 million or more, by or on behalf of a mental hospital, psychiatric hospital, intermediate care facility or medical care facility related to the provision of mental health, psychiatric or mental retardation services.

In FY2001, there was one COPN application for psychiatric services. An applicant submitted a COPN request to establish a 32-bed inpatient psychiatric service in Richmond. The Commissioner approved the project citing broad-based community and professional support including an overwhelming recommendation for approval from the health planning agency. The project had a capital cost of $4.7 million.

Appropriateness and Effectiveness of COPN Program for Psychiatric Services

A determination of the appropriateness of continuing the certificate of public need program for psychiatric services must begin with an analysis of state-wide policy for psychiatric services. The state agency with primary responsibility for the provision of mental health services is the

Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). DMHMRSAS has developed a comprehensive plan to guide the coordination of the provision of mental health services, including psychiatric services. This plan is based upon the vision provided in the Governor's document entitled *Building Virginia's Future A Time for All Virginians: A Strategic Plan for the Commonwealth of Virginia.*

The plan describes as a goal the provision of mental health services in outpatient, community-based settings and seeks to accomplish this goal by encouraging competition and fostering innovation. In other words, it seeks to utilize market forces in implementing change. Thus, the continued imposition of COPN, with its goal of artificially holding down costs by strict regulation, may serve to impede the efforts espoused by DMHMRSAS.

Also, in recent years, VDH has taken an incremental approach to reviewing COPN regulation, by de-emphasizing regulation of replacement and smaller, non-clinically related expenditures, and focusing COPN regulation on new facilities development, new services development, and expansion of service capacity. Therefore, continuing the requirement of COPN review for inpatient psychiatric services when such services are likely to be rendered in an outpatient setting may prove to be of little utility.

As mentioned above, the Code requires an analysis of the effectiveness of the application review procedures used by the regional health planning agencies and the Department. Section 32.1-102.6 of the Code details the review time required during the past year for various projects. The review time for all FY01 COPNS was within the statutory limit; thus review time for psychiatric services was within statutory limits.

Number of Contested or Opposed Psychiatric Service Applications

The Code requires this report to describe the number of contested or opposed psychiatric service applications. Contested or opposed projects would result in an IFFC and possibly litigation. A review of VDH files reveals no COPNs concerning the provision of psychiatric services were sent to IFFC in FY2001.

Nor did any psychiatric service COPN applications result in deemed VDH approval due to regional health planning agency untimeliness. A timely response by the regional health planning agency is one that is completed within sixty calendar days of the day that begins the appropriate batch review cycle as defined in the Code. If the regional health planning agency does not complete its review within the specified sixty calendar days, or relevant period for applicants that request an extension, and submit its recommendations on the application and the reasons therefore within ten calendar days after the completion of its review, the DCOPN shall, on the eleventh calendar day after the expiration of the regional health planning agency review period, proceed as though the regional health planning agency has recommended project approval.

Options:

No Change: Continue the applying the COPN program to psychiatric services as currently outlined. Ongoing efforts to review, and where appropriate, update the SMFP will address necessary changes to the review criteria.

Minimal Change: In collaboration with the DMHMRSAS, the hospital industry, physicians, consumers and advocates, VDH could produce a comprehensive assessment of the State's needs for psychiatric services and publicize the locations where a demonstrated need for new or additional psychiatric services existed as a means of stimulating interest in requesting authorization for development of the service.

Deregulation: Support efforts outside the comprehensive Joint Commission on Health Care's plan to deregulate just psychiatric services.

RECOMMENDATION: Support efforts to deregulate psychiatric services. There are typically few to no requests for psychiatric services and the service falls under the auspices of the DMHMRSAS, which favors deregulation of their services from COPN.

Substance Abuse Services

Substance Abuse services for the purposes of COPN review are:

- the establishment of a medical care facility for psychiatric services
  - a substance abuse medical care facility subject to COPN review excludes "any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS)"
- the introduction into an existing medical care facility of any new substance abuse service that the facility has never provided or not provided in the previous 12 months
- any capital expenditures of $5 million or more, by or on behalf of a mental hospital, psychiatric hospital, intermediate care facility or medical care facility related to the provision of substance abuse treatment services.

In FY2001, there were no COPN applications for substance abuse services.

Appropriateness and Effectiveness of COPN Program for Substance Abuse Services

COPN review of requests for substance abuse programs provides an opportunity for the State to assure these programs are developed within a sound planning framework and are not solely developed in affluent or urban areas at the exclusion of lower income, rural or other underserved areas of the Commonwealth.

Number of Contested or Opposed Psychiatric Service Applications

In FY2001, there were no COPN applications for substance abuse services and therefore no contested or opposed applications.

Options:

No Change: Continue the applying the COPN program to substance abuse services as currently outlined. Ongoing efforts to review, and where appropriate, update the SMFP will address necessary changes to the review criteria.

Minimal Change: In collaboration with the DMHMRSAS, the hospital industry, physicians, consumers and advocates, VDH could produce a comprehensive assessment of the State's needs for substance abuse services and publicize the locations where a demonstrated need for new or additional substance abuse services existed as a means of stimulating interest in requesting authorization for development of the service.

Deregulation: Support efforts outside the comprehensive Joint Commission on Health Care's plan to deregulate just substance abuse services.

RECOMMENDATION: Support efforts to deregulate substance abuse services. There are typically no requests for substance abuse services and the service falls under the auspices of the DMHMRSAS, which favors deregulation of their services from COPN.

Capital Expenditure of $5 million or More

COPN authorization is required for major capital expenditures of $5 million or more made by or in behalf of an existing medical care facility when the project is not otherwise defined as a project under COPN. Typically these projects include major renovations to facilities, construction of parking structures, replacement of information systems, and so forth. In FY 2001 there were 8 decisions made for requests for COPNs for the expenditure of $5 million or more. All 8 requests were approved for a total authorized capital expenditure of $193,888,992.

In FY2001 decisions were made for the following COPN requests:

- A request for the expenditure of $15,135,949 for facility renovations and upgrades, primarily to the hospital's inpatient obstetric unit. The request was approved because the growth in demand for services in the area was not being met by the existing inventory of obstetric beds.
- A request for the expenditure of $11,900,000 for the renovation of a hospital emergency department. The request was approved because of the need for an enlarged and modernized emergency department service was demonstrated and the proposed capital expenditure was reasonable for the scope of the project.
- A request for the expenditure of $43,646,400 for the construction of a hospital cardiac services tower. The request was approved to accommodate program growth and quality enhancement in the largest and fastest growing cardiac program in the area.
- A request for the expenditure of $9,892,530 for the construction of a hospital trauma services facility. The request was approved because the project expands and modernizes the only level II trauma center in a growing area, improving access and quality.

- A request for the expenditure of $24,555,377 for the renovation and expansion of a hospital's operating suite. The request was approved because the renovations were necessary to modernize a 20-year-old suite.
- A request for the expenditure of $11,000,587 for the construction of a Women's and Children's facility as part of an existing hospital. Existing beds were used. The request was approved because a public need was demonstrated and the project could be accomplished without adversely impacting other programs.
- A request for the expenditure of $11,333,727 for the expansion and renovation of a hospital.
- A request for the expenditure of $21,378,453 for the expansion and renovation of a hospital.

The age of various facilities, the need to accommodate new technology, increased outpatient and emergency department patient volume and competitive market forces that demand larger and more aesthetically pleasing environments have, and will continue to contribute to the requests for these types of projects.

Appropriateness and Effectiveness of COPN Program for Capital Expenditures

While facilities need to be able to maintain functional, modern physical plants and VDH is reluctant to prevent this, as evidenced by the approval of all 9 FY2001 requests. However, these projects need to be authorized under the scrutiny of a COPN review process to assure that the projects are reasonable both in scope and cost. In highly competitive markets there would be great temptation to invest health care dollars in non-health care amenities aimed at attracting patients with higher reimbursement, to the loss of those citizens without the means to choose. As with most project categories, but perhaps on a greater scale with these large capital expenditures, what cannot be evaluated is the deterrent effect COPN has on preventing projects from even being requested which, absent the COPN process, who have proceeded undeterred.

Over the past few years there have been several capital expenditure requests made by or in behalf of a medical care facility for the development of parking structures, and even one for improvements to a highway, to serve a hospital. These types of projects are outside the intent and scope of the COPN regulations and should be excluded from the requirements for review.

Options:
No Change: Continue the applying the COPN program to capital expenditure requests as currently outlined. Ongoing efforts to review, and where appropriate, update the SMFP will address necessary changes to the review criteria.

Minimal Change: The minimum dollar threshold for review could be increased to a level that would require review of only the largest projects. Additionally, VDH would support legislative action to specifically exempt from COPN review capital expenditures for parking structures and road improvements made by or in behalf of a medical care facility.

Deregulation: Support efforts outside the comprehensive Joint Commission on Health Care's plan to deregulate COPN review of capital expenditures of $5 million or more.

RECOMMENDATION: Continue to review all capital expenditures of $5 million or more to assure appropriate use of limited health care dollars, except for expenditures for parking structures and road improvements.

Any Other Data Relevant to Efficient Operation of COPN Program

The final consideration in the analysis of project categories specified by Code section 32.1-102.12 is that the Commissioner include any other data she determines to be relevant to the efficient operation of the COPN program.

Although there were no COPN applications for the establishment of freestanding psychiatric hospitals in FY2001, there have been nine applications in FY2002 thus far for related facilities. This increase may develop into a trend as closure of the three state operated mental hospitals is expected to be complete by the end of 2006.

Health Care Market Reform

The major health market reforms during this time period concerned managed care. Because an earlier study examined managed care initiatives, this section will be limited to a brief review of studies from other states concerning COPN.

A study by the National Conference of State Legislatures reviewed health related statistics of nine states that underwent a form of Certificate of Public Need repeal during the years 1983-1995. The study found that four of the nine states experienced a marked increase in nursing home construction after the law was repealed. Another state had a drop in hospital occupancy rates as the rate of hospital construction increased. The repeal lead to an increase in psychiatric beds in two states. Finally, five states did not witness any significant change in areas that were previously regulated.

The State of Washington published a report in 1999 entitled *Effects of Certificate of Need and Its Possible Repeal.* The study reviewed the findings of similar studies performed in other states. It concluded that there is strong evidence that COPN is not an effective mechanism for controlling overall health care spending nor is it effective in controlling hospital costs. COPN can, however, be effective in slowing the expansion of some services. The study also determined that the effect of COPN on quality is inconclusive and that evidence regarding the effect of COPN on access to health services is conflicting.

Another study conducted in 1999 concerned COPN in Illinois. The study concluded that COPN in that state was not effective in achieving its goal of cost containment. The study questioned whether Illinois policymakers should have a role in regulating low-intensity services, when there has not been a positive correlation between quality and volume.

While the results of these studies have not been consistent, the underlying theme that each asserts is that effects of COPN repeal vary among states and while it may be difficult to predict the outcome of repeal in one state based upon the history of another state there does seem to be a general consensus that COPN is ineffective at achieving the goals for which it was designed. Many suggest that it stifles efforts to improve access to outpatient surgery and other services and does little to improve access to care for the poor. Rarely, if ever, are the benefits of the program touted by anyone, including the general public, other than those who are already providing the regulated services and who are enjoying the barrier to market entry provided by COPN.

One major market force that may change the way COPN will be evaluated in the future is the introduction of prospective payment systems for the payment of services rendered on an outpatient basis. In the past, COPN studies addressed issues concerning charges, as this variable was important in various reimbursement schemes. However, in a payment system that is prospectively based, that is, the insurance company determines what it will pay for a particular service before it is rendered, the issues of charges becomes less important. Thus, any meaningful evaluation of COPN must address outpatient prospective payment systems, and not charges.

Accessibility of Regulated Health Care Services by the Indigent

One of the considerations of the COPN program is whether the indigent have access to health care services. One of the 20 factors considered in the COPN process is the provision of charity care by the applicant. Applicants that have not demonstrated a historical commitment to charity care consistent with other providers in their planning district may have a condition that they provide some level of charity care placed upon any COPNs they might be subsequently awarded. For the years 1996 – 1998 there were 162 certificates of public need issued to hospitals, only 34 of those certificates included conditions requiring the provision of charity care. Compliance with the conditions to provide charity care is relatively poor and other than being used as an influence on decisions for future COPN requests by a provider little is done to enforce the conditions.

For a detailed chart of charity care provided by hospitals within each planning district, please see Attachment G.

Relevance of COPN to Quality of Care Rendered by Regulated Facilities

One of the most important features of the COPN program is its goal of assuring quality by instituting volume thresholds. One study from the University of California San Francisco concluded that there is scientific evidence supporting the contention that, for some procedures or diagnoses, higher hospital volume is associated with lower patient mortality. Other studies refute any correlation between COPN programs and quality of services rendered.

VDH believes that as data concerning quality of care become available from VHI, they can be used as measures for the COPN program. There are certain managed care legislative initiatives whereby managed care health insurance plans will have to report quality statistics to

the Virginia Health Information, Inc. Assuming these data are collected in a manner that allows for the identification of regulated facilities, the information might be useful in future studies on quality of care rendered in regulated facilities.

Equipment Registration

FY2001

The legislation defining the scope of this report requires an analysis of equipment registrations, including the type of equipment, whether the equipment is an addition or a replacement, and the equipment costs.

In FY2001, there were 12 equipment registrations. Three of these were registered for CT scanners, 3 were for MRIs, 3 were for cardiac catheterization equipment, 2 were for lithotripters, and 1 was for a linear accelerator.

In FY2000 there were a total of 10 equipment registrations. The type, number and the corresponding dollar amounts are depicted in Chart 3.

Chart 3 Equipment Registrations

	2000		2001	
Type of Equipment	**Number of Registrations**	**Capital Expenditure**	**Number of Registrations**	**Capital Expenditure**
MRI	4	$5,776,620	3	$4,340,799
CT scanners	3	$3,338,449	3	$2,217,899
Lithotripter	1	$ 150,000	2	$1,025,000
Linear Accelerator	1	$1,963,800	1	$1,756,951
Cardiac Catheterization	1	$1,640,083	3	$5,371,662
TOTAL	10	$12,868,952	12	$14,712,311

Appendix A

§ 32.1-102.12. Report required.

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

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

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

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

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

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

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

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

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

(1997, c. 462; 1999, cc. 899, 922.)

Appendix B

Database updated through 17:11 Va.R. February 12, 2001

12VAC5-220-10. Definitions.

"Medical care facility" means any institution, place, building, or agency, at a single site, whether or not licensed or required to be licensed by the board or the State Mental Health, Mental Retardation and Substance Abuse Services Board, whether operated for profit or nonprofit and whether privately owned or operated or owned or operated by a local governmental unit, (i) by or in which facilities are maintained, furnished, conducted, operated, or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical, or nursing attention or services as acute, chronic, convalescent, aged, physically disabled, or crippled or (ii) which is the recipient of reimbursements from third party health insurance programs or prepaid medical service plans. For purposes of this chapter, only the following medical care facility classifications shall be subject to review:

1. General hospitals.

2. Sanitariums.

3. Nursing homes.

4. Intermediate care facilities.

5. Extended care facilities.

6. Mental hospitals.

7. Mental retardation facilities.

8. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.

9. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, nuclear medicine imaging, or such other specialty services as may be designated by the board by regulation.

10. Rehabilitation hospitals.

11. Any facility licensed as a hospital.

For purposes of this chapter, the following medical care facility classifications shall not be subject to review:

1. Any facility of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

2. Any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services Comprehensive Plan.

3. Any physician's office, except that portion of the physician's office which is described in subdivision 9 of the definition of "medical care facility."

4. The Woodrow Wilson Rehabilitation Center of the Virginia Department of Rehabilitative Services.

"Project" means:

1. The establishment of a medical care facility. See definition of "medical care facility."

2. An increase in the total number of beds or operating rooms in an existing or authorized medical care facility.

3. Relocation at the same site of 10 beds or 10% of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of 10% of its beds as nursing home beds as provided in §32.1-132 of the Code of Virginia.

4. The introduction into any existing medical care facility of any new nursing home service such as intermediate care facility services, extended care facility services or skilled nursing facility services except when such medical care facility is an existing nursing home as defined in §32.1-123 of the Code of Virginia.

5. The introduction into an existing medical care facility of any new cardiac catheterization, computed tomography (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), medical rehabilitation, neonatal special care services, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, organ or tissue transplant service, radiation therapy, nuclear medicine imaging, psychiatric or substance abuse treatment, or such other specialty clinical services as may be designated by the board by regulation, which the facility has never provided or has not provided in the previous 12 months.

6. The conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds.

7. The addition or replacement by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomography (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, or other specialized service designated by the board by regulation, except for the replacement of any medical equipment identified in this part which the commissioner has determined to be an emergency in accordance with 12VAC5-220-150 or for which it has been determined that a certificate of

public need has been previously issued for replacement of the specific equipment according to 12VAC5-220-105.

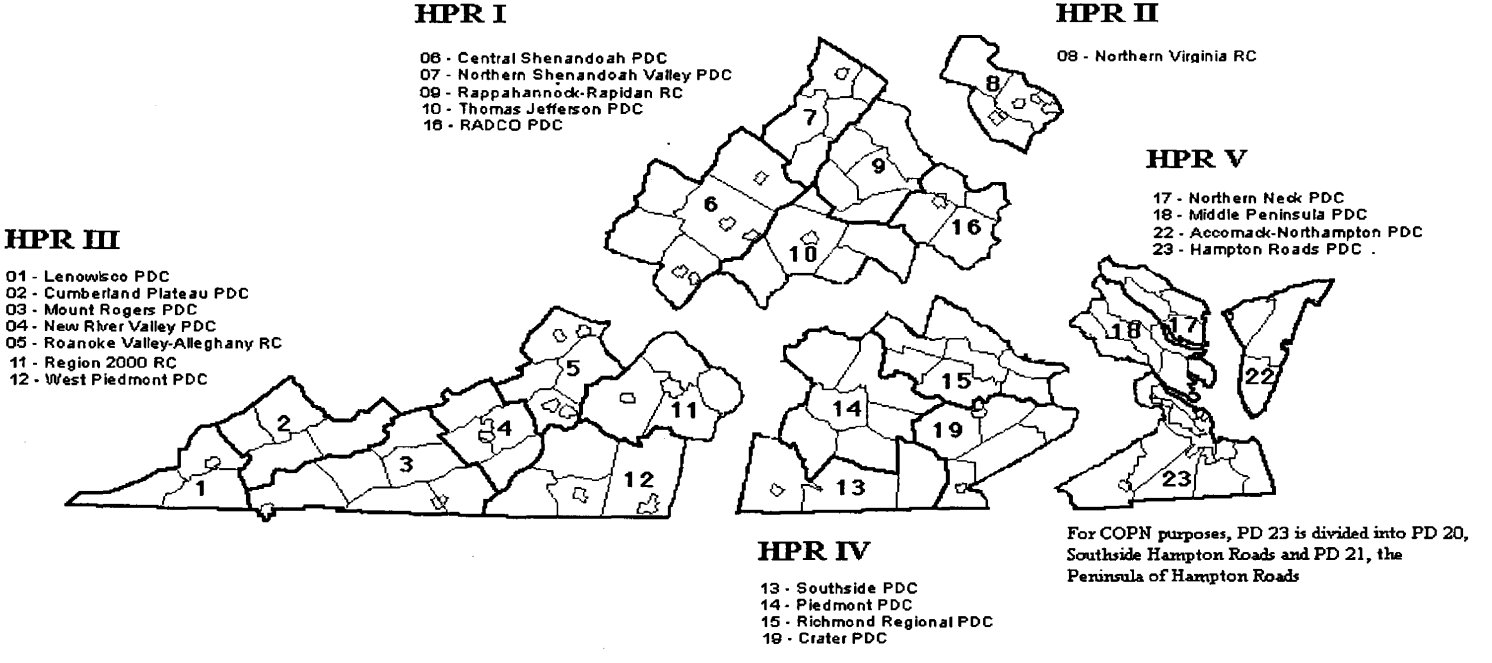
8. Any capital expenditure of $5 million or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. However, capital expenditures between $1 million and $5 million shall be registered with the commissioner.

Appendix C Authorized COPN Requests by Fiscal Year

Project Categories	FY 2001		FY 2000	
	Number of Projects	Capital Costs	Number of Projects	Capital Costs
Batch Group A General Hospitals, obstetrical Services, neonatal special care services	14		14	
Subtotal		**$456,118,796**		**$48,610,553**
Batch Group B Open heart surgery, cardiac catheterization, ambulatory surgery centers, operating room additions, transplant services	16		12	
Subtotal		**$31,648,116**		**$45,880,161**
Batch Group C Psychiatric Facilities, substance abuse treatment, mental retardation facilities	2		0	
Subtotal		**$7,274,262**		**$0**
Batch Group D Diagnostic Imaging	22		27	
Subtotal		**$35,296,274**		**$30,281,586**
Batch Group E Medical rehabilitation	0		0	
Subtotal		**$0**		**$0**
Batch Group F Gamma knife surgery, lithotripsy, radiation therapy	5		4	
Subtotal		**$5,093,064**		**$3,679,450**
Batch Group G Nursing Home beds, capital expenditures	5		15	
Subtotal		**$50,160,903**		**$80,110,069**
COPN Program Total	**64**	**$585,591,415**	**72**	**$208,562,819**

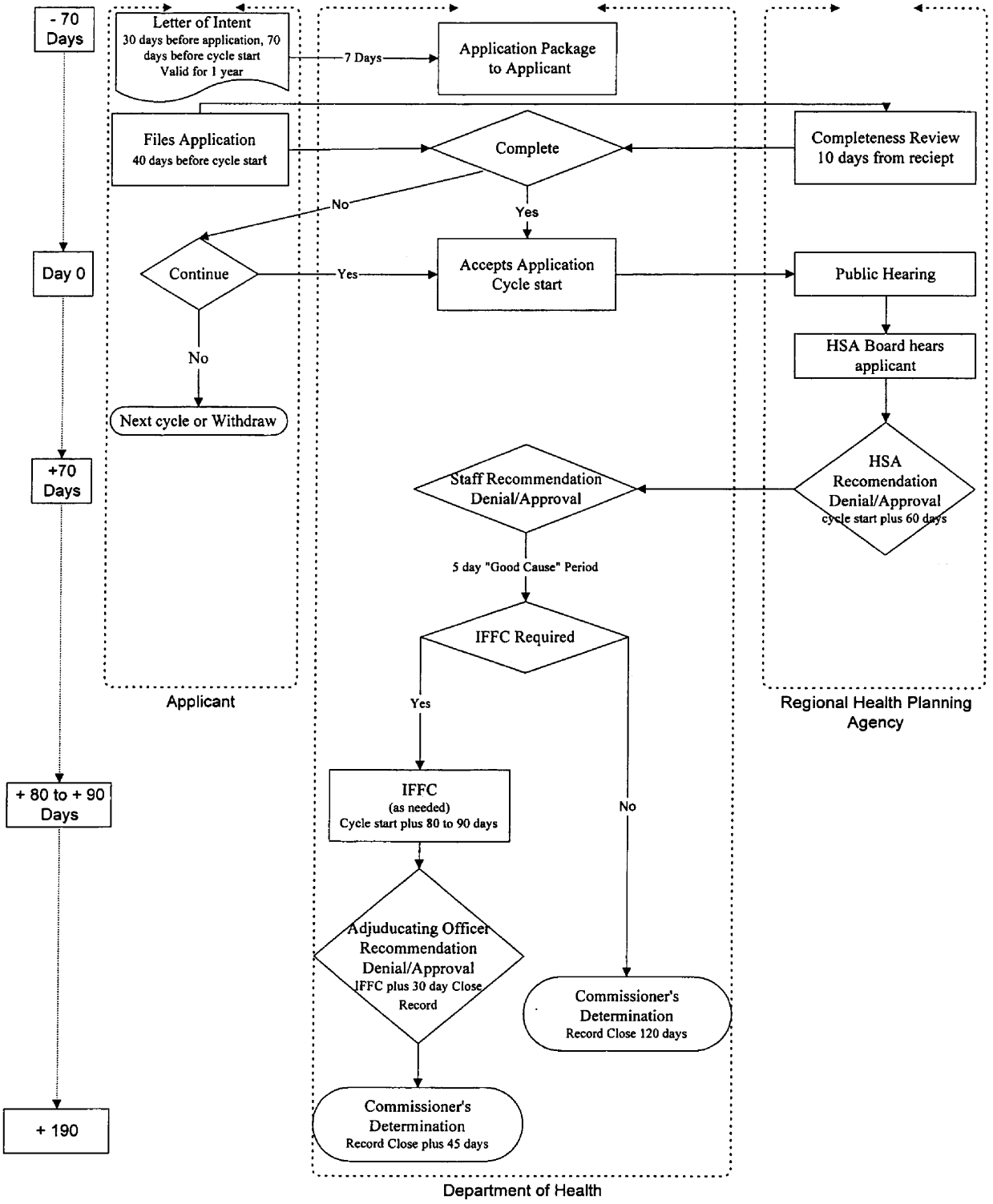
APPENDIX D

Virginia's Health Planning Regions
Virginia's Planning Districts



Appendix E

Certificate of Public Need Process



Appendix F

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

Annual Report - 2001

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

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

Annual Report - 2002

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

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

Annual Report - 2003

Group D Diagnostic Imaging

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

Annual Report - 2004

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

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

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

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

Appendix G Charity Care

Health Planning Region I

	1997			1998			1999		
	Gross Pt Rev	Charity Care	%	Gross Pt Rev	Charity Care	%	Gross Pt Rev	Charity Care	%
Augusta Medical Center	$ 130,932,440	$ 2,304,465	1.8%	$ 138,690,661	$ 1,751,910	1.3%	$ 155,540,490	$ 2,487,703	1.6%
Bath County Hospital	$ 5,071,889	$ 21,473	0.4%	$ 5,297,263	$ 26,864	0.5%	$ 5,177,252	$ 45,272	0.9%
Culpeper Memorial Hospital	$ 36,992,905	$ 862,855	2.3%	$ 43,489,024	$ 1,178,854	2.7%	$ 47,280,013	$ 1,220,126	2.6%
Fauquier Hospital	$ 56,710,556	$ 1,461,108	2.6%	$ 59,915,548	$ 1,639,661	2.7%	$ 68,369,543	$ 1,620,415	2.4%
Martha Jefferson Hospital	$ 99,945,479	$ 798,590	0.8%	$ 102,373,117	$ 970,170	0.9%	$ 116,418,603	$ 965,942	0.8%
Mary Washington Hospital	$ 205,719,656	$ 4,322,017	2.1%	$ 215,225,738	$ 5,023,677	2.3%	$ 251,429,118	$ 5,213,967	2.1%
Page Memorial Hospital	$ 17,846,629	$ 92,802	0.5%	$ 18,750,105	$ 115,638	0.6%	$ 20,713,627	$ 150,040	0.7%
Rochingham, Memorial Hospital	$ 135,784,952	$ 1,882,699	1.4%	$ 138,298,637	$ 1,849,707	1.3%	$ 157,657,581	$ 1,733,535	1.1%
Shenandoah memorial Hospital	$ 29,435,257	$ 1,128,499	3.8%	$ 29,040,789	$ 1,143,330	3.9%	$ 31,911,242	$ 239,491	0.8%
Stonewall Jackson Hospital	$ 18,934,342	$ 505,943	2.7%	$ 19,596,809	$ 501,733	2.6%	$ 22,732,645	$ 524,147	2.3%
University of Virginia Medical Center	$ 490,219,987	$ 65,357,663	13.3%	$ 535,878,456	$ 57,874,874	10.8%	$ 572,775,834	$ 59,630,774	10.4%
Warren Memorial Hospital	$ 21,504,913	$ 331,167	1.5%	$ 22,729,702	$ 452,249	2.0%	$ 26,223,877	$ 480,562	1.8%
Winchester Medical Center	$ 202,233,968	$ 8,587,089	4.2%	$ 223,800,970	$ 8,473,689	3.8%	$ 271,478,164	$ 3,052,166	1.1%
Total Facilities:			13			13			13
HPR I Median			**2.1%**			**2.3%**			**1.6%**

Health Planning Region II

	1997			1998			1999		
	Gross Pt Rev	Charity Care	%	Gross Pt Rev	Charity Care	%	Gross Pt Rev	Charity Care	%
Arlington Hospital	$ 233,596,008	$ 5,533,652	2.4%	$ 258,447,867	$ 6,376,698	2.5%	$ 298,198,210	$ 6,877,862	2.3%
Inova Alexandria Hospital	$ 210,474,747	$ 6,611,592	3.1%	$ 224,210,327	$ 5,566,873	2.5%	$ 258,855,592	$ 6,490,515	2.5%
Inova Fair Oaks Hospital	$ 115,113,404	$ 1,461,528	1.3%	$ 130,689,114	$ 1,541,829	1.2%	$ 152,831,232	$ 2,080,035	1.4%
Inova Fairfax Hospital	$ 658,767,344	$ 13,600,872	2.1%	$ 739,256,452	$ 14,839,326	2.0%	$ 839,559,964	$ 16,408,631	2.0%
Inova Mount Vernon Hospital	$ 141,089,145	$ 4,172,032	3.0%	$ 143,068,121	$ 4,144,380	2.9%	$ 162,814,774	$ 4,722,389	2.9%
Loudoun Hospital Center	$ 80,554,462	$ 736,760	0.9%	$ 95,023,296	$ 589,939	0.6%	$ 117,329,222	$ 956,723	0.8%
Northern Virginia Community Hosp	$ 80,452,266	$ 2,059,606	2.6%	$ 76,042,189	$ 841,719	1.1%	$ 95,798,198	$ 1,639,824	1.7%
Pentagon City Hospital	$ 46,274,111	$ -	0.0%	$ 54,849,465	$ -	0.0%			
Potomac Hospital	$ 112,645,502	$ 2,107,064	1.9%	$ 123,694,468	$ 1,204,667	1.0%	$ 139,238,092	$ 2,596,343	1.9%
Prince William Hospital	$ 94,631,120	$ 1,214,595	1.3%	$ 100,771,709	$ 1,788,192	1.8%	$ 125,290,500	$ 2,528,861	2.0%
Reston Hospital Center	$ 154,466,118	$ 848,903	0.5%	$ 174,816,384	$ 309,437	0.2%	$ 193,630,531	$ 449,767	0.2%
Total Facilities:			11			11			10
HPR II Median			**1.9%**			**1.2%**			**2.0%**

Appendix G Health Planning Region III

	1997			1998			1999		
	Gross Pt Rev	Charity Care	%	Gross Pt Rev	Charity Care	%	Gross Pt Rev	Charity Care	%
Alleghany Regional Hospital	$ 60,607,930	$ 590,303	1.0%	$ 68,078,406	$ 742,835	1.1%	$ 70,436,899	$ 532,371	0.8%
Buchanan General Hospital	$ 45,524,144	$ 623,453	1.4%	$ 45,625,310	$ 868,162	1.9%	$ 47,010,133	$ 823,696	1.8%
Carilion Bedford County Memorial Hospital	$ 22,035,617	$ 438,212	2.0%	$ 23,310,566	$ 694,038	3.0%	$ 24,740,907	$ 657,227	2.7%
Carilion Franklin Memorial Hospital	$ 23,728,845	$ 740,148	3.2%	$ 26,740,400	$ 663,629	2.5%	$ 31,538,126	$ 676,491	2.1%
Carilion Giles Memorial Hospital	$ 21,400,521	$ 543,977	2.5%	$ 23,234,800	$ 680,278	2.9%	$ 22,688,884	$ 505,907	2.2%
Carilion Medical Center	Roanoke & Community			$ 516,321,043	$ 13,218,240	2.6%	$ 577,501,049	$ 14,289,472	2.5%
Carilion New River Valley Medical Center	Radford Community			$ 76,050,119	$ 1,165,296	1.7%	$ 86,879,088	$ 1,646,644	1.9%
Carilion Radford Community Hospital	$ 66,463,440	$ 1,375,509	2.1%	Carilion New River Med Cen					
Carilion Roanoke Community Hospital	$ 160,058,192	$ 4,400,523	2.8%	Carilion Medical Center					
Carilion Roanoke Memorial Hospital	$ 318,828,074	$ 9,498,143	3.0%	Carilion Medical Center					
Centra Health	$ 233,864,618	$ 3,283,956	1.4%	$ 251,800,822	$ 4,395,491	1.7%	$ 288,129,309	$ 3,947,194	1.4%
Clinch Valley Medical Center	$ 104,168,882	$ 624,834	0.6%	$ 115,775,504	$ 988,032	0.9%	$ 115,253,254	$ 1,325,585	1.2%
Danville Regional Medical Center	$ 158,150,783	$ 1,582,857	1.0%	$ 157,639,076	$ 2,456,692	1.6%	$ 164,091,779	$ 2,069,559	1.3%
Dickenson County Medical Center	$ 25,627,226	$ 178,899	0.7%	$ 20,710,674	$ 196,411	0.9%	$ 16,768,244	$ 179,023	1.1%
Johnston Memorial Hospital	$ 59,065,421	$ 1,172,833	2.0%	$ 69,978,063	$ 1,165,296	1.7%	$ 81,959,402	$ 1,483,006	1.8%
Lee County Community Hospital	$ 58,713,576	$ 1,356,214	2.3%	$ 60,179,622	$ 363,629	0.6%	$ 49,426,043	$ -	0.0%
Lewis-Gale Medical Center	$ 222,972,223	$ 1,254,871	0.6%	$ 232,326,730	$ 825,624	0.4%	$ 238,418,315	$ 708,785	0.3%
Memorial Hospital of Martinsville & Henry County	$ 81,957,079	$ 1,210,499	1.5%	$ 91,317,299	$ 1,047,434	1.1%	$ 98,940,434	$ 1,248,841	1.3%
Montgomery Regional Hospital	$ 77,355,033	$ 533,059	0.7%	$ 78,691,799	$ 1,353,006	1.7%	$ 85,470,854	$ 759,302	0.9%
Norton Community Hospital	$ 48,681,437	$ 355,742	0.7%	$ 55,748,284	$ 443,391	0.8%	$ 55,826,287	$ 666,190	1.2%
Patrick Community Hospital	$ 10,533,029	$ 27,044	0.3%	$ 11,902,318	$ 27,008	0.2%			
Pulaski Community Hospital	$ 49,036,471	$ 498,415	1.0%	$ 53,153,241	$ 750,751	1.4%	$ 60,658,176	$ 664,813	1.1%
Russell County Medical Center	$ 46,933,399	$ 360,031	0.8%	$ 48,632,785	$ 342,134	0.7%	$ 50,650,704	$ 389,292	0.8%
Smyth County Community Hospital	$ 47,788,354	$ 680,426	1.4%	$ 49,482,156	$ 965,277	2.0%	$ 55,770,383	$ 1,010,637	1.8%
St. Mary's Hospital (Norton)	$ 36,348,645	$ 656,322	1.8%	$ 47,026,017	$ 935,018	2.0%	$ 57,024,671	$ 732,791	1.3%
Tazewell Community Hospital	$ 15,317,553	$ 180,849	1.2%	$ 9,386,788	$ 172,977	1.8%	$ 16,464,076	$ 235,911	1.4%
Twin County Regional Hospital	$ 48,567,105	$ 1,469,549	3.0%	$ 53,341,639	$ 1,609,809	3.0%	$ 60,949,985	$ 1,325,355	2.2%
Wellmont Lonesome Pine Hospital	$ 24,602,061	$ 513,432	2.1%	$ 23,310,566	$ 694,038	1.6%	$ 25,181,697	$ 456,667	1.8%
Wise Appalachian Regional Hospital	$ 18,896,151	$ 242,896	1.3%	$ 12,392,409	$ 141,595	1.1%	Closed 4/1/98		
Wythe County Community Hospital	$ 36,587,343	$ 1,160,406	3.2%	$ 39,705,604	$ 894,070	2.3%	$ 42,314,804	$ 859,453	2.0%
Total Facilities:			28			27			25
HAS III Median			**1.4%**			**1.7%**			**1.3%**

Health Planning Region IV

	1997			1998			1999		
	Gross Pt Rev	Charity Care	%	Gross Pt Rev	Charity Care	%	Gross Pt Rev	Charity Care	%
Bon Secours-Richmond Community Hospital	$ 27,765,194	$ 248,344	0.9%	$ 29,488,324	$ 115,600	0.4%	$ 32,472,056	$ 651,558	2.0%
Bon Secours-Stuart Circle Hospital	$ 62,157,252	$ 621,388	1.0%	$ 62,092,588	$ 498,742	0.8%	$ 60,766,099	$ 350,007	0.6%
Capitol Medical Center	$ 57,531,658	$ 201,003	0.4%	$ 53,700,074	$ 397,295	0.7%	$ 57,942,801	$ 484,115	0.8%
Children's Hospital	$ 10,964,802	$ 169,148	1.5%	$ 12,344,782	$ 150,880	1.2%	$ 12,986,892	$ 127,113	1.0%
Chippenham & Johnston-Willis Hospitals	$ 727,189,337	$ 555,472	0.0%	$ 838,973,599	$ 5,714,551	0.7%	$ 926,083,229	$ 2,879,593	0.3%
Community Memorial Healthcenter	$ 58,717,919	$ 2,238,176	3.8%	$ 60,298,543	$ 2,072,721	3.4%	$ 59,438,817	$ 1,538,617	2.6%
Greensville Memorial Hospital	$ 36,049,339	$ 552,435	1.5%	$ 37,633,009	$ 784,390	2.1%			
Halifax Regional Hospital	$ 64,430,348	$ 886,291	1.4%	$ 66,894,575	$ 1,097,336	1.6%	$ 72,379,097	$ 1,069,139	1.5%
HealthSouth Medical Center	$ 79,826,586	$ 28,524	0.0%	$ 82,523,898	$ 19,133	0.0%	$ 96,804,206	$ 22,935	0.0%
Henrico Doctors' Hospital	$ 419,508,013	$ 1,376,994	0.3%	$ 474,399,929	$ 1,702,059	0.4%	$ 501,797,623	$ 1,318,331	0.3%
John Randolph Hospital	$ 129,112,710	$ 209,734	0.2%	$ 149,764,520	$ 1,123,059	0.7%	$ 160,800,907	$ 1,123,415	0.7%
Medical College of Virginia Hospital	$ 643,882,631	$ 116,747,770	18.1%	$ 667,929,830	$ 116,739,190	17.5%	$ 699,718,783	$ 120,371,479	17.2%
Memorial Regional Medical Center	Replaced Richmond Memorial						$ 168,576,198	$ 427,508	0.3%
Retreat Hospital	$ 65,415,418	$ 1,763	0.0%	$ 84,390,737	$ 515,199	0.6%	$ 91,785,593	$ 416,029	0.5%
Richmond Eye & Ear Hospital	$ 16,384,064	$ 65,356	0.4%	$ 16,012,571	$ 52,094	0.3%	$ 16,417,576	$ 77,642	0.5%
Richmond Memorial Hospital	$ 119,119,763	$ 1,578,010	1.3%	$ 113,034,970	$ 543,275	0.5%	Replaced by Memorial Regional		
Southside Community Hospital	$ 46,359,704	$ 1,336,671	2.9%	$ 47,057,593	$ 1,457,677	3.1%	$ 53,823,775	$ 1,706,248	3.2%
Southside Regional Medical Center	$ 200,267,470	$ 3,964,146	2.0%	$ 220,928,104	$ 3,820,888	1.7%	$ 227,003,956	$ 3,503,000	1.5%
St. Mary's Hospital (Richmond)	$ 326,660,569	$ 1,846,566	0.6%	$ 336,269,000	$ 1,542,518	0.5%	$ 357,544,860	$ 1,765,496	0.5%
Total Facilities:			18			18			17
HSA IV Median			**1.0%**			**0.7%**			**0.7%**

Health Planning Region V

	1997			1998			1999		
	Gross Pt Rev	Charity Care	%	Gross Pt Rev	Charity Care	%	Gross Pt Rev	Charity Care	%
Bon Secours Portsmouth General Hospital	$ 67,033,690	$ 1,673,573	2.5%	$ 38,647,881	$ 670,000	1.7%	Closed		
Bon Secours-DePaul Medical Center	$ 97,137,103	$ 4,209,939	4.3%	$ 112,120,105	$ 5,002,224	4.5%	$ 119,717,590	$ 4,911,155	4.1%
Bon Secours-Mary Immaculate Hospital	$ 65,864,041	$ 577,200	0.9%	$ 104,343,714	$ 406,799	0.4%	$ 107,710,239	$ 377,000	0.4%
Bon Secours-Maryview Hospital	$190,721,401	$ 4,078,510	2.1%	$ 222,001,463	$ 8,540,173	3.8%	$ 259,734,581	$ 4,723,305	1.8%
Chesapeake General Hospital	$192,149,434	$ 2,456,624	1.3%	$ 201,981,827	$ 2,412,401	1.2%	$ 218,453,086	$ 3,172,812	1.5%
Children's Hospital of the King's Daughters	$132,986,000	$ 423,000	0.3%	$ 134,519,193	$ 244,033	0.2%	$ 148,009,878	$ 105,698	0.1%
Lake Taylor Hospital	$ 11,015,696	$ -	0.0%	$ 10,917,370	$ -	0.0%	$ 13,773,803	$ -	0.0%
Louise Obici Memorial Hospital	$ 99,123,613	$ 1,952,346	2.0%	$ 106,477,284	$ 1,824,671	1.7%	$ 117,142,091	$ 1,598,901	1.4%
Norfolk Community Hospital	Did not report			Closed					
Rappahannock General Hospital	$ 36,942,680	$ 563,348	1.5%	$ 34,663,706	$ 569,822	1.6%	$ 37,615,107	$ 557,202	1.5%
Riverside Regional Medical Center	$308,231,364	$ 3,723,380	1.2%	$ 316,240,128	$ 2,715,195	0.9%	$ 371,677,495	$ 4,106,792	1.1%
Riverside Tappahannock Hospital	$ 24,852,371	$ 41,421	0.2%	$ 25,158,276	$ 48,178	0.2%	$ 29,397,497	$ 205,528	0.7%
Riverside Walter Reed Hospital	$ 35,837,426	$ 343,029	1.0%	$ 34,777,787	$ 52,606	0.4%	$ 37,157,390	$ 184,144	0.5%
Sentara Bayside Hospital	$ 92,972,000	$ 1,109,809	1.2%	$ 99,350,000	$ 1,182,695	1.2%	$ 95,569,811	$ 981,228	1.0%
Sentara Hampton General Hospital	$122,862,473	$ 3,246,138	2.6%	$ 133,827,133	$ 2,001,000	1.5%	$ 145,015,165	$ 1,738,644	1.2%
Sentara Leigh Hospital	$150,758,375	$ 1,081,357	0.7%	$ 172,356,580	$ 88,561	0.5%	$ 203,375,011	$ 1,354,237	0.7%
Sentara Norfolk General Hospital	$446,693,000	$ 12,036,596	2.7%	$ 477,386,000	$13,037,956	2.7%	$ 532,572,000	$ 11,980,624	2.2%
Sentara Virginia Beach General Hospital	$184,709,264	$ 4,349,399	2.4%	$ 204,224,421	$ 4,035,426	2.0%	$ 222,850,378	$ 4,508,361	2.0%
Shore Memorial Hospital	$ 51,025,062	$ 1,917,169	3.8%	$ 52,147,066	$ 1,509,000	2.9%	$ 60,902,977	$ 943,589	1.5%
Southampton Memorial Hospital	$ 37,477,595	$ -	0.0%	$ 39,486,197	$ 663,083	1.7%			
Williamsburg Community Hospital	$ 89,721,754	$ 762,090	0.9%	$ 105,101,850	$ 939,028	0.9%	$ 127,451,751	$ 936,402	0.7%
Total Facilities:			21			20			18
HSA V Median			1.2%			1.4%			1.2%