REPORT OF THE
DEPARTMENT OF HEALTH

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

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
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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 of specific project categories; and to discuss 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 2011).

Program activity for the period covered in this report includes the issuance of 53 decisions. The State Health Commissioner authorized 45 projects with a total expenditure of $732,334,862 and denied eight projects with proposed capital expenditures of $44,249,326. Appendix D summarizes the authorization decisions. Additional program activities are described in the "Summary of the State Health Commissioner's Actions" beginning on page 1.

The following project categories are analyzed in this report: psychiatric services, substance abuse treatment services and miscellaneous capital expenditures. The section on project analysis addresses the history of COPN regulation for these project categories, the nature of the specific services, the current state of the service in the Commonwealth and two potential options for the future of each of the categories with a recommended action. The Virginia Department of Health (VDH) recommends maintaining the current COPN review process for the review of psychiatric services, substance abuse treatment services and miscellaneous capital expenditures.

Applicants that have not demonstrated a historical commitment to charity care, consistent with other providers in their health service area, may have a "condition" to provide some level of indigent care placed upon any COPNs they are awarded. Compliance with the conditions to provide indigent care has improved considerably. Historically, many conditioned COPN holders have either not reported their compliance with conditions or have reported that they have been unable, for various reasons, to reach the required level of indigent care. Language for the "conditioning" of COPNs includes the second type of condition allowed in the *Code*, namely that the applicant facilitate access through the development and operation of primary health care services for special populations. Aggressive follow-up with non-reporting holders of conditioned COPNs has dramatically improved compliance.

During FY 2011 the application review process was completed as directed by the *Code*. There were no delays in receiving recommendations from regional health planning agencies that adversely affected timely decision-making.

Preface

This 2011 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 (2011). A copy of the enabling *Code* section is provided in Appendix A.

The COPN program is a regulatory program administered by the Virginia Department of Health (VDH). The program was established in 1973. The historical 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 COPN program is shown in Appendix B.

The statute establishing Virginia's COPN program is found in Article 1 of Chapter 5 of Title 32.1 of the *Code* (§ 32.1-102.1 et seq.). The State Health Commissioner (Commissioner) authorizes 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 8 factors (Appendix C) 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 YEAR 2011

Project Review

Decisions

During FY 2011, the Division of Certificate of Public Need (DCOPN), which assists the Commissioner in administering the COPN program, received 81 letters of intent to submit COPN requests and 53 applications for COPNs. 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 DCOPN to batch the project in an appropriate review cycle 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.

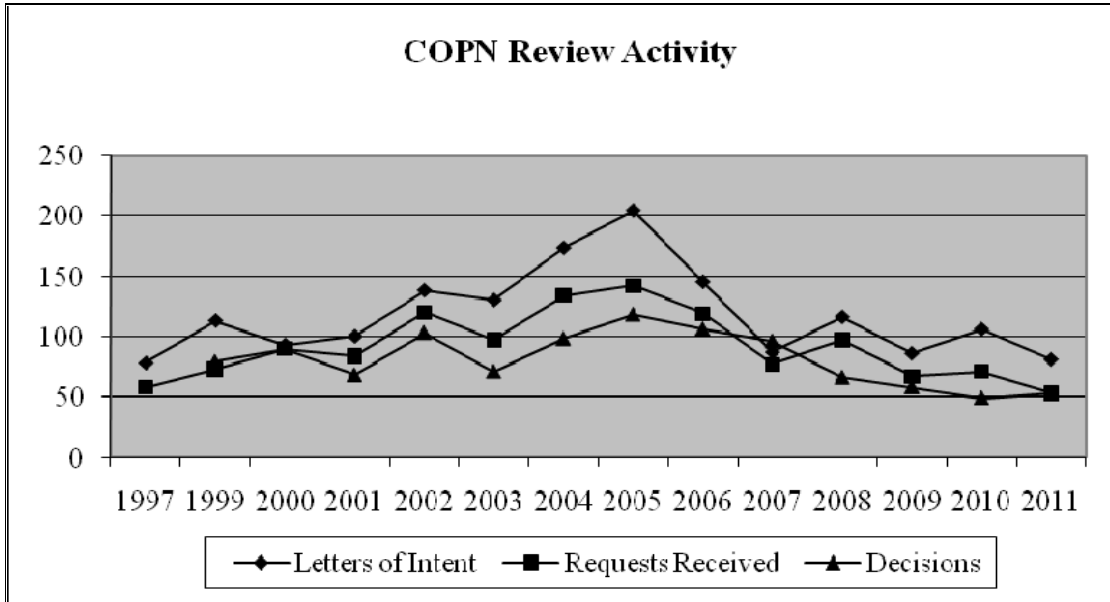
Table 1 summarizes COPN review activity for FY 2011. Graph 1 puts this activity in historical context. The Commissioner issued 53 decisions on applications to establish new medical care facilities or modify existing medical care facilities in FY 2011. Forty-five (85%) of these decisions were to approve or conditionally approve the request, for a total authorized capital expenditure of $732,334,862. Eight (15%) requests were denied. These eight denied projects had proposed total capital expenditures of $44,249,326. COPN decisions made in FY 2011 are profiled in Appendix D.

Table 1. COPN Activity Summary

Fiscal Year	Total Letters of Intent Received	Total COPN Applications Received	Applications Withdrawn	Approvals	Denials	Appeals to Circuit Court	Determined to be Not Reviewable
2011	81	53	0	45	8	0	0

Source: DCOPN

Chart 1



Source: DCOPN

In addition to assisting the Commissioner in the administration of the COPN program, DCOPN 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 prior to the end of the review.

COPN reports and recommendations for COPN requests from Northern Virginia are also provided to the Commissioner by a regional health planning agency. The Health Systems Agency of Northern Virginia regional health planning agency is a not-for-profit corporation that conducts regional health planning and provides an independent recommendation to assist the Commissioner in the COPN decision process. The regional health planning agency conducts public hearings and makes recommendations to the Commissioner concerning the public's need for proposed projects in their respective region. In the absence of an appropriately designated regional health planning agency, the DCOPN conducts the public hearing and solicits local input. The five health planning regions in Virginia are shown on the map in Appendix E. As of the close of the fiscal year Health Planning Region II, Northern Virginia, is the only region with a health planning agency designated. The health planning agencies for the other four regions have either closed or terminated their status as a designated health planning agency.

Adjudication

If the DCOPN or a designated regional health planning agency 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. 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. The adjudicatory process, held before the Commissioner's Adjudication Officer, is a mechanism for providing full due process to applicants before a final agency decision is made. These conferences, conducted in accordance with the Administrative Process Act, are held to provide the applicant an opportunity to submit information and testimony in support of a project application. An IFFC is also held when two or more requests are competing to provide the same or similar services in the same jurisdiction and one or more of the requests are recommended for denial. Another purpose for IFFCs is to permit persons opposed to a project, who have shown good cause, to voice their concerns. Following an IFFC, the Adjudication Officer reviews the entire agency record and prepares a recommended decision for the Commissioner's consideration and, should it meet with her agreement, adoption.

There were eleven COPN applications heard before a VDH Adjudication Officer at eight individual IFFC's in FY 2011. An additional two applications were exempted from participation in IFFC's with competing applicants due to an agreed upon stipulation agreement. Five of the COPN requests warranting an IFFC were approved in FY 2011. Four requests were denied after the IFFC. Two projects heard at an IFFC in FY 2011 still have decisions pending and will be resolved in the fall of 2011.

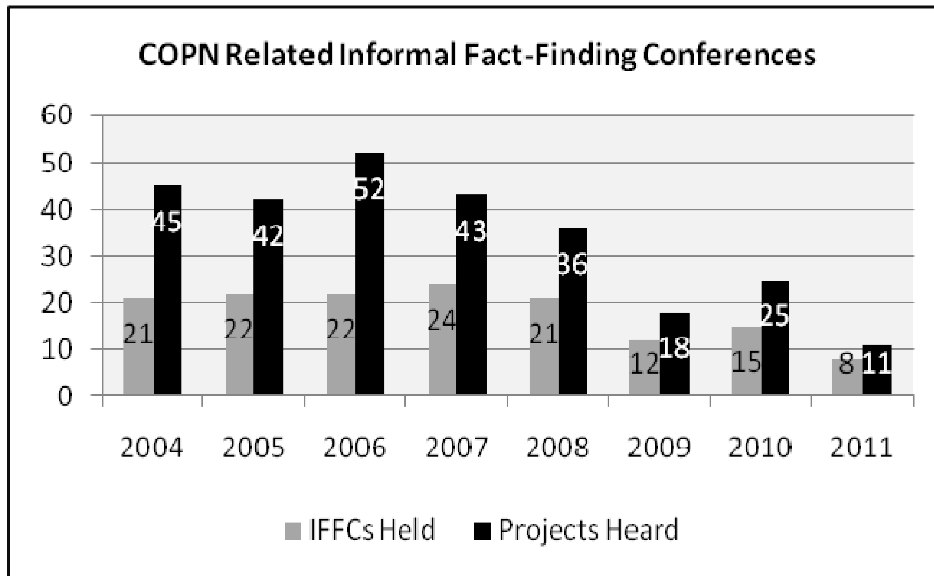
Table 2 illustrates the types of projects that were forwarded to an IFFC in FY 2011.

Table 2 Projects at IFFC in FY 2011

Project Type	Approved	Denied	Pending	Total
Establish/Relocate/Replace Inpatient Hospital			1	1
Add Operating Rooms	1			1
Add Acute Care Beds	1			1
Diagnostic Imaging	2	1	1	4
Radiation Therapy	1	2		3
Establish or Add Psychiatric Service		1		1
TOTAL	5	4	2	11

Source: DCOPN

Chart 2



Source: DCOPN

Judicial Review

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. No appeals were perfected with a filed appeal in FY 2011.

Table 3 Prior COPN Appeals Determined in FY 2011 or Still In Process

COPN Requests	Project	COPN Decision	Appellants	Court Status
COPN Request Nos.VA-7467, 7473, 7474, 7475, and 7476	Requests to establish 3 new PD 20 hospitals through the replacement of Bon Secours DePaul Medical Center, establish a new hospital through the replacement of Sentara Bayside Hospital add beds at Sentara Obici Hospital.	The two Sentara requests were approved, the three Bon Secours requests were denied.	Bon Secours DePaul Medical Center	This case was settled and an order of dismissal signed by the Court.
COPN Request No. VA-7541	Petersburg Hospital Company, LLC d/b/a Southside Regional Medical Center requested authorization to introduce open heart surgery services at the hospital.	Good cause party standing was granted and the COPN was denied.	Petersburg Hospital Company, LLC d/b/a Southside Regional Medical Center	In 2 separate appeals Southside Regional Medical Center appealed the granting of good cause status and the denial of the COPN. The Circuit Court's decision is pending.

Certificate Surrenders

Infrequently, an applicant awarded a COPN may have reasons to surrender it. Typical reasons for certificate surrenders are the applicant's inability to proceed with the project or changes in business direction. In FY 2011 two certificates, COPN numbers VA-04022, Hospice of Central Virginia, Establish a 15-bed Freestanding Inpatient Hospice Facility in Planning District 15, issued in July 2006, and VA-04113, Establish a Long Term Acute Care Hospital in Planning District 8 issued in October 2007, were surrendered.

Significant Changes

A significant change results when there has been an alteration, modification, or adjustment to a reviewable project for which a COPN approval has been issued. To be considered a significant change, the 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 received fifteen requests for significant changes to COPN projects in FY 2011. Eleven requests were for extension of the schedule beyond the three-year generic time limit or the time authorized on the certificate. Two requests were to increase the authorized capital cost, and two requests were to change the authorized site for the project. All fifteen reviewed significant change requests were authorized.

Competitive Nursing Home Review

Beginning in 1988, 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," was imposed. Effective July 1, 1996 the moratorium was replaced with an amended process governing COPN regulation of increases in nursing home bed supply (*Code of Virginia* §32.1-102.3:2). The amended process requires the Commissioner to issue, at least annually in collaboration with Virginia's Department of Medical Assistance Services, a Request for Applications (RFA) that will target geographic areas for consideration of increased bed supply and establish competitive review cycles for the submission of applications.

An RFA was issued for the addition of 60 Medicaid-certified nursing facility beds in Planning District 9, 60 Medicaid-certified nursing facility beds in Planning District 10, and 30 Medicaid-certified nursing facility beds in Planning District 18. Decisions on the applications received are expected in the fall of 2011.

Timeliness of COPN Application Review

As a result of legislative changes in 1999 and 2000, all COPN recommendations by DCOPN must be completed by the 70th day of the review cycle, with the final decision due by the 190th day of the review cycle. Review cycles begin on the 10th day of each month. Only the applicant

has the authority to extend the review schedule. In FY 2011, all COPN applications were reviewed within the statutory or applicant extended time limit. A flow chart illustrating COPN timelines as a result of these and other bills can be found at Appendix F. The flow chart identifies the time periods within which VDH is to perform certain COPN functions.

The *Code* also specifies that the Commissioner has up to 70 days from the close of the record to render a decision unless the schedule is extended by the applicant. Failure to do so results in a deemed approval of the request. The average time to review a COPN request in FY 2011, from the start of the cycle to a decision being made, was 171 days (range 97 – 391 days). The average time for requests that were not heard at an IFFC was 113 days (range 97 -- 269 days). Requests that needed to be heard at IFFC had an average review time of 283 days (range 168 – 391 days). In FY 2011, all of the Commissioner's decisions were rendered within the statutory or applicant extended time limit.

Legislation

In the 2011 session of the General Assembly, there were five House bills, seven Senate bills and a budget amendment that addressed some aspect of the COPN program. There was no central theme to the types of bills considered during the session.

Table 4 COPN Bills in the 2011 Session of the Virginia General Assembly

Bill	Patron	Topic in Relation to COPN	Status
HB 1456	Del. Knight	The bill continues indefinitely a special exemption for any continuing care retirement community (CCRC) authorized by certificate of public need prior to October 3, 1995 from the requirement to only admit residents who are contract holders of the CCRC.	Passed
HB 1643	Del. O'Bannon	The bill causes the State Health Commissioner to accept applications for a COPN and allows the issuance of a COPN, for ten new Medicaid-eligible nursing home beds in Planning District 15 (PD 15). The bill stipulates that only such applications for a certified nursing home that: i) is operated not for profit; ii) is located in PD 15; iii) will accept residents from outside of PD 15; and, iv) that provides care regardless of the resident's ability to pay, will be accepted.	Passed
HB 1697	Del. Athey	The bill exempted the Virginia Department of Veterans Services from the requirement to obtain certificate of public need authorization to offer any of the certificate of public need regulated health care services within their facilities. SB986 is a companion bill.	Passed
HB 2427	Del. Putney	The bill provided a special exemption for The Glebe nursing facility of Virginia Baptist Home in Daleville, Virginia. The bill allows The Glebe to admit patients that are not continuing care contract holders of The Virginia Baptist Home until December 31, 2014. SB 1212 is a companion bill.	Passed
HB 2453	Del. Garrett	This bill requires the State Health Commissioner to accept applications for a COPN for up to 50 new nursing home beds in Planning District 11.	Passed

SB 818	Sen. McEachin	The bill would exempt the construction and equipping of an outpatient radiation therapy center from certificate of public need when that center was found to be exempt from certificate of public need requirements in a 1993 decision.	Stricken at the request of the patron
SB 986	Sen. Locke	The bill exempted the Virginia Department of Veterans Services from the requirement to obtain certificate of public need authorization to offer any of the certificate of public need regulated health care services within their facilities. HB1697 is a companion bill.	Passed
SB 1039	Sen. Barker	The bill removed language that resulted in the unintended consequence of reversing conditions placed on all previous Continuing Care Retirement Communities COPNs and places the exempting language in a part of the *Code of Virginia* that limits its application to just the intended facilities in PD 8.	Passed
SB 1149	Sen. Quayle	The bill provided a special exemption for the nursing home at Lake Prince Woods in Suffolk, Virginia. The bill allows Lake Prince Woods to admit patients who are not continuing care contract holders of the real estate cooperative until December 31, 2014. The amendment preserved the Commissioner’s discretion in the COPN decision process.	Passed
SB 1212	Sen. Smith	The bill provided a special exemption for The Glebe nursing facility of Virginia Baptist Home in Daleville, Virginia. The bill allows The Glebe to admit patients that are not continuing care contract holders of The Virginia Baptist Home until December 31, 2014. HB 2427 is a companion bill.	Passed
SB 1321	Sen. Newman	This bill allows a nursing facility owner to relocate any remaining beds from a facility with previously relinquished beds to a receiving facility, either existing or new and under common ownership or control, without regard to the relocation criteria set forth in the statute, provided the Commissioner had been notified of the owners intent to close the facility from which the beds were moved.	Passed
SB 1434	Sen. Smith	This bill causes the State Health Commissioner to issue a Request for Applications and accept applications for a certificate of public need for 50 new nursing home beds in Planning District 11. The bill also gives preference to requests that propose a new 90-bed nursing facility that replace an existing 45-bed facility that had at least an 85% occupancy in 2009.	Passed
	Budget item 297#25c	Provided a special exception to the request for applications process to allow the addition of five nursing home beds in Planning District 14.	Passed

Source: Virginia Legislative Information System

Regulation

House Bill 396, passed by the 2008 session of the Virginia General Assembly, requires the formation of a Task Force to meet at least every two years. The Task Force is to review, and

where appropriate, update the SMFP at least every four years. The Task Force has been established and met three times in FY 2009 and twice in FY 2010. The Task Force's work for this cycle will be finished in FY 2012 and made available for possible regulatory action to update the SMFP.

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 38 years can be segmented into three distinct periods. These periods 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 not only 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. Project review standards were updated and tightened and a more rigorous approach was taken 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, the Joint Commission on Health Care (JCHC) developed a plan for the phased deregulation of COPN in a manner that preserved 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. The Act that required the development of the phased deregulation was repealed by the 2007 session of the General Assembly.

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. The five-year schedule is shown in Appendix G.

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 categories of these proposed projects;
- The number of applications upon which the regional health planning agencies have failed to act in accordance with the timelines 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;
- The number of applications reviewed from health planning regions for which not regional health planning agency was appropriately designated; and
- Any other data determined by the Commissioner to be relevant to the efficient operations of the program.

Section 32.1-102.12 of the *Code* requires this report to consider at least three COPN project categories. For FY 2010, the project categories are:

> Psychiatric services, substance abuse treatment services and miscellaneous capital expenditures.

The following list is the specific project definitions for the categories considered in this report:

- 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; and
- Any capital expenditure of $16,646,371 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

For each project type reviewed in this report two options are presented regarding the continued regulation of the service. While not exhaustive of the options available, the two actions represent a continuum of possibilities.

As the following discussions will note, the majority of COPN requests are approved. This does not imply that the COPN process is ineffective at limiting the number of new services or capital expenditures. Indications are that, for the most part, applicants are only submitting requests for projects that meet the criteria for approval and the number of speculative requests has declined. While impossible to quantify, the presence of the deterrent effect of COPN on the development of duplicative, speculative or unnecessary services is generally accepted.

Psychiatric Services and Substance Abuse Treatment Services

The Code of Virginia, at §32.1-102.1, establishes the types of projects that require COPN authorization. They include the establishment of a medical care facility; which includes general hospitals, mental hospitals, and any facility licensed as a hospital; an increase in the total number of beds in an existing or authorized medical care facility, the introduction into an existing medical care facility of any new psychiatric and substance abuse treatment services and the conversion of beds in an existing medical care facility to psychiatric beds.

The 2009 session of the Virginia General Assembly passed an omnibus COPN reform bill (HB 1598), that, among other changes, made the addition and introduction of psychiatric services subject to the Request for Applications (RFA) process. The RFA process proactively conducts a statewide assessment and establishes the existence of a public need for a service in advance and solicits applications for COPN authorization to fulfill that identified need. The RFA process has been used successfully to manage the inventory of nursing home beds for some years now. Annual RFAs are based on planning district need and are designed to meet the planned need for new or expanded services in a market competitive manner.

Including psychiatric services in the RFA process allows the Commonwealth to target psychiatric services where needed. Virginia does not have a problem with limiting an oversupply of psychiatric services, the traditional role of COPN, but rather the problem rested with having enough psychiatric services and assuring the availability of those services. Use of the RFA process was expected to reduce the number of speculative COPN requests, since applications would only be accepted in response to a process that predetermined that a public need existed for the service. This was expected to increase an applicant's confidence of success in a COPN review. Use of the RFA process was expected to attract applicants to areas of the State with an

identified need since the potential applicants would know that a state determination of need had already been made and therefore the likelihood of successfully obtaining a COPN is increased.

A provision was added that the psychiatric and substance abuse beds approved under the RFA process could not be converted to non-psychiatric or non-substance abuse treatment beds without COPN authorization. This is a departure from the general ability of providers being able to freely convert psychiatric and substance abuse beds to other acute care beds, e.g., medical/surgical beds, at will. This provision prevented applicants from using the addition of psychiatric beds as a means to increase their medical/surgical bed inventory and ultimately not meeting the identified need for additional psychiatric services.

The SMFP describes "substance abuse treatment services" as services provided to individuals for the prevention, diagnosis, treatment, and/or palliation of chemical dependency, which may include attendant medical and psychiatric complications of chemical dependency.

Inpatient psychiatric beds in general hospitals are dually licensed by the Virginia Department of Health and the Department of Behavioral Health and Developmental Services (DBHDS). Free-standing psychiatric hospitals are licensed solely by DBHDS. There are 1,520 non-state run inpatient psychiatric beds in Virginia, 282 fewer than were reported in 2006. Of the 1,520 beds, 1,181 (77.7%) were reported as staffed (open for service) in 2009.

The number of COPN requests for new or expanded psychiatric and substance abuse beds and services has never been very high. In the last five years there have been 15 COPN requests involving psychiatric services and only one for substance abuse services, compared to approximately 400 COPN requests over all. Only one of the psychiatric services requests was denied. An additional seven letters of intent for projects involving psychiatric beds were received but expired without an application being submitted. Table 4 summarizes the types of projects requested and the disposition of those requests.

Table 5 Psychiatric COPN Requests FY 2006 – FY 2011

	Total Requests	Approved	Denied	Withdrawn /Delayed	Pending
Add inpatient psychiatric beds	7	6	0	1	0
Establish an inpatient psychiatric facility	5	4	1	0	0
Introduce inpatient psychiatric services in an existing acute care hospital		0	0	0	0
Transfer existing psychiatric beds from one existing facility to another	3	3	0	0	0
Total	**15**	**13**	**1**	**1**	**0**

Source: Division of Certificate of Public Need

The thirteen approved requests represent a five-year authorized capital outlay for psychiatric services of $80.1 million. Over the last five years 281 additional non-state, acute care, inpatient psychiatric beds and four new facilities have been authorized under COPN.

In the last five years there has been a single COPN request for a substance abuse program. The review of the request for a long-term residential treatment facility in Planning District 9 at a capital cost of $23,742,468 has been placed on hold by the applicant.

Table 6 Authorized Virginia Inpatient Psychiatric Providers (non-governmental)

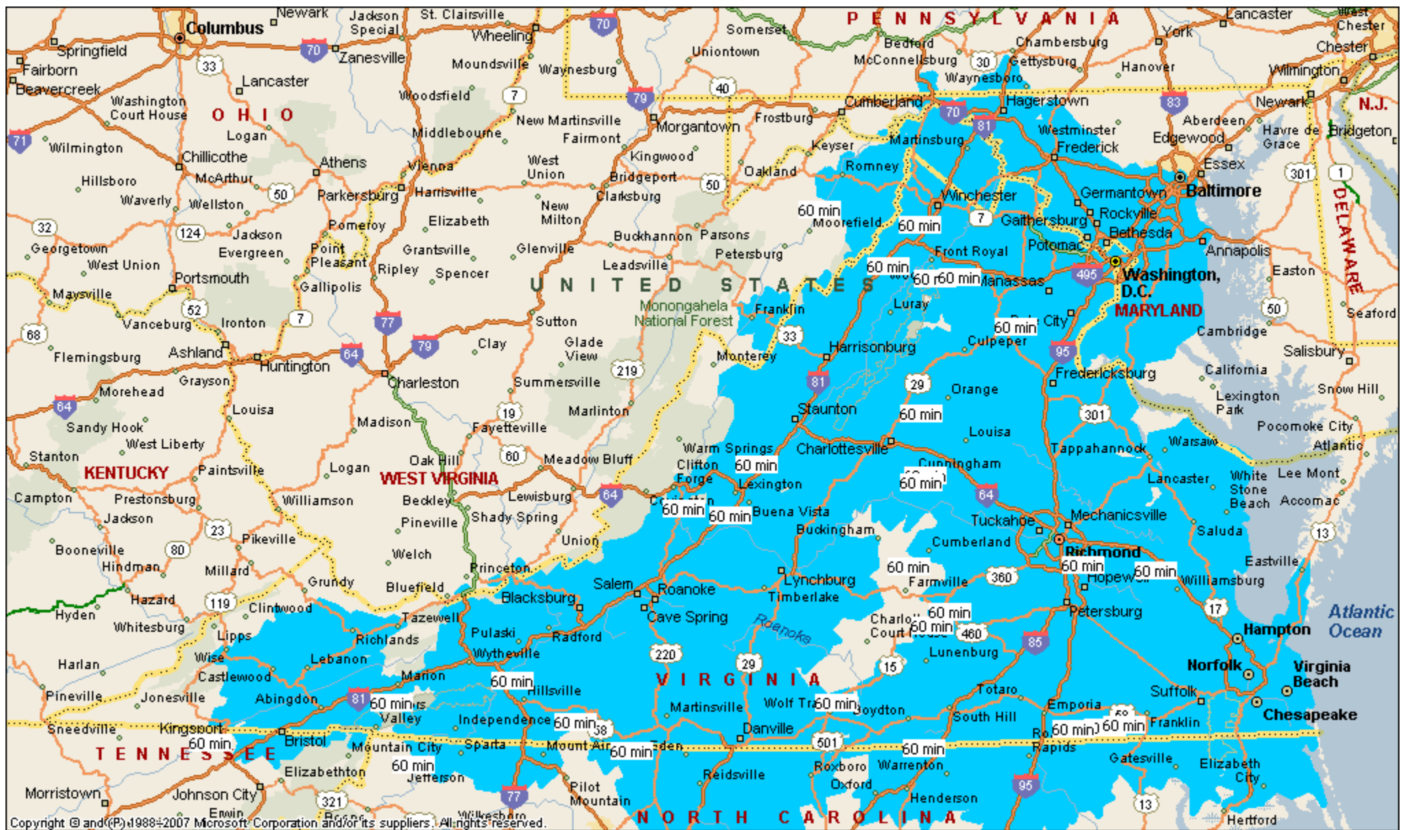
	PD	Licensed Beds	Staffed Beds
Russell County Medical Center	2	20	20
Twin County Regional Hospital	3	14	14
Carilion New River Valley Medical Center	4	36	36
Carilion Roanoke Memorial Hospital	5	51	30
Lewis-Gale Medical Center	5	145	33
Augusta Health	6	28	21
Rockingham Memorial Hospital	6	20	20
Winchester Medical Center	7	26	26
Dominion Hospital	8	100	70
Inova Fairfax Hospital	8	34	34
Inova Loudoun Hospital	8	22	22
Inova Mount Vernon Hospital	8	30	30
Prince William Hospital	8	32	32
Virginia Hospital Center	8	40	20
University of Virginia Medical Center	10	40	40
Virginia Baptist Hospital	11	47	41
Danville Regional Medical Center	12	25	18
Memorial Hospital of Martinsville & Henry County	12	12	12
Community Memorial Healthcenter	13	24	12
Bon Secours Richmond Community Hospital	15	40	40
Bon Secours St. Mary's Hospital	15	32	32
Chippenham Hospital	15	113	112
VCU Health System	15	92	60
Mary Washington Hospital	16	40	40
Rappahannock General Hospital	17	10	10
John Randolph Medical Center	19	24	21
Southside Regional Medical Center	19	30	30
Southern Virginia Regional Medical Center	19	10	10
Bon Secours Maryview Medical Center	20	54	54
Chesapeake Regional Medical Center	20	24	24
Sentara Norfolk General Hospital	20	34	24
Sentara Obici Hospital	20	10	10
Virginia Beach Psychiatric Center	20	100	100
Riverside Behavioral Health Center	21	147	69

Source: Virginia Health Information 2009

There are five planning districts (1, 9, 14, 18 and 22) that have no non-governmental inpatient psychiatric services. These five planning districts account for 6.5% of the 2009 population of Virginia. The SMFP calls for inpatient psychiatric services to be within one hour's drive under normal driving conditions for 95% of the population. Some of the population of Planning Districts 1 and 22 lives within an hour of inpatient psychiatric services in neighboring Planning

Districts. Much of the population of Planning District 14 lives within an hour of services in other planning districts and the vast majority of the population of Planning Districts 9 and 18 lives within an hour of inpatient psychiatric services in the surrounding Planning Districts. Given this distribution of services, greater than 95% of Virginia's population does live within an hour's drive of an inpatient psychiatric service provider, even given that there are pockets within individual planning districts that are not within an hour's drive.

Map 1 - 60 Minute Drive Area from Virginia Acute Care Psychiatric Services



Psychiatric Request for Applications

The Request for Applications (RFA) issued following the 2009 change to the Code of Virginia making psychiatric services subject to the RFA showed a need for an additional 235 psychiatric beds in 10 planning districts. COPN applications were received in response to the RFA to add beds in three of the ten authorized planning districts, 83 beds added in Planning District 8 and 37 beds added in Planning District 21. The request to add four beds in Planning District 6 was deemed to not meet the needs of the population and was denied. There was no interest in responding to the RFA to add 111 beds in the remaining seven planning districts found to have a need.

Additional special legislation was passed by the 2010 session of the Virginia General Assembly that allowed the establishment of a new inpatient psychiatric service at an existing

general hospital by relocating existing inpatient psychiatric beds. The COPN authorizing that project to improve the distribution of services without increasing capacity was issued in late 2010.

Appropriateness of Continuing COPN for Psychiatric Services and Substance Abuse Treatment Services

The COPN experience concerning psychiatric services supports a contention that the program is appropriate for these services. The presence of a COPN program is thought to serve as a deterrent to speculative requests and facilitates a planning process for individual providers. The number of withdrawn requests and unfulfilled letters of intent tends to support this idea. However, there are alternatives to consider.

Options:
No Change: Continue applying the COPN program to the establishment of new and expansion of existing psychiatric programs as currently mandated. Ongoing efforts to review, and where appropriate, update the SMFP, will address necessary changes to the review criteria. All key stakeholders would likely support this option.

Deregulation: Support efforts to deregulate psychiatric services. It is doubtful key stakeholders would support this option.

RECOMMENDATION: Make changes to the review criteria in the State Medical Facilities Plan necessary to remain current and continue applying the COPN program to the establishment of new medical care facilities for psychiatric services and the addition of psychiatric capacity at existing programs as currently mandated.

Miscellaneous Capital Expenditures

The Code of Virginia defines a project requiring COPN authorization, in part, as "Any capital expenditure of $15 million or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. ….. The amounts specified in this subdivision shall be revised effective July 1, 2008, and annually thereafter to reflect inflation using appropriate measures incorporating construction costs and medical inflation". This is an all-encompassing provision based solely on the estimated capital cost of the project. The types of requests typically reviewed under this category include renovations and expansions to facilities, replacement of information systems, the construction of parking structures, replacement of structures on site, construction to add support space and even the construction of a highway off-ramp by a hospital.

The 2007 session of the Virginia General Assembly increased the minimum capital threshold from the previous level of $5 million to $15 million and added a requirement to increase the threshold annually to keep pace with inflation. In FY 2011 the miscellaneous capital expenditure below which no COPN authorization is required was $16,646,371.

In the last five years, 23 requests for miscellaneous capital expenditures were approved with a cumulative capital authorization of $1,180,035,186. One additional request was withdrawn by the applicant. No requests for miscellaneous capital expenditures were denied in the last five years.

Seventeen of the approved requests were from general hospitals or hospital systems. One request was from a nursing home and five requests were from academic medical centers. In the two years prior to the increase in the capital threshold from $5 million to $15 million there were 14 COPNs (value $368,835,797) issued for miscellaneous capital expenditures. In the three years since the threshold was increased there were nine COPNs (value $811,199,389) issued.

Table 7 Miscellaneous Capital Expenditures FY 2007 – FY 2011

	Capital Threshold $5 M FY 2007 - 2008	**Capital Threshold >$15M FY 2009 - 2011**
Project Type	**Approved**	**Approved**
Facility Renovation / Space Expansion	10	7
Construct Parking Structure	1	0
Information System Replacement / Upgrade	2	0
Construct additional building on campus	1	2
Total	14	9

Source: Division of Certificate of Public Need

At an average capital expenditure per request of just over $90 million (range $21M - $171M), the miscellaneous capital expenditure category represents the highest average cost per project of all project types reviewed. The lack of denied requests should not detract from the usefulness of requiring COPN review of this type of request. The COPN process requires a close review by both internal and external parties. Such a review can only lead to well thought out requests and the abandonment of less feasible projects.

Appropriateness of Continuing COPN for Miscellaneous Capital Expenditures

The COPN experience concerning miscellaneous capital expenditures supports a contention that the program is appropriate for these services. The presence of a COPN program is thought to serve as a deterrent to speculative requests and facilitates a planning process for individual providers. However, there are alternatives to consider.

Options:

No Change: Continue applying the COPN program to miscellaneous capital expenditures as currently mandated. Ongoing efforts to review, and where appropriate, update the SMFP will address necessary changes to the review criteria. Current providers would probably support this option.

Deregulation: Support efforts to deregulate miscellaneous capital expenditures. It is expected there would be a loss of the benefits of comprehensive planning incentive.

RECOMMENDATION: Continue applying the COPN program to miscellaneous capital expenditures as currently mandated. The annual adjustment of the capital threshold defining

the project keeps the review of this category in the range of very significant capital expenditures.

Effectiveness of the COPN Application Review Procedures for FY 2011 Project Categories

The statute defining the contents of this report 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. 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 FY 2011 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.

Following several years of declining appropriations, the 2008 session of the Virginia General Assembly eliminated the General Fund component of the funding allotment to the Regional Health Planning Agencies. This left the Regional Health Planning Agencies with two sources of revenue, their own generated revenue from grants and consulting and the excess COPN application fees not spent in support of the State's administration of the program. The excess application fee revenue has declined as a response to a decrease in the number of applications received, a decrease in the average value (which serves to set the application fee amount) of the projects applied for, and an increase in the Department's expenses such that in FY 2011 there were no excess fees available for distribution to the single remaining Regional Health Planning Agency. The Health Systems Agency of Northern Virginia remains the only designated regional health planning agency in the Commonwealth, serving Health Planning Region II, Northern Virginia.

The application review process was completed in a timely manner as mandated by the *Code*. In FY 2011 30 of 53 decisions (57%) were made without a recommendation from a designated Regional Health Planning Agency. 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.

Accessibility of Regulated Health Care Services by the Indigent

One of the eight factors considered in the COPN process is whether the indigent have access to health care services. Applicants that have not demonstrated a historical commitment to charity care, consistent with other providers in their health service area, may have a "condition" to provide some level of charity care placed upon any COPNs they are awarded.

Prior to 2002 most conditioned COPNs included a requirement to report compliance with the condition for three years. The language used for most conditions on COPNs since 2002 has dropped the three-year reporting requirement in favor of an annual reporting requirement over the life of the service.

Beginning in June 2002, the DCOPN began recommending that the certificate language for the "conditioning" of COPNs be augmented to include the second type of condition allowed in the *Code*, namely that the applicant facilitate the development and operation of primary care for special populations. This added condition requirement allows an applicant a further opportunity for meeting the conditions placed on a COPN. Facilities not able to meet the conditioned requirement to provide service directly as charity care to the indigent can meet the obligation by supporting, including by direct monetary support, the development and operation of primary care through safety net providers such as the free clinics or community health centers. COPN holders opting to meet their condition obligation in this manner do so by making their contribution to the Virginia Association of Free Clinics, the Virginia Health Care Foundation, and/or the Virginia Primary Care Association, Inc., each of which has a memorandum of understanding with the Virginia Department of Health to distribute all such funds received.

The 2009 session of the Virginia General Assembly passed House Bill 1598 which, among other changes, codified the process by which the holder of a conditioned COPN could satisfy the condition. The codified process generally follows the process that had been in practice, such as allowing direct monetary donations to safety net providers when the direct provision of the conditioned service failed to achieve the required level of indigent care. The option of making direct payments to private nonprofit foundations that fund basic health insurance for indigents was added to the list of alternatives available to the holders of conditioned COPNs in satisfying their obligations.

In FY 2011 34 of 45 COPNs were issued with a condition for the performance of a certain level of charity, indigent and/or primary care. This represents 75.6% of all COPNs issued in FY 2011. The table presented in Appendix H lists all COPNs issued in FY 2011 with a condition that the applicant provide free or reduced cost care for the indigent and facilitate the development and operation of primary care for special populations.

Failure to comply with obligations accepted as conditions on the receipt of a COPN can have negative consequences for providers. There are provisions for fines, revocation of the COPN, and conditioning the issuance or renewal of a facility license for failure to meet the obligations of the condition. The alternatives already discussed were developed, at least in part, to help providers meet their agreed upon conditions when, for a host of legitimate reasons, they could not meet the condition through the provision of the conditioned service.

There are 256 active COPN authorized and conditioned projects, (i.e., those that are operational and have annual reporting requirements). This number is up from 128 in FY 2007, and 201 in FY 2010. The increase reflects the number of conditioned projects that have been completed less the number of projects that no longer are required to report. By the end of FY 2011, 175 (of 231 due by the end of the fiscal year) active COPN projects, reported compliance with conditions. The non-reporting facilities are being contacted with reminders and those failing to meet their conditioned obligation are being reminded of the options in the Guidance Document such as making direct contributions to safety net providers in support of primary care for indigent patients. It is expected the report due for FY 2011 activity will again be 100% as reports continue to be submitted in the first two quarters of FY 2012.

Appendix I is a list of organizations holding COPNs that were issued conditioned on the performance of a certain level of charity, indigent and/or primary care. The list also shows the number of conditioned COPN projects for which each organization has reported compliance and the number of COPN projects for which a report of compliance on the condition was due in FY 2011 and was not received. There are a total of 68 organizations with conditioned projects that were expected to report compliance.

Relevance of COPN to Quality of Care Rendered by Regulated Facilities

One of the features attributed to the COPN program is its goal of assuring quality by instituting volume thresholds. One study from the University of California at 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. However, there is little dispute about the relationship between quality and patient volume in open-heart surgery, cardiac catheterization and organ transplant services. By using COPN to limit the number of service providers, patient care is concentrated in centers where the service volume is maintained at a high level, which statistically allows for better patient outcomes. This is the idea behind the concept of regionalization of services and has been demonstrated as a factor in the quality of cardiac and transplant services.

Equipment Registration

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 FY 2011, there were fifteen equipment replacement registrations (Table 8) and one registration of capital expenditures in excess of $5 million but less than $16.6 million (Table 9). All registered expenditures appeared to be appropriate to the mission of the facility and to the life cycle of the equipment being replaced.

Table 8 Equipment Registrations

Project Type	Number of Registrations	Capital Expenditure
Replace cardiac catheterization equipment	2	$6,276,383
Replace MRI equipment	6	$12,230,578
Replace computed tomography equipment	3	$4,393,650
Replace linear accelerator	4	$14,291,535
TOTAL	15	$37,192,146

Table 9 Capital Expense Registrations

Project Type	Number of Registrations	Capital Expenditure
Nursing Home renovation	1	$6,056,710
TOTAL	1	$6,056,710

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 regional health planning agencies, if any, 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 regional health planning agencies have failed to act in accordance with the timelines of § 32.1-102.6 B, the number of applications reviewed in health planning regions for which no regional health planning agency was designated, and the number of deemed approvals from the Department because of their failure to comply with the timelines required by subsection E of § 32.1-102.6, 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; 2009, c. 175.)

Appendix B

12VAC5-220-10. Definitions.

"Medical care facility," as used in this title, means any institution, place, building or agency, whether or not licensed or required to be licensed by the Board or the Department of Behavioral Health and Developmental Services, whether operated for profit or nonprofit and whether privately owned or privately operated or owned or operated by a local governmental unit, (i) by or in which health services are 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 article, only the following medical care facilities shall be subject to review:

1. General hospitals.

2. Sanitariums.

3. Nursing homes.

4. Intermediate care facilities, except those intermediate care facilities established for individuals with mental retardation that have no more than 12 beds and are in an area identified as in need of residential services for individuals with mental retardation in any plan of the Department of Behavioral Health and Developmental Services.

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 individuals with substance abuse.

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, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging, except for the purpose of nuclear cardiac 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.

The term "medical care facility" shall not include any facility of (i) the Department of Behavioral Health and Developmental Services; (ii) any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Behavioral Health and Developmental Services' Comprehensive State Plan; (iii) an intermediate care facility for individuals with mental retardation that has no more than 12 beds and is in an area identified as in need of residential services for people with mental retardation in any plan of the Department of Behavioral Health and Developmental Services; (iv) a physician's office, except that portion of a physician's office described above in subdivision 9 of the definition of "medical care facility"; (v) the Woodrow Wilson Rehabilitation Center of the Department of Rehabilitative Services; (vi) the Department of Corrections; or (vii) the Department of Veterans Services. "Medical care facility" shall also not include that portion of a physician's office dedicated to providing nuclear cardiac imaging.

"Project" means:

1. Establishment of a medical care facility;

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

3. Relocation of beds from one existing facility to another; provided that "project" shall not include the relocation of up to 10 beds or 10 percent of the beds, whichever is less, (i) from one existing facility to another existing facility at the same site in any two-year period, or (ii) in any three-year period, from one existing nursing home facility to any other existing nursing home facility owned or controlled by the same person that is located either within the same planning district, or within another planning district out of which, during or prior to that three-year period, at least 10 times that number of beds have been authorized by statute to be relocated from one or more facilities located in that other planning district and at least half of those beds have not been replaced; provided further that, however, a hospital shall not be required to obtain a certificate for the use of 10 percent of its beds as nursing home beds as provided in § 32.1-132;

4. Introduction into an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided;

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

6. Conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds;

7. The addition by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart

surgery, positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy, proton beam therapy, or other specialized service designated by the Board by regulation. Replacement of existing equipment shall not require a certificate of public need;

8. Any capital expenditure of $15 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 $5 and $15 million shall be registered with the Commissioner pursuant to regulations developed by the Board. The amounts specified in this subdivision shall be revised effective July 1, 2008, and annually thereafter to reflect inflation using appropriate measures incorporating construction costs and medical inflation; or

9. Conversion in an existing medical care facility of psychiatric inpatient beds approved under § 32.1-102.3:2 to nonpsychiatric inpatient beds.

Appendix C

§32.1-102.3

B. In determining whether a public need for a project has been demonstrated, the Commissioner shall consider:

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

2. The extent to which the project will meet the needs of the residents of the area to be served, as demonstrated by each of the following: (i) the level of community support for the project demonstrated by citizens, businesses, and governmental leaders representing the area to be served; (ii) the availability of reasonable alternatives to the proposed service or facility that would meet the needs of the population in a less costly, more efficient, or more effective manner; (iii) any recommendation or report of the regional health planning agency regarding an application for a certificate that is required to be submitted to the Commissioner pursuant to subsection B of § 32.1-102.6; (iv) any costs and benefits of the project; (v) the financial accessibility of the project to the residents of the area to be served, including indigent residents; and (vi) at the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a project;

3. The extent to which the application is consistent with the State Medical Facilities Plan;

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

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

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

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

8. In the case of a project proposed by or affecting a teaching hospital associated with a public institution of higher education or a medical school in the area to be served, (i) the unique research, training, and clinical mission of the teaching hospital or medical school, and (ii) any contribution the teaching hospital or medical school may provide in the delivery, innovation, and improvement of health care for citizens of the Commonwealth, including indigent or underserved populations.

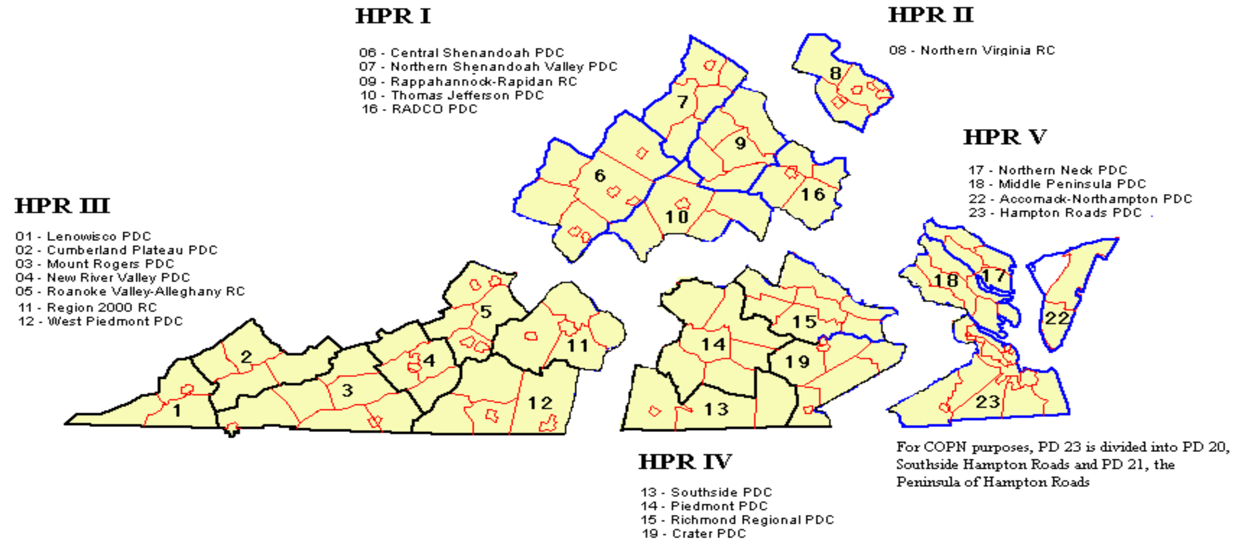
(1982, c. 388; 1984, c. 740; 1993, c. 704; 1999, c. 926; 2000, c. 931; 2004, cc. 71, 95; 2008, c. 292; 2009, c. 175.)

Appendix D

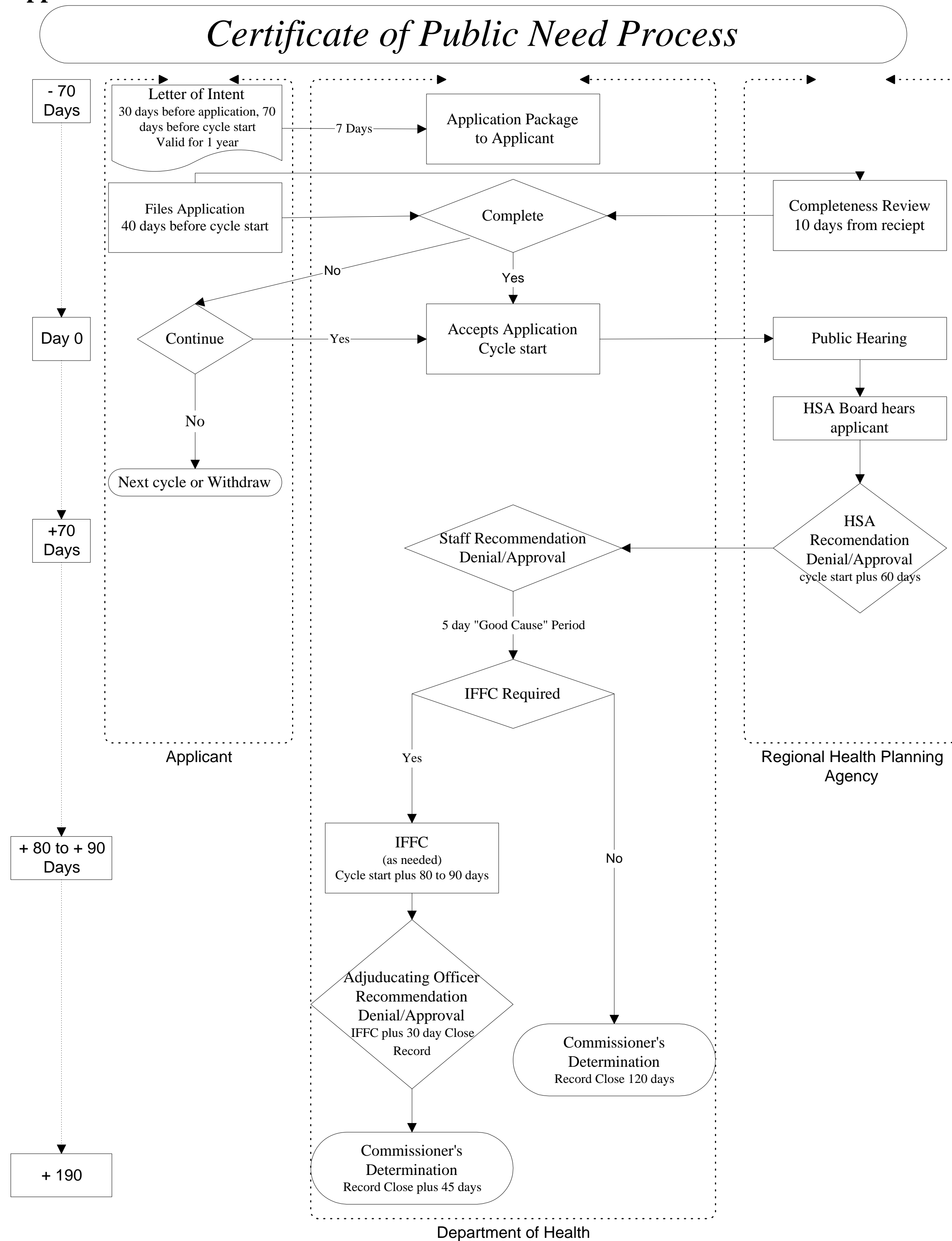
COPN Decisions in Fiscal Year 2011				
	Authorized Projects		**Denied Projects**	
Project Categories	**Number of Projects**	**Capital Costs**	**Number of Projects**	**Capital Costs**
Batch Group A General hospitals, obstetrical services, neonatal special care services				
Subtotal	6	**$256,535,581**	0	**$0**
Batch Group B Open heart surgery, cardiac catheterization, ambulatory surgery centers, operating room additions, transplant services				
Subtotal	8	**$367,897,796**	2	**$17,949,572**
Batch Group C Psychiatric facilities, substance abuse treatment, mental retardation facilities				
Subtotal	6	**$10,188,760**	1	**$195,000**
Batch Group D Diagnostic imaging				
Subtotal	15	**$25,959,889**	2	**$10,988,837**
Batch Group E Medical rehabilitation				
Subtotal	0	**$0**	0	**$0**
Batch Group F Gamma knife surgery, lithotripsy, radiation therapy, comprehensive cancer care centers				
Subtotal	7	**$28,541,561**	3	**$15,115,917**
Batch Group G Nursing home beds, capital expenditures				
Subtotal	3	**$43,546,318**	0	**$0**
COPN Program Total	**45**	**$732,334,862**	**8**	**$44,249,326**
Total Reviewed	**53**	**$776,584,188**		

Virginia's Health Planning Regions

Virginia's Planning Districts



Appendix F



Appendix G

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

Fifteenth Annual Report – 2011
Group 5 Psychiatric services, substance abuse treatment services and miscellaneous capital expenditures

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

Sixteenth Annual Report - 2012
Group 1 General hospitals, general surgery, specialized cardiac services and organ and tissue transplantation

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

Seventeenth Annual Report – 2013
Group 2 Diagnostic Imaging

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

Eighteenth Annual Report – 2014

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

- Establishment of a medical rehabilitation hospital
- Introduction by an existing medical care facility of any new medical rehabilitation service
- Conversion of beds in an existing medical care facility to medical rehabilitation beds
- Establishment of a long-term care hospital
- Establishment of a nursing home
- Establishment of an 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

Nineteenth Annual Report – 2015

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

- Establishment of a specialized center or clinic or that portion of a physician's office developed for the provision of radiation therapy, including gamma knife surgery
- Introduction into an existing medical care facility of any new radiation therapy, including gamma knife surgery, service
- Addition 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 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

Project Categories Presented in the Last Five Years of Annual Reports (2006 – 2010)

Tenth Annual Report - 2006

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

Eleventh Annual Report - 2007

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

Twelfth Annual Report - 2008

Group 2 Diagnostic Imaging

Thirteenth Annual Report – 2009

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

Fourteenth Annual Report – 2010

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

Appendix H

Certificates of Public Need Issued With Conditions Requiring the Provision of Indigent Care and/or the Development and/or Operation of Primary Care For Underserved Populations in FY 2011

Applicant/Project Location	Project	PD	COPN #	Decision Date	Conditions
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Establish a six OR Outpatient Surgical Hospital by relocating the Falls Church Ambulatory Surgery Center	8	VA- 04259	07/01/2010	4.1% indigent / primary care
MediCorp Health System and MediCorp at Stafford, LLC	Introduce Neonatal Special Care Services - Intermediate Level	16	VA- 04260	07/02/2010	Hospital wide (2.4%)
Riverside Behavioral Health Center	Add 20 Acute Psychiatric beds	21	VA- 04261	07/27/2010	4.0% indigent / primary psych care
Diamond Healthcare of Williamsburg, Inc.	Add 30 psychiatric beds at an approved but not constructed psychiatric hospital	21	VA- 04262	07/27/2010	3.3% indigent / primary psych care
Reston Hospital Center, LLC	Add one MRI Scanner	8	VA- 04263	07/20/2010	3.7% indigent/ primary care
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Establish a Specialized Center for CT and MRI Imaging in Reston	8	VA- 04264	08/31/2010	4.1% care within plans
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Establish a Specialized Center for CT and MRI Imaging by Relocating Existing Equipment	8	VA- 04265	08/31/2010	4.1% care within plans
Inova Loudoun Surgery Center, LLC	Add One Operating Room	8	VA- 04268	08/25/2010	4.1% indigent / primary care
Bon Secours - DePaul Medical Center and Maryview Hospital, Inc.	Introduce Stereotactic Radiosurgery Services at Bon Secours DePaul Medical Center	20	VA- 04269	09/21/2010	4.0% indigent / primary care
Mary Washington Hospital, Inc.	Add one Linear Accelerator and one CT Simulator	16	VA- 04270	10/15/2010	Subject to system wide condition
Stafford Hospital, LLC	Add one Linear Accelerator and one CT Simulator	16	VA- 04271	10/15/2010	Subject to system wide condition
Spotsylvania Medical Center, Inc.	Introduce Renal Lithotripsy Services (mobile site)	16	VA- 04273	10/19/2010	4.2% indigent / primary care
Sentara Hospitals	Add one MRI Scanner at Sentara Princess Anne Hospital	20	VA- 04274	03/03/2011	Subject to facility wide condition
Inova Health System	Capital Expenditure of $16,083,450 or more to Expand and Renovate the Inova Loudoun Hospital Cornwall Campus and the add one CT Scanner	8	VA- 04275	11/15/2010	4.1% indigent / primary care
Sentara Leigh Hospital	Capital Expenditure of $16,083,450 or more (renovate and expand with new bed tower)	20	VA- 04276	11/15/2010	4.1% indigent / primary care
Sentara Hospitals	Introduce Special Care Nursery Services at Sentara Princess Anne Hospital	20	VA- 04277	11/15/2010	3.2% indigent / primary care
Sentara Hospitals	Add one CT Scanner at Sentara Princess Anne Hospital	20	VA- 04278	12/14/2010	Subject to facility wide condition
Prince William Health System	Establish a General Acute Care Hospital	8	VA- 04282	12/13/2010	4.1% indigent / primary care, System Wide

Danville Regional Medical Center	Add one MRI and one CT Scanner	12	VA- 04284	01/18/2011	3.1% indigent / primary care
The Village at Orchard Ridge, Inc.	Establish a 60-bed CCRC Nursing Home	7	VA- 04285	02/16/2011	CCRC
Culpeper Regional Hospital	Add one CT Scanner (for both Diagnostic and Radiation Therapy Simulation)	9	VA- 04286	02/17/2011	4.2% indigent / primary care
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Introduce Non-Cardiac Nuclear Medicine Services at the Kaiser Permanente Tysons Corner Imaging Center	8	VA- 04287	02/17/2011	4.1% indigent / primary care
Sentara Virginia Beach General Hospital	Add one CT Scanner	20	VA- 04289	02/15/2011	4.0% indigent / primary care
Sentara Potomac Hospital	Establish a Specialized Center for CT Imaging	8	VA- 04291	03/04/2011	4.1% indigent / primary care
Psychiatric Solutions, Inc.	Establish an 83-bed inpatient psychiatric facility (15 approved)	8	VA- 04293	02/28/2011	1.3% indigent / primary care
Virginia Psychiatric Company, Inc.	Add inpatient Psychiatric Beds at Dominion Hospital in Falls Church (68 approved)	8	VA- 04294	02/28/2011	1.3% indigent / primary care
Bon Secours DePaul Medical Center	Add Four General Purpose Operating Rooms, 2 ORs approved	20	VA- 04296	03/25/2011	Subject to system wide condition
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	Relocate Mobile Lithotripsy Service from Falls Church, Virginia to Tysons Corner in McLean, Virginia	8	VA- 04297	04/20/2011	4.1% indigent / primary care
Inova Loudoun Surgery Center, LLC	Introduce Lithotripsy Services (Mobile Site for Renal)	8	VA- 04298	04/20/2011	4.1% indigent / primary care
Sentara Hospitals	Add 12 OB Beds at Sentara Princess Anne Hospital	20	VA- 04299	06/06/2011	3.2% facility wide
Bon Secours - St. Francis Medical Center, Inc. & Bon Secours St. Mary's Hospital of Richmond, Inc.	Add a Second Cardiac Catheterization Lab	15	VA- 04300	06/06/2011	3.0% indigent / primary care
Skin Surgery Center of Virginia, LLC	Add a Second Operating Room	15	VA- 04301	06/15/2011	3.1% indigent / primary care
Reston Hospital Center, LLC	Add 4 Operating Rooms	8	VA- 04304	06/15/2011	4.7% indigent / primary care
The Cancer Center at Lake Manassas	Add a Linear Accelerator with SRS (Lin Ac approved, SRS Denied)	8	VA- 04306	06/03/2011	4.1% indigent / primary care

Appendix I

Condition Compliance Reporting Status of Facilities / Organizations / Systems with Certificates of Public Need Issued With Conditions Requiring the Provision of Indigent Care and/or the Development and/or Operation of Primary Care for Underserved Populations

(As of June 30, 2011 for reports due during FY 2011)

COPNs With Reports Due And:		
Reported Conditions Met	**Submitted No Report**	**Owner**
0	1	Alliance Imaging
0	1	Associates in Radiation Oncology P.C.
0	3	Association of Alexandria Radiologists
3	0	Augusta Hospital Corporation
1	0	Bath County Community Hospital
17	11	Bon Secours Virginia
4	2	Carilion
0	1	Centra Health
7	0	Chesapeake Hospital Authority
1	2	Community Health Systems
0	1	Community Memorial Health Center
0	1	Community Radiology of Virginia, Inc.
2	3	Culpeper Regional Hospital
1	0	Cumberland Hospital for Children and Adolescents
4	0	Diagnostic Health
1	0	Drs. Mark & Christine Rauch
1	0	Eye Surgery Limited, LLC
1	0	Fairfax Radiological Consultants, P.C.
1	0	Fairlawn Surgical Center
2	1	Falls Church Lithotripsy Associates, L.L.C.
1	0	Fauquier Health
2	0	First Meridian Medical Corporation / MRI & CT Diagnostics
1	0	Halifax Regional Hospital, Inc.
1	0	Hampton Roads Orthopaedics & Sports Medicine
1	0	Hampton Roads Otolaryngology Associates PLLC
30	0	HCA
3	1	HealthSouth
14	12	Inova
1	0	Institute for Women's Imaging
1	0	Kindred Hospitals East
2	5	Lifepoint
10	0	Mary Washington Healthcare (formerly Medicorp)
1	0	Mid-Rivers Cancer Center
1	1	Mountain States Health Alliance
2	0	MRI & Imaging of Virginia (MedQuest)
1	0	Northern Virginia Eye Surgery Center

5	2	Novant
1	0	Orthopaedic Center of Central Virginia
1	0	Orthopaedic Surgery & Sports Medicine Specialists
1	0	OrthoVirginia
1	0	Osteopathic Surgical Centers, LLC
1	0	Psychiatric Solutions
1	0	Radiology Consultants of Lynchburg
3	0	Radiology Imaging Associates
1	0	Reston Radiology Consultants
7	0	Riverside
1	0	Roanoke Ambulatory Surgery Center, LLC
1	0	Roanoke Valley Center for Sight
9	20	Sentara Healthcare
0	1	Shore Health Services
0	1	The Center for Cosmetic Laser & Dermatologic Surgery
0	1	The Skin Cancer Surgery Center
2	0	Tidewater Physicians Multispecialty Group
1	0	Tuckahoe Orthopaedic Associates, LTD
1	0	Twin County Regional Hospital
0	1	UVa Medical Center
3	4	Valley Health
1	0	Virginia Beach Eye Center
1	0	Virginia Cancer Institute, Inc.
1	0	Virginia Cardiovascular Specialists (Intercardia)
6	1	Virginia Hospital Center
0	1	Virginia Medical Imaging
2	0	Virginia Physicians
1	0	Virginia Surgery Center
0	3	Virginia Urology
1	0	Washington Radiology Associates, P.C.
0	1	Wellmont Health System
1	0	Winchester Eye Surgery Center, LLC