COMMONWEALTH of VIRGINIA

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December 3, 2024

MEMORANDUM

TO: The Honorable Janet V. Kelly
Secretary, Health and Human Resources

The Honorable Ghazala F. Hashmi
Chair, Senate Education and Health Committee

The Honorable Mark D. Sickles
Chair, House Health and Human Services Committee

FROM: Karen Shelton, MD
State Health Commissioner, Virginia Department of Health

SUBJECT: Report on the State Health Services Plan Task Force Recommendations for Inclusion in an Expedited Review Process

This report is submitted in compliance with the 2024 Virginia Acts of the Assembly – Chapter 423, which states:

§ 1. That the Board of Health shall convene the State Health Services Plan Task Force (the Task Force) established by § 32.1-102.2:1 of the Code of Virginia to develop recommendations on expedited review of project types subject to certificate of public need requirements that are generally noncontested and present limited health planning impacts. The Task Force shall also create recommendations regarding (i) what facilities and project types listed in § 32.1-102.1:3 of the Code of Virginia should be added to the expedited review process, (ii) criteria that should apply to any project types subject to expedited review, and (iii) a framework for the application and approval process of such projects. Project types for consideration shall include (a) increases in inpatient psychiatric beds, (b) relocation of inpatient psychiatric beds, (c) introduction of psychiatric services into an existing medical care facility, and (d) conversion of beds in an existing medical care facility to psychiatric inpatient beds. The

Task Force shall meet in person at least four times, and shall complete its meetings by October 1, 2024. The Commissioner of Health shall provide a report of these recommendations to the Secretary of Health and Human Resources, the Chairman of the Senate Committee on Education and Health, and the Chairman of the House Committee on Health and Human Services by November 1, 2024.

Should you have any questions or need additional information, please feel free to contact me at (804) 864-7002.

KS/AJ
Enclosure

2024

RECOMMENDATIONS OF THE STATE HEALTH SERVICES PLAN TASK FORCE

REPORT TO THE SECRETARY AND THE GENERAL ASSEMBLY

VIRGINIA DEPARTMENT OF HEALTH

PREFACE

The Virginia Department of Health is submitting this report in response to the legislative mandate in Chapter 423 of the 2024 Acts of Assembly, which directed the State Board of Health to "convene the State Health Services Plan Task Force (the Task Force) established by § 32.1-102.2:1 of the Code of Virginia to develop recommendations on expedited review of project types subject to certificate of public need requirements that are generally noncontested and present limited health planning impacts." The legislative mandate required the State Health Commissioner to "provide a report of these recommendations to the Secretary of Health and Human Resources, the Chairman of the Senate Committee on Education and Health, and the Chairman of the House Committee on Health and Human Services by November 1, 2024."

WORKGROUP MEMBERS

LeadingAge Virginia
Carrie Davis, Administrator at Covenant Woods and Board Member of LeadingAge Virginia
Medical Society of Virginia
Dr. Keith E. Berger, Physician
Dr. Thomas Eppes Jr., Physician - Chair
Representative Appointed by the State Health Commissioner
Karen Cameron, Senior Health Policy Analyst for Virginia Commonwealth University - Vice Chair
Maribel Ramos, Director of Federal Government Relations for the National Women's Law Center
Representative from a Self-Insured or Full-Insured Company
Michael Desjadon, Chief Executive Officer for Anomaly Insights
Representative of a Teaching Hospital Affiliated with a Public Institution of Higher Education
Dr. Kathy Baker, Chief Nursing Officer for the University of Virginia Medical Center
Amanda Dulin, Vice President of Strategic Planning and Business Development for Virginia Commonwealth University Medical Center
Representative with Experience in Health Facilities Planning
Dr. Marilyn West, Owner of M. H. West & Co., Inc.
The Virginia Health Care Association
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Virginia Association of Free and Charitable Clinics
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Virginia Hospital & Healthcare Association
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VIRGINIA DEPARTMENT OF HEALTH STAFF CONTRIBUTORS

Virginia Department of Health[1]
Joseph Hilbert, Deputy Commissioner for Governmental and Regulatory Affairs, Office of the Commissioner

[1] The Virginia Department of Health staff contributors are responsible for the administrative duties of the Task Force and do not hold a member seat on this workgroup.

Erik Bodin, Division Director for Certificate of Public Need, the Cooperative Agreement, and Managed Care Health Insurance Plans, Office of Licensure and Certification.
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EXECUTIVE SUMMARY

The General Assembly directed the State Board of Health to "convene the State Health Services Plan Task Force (the Task Force) established by § 32.1-102.2:1 of the Code of Virginia to develop recommendations on expedited review of project types subject to certificate of public need requirements that are generally noncontested and present limited health planning impacts." The legislative mandate required the State Health Commissioner to "provide a report of these recommendations to the Secretary of Health and Human Resources, the Chairman of the Senate Committee on Education and Health, and the Chairman of the House Committee on Health and Human Services by November 1, 2024." The VDH OLC convened seven meetings throughout 2024, during which several informational presentations were given, and robust debate ensued amongst the assembled Task Force members. The Task Force developed the following recommendations, grouped by the likeliest method by which they could be accomplished, if they are adopted, and the service area the recommendation affects.

RECOMMENDATIONS

Legislative. Implementation of any of the recommendations below would require the General Assembly to amend either the Code of Virginia, or the Appropriation Act. The Task Force vote will be denoted alongside the associated recommendation below. Recommendations below all refer to including certain types of Certificate of Public Need (COPN) applications into an expedited review process.

LEGISLATIVE RECOMMENDATIONS – PSYCHIATRIC

1. Allow facilities that already provide psychiatric service to add[2] psychiatric beds, up to 10 beds or 10% of beds, whichever is greater, in any two-year period using the expedited review process. A psychiatric bed added using the expedited COPN review process may not be converted to a non-psychiatric bed without COPN review. *Unanimously adopted as a recommendation.*

2. Allow facilities to relocate psychiatric beds within the same planning district through the expedited process. *Unanimously adopted as a recommendation.*

3. Allow facilities that already provide psychiatric services to establish[3] a new psychiatric facility within the same planning district though the expedited review process. *Adopted as a recommendation on a vote of 7-Yes, 4-No, 1-Abstain.*

LEGISLATIVE RECOMMENDATIONS – HOSPITAL

The following recommendation was adopted by the Task Force as a recommendation on a vote of 10-Yes 1-No.

1. Add new hospital beds by relocation of existing hospital beds through the expedited review process.

LEGISLATIVE RECOMMENDATIONS – CARDIAC CATHETERIZATION

The following recommendation was adopted by the Task Force as a recommendation unanimously.

1. Add a cardiac catheterization lab in an existing hospital with cardiac catheterization services.

[2] For the purposes of this report, "add" means the expansion of a service at a facility that already provides that service.

[3] For the purposes of this report, "establish" means the establishment of a new medical care facility and the services, machines, and beds associated with such establishment.

LEGISLATIVE RECOMMENDATIONS – SURGICAL

The following recommendation was adopted by the Task Force as a recommendation unanimously.

1. Add new operating rooms in an existing outpatient surgical hospital by relocating existing ORs from another hospital.

LEGISLATIVE RECOMMENDATIONS – MEDICAL REHABILITATION

The following recommendations were adopted by the Task Force as recommendations unanimously.

1. Add new medical rehabilitation beds in a hospital with existing rehabilitation services.

2. Add rehabilitation beds in a hospital with existing rehabilitation services by converting medical-surgical beds.

LEGISLATIVE RECOMMENDATIONS – RADIATION THERAPY & CANCER TREATMENT

The following recommendations were adopted by the Task Force as recommendations unanimously.

1. Add a linear accelerator by relocating an existing linear accelerator to a hospital with an existing linear accelerator.

2. Add a linear accelerator in an existing hospital with an existing linear accelerator.

3. Add a linear accelerator in an existing outpatient surgical hospital with an existing linear accelerator.

4. Add a linear accelerator in an existing radiation treatment center with a linear accelerator.

5. Add stereotactic radiosurgery (SRS) equipment in an existing radiation treatment center with existing SRS.

LEGISLATIVE RECOMMENDATIONS - OPERATIONAL

1. Allow the Commissioner to condition psychiatric projects on the acceptance of Temporary Detention Orders. *Adopted as a recommendation on a vote of 10-Yes 1-No.*

2. Require facilities to request a COPN in order to convert beds from psychiatric beds to non-psychiatric beds. *Unanimously adopted as a recommendation.*

Regulatory. Implementation of any of the recommendations below would require the State Board of Health to initiate one or more regulatory actions under the Virginia Administrative Process Act. The Task Force vote will be denoted alongside the associated recommendation below.

REGULATORY RECOMMENDATIONS – OPERATIONAL

1. Extend expedited review from 45 days to 90 days. All expedited review projects will be considered in one of four batch cycles per year specifically for expedited review projects. *Adopted as a recommendation on a vote of 7-Yes 5-No.*

2. Allow members of the public to request a hearing for an expedited review project. *Adopted as a recommendation on a vote of 7-Yes 4-No.*

INTRODUCTION

WORKGROUP MANDATE

Chapter 423 of the 2024 Acts of Assembly requires the State Board of Health to "convene the State Health Services Plan Task Force (the Task Force) established by § 32.1-102.2:1 of the Code of Virginia to develop recommendations on expedited review of project types subject to certificate of public need requirements that are generally noncontested and present limited health planning impacts." (Appendix A)

WORKGROUP ACTIVITIES

In response to the legislative mandate, the Office of Licensure and Certification (OLC) at the Virginia Department of Health (VDH) convened the Task Force, which held seven meetings during 2024: February 9th, March 8th, May 30th, July 12th, August 9th, August 23rd, and September 6th. The meeting minutes for each meeting of the Task Force can be found in Appendix E.

FEBRUARY 9 MEETING

At the first in-person meeting, the Task Force reviewed and adopted the bylaws, elected the Task Force Chair and Vice Chair, and adopted the Remote Participation Policy by voice-vote. The Task Force then moved to a discussion portion, where VDH staff provided a high-level overview of the existing Certificate of Public Need (COPN) standard review and expedited review processes, and the Task Force's mandate. The Task Force also agreed to focus first on psychiatric services followed by other project types during later meetings.

MARCH 8 MEETING

VDH staff began the in-person meeting with an educational presentation on the COPN process in Virginia, covering application procedures, project types, and the expedited review process. Then, VDH staff gave another presentation on an overview of the mandate in Chapter 423 of the 2024 Acts of Assembly, data trends for psychiatric beds and services in the state, comparisons of COPN programs and psychiatric services between Virginia and other states, related past legislative efforts, and applicable reports of interest to consider.

Following this, members broke out into three smaller groups to discuss the information received and preliminary recommendations and next steps. Finally, Task Force members regrouped to review each group's recommendations and additional data requests.

MAY 30 MEETING

At the start of the in-person meeting, the Task Force members received a presentation from the Commissioner for the Department of Behavioral Health and Developmental Services on the Governor's *Right Help, Right Now* Plan, public and private psychiatric bed estimates, temporary detention orders, and a Nationwide COPN Overview. The presentation was followed by discussion on the licensure of crisis centers, exclusionary criteria, and the effectiveness and capacity of crisis stabilization centers.

VDH staff then presented on the Task Force mandate, the future meeting schedule, and the options for consideration moving forward. The Task Force members then broke into three smaller groups for breakout sessions. Following their discussions, Task Force members submitted both individual and group votes on 13 policy options presented to them, with the opportunity to submit additional options or amendments for voting during a future meeting.

JULY 12 MEETING

Task Force members convened an all-virtual meeting where VDH staff reviewed meeting materials regarding potential policy options and COPN project types by action and by service. Following Robert's Rules of Order, the Task Force moved to vote on policy options for expedited review specifically for psychiatric services, completing voting for 8 policy options and their resulting amendments. The meeting adjourned after members discussed next steps and information needed to fulfill the rest of the mandate related to recommendations surrounding other services regulated by the State Health Services Plan (currently the SMFP).

AUGUST 9 MEETING

Task Force members convened an all-virtual meeting where VDH staff reviewed meeting materials regarding potential options for recommendation and COPN project types by action and by service. The meeting was originally planned as an in-person meeting but was changed to an all-virtual meeting due to the declared state of emergency in Virginia. The planned vote for the remaining COPN projects was deferred to the August 23 meeting.

AUGUST 23 MEETING

Task Force members convened an in-person meeting where VDH staff reviewed the meeting materials regarding the potential options for recommendation by service type. The Task Force then voted on the options presented by service type, resulting in the Task Force completing the remainder of their mandate contained in Chapter 423 of the 2024 Acts of Assembly. The Task Force then discussed the next steps for the September 6 meeting.

SEPTEMBER 6 MEETING[4]

Task Force members convened an in-person meeting where VDH staff reviewed the remainder of the Task Force's mandate. During this meeting, the Task Force voted to rescind the previous recommendation to include the imaging block in the recommendations for inclusion in an expedited review process. The Task Force then discussed the next steps for completing the remainder of their mandate in § 32.1-102.2:1 of the Code of Virginia.

REPORT OUTLINE

Following the discussion of the study mandate, the report provides a summary of the Task Force, what COPN is, and Virginia's current COPN processes. The report concludes with the recommendations, grouped according to the method by which they may be implemented, and a brief overview of the Task Force's next steps.

[4] The minutes for the September 6, 2024, meeting have been attached to this report in their draft form; the Task Force will not be convening to review and approve these minutes until after the report deadline, and therefore the final version is not available.

THE STATE HEALTH SERVICES PLAN TASK FORCE

TASK FORCE COMPOSITION AND MANDATE

Section 32.1-102.2:1 of the Code of Virginia establishes the Task Force for the purposes of advising the Board of Health on the contents of the State Health Services Plan (SHSP). The Task Force has two separate mandates they are required to fulfill; the mandate in Chapter 423 of the 2024 Acts of Assembly, and the amendment to § 32.1-102.2:1 of the Code of Virginia due to the enactment of Chapter 1271 of the 2020 Acts of Assembly. The changes made in Chapter 1271 can be found in Appendix C. While the mandate in Chapter 1271 was enacted in 2020, the Task Force did not hold its first meeting until February 9, 2024; the COVID-19 pandemic and the role VDH played in the public health response to that pandemic is attributed to the Task Force's meeting delays.

The Task Force consists of 15 members who are broadly representative of the interests of all residents of the Commonwealth and across various geographic regions, including:

> *… two members two representatives of the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, the Virginia Health Care Association, and physicians or administrators representing teaching hospitals affiliated with a public institution of higher education; one representative each of the Virginia Association of Health Plans, the Virginia Association of Free and Charitable Clinics, the Virginia Community Healthcare Association, LeadingAge Virginia, a company that is self-insured or full-insured for health coverage, a nonprofit organization located in the Commonwealth that engages in addressing access to health coverage for low-income individuals, and a rural locality recognized as a medically underserved area; one individual with experience in health facilities planning; and such other individuals as the Commissioner determines is appropriate.*

For the full membership roster of the Task Force, please refer to the SHSP section on the Virginia Department of Health's website.[5]

The Task Force is responsible for the providing recommendations related to the following[6]:

- Periodic revisions to the State Health Services Plan;
- Specific objective standards of review for each type of medical care facility or project type for which a certificate of public need is required;
- Project types that are generally noncontested and present limited health planning impacts;
- Whether certain projects should be subject to expedited review rather than the full review process; and
- Improvements in the certificate of public need process.

BILL HISTORY

Initially, Senate Bill 277 (later Chapter 423 of the 2024 Acts of Assembly), patroned by Senator Ghazala Hashmi, amended and reenacted §§ 32.1-102.2 and 32.1-102.6 of the Code of Virginia in an attempt to eliminate the standard review process by placing all projects into the expedited review cycle. Following conversations

[5] https://www.vdh.virginia.gov/licensure-and-certification/the-certificate-of-public-need-program/state-health-services-plan-task-force/

[6] Va. Code § 32.1-102.2:1(A).

with stakeholders, the bill was amended in the nature of a substitute in the Senate Committee on Education and Health to direct the State Board of Health to convene the Task Force to make recommendations on the expedited review of projects subject to COPN requirements; this substitute amendment included none of the original bill language and was the final form of the bill that was eventually enacted as Chapter 423 of the 2024 Acts of Assembly.

In addition to the legislation requiring the State Board of Health to convene the Task Force, Senator Hashmi also submitted a budget amendment requesting an appropriation of $150,000 in the first and second year of the biennial budget for VDH to hire a private consultant to assist in the development of the SHSP. The budget amendment was ultimately not approved by the Committee for adoption into the proposed biennial budget.

Senator Hashmi's bill was not the first of its kind related to the reform of the COPN program in Virginia, as this program has remained an area of contention since its inception. During the 2023 General Assembly Session, two bills (House Bill 1600 and Senate Bill 953) were proposed seeking to amend the existing expedited review process through the expansion of eligible project types while still preserving the standard review process. Both bills were ultimately unsuccessful, having failed in their first subject matter committees. Between 2016 and 2023, there have been approximately eight bills[7] aimed at expanding the projects eligible for expedited review, none of which were successful. Since 2016, Chapter 1271 of the 2020 Acts of Assembly has been the only successful bill to have made substantial reform to the COPN process.

WHAT IS A CERTIFICATE OF PUBLIC NEED?

COPN programs, or Certificate of Need programs, are state-level regulatory programs that require healthcare facilities to apply for and receive approval from the state prior to expansions in service capacity, the establishment of new facilities, or large capital expenditures. Grounded in measures of community need, the COPN decision-making process is based on the assumption that managing the supply of healthcare facilities and equipment is a viable strategy to contain medical care costs. Furthermore, COPN processes intend to help ensure that providers invest in medically underserved areas, promote access to quality healthcare for indigent populations, decrease the likelihood of facilities raising prices to compensate for excess bed or service capacity, and support facilities who offer both profitable and unprofitable services by restricting market access of facilities that only provide profitable services. Every state has its own set of regulations outlining the specific criteria facilities must meet to obtain approval as well as what types of equipment or capacity additions fall under COPN oversight. Currently, 35 states and Washington DC operate some variation of a COPN program.[8]

COPN was initially codified into federal law by the National Health Planning and Resource Development Act of 1974, which required all states to enact such programs to continue receiving funding. Although the federal statute was eventually repealed in 1986[9], the Virginia COPN program remained largely intact since its inception in 1973. Virginia's COPN program may be divided into three distinct periods: i) relatively consistent regulation from 1973 to 1986, ii) dramatic deregulation for most specialized diagnostic and treatment facilities and services from 1986 to 1992, and iii) a return to regulation from 1996 to the present. In

[7] The respective bills are as follows: House Bill 193, House Bill 350, House Bill 1083, and Senate Bill 641 from the 2016 Regular Session; House Bill 2337 from the 2017 Regular Session; Senate Bill 205 from the 2022 Regular Session; House Bill 1600 and Senate Bill 953 from the 2023 Session.

[8] National Conference of State Legislatures, *Certificate of Need State Laws,* February 26, 2024, https://www.ncsl.org/health/certificate-of-need-state-laws#:~:text=CON%20programs%20primarily%20aim%20to,with%20wide%20variation%20by%20state.

[9] U.S. Government Accountability Office, *Status of the Implementation of the National Health Planning and Resources Development Act of 1974*, November 2, 1978, https://www.gao.gov/products/hrd-77-157.

recent years, VDH has taken an incremental approach to responding to legislative initiatives, including de-emphasizing regulation of replacement and of smaller, non-clinically related expenditures, focusing instead on new facilities development, new services additions, and expansion of service capacity.

CORE REQUIREMENTS

Article 1.1 of Chapter 4 of Title 32.1 of the Code of Virginia (§ 32.1-102.1 *et seq*.) establishes Virginia's COPN program, specifying the types of medical care facilities and project types that require COPN authorization, the criteria that must be considered in the determination of public need, and the application review procedures that applicants and VDH must adhere to.

Certain Medical Facilities Require Certification. Hospitals, nursing homes, intermediate care facilities for individuals with developmental disabilities, and intermediate care facilities intended for treatment and rehabilitation of individuals with substance use disorders all require COPN authorization. In addition to the facilities listed, specialized centers or portions of physicians' offices developed for certain medical procedures must also receive certification, including outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, magnetic resonance imaging (MRI), positron emission tomographic (PET) scanning, lithotripsy, radiation therapy, and several other specialty services.

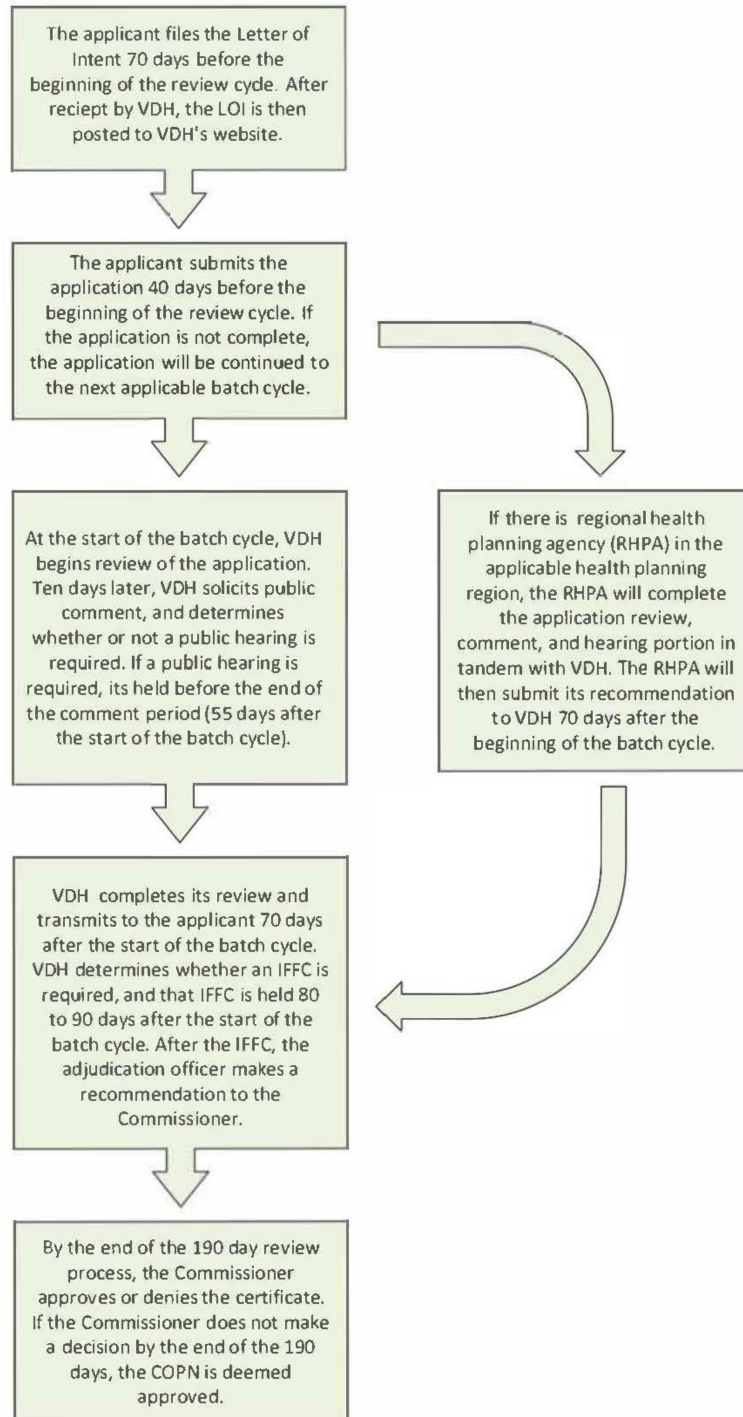
Furthermore, a COPN is also required for i) the establishment of any medical care facility listed above, ii) an increase in the total number of beds in a facility, iii) the relocation of beds from an existing facility, iv) the introduction or addition of any new specialty services or medical equipment, v) the conversion of beds to medical rehabilitation or psychiatric beds, and vi) any capital expenditure of $15 million or more. VDH is also required by the Code to regularly review and provides recommendation at least once every five years to the Governor and the General Assembly regarding the types of medical care facilities that should be subject to COPN review.[10]

STANDARD REVIEW PROCESS

The COPN program divides medical facilities and project types into 7 batch cycle groups and requires the Division of Certificate of Public Need (DCOPN), which assists the Commissioner in administering the COPN program, to review completed applications using a 190-day review schedule. By using a structured batching process, the program seeks to avoid unnecessary duplication of medical care facilities and services; however, this means that there are only two opportunities per year to apply for each type of COPN project. It is also important to note that applicants, and only the applicants, have the authority to extend any of the deadlines for review of the application, after which the Commissioner, with the consent of all relevant parties, establishes a new schedule for the remaining time periods.[11] For further information about COPN and Virginia's regulatory process, please refer to Appendix D, or the following flow-chart.

[10] Va. Code § 32.1-102.1:3.

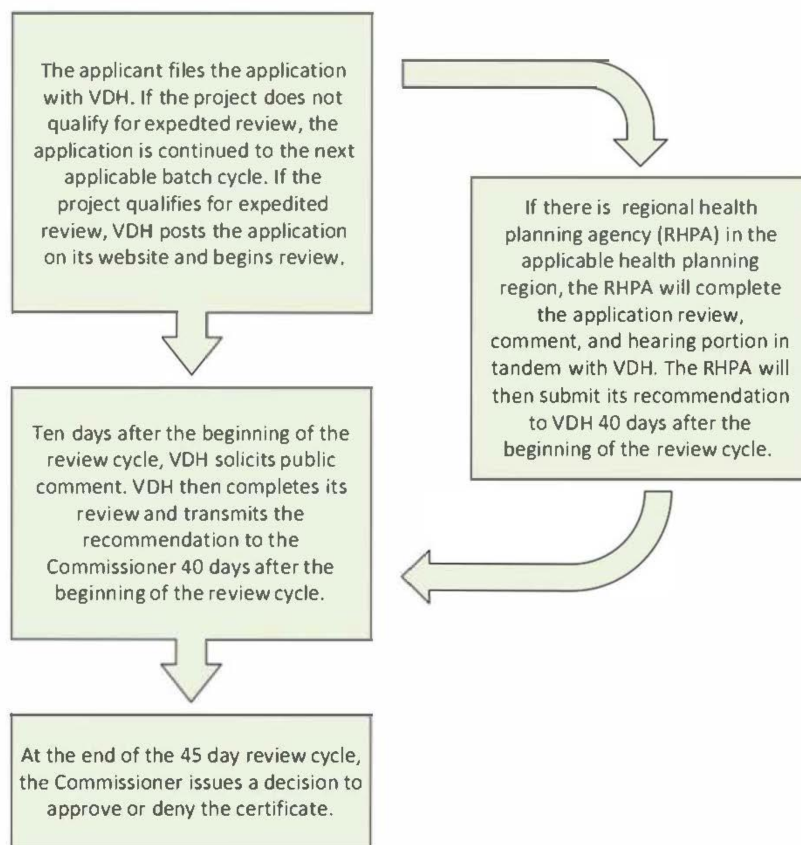
[11] 12VAC5-220-230(C).


The Standard COPN Application Review Process
The applicant files the Letter of Intent 70 days before the beginning of the review cycle. After reciept by VDH, the LOI is then posted to VDH's website.
The applicant submits the application 40 days before the beginning of the review cycle. If the application is not complete, the application will be continued to the next applicable batch cycle.
At the start of the batch cycle, VDH begins review of the application. Ten days later, VDH solicits public comment, and determines whether or not a public hearing is required. If a public hearing is required, its held before the end of the comment period (55 days after the start of the batch cycle).
If there is regional health planning agency (RHPA) in the applicable health planning region, the RHPA will complete the application review, comment, and hearing portion in tandem with VDH. The RHPA will then submit its recommendation to VDH 70 days after the beginning of the batch cycle.
VDH completes its review and transmits to the applicant 70 days after the start of the batch cycle. VDH determines whether an IFFC is required, and that IFFC is held 80 to 90 days after the start of the batch cycle. After the IFFC, the adjudication officer makes a recommendation to the Commissioner.
By the end of the 190 day review process, the Commissioner approves or denies the certificate. If the Commissioner does not make a decision by the end of the 190 days, the COPN is deemed approved.

EXPEDITED REVIEW PROCESS

Currently, the projects eligible for expedited review include capital expenditures of $15 million ($22,178,713[12] as adjusted for inflation) or more taken by or on behalf of a medical care facility other than a general hospital. If, after review, a project meets the standards for expedited review and the applicant submits a request, DCOPN will transmit the necessary application forms within 7 days of receipt. All requests for a COPN under the expedited review process must be reviewed by DCOPN and the relevant RHPA, then the recommendation is transmitted to the Commissioner within 40 days. No application will be reviewed until the application is deemed complete and the appropriate application fees have been paid to DCOPN.[13]

Any persons directly affected by the proposed project may submit written opinions to the appropriate RHPA or to the Commissioner[14] prior to their final action, which must occur within 45 days from DCOPN's initial receipt of the application. If the Commissioner determines that a project does not meet the criteria of expedited reviews, the applicant must go through the standard review process detailed above if they wish to continue their application.[15]



[12] Derived from the March 2024 General Notice titled "Public Notice regarding Annual Adjustment of Capital Expenditure Threshold for Certificate of Public Need Program."
[13] 12VAC5-220-290.
[14] 12VAC5-220-300.
[15] 12VAC5-220-310.

STATE HEALTH SERVICES PLAN

Virginia's COPN program requires applicants to demonstrate a public need for the facility or service, and the Commissioner is responsible for determining and certifying that such a need exists. Prior to authorizing any project's implementation, the Commissioner must be satisfied that it meets eight conditions:[16]

> *"1. The extent to which the proposed project will provide or increase access to health care services for people in the area to be served and the effects that the proposed project will have on access to health care services in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to health care;*
>
> *2. The extent to which the proposed project will meet the needs of people in the area to be served, as demonstrated by each of the following: (i) the level of community support for the proposed project demonstrated by people, businesses, and governmental leaders representing the area to be served; (ii) the availability of reasonable alternatives to the proposed project that would meet the needs of people in the area to be served 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 proposed project; (v) the financial accessibility of the proposed project to people in the area to be served, including indigent people; and (vi) at the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a proposed project;*
>
> *3. The extent to which the proposed project is consistent with the State Health Services Plan;*
>
> *4. The extent to which the proposed project fosters institutional competition that benefits the area to be served while improving access to essential health care services for all people in the area to be served;*
>
> *5. The relationship of the proposed 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 proposed project, including the financial benefits of the proposed 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 proposed project provides improvements or innovations in the financing and delivery of health care 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 health care 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 services for citizens of the Commonwealth, including indigent or underserved populations."*

As stated in the conditions above, any decision on the issuance of a COPN must be also consistent with the SHSP, formerly the SMFP, which is approved by the State Board of Health and subject to periodic revision every two years. The SHSP includes methodologies and formulas for calculating and projecting the need for medical facility beds and services in a given health planning district.

[16] Va. Code § 32.1-102.3(B).

Below are the services for which the SMFP currently provides guidance:[17]

- CT machines;
- MRI machines;
- PET machines;
- noncardiac nuclear imaging;
- stereotactic imaging;
- cardiac catheterization services;
- open heart surgery;
- general surgical services;
- inpatient beds;
- nursing facilities;
- lithotripsy service;
- organ transplants;
- medical rehabilitation;
- acute psychiatric treatment services;
- acute psychiatric substance use disorder treatment services;
- obstetrical services; and
- neonatal special care services.

[17] 12VAC5-230.

TASK FORCE RECOMMENDATIONS FOR INCLUSION IN AN EXPEDITED REVIEW PROCESS

The recommendations below are grouped by the likeliest method by which they could be accomplished, if they are adopted, and the service area the recommendation affects. The two methods are legislative and regulatory. Legislative recommendations below would require the General Assembly to amend either the Code of Virginia, or the Appropriation Act. All legislative recommendations below refer to including certain types of COPN applications into an expedited review process. Regulatory recommendations below would require the State Board of Health to initiate one or more regulatory actions under the Virginia Administrative Process Act.

LEGISLATIVE RECOMMENDATIONS – PSYCHIATRIC

1. Allow facilities that already provide psychiatric service to add psychiatric beds, up to 10 beds or 10% of beds, whichever is greater, in any two-year period using the expedited review process. A psychiatric bed added using the expedited COPN review process may not be converted to a non-psychiatric bed without COPN review. *Unanimously adopted as a recommendation.*

2. Allow facilities to relocate psychiatric beds within the same planning district through the expedited process. *Unanimously adopted as a recommendation.*

3. Allow facilities that already provide psychiatric services to establish a new psychiatric facility within the same planning district though the expedited review process. *Adopted as a recommendation on a vote of 7-Yes, 4-No, 1-Abstain.*

LEGISLATIVE RECOMMENDATIONS – HOSPITAL

The following recommendation was adopted by the Task Force as a recommendation on a vote of 10-Yes 1-No.

1. Add new hospital beds by relocation of existing hospital beds.

LEGISLATIVE RECOMMENDATIONS – CARDIAC CATHETERIZATION

The following recommendation was adopted by the Task Force as a recommendation unanimously.

1. Add a cardiac catheterization lab in an existing hospital with cardiac catheterization services.

LEGISLATIVE RECOMMENDATIONS – SURGICAL

The following recommendation was adopted by the Task Force as a recommendation unanimously.

1. Add new operating rooms in an existing outpatient surgical hospital by relocating existing ORs from another hospital.

LEGISLATIVE RECOMMENDATIONS – MEDICAL REHABILITATION

The following recommendations were adopted by the Task Force as recommendations unanimously.

1. Add new medical rehabilitation beds in a hospital with existing rehabilitation services.

2. Add rehabilitation beds in a hospital with existing rehabilitation services by converting medical-surgical beds.

LEGISLATIVE RECOMMENDATIONS – RADIATION THERAPY & CANCER TREATMENT

The following recommendations were adopted by the Task Force as recommendations unanimously.

1. Add a linear accelerator by relocating an existing linear accelerator to a hospital with an existing linear accelerator.

2. Add a linear accelerator in an existing hospital with an existing linear accelerator.

3. Add a linear accelerator in an existing outpatient surgical hospital with an existing linear accelerator.

4. Add a linear accelerator in an existing radiation treatment center with a linear accelerator.

5. Add stereotactic radiosurgery (SRS) equipment in an existing radiation treatment center with existing SRS.

LEGISLATIVE RECOMMENDATIONS - OPERATIONAL

3. Allow the Commissioner to condition psychiatric projects on the acceptance of Temporary Detention Orders. *Adopted as a recommendation on a vote of 10-Yes 1-No.*

4. Require facilities to request a COPN in order to convert beds from psychiatric beds to non-psychiatric beds. *Unanimously adopted as a recommendation.*

REGULATORY RECOMMENDATIONS – OPERATIONAL

3. Extend expedited review from 45 days to 90 days. All expedited review projects will be considered in one of four batch cycles per year specifically for expedited review projects. *Adopted as a recommendation on a vote of 7-Yes 5-No.*

4. Allow members of the public to request a hearing for an expedited review project. *Adopted as a recommendation on a vote of 7-Yes 4-No.*

WORKGROUP NEXT STEPS

As the Task Force has completed the mandate contained in Chapter 423 of the 2024 Acts of Assembly, the group will now begin to address the mandate within § 32.1-102.2:1 of the Code of Virginia to develop "... recommendations for a comprehensive State Health Services Plan for adoption by the Board that includes (i) specific formulas for projecting need for medical care facilities and services subject to the requirement to obtain a certificate of public need, (ii) current statistical information on the availability of medical care facilities and services, (iii) objective criteria and standards for review of applications for projects for medical care facilities and services, and (iv) methodologies for integrating the goals and metrics of the State Health Improvement Plan established by the Commissioner into the criteria and standards for review."

APPENDIX A – CHAPTER 423 OF THE 2024 ACTS OF ASSEMBLY

VIRGINIA ACTS OF ASSEMBLY -- 2024 SESSION

CHAPTER 423

An Act to direct the Board of Health to convene the State Health Services Plan Task Force to make recommendations on expedited review of projects subject to certificate of public need requirements.

[S 277]

Approved April 4, 2024

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Board of Health shall convene the State Health Services Plan Task Force (the Task Force) established by § 32.1-102.2:1 of the Code of Virginia to develop recommendations on expedited review of project types subject to certificate of public need requirements that are generally noncontested and present limited health planning impacts. The Task Force shall also create recommendations regarding (i) what facilities and project types listed in § 32.1-102.1:3 of the Code of Virginia should be added to the expedited review process, (ii) criteria that should apply to any project types subject to expedited review, and (iii) a framework for the application and approval process of such projects. Project types for consideration shall include (a) increases in inpatient psychiatric beds, (b) relocation of inpatient psychiatric beds, (c) introduction of psychiatric services into an existing medical care facility, and (d) conversion of beds in an existing medical care facility to psychiatric inpatient beds. The Task Force shall meet in person at least four times, and shall complete its meetings by October 1, 2024. The Commissioner of Health shall provide a report of these recommendations to the Secretary of Health and Human Resources, the Chairman of the Senate Committee on Education and Health, and the Chairman of the House Committee on Health and Human Services by November 1, 2024.*

APPENDIX B – ACRONYMS AND ABBREVIATIONS

This is a listing of the acronyms and abbreviations appearing throughout the report and its appendices.

COPN – Certificate of Public Need

CT – Computed Tomography

DCOPN – Division of Certificate of Public Need

HPR – Health Planning Region

HSANV – Health Services Agency of Northern Virginia

IFFC – Informal Fact-Finding Conference

LOI – Letter of Intent

MRI – Magnetic Resonance Imaging

OLC – Office of Licensure and Certification

PET – Positron Emission Tomography

RHPA – Regional Health Planning Agency

SHSP – State Health Services Plan

SMFP – State Medical Facilities Plan

SRS - stereotactic radiosurgery

Task Force – the State Health Services Plan Task Force

TDO – Temporary Detention Order

VDH – Virginia Department of Health

APPENDIX C – CHAPTER 1271 OF THE 2020 ACTS OF ASSEMBLY

This is an excerpt from Chapter 1271 of the 2020 Acts of Assembly detailing the changes made to § 32.1-102.2:1 of the Code of Virginia, creating the State Health Services Plan Task Force.

external beam radiation therapy, or nuclear imaging services shall not require registration. Such regulations shall include provisions for (i) establishing the agreement of the applicant to provide a level of care in services or funds that matches the average percentage of indigent care provided in the appropriate health planning region and to participate in Medicaid at a reduced rate to indigents, (ii) obtaining accreditation from a nationally recognized accrediting organization approved by the Board for the purpose of quality assurance, and (iii) reporting utilization and other data required by the Board to monitor and evaluate effects on health planning and availability of health care services in the Commonwealth.

§ 32.1-102.2:1. State ~~Medical Facilities~~ *Health Services* Plan; ~~task force~~ *Task Force*.

~~The Board shall appoint and convene a task force of no fewer than 15 individuals to meet at least once every two years. The task force shall consist of representatives from the Department and the Division of Certificate of Public Need, representatives of regional health planning agencies, representatives of the health care provider community, representatives of the academic medical community, experts in advanced medical technology, and health insurers. The task force shall complete a review of the State Medical Facilities Plan updating or validating existing criteria in the State Medical Facilities Plan at least every four years.~~

A. The Board shall appoint and convene a State Health Services Plan Task Force for the purpose of advising the Board on the content of the State Health Services Plan. The Task Force shall provide recommendations related to (i) periodic revisions to the State Health Services Plan, (ii) specific objective standards of review for each type of medical care facility or project type for which a certificate of public need is required, (iii) project types that are generally noncontested and present limited health planning impacts, (iv) whether certain projects should be subject to expedited review rather than the full review process, and (v) improvements in the certificate of public need process. All such recommendations shall be developed in accordance with an analytical framework established by the Commissioner that includes a specific evaluation of whether State Health Services Plan standards are consistent with the goals of (a) meeting the health care needs of the indigent and uninsured citizens of the Commonwealth, (b) protecting the public health and safety of the citizens of the Commonwealth, (c) promoting the teaching missions of academic medical centers and private teaching hospitals, and (d) ensuring the availability of essential health care services in the Commonwealth, and are aligned with the goals and metrics of the Commonwealth's State Health Improvement Plan.

B. The Task Force shall consist of no fewer than 19 individuals appointed by the Commissioner who are broadly representative of the interests of all residents of the Commonwealth and of the various geographic regions, including two representatives of the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, the Virginia Health Care Association, and physicians or administrators representing teaching hospitals affiliated with a public institution of higher education; one representative each of the Virginia Association of Health Plans, the Virginia Association of Free and Charitable Clinics, the Virginia Community Healthcare Association, LeadingAge Virginia, a company that is self-insured or full-insured for health coverage, a nonprofit organization located in the Commonwealth that engages in addressing access to health coverage for low-income individuals, and a rural locality recognized as a medically underserved area; one individual with experience in health facilities planning; and such other individuals as the Commissioner determines is appropriate.

C. The powers and duties of the Task Force shall be:

1. To develop, by November 1, 2022, recommendations for a comprehensive State Health Services Plan for adoption by the Board that includes (i) specific formulas for projecting need for medical care facilities and services subject to the requirement to obtain a certificate of public need, (ii) current statistical information on the availability of medical care facilities and services, (iii) objective criteria and standards for review of applications for projects for medical care facilities and services, and (iv) methodologies for integrating the goals and metrics of the State Health Improvement Plan established by the Commissioner into the criteria and standards for review. Criteria and standards for review included in the State Health Services Plan shall take into account current data on drive times, utilization, availability of competing services, and patient choice within and among localities included in the health planning district or region; changes and availability of new technology; and other relevant factors identified by the Task Force. The State Health Services Plan shall also include specific criteria for determining need in rural areas, giving due consideration to distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care in such areas and providing for weighted calculations of need based on the barriers to health care access in such rural areas in lieu of the determinations of need used for the particular proposed project within the relevant health planning district or region as a whole.

2. To engage the services of private consultants or request the Department to contract with any private organization for professional and technical assistance and advice or other services to assist the Task Force in carrying out its duties and functions pursuant to this section. The Task Force may also solicit the input of experts with professional competence in the subject matter of the State Health Services Plan, including (i) representatives of licensed health care providers or health care provider organizations owning or operating licensed health facilities and (ii) representatives of organizations

concerned with health care consumers and the purchasers and payers of health care services; and

3. To review annually and, if necessary, develop recommendations for revisions to each section of the State Health Services Plan on a rotating schedule defined by the Task Force at least every two years following the last date of adoption by the Board.

D. The Task Force shall exercise its powers and carry out its duties to ensure:

1. The availability and accessibility of quality health services at a reasonable cost and within a reasonable geographic proximity for all people in the Commonwealth, competitive markets, and patient choice;

2. Appropriate differential consideration of the health care needs of residents in rural localities in ways that do not compromise the quality and affordability of health care services for those residents;

3. Elimination of barriers to access to care and introduction and availability of new technologies and care delivery models that result in greater integration and coordination of care, reduction in costs, and improvements in quality; and

4. Compliance with the goals of the State Health Services Plan and improvement in population health.

E. The Department shall post on its website information regarding the process by which the State Health Services Plan is created and the process by which the Department determines whether a proposed project complies with the State Health Services Plan on its website.

§ 32.1-102.3. Demonstration of public need required; criteria for determining need.

A. ~~No person shall commence any project without first obtaining a certificate issued by the Commissioner.~~ No certificate may be issued unless the Commissioner has determined that a public need for the project has been demonstrated. If it is determined that a public need exists for only a portion of a project, a certificate may be issued for that portion and any appeal may be limited to the part of the decision with which the appellant disagrees without affecting the remainder of the decision. Any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provisions of the State ~~Medical Facilities~~ *Health Services* Plan; however, if the Commissioner finds, upon presentation of appropriate evidence, that the provisions of such plan are not relevant to a rural locality's needs, inaccurate, outdated, inadequate or otherwise inapplicable, the Commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan. In cases in which a provision of the State ~~Medical Facilities~~ *Health Services* Plan has been previously set aside by the Commissioner and relevant amendments to the Plan have not yet taken effect, the Commissioner's decision shall be consistent with the applicable portions of the State ~~Medical Facilities~~ *Health Services* Plan that have not been set aside and the remaining considerations in subsection B.

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

2. The extent to which the *proposed* 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 *proposed* 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~~ *project* 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 *proposed* project; (v) the financial accessibility of the *proposed* 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 *proposed* project;

3. The extent to which the ~~application~~ *proposed project* is consistent with the State ~~Medical Facilities~~ *Health Services* Plan;

4. The extent to which the proposed ~~service or facility~~ *project* 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 *proposed* 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 *proposed* project, including the financial benefits of the *proposed* 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 *proposed* project provides improvements or innovations in the financing and delivery of health *care* 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

APPENDIX D – CERTIFICATE OF PUBLIC NEED PROCESS

This is an in-depth summary of the steps in the standard COPN review process.

LETTER OF INTENT AND APPLICATION SUBMISSION

All persons intending to become applicants for a COPN must begin by submitting a Letter of Intent (LOI), which describes the proposed project in enough detail to enable DCOPN to place the project into the appropriate batch cycle and provide the applicant with the appropriate application package. As such, applicants must meet specific LOI deadlines to be considered during the upcoming batch review cycle, and a LOI will lapse if a COPN application is not submitted within a year of the time the letter was filed.[18] Furthermore, the COPN application must be submitted with an application fee of 1% of the proposed total capital cost of the project, with a minimum of $1,000 and maximum of $20,000.[19]

APPLICATION COMPLETENESS REVIEW

DCOPN has 15 days after an application is submitted to assign staff to determine if it is complete. If staff identify areas of incompleteness, have clarifying questions, or request additional information, the applicant must submit any supporting documents at least five days prior to the first day of a review cycle to be considered complete for review. Once the requisite information is obtained and an application is deemed complete, the review process begins.[20]

PUBLIC HEARINGS

After a project is accepted for review, the general public is given 45 days to submit comments. DCOPN or an RHPA may schedule a public hearing at the request of the applicant, a locality, another service provider, or any member of the public. Public hearings offer the applicant the ability to give a structured presentation and the opportunity for the public to state their opinions about the proposed projects, as well as allow DCOPN and the RHPA to gather feedback from the general public.[21]

DCOPN STAFF REPORT

By the 70th day of the review cycle, DCOPN is required to provide a written advisory report to the Commissioner addressing the merits of approval or denial of the application. The staff report includes an analysis of the project's adherence to COPN approval criteria, a review of relevant population need and financial feasibility, and a recommendation to the Commissioner for approval or denial. If DCPON recommends approval or conditional approval and no "good cause" petitions (discussed below) have been submitted, the report is sent to the Commissioner for the final decision.

GOOD CAUSE PETITION AND HEARING

No later than 4 days after DCOPN staff have completed their review and submitted their recommendation and report, interested persons or entities have the opportunity to file a "good cause" petition to be made a party to the case.[22] A brief hearing, held separately and before an IFFC, allows the petitioner to state their grounds for good cause and provide the factual basis therefor.[23] For purposes of COPN review,

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[18] 12VAC5-220-180(A).
[19] 12VAC5-220-180(B).
[20] 12VAC5-220-190.
[21] 12VAC5-220-230(A).
[22] Va. Code § 32.1-102.6.
[23] 12VAC5-220-230(A).

good cause applies when "(i) there is significant, relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hearing, or (iii) there is a substantial material mistake of fact or law in the department staff's report on the application or in the report submitted by the regional health planning agency."[24]

INFORMAL FACT-FINDING CONFERENCE (IFFC)

IFFCs are purely administrative proceedings held before a designated Adjudication Officer and involve the presentation of witnesses, documents, and legal arguments and rebuttals, typically engaging the use of legal counsel.[25] If DCOPN or the relevant RHPA recommends denial of a project or any person, such as a competing service provider, successfully petitions to be recognized as a good cause party, the applicant has the opportunity to request for an IFFC to be held. Rarely, IFFCs may also be held after DCOPN recommends approval of the project, oftentimes because the applicant wishes to dispute the level of charity care conditioned. While DCOPN provisionally sets an IFFC date, the applicant may request to cancel or reschedule the meeting without penalty. Upon the conclusion of an IFFC, the Adjudication Officer submits a report and recommendation to the Commissioner and closes the IFFC record.[26]

REVIEW AND FINAL DECISION BY COMMISSIONER

After the Commissioner makes their decision on a proposed project, they must provide written notification detailing the reasons of such determination to the applicant with a copy to the RHPA, if applicable. For project approvals, the Commissioner is required to condition a project on the agreement by the applicant to i) provide an acceptable level of charity care to at a reduced rate to indigents, ii) provide care to persons with special needs, or iii) facilitate the development and operation of medical care services in designated medically underserved regions.[27]

WITHDRAWALS OF AND AMENDMENTS TO AN APPLICATION

Applicants may withdraw an application from consideration at any time, without prejudice and without need for written notification to the Commissioner.[28] Applicants also have the right to amend an application at any time, but any amendment submitted after the public hearing and before the issuance of a certificate constitutes a new application and is thus re-subject to the standard review process. Furthermore, if amendments are made subsequent to the issuance of a certificate, it is considered a "significant change" and cannot be made without prior approval of the Commissioner.[29] If the Commissioner fails to render a decision by the end of the 190-day review cycle, the certificate is deemed approved.

SIGNIFICANT CHANGES

Any requests for a "significant change" must be submitted in writing to the Commissioner with a copy to the appropriate RHPA along with the appropriate application fee to DCOPN. The RHPA must review the request and notify the Commissioner of its decision within 30 days of receipt, after which the recommendation would be a deemed approval. The Commissioner has 35 days from receipt to issue a decision, and a public hearing during the review of a proposed change is not required unless deemed necessary by the Commissioner.

[24] Va. Code § 32.1-102.3.
[25] Va. Code § 2.2-4019.
[26] 12VAC5-220-230(B).
[27] 12VAC5-220-230(C).
[28] 12VAC5-220-260.
[29] 12VAC5-220-250.

The Commissioner can approve neither a significant change in cost for a project which exceeds the initial approved capital expenditure by more than 20% nor an extension of the schedule of completion by more than three years from the date of issuance of the COPN. Exceptions include satisfactory proof by the applicant that the cost increases are necessary and reasonable, or that delays in completion resulted from events beyond the control of the owner and that the owner is taking substantive action to continue progress.[30]

REGIONAL HEALTH PLANNING AGENCIES

RHPAs are not-for-profit organizations that receive state funding to assist the Commissioner in the COPN decision process by representing regional health planning interest by holding public hearings and making independent recommendations to the Commissioner concerning the public's need for proposed projects.[31] While the Board of Health originally designed five regional RHPAs in accordance with Virginia's five health planning regions (HPRs), only the one in HPR II in northern Virginia, Health Systems Agency of Northern Virginia (HSANV), continues to operate today.

[30] 12VAC5-220-130.
[31] Va. Code § 32.1-122.05.

APPENDIX E – STATE HEALTH SERVICES PLAN TASK FORCE MEETING MINUTES

This is the meeting minutes from each meeting of the State Health Services Plan Task Force.

State Health Services Plan Task Force
February 9th, 2024
Time 9:00 a.m.
Perimeter Center, Board Room 3
9960 Mayland Drive
Henrico, VA 23233

Task Force Members in Attendance – Entire Meeting (alphabetical by last name): Jeannie Adams; Kathy Baker; Dr. Keith E. Berger; Karen Cameron; Carrie Davis; Michael Desjadon; Paul Dreyer; Kyle Elliott; Dr. Thomas Eppes, Jr.; Paul Hedrick; Shaila Camile Menees; Tom Orsini.

Task Force Members in Attendance – Partial Meeting (alphabetical by last name): Rufus Phillips.

Staff in Attendance (alphabetical by last name): – Rebekah E. Allen, Senior Policy Analyst, Virginia Department of Health (VDH) Office of Licensure and Certification (OLC); Kimberly F. Beazley, Director, VDH OLC; Erik O. Bodin, COPN Director, VDH OLC; Allyson Flinn, Policy Analyst, VDH OLC; Joseph Hilbert, Deputy Commissioner of Governmental and Regulatory Affairs, VDH; Val Hornsby, Policy Analyst, VDH OLC; R. Christopher Lindsay, Chief Operating Officer, VDH; Dr. Karen Shelton, State Health Commissioner, VDH.

1. **Call to Order and Introductions**

   Dr. Karen Shelton called the meeting to order at 9:08 a.m. by providing opening comments about the charge of the Task Force and leading the introduction of the Task Force members.

2. **Review of Agenda**

   Rebekah E. Allen reviewed the agenda.

3. **Public Comment Period**

   No Task Force members or members of the public signed up to give public comment, and no public comments were received.

4. **Adoption of Bylaws**

   Ms. Allen reviewed the draft Bylaws with the Task Force. The Bylaws were moved by Karen Cameron and seconded by Michael Desjadon. The Task Force unanimously adopted the draft Bylaws by voice-vote.

5. **Election of the State Health Services Task Force Chair and Vice Chair**

   Ms. Allen reviewed the requirement for the Task Force to elect a Chair and Vice Chair and asked the group for its nominations. Dr. Keith Berger nominated Dr. Thomas Eppes for Task Force Chair and seconded by Carrie Davis. The Task Force unanimously elected Dr. Eppes by voice-vote.

Ms. Cameron was nominated for Vice Chair by Rebecca Butler and seconded by Mr. Desjadon. The Task Force unanimously elected Ms. Cameron by voice-vote.

6. Adoption of the Remote Participation Policy

Ms. Allen reviewed the draft Remote Participation Policy with the Task Force. There was discussion regarding the distance required by the policy between a meeting and a member's primary residence and whether the meeting technology available to the Task Force will allow Task Force members joining virtually to be seen and heard by the group.

Mr. Desjadon moved to adopt the draft Remote Participation Policy with Jeannie Adams seconding that motion. The Task Force unanimously adopted the Remote Participation Policy by voice-vote.

7. Discussion

The discussion portion of the meeting was led by Dr. Eppes, who expressed the need for the Task Force to schedule at least 3 meetings between now and October 1, 2024. Ms. Cameron requested that the VDH provide data regarding Certificate of Public Need (COPN) applications in recent years to posture the Task Force to what COPN looks like in Virginia.

Mr. Desjadon discussed the content that the Task Force may want to focus on for upcoming meetings, suggesting one meeting focus on psychiatric services and the next focus on expedited review.

Carrie Davis requested location data regarding COPN requests from VDH for the next meeting to see where projects have occurred. Tom Orsini requested VDH also provide some kind of information or training regarding expedited review and how that process currently works in Virginia. Ms. Cameron then requested timeline visualizations from VDH to show the COPN processes to which projects are subject.

Erik Bodin explained the expedited review process and clarified with the Task Force that VDH has not received a request for an expedited project in a long time because so few projects meet the current statutory criteria for expedited review. Mr. Bodin also suggested the Task Force consider for its recommendations "triggers" that will take a project out of expedited review and into full review if a project becomes contested. Mr. Bodin further explained the differences between the expedited process and the full review process. Ms. Adams inquired with Mr. Bodin whether the Task Force will be making recommendations on the process of expedited review, to which Mr. Bodin answered that the Task Force is directed to make those recommendations by the Code of Virginia. Ms. Allen then clarified that project types for expedited review are limited to capital expenditures over $15 million, as adjusted for inflation, taken by or on behalf of facilities that are not a general hospital.

Ms. Cameron requested VDH create a color-coded map detailing the different batching cycles by location and the results of those projects. Ms. Cameron clarified that this will allow the Task Force to consider geography when creating their mandated recommendations. Dr. Eppes asked VDH how long they expected this to take to which Ms. Allen responded one month. Kathy Baker then requested VDH provide the Task Force with the specific goals and metrics of the State Health Improvement Plan that the Task Force will need to consider when creating recommendations.

Ms. Cameron suggested to the Task Force that they could consider hosting the meeting at different locations in the area if VDH was unable to secure a room at the Perimeter Center on the date the Task Force has planned to meet.

Ms. Allen offered the Task Force data regarding the COPN process in other states, with specific focus on how these states handle expedited review and psychiatric services.

Shaila Menees requested that VDH create a data sharing process for Task Force members to access documents.

Dr. Eppes reviewed the meeting schedule with the Task Force and asked that their next meeting be scheduled for March 8th. The Task Force agreed that Fridays are best for everyone's schedules, as well as mornings. Dr. Eppes asked that the first half of the March 8th meeting be focused on educating the Task Force about the standard COPN process and expedited review process.

Dr. Berger requested an overview of the COPN process, to which Mr. Bodin gave a high-level explanation of how this process currently works. Dr. Eppes then requested that VDH supply the Task Force with documents on how the COPN process works for the March 8th meeting. Dr. Eppes recommended the third Task Force meeting of the year be held on May 17th. Dr. Eppes acknowledged that the summer months may be challenging for scheduling a meeting and recommended the fourth meeting be held on September 6th. Dr. Eppes then suggested that the Task Force plan an all-virtual meeting over the summer in order to ensure all business is handled.

Ms. Cameron requested that VDH create a roster of the Task Force members to include their names and contact information. Ms. Allen then reviewed the list of requested deliverables from the Task Force. Dr. Eppes requested that the Task Force members create a paragraph regarding their biases and where they stand on the COPN process before the next meeting. Ms. Davis requested VDH supply the Task Force with the batch group timelines for review. Mr. Desjadon then requested that VDH create a list of all current COPN applications for the Task Force to see what projects are currently in process. Ms. Menees then requested that the Task Force members provide information regarding their current experience with the COPN process in Virginia or another state.

Mr. Desjadon discussed the potential conflict of interest that may stem from Ms. Cameron's earlier suggestion to hold meeting at different stakeholder buildings in the area and asked the Task Force to reconsider holding the meetings at stakeholder buildings. Ms. Cameron clarified with the Task Force that the members cannot meet in groups larger than 2 members to discuss Task Force-related work.

Ms. Cameron asked the Task Force what the group would like to focus on for the upcoming meetings. Dr. Eppes requested the Task Force focus on psychiatric services and what other states do first, and then focus more on expedited review during later meetings. Ms. Menees reminded the Task Force that there are certain mandated considerations for the Task Force, and that it would be prudent to focus on those mandates. Mr. Desjadon suggested the Task Force focus on creating an ABC approach to recommendations, starting with the recommendations that already exist, then recommendations that have been considered, and finally recommendations that have not yet been considered.

Dr. Eppes requested that the next meeting have time scheduled where the Task Force members are split into groups of 5 to discuss potential recommendations. Joe Hilbert reminded the Task Force that this activity would need to be posted on the agenda to ensure the Task Force did not violate the Freedom of Information Act (FOIA). Ms. Cameron inquired about how the split group idea would work with virtual members, to which Ms. Allen responded that she would need to investigate the inquiry further to ensure compliance with FOIA.

Ms. Menees inquired about the possibility of VDH hosting office hours throughout the month for the Task Force members to attend in order to ask questions prior to the March 8th meeting. Ms. Cameron reminded the Task Force that no more than 3 members would be able to attend the office hours at a time, and that the virtual meeting requirements are either 2 meetings per year or 25% of the Task Forces meetings. Ms. Adams expressed concern over the office hours, stating that all members should hear the education and guidance provided by VDH staff.

In lieu of office hours, Ms. Cameron suggested the Task Force plan for a long meeting on March 8th to cover all the material planned for that date. Mr. Desjadon also suggested that the group collect their questions for VDH prior to the meeting to ensure all questions are answered and that VDH staff have prepared answers to ensure the meeting be as efficient as possible. Ms. Davis requested the March 8th meeting be held in 2 parts, with one session in the morning and the next in the afternoon after a break for lunch. Dr. Eppes concurred with Ms. Davis.

Dr. Eppes requested the March 8th meeting be held at 9 am to cover all educational material requested from VDH. Mr. Dreyer reminded the Task Force that there are many topics that the Task Force will need to make recommendations on, and that the members will need to be mindful of this as they move forward in the planning process. Ms. Cameron requested the members think about services that may not be appropriate for expedited review due to their critical nature and/or volume dependence, such as cardiac surgery or neonatal intensive care. Ms. Menees

suggested that the Task Force create a schedule of topics to discuss for future meetings by the end of the March 8th meeting.

8. Meeting Adjournment

The meeting adjourned at 10:34 a.m.

State Health Services Plan Task Force
March 8th, 2024
Time 9:00 a.m.
Perimeter Center, Board Room 4
9960 Mayland Drive
Henrico, VA 23233

Task Force Members in Attendance – Entire Meeting (alphabetical by last name): Jeannie Adams; Dr. Kathy Baker; Dr. Keith E. Berger; Karen Cameron; Carrie Davis; Michael Desjadon; Paul Dreyer; Amanda Dulin; Kyle Elliott; Dr. Thomas Eppes, Jr.; Paul Hedrick; Shaila Camile Menees; Rufus Phillips; Tom Orsini; Dr. Marilyn West.

Staff in Attendance (alphabetical by last name): – Rebekah E. Allen, Senior Policy Analyst, Virginia Department of Health (VDH) Office of Licensure and Certification (OLC); Kimberly F. Beazley, Director, VDH OLC; Erik O. Bodin, COPN Director, VDH OLC; Allyson Flinn, Policy Analyst, VDH OLC; Joseph Hilbert, Deputy Commissioner of Governmental and Regulatory Affairs, VDH; Val Hornsby, Policy Analyst, VDH OLC; Vanessa MacLeod, Adjudication Officer, VDH; Dr. Karen Shelton, State Health Commissioner, VDH.

1. **Call to Order and Welcome**

   Dr. Thomas Eppes, Jr. called the meeting to order at 9:03 a.m.

2. **Review of Agenda**

   Rebekah E. Allen reviewed the agenda.

3. **Staff Presentation: COPN Program**

   Ms. Allen presented an educational PowerPoint to the Task Force regarding the Certificate of Public Need (COPN) process in Virginia. The presentation covered what COPN is applicable to in Virginia, project types, and the application processes.

   While discussing current project types, Mr. Desjadon inquired about the $15 million threshold for capital expenditures and how this threshold had been established. Erik O. Bodin explained the history of the capital expenditure threshold and how inflation contributes to the increase of that threshold.

   Thomas Orsini asked Mr. Bodin if increasing the number of batch cycles available for each project type would increase the timeliness of the COPN process by reducing the amount of time needed to reach a decision. Mr. Bodin determined that while it may marginally decrease the time needed for review, the 190-day review period would still exist. Mr. Orsini then clarified that the “hang up” for the process is not the batch cycles, but the 190 days set forth for review, to which Mr. Bodin agreed.

Rufus Phillips inquired about the triggers for an IFFC, to which Ms. Allen explained that competing applications and third-party claims for good cause would trigger an IFFC. Ms. Allen deferred to Mr. Bodin, who stated that recommendations for denial would also trigger an IFFC for a project.

Ms. Allen informed the group that the Health Systems Agency of Northern Virginia is the only regional health planning agency currently in operation. Ms. Cameron then clarified for the group that the lack of a regional health planning agency does not change the review timeline for the Virginia Department of Health (VDH), to which Ms. Allen confirmed. Ms. Cameron then inquired if the applicant could continue to add and adjust the application throughout the process, to which Mr. Bodin explained that a recent law change stopped applicants from being able to submit “shell applications” and continuously build up the application throughout the review process.

Kyle Elliott inquired whether there was a burden on an applicant to justify the approval of their application, and if there were any assumptions by the adjudication officer on reasons to approve or deny an application. Mr. Bodin explained that the burden is on the applicant due to the fact that the adjudication officer is firewalled from the process until the IFFC occurs.

As Ms. Allen explained the expedited review process, Jeannie Adams asked how the public would be informed if an expedited review application were filed under the current process. Mr. Bodin explained that while there currently is no mechanism in place, VDH would post it to its website as a way to notify the public. Ms. Allen then clarified that the Code of Virginia requires an expedited process, but that the timelines and requirements of that process are not dictated by the Code. Ms. Allen continued, explaining that the project types allowable for expedited review cannot be changed by the regulations, but that the expedited process can be.

Dr. Marilyn West inquired about the earlier discussion regarding application responses and what constitutes a satisfactory response. Mr. Bodin explained that the applicant needs to have provided a response to each application question, and that it is up to the applicant to decide what kind of response will be given, as that response will be used for the remainder of the application review process.

Shaila Camile Menees reminded the group that an application for expedited review can be filed at any time, and that the Task Force needs to keep this in mind while making recommendations for the expedited review process. Dr. Eppes inquired whether the group could use the specific recommendations discussed in the 2021 COPN report as the recommendations of the Task Force, to which Ms. Allen replied in the affirmative, stating that some recommendations would require legislation, while others from that report may use regulations as a mechanism for change.

Dr. West discussed the role of the State Board of Health (Board) as it relates to the regulatory process and expressed concern that the Board was under no obligation to accept the recommendations made by the Task Force for regulatory changes. Dr. Karen Shelton told the Task Force that all efforts would be made to ensure that the recommendations of the Task Force go to the Board and that the Task Force meeting and making recommendations would be an ongoing process.

Dr. Eppes called for a brief break. The Task Force then resumed its meeting a 10:00 a.m.

4. Roll Call

Dr. Eppes led the roll call of the Task Force at 10:04 a.m. All Task Force members were present with the exception of Steve Gravely.

5. Approval of Prior Meeting Minutes

The minutes from the February 9, 2024 meeting were reviewed. Ms. Cameron made a motion to amend the minutes by:

- On Page 2, Item 3, first paragraph, first sentence, adding that Ms.Cameron's nomination for Vice-Chair was seconded by Mr. Desjadon;
- On Page 2, Item 7, third paragraph, last sentence, replacing "additional data" with "timeline";
- On Page 4, Item 7, first paragraph, last sentence, replacing "3" with "2"; and
- On Page 4, Item 7, last paragraph, second-to-last sentence, replacing "due to controversy" with "due to their critical nature and/or volume dependence, such as cardiac surgery for neonatal intensive care."

Mr. Desjadon seconded the amendments and the motion passed unanimously by voice vote. The meeting minutes as amended were approved without objection.

6. Public Comment Period

One member of the public signed up to give public comment. Bill Ellwood, representing Universal Health Services (UHS), discussed the current standard review process in Virginia, stating that the process worked well and that expediting this process would not fix the problems present. Mr. Ellwood asked that if the Task Force chooses to expedite this process, that they ensure it is robust and that conditions and enforcements are put in place to protect Virginians.

Mr. Desjadon inquired if there have been any competing applications for psychiatric services in the past 10 years, to which Mr. Bodin replied in the affirmative. Dr. Eppes inquired about where the UHS facilities were located, and how many Temporary Detention Orders, if any, did their facilities accept. Mr. Orsini inquired whether UHS has experienced any occupancy issues related to their psychiatric beds. Mr. Dreyer asked Mr. Ellwood if UHS had any psychiatric beds in the western part of the state, to which Mr. Ellwood responded in the negative.

Mr. Desjadon then inquired if the UHS facilities participated in the Patriot Program, to which Mr. Ellwood responded that he was not sure.

7. Psychiatric Beds and Services & Expedited Review

7.1. Staff Presentation

Allyson Flinn presented the Task Force with an overview of the directive found in SB 277, data trends for psychiatric beds and services in the state, past legislative efforts related to psychiatric beds and services, and applicable reports of interest to the group. While presenting an overview of COPN denials since SFY13, Dr. Eppes inquired with Ms. Flinn about the two denials, to which Ms. Flinn answered that the 2 were from a competing application pool in planning district (PD) 8.

Ms. Menees inquired with Ms. Flinn about obtaining data for the total counts of psychiatric beds and a list of the facilities where these beds exist. Mr. Desjadon requested VDH provide the bed numbers by planning district and per 100,000 using both the state and national average. Ms. Dulin inquired about the free-standing psychiatric facility located in far southwest Virginia, and the area that this facility serviced. Dr. Shelton replied that while it may serve some residents of Tennessee and North Carolina, the facility could not accept patients under temporary detention orders (TDOs) from other states, as they are unable to cross state lines.

Dr. Baker requested the average census of the psychiatric facilities as it was unclear whether the problem is capacity or staffed beds, to which Ms. Flinn confirmed that VDH could provide the number of staffed beds. Mr. Bodin recommended that the denominator of licensed beds should be used for staffing calculations, to which Ms. Cameron agreed. Dr. Baker then requested the data regarding TDOs and the length of time in which it takes for those to be placed, to which Mr. Bodin responded that VDH does not have that data on hand. Heidi Dix informed VDH staff that the Department of Behavioral Health and Disability Services (DBHDS) can provide the average wait times for TDO placement but will not be able to provide that data by planning district.

While discussing past legislative efforts, Ms. Cameron inquired about whether a facility could convert a psychiatric bed to a medical-surgical bed without a COPN, to which Dr. Shelton answered in the negative, stating that she did not believe beds could be freely converted. Mr. Phillips inquired about the ability to convert beds during COVID-19, to which Ms. Flinn responded in the affirmative. Ms. Allen clarified that it was the addition of beds under an executive order, not the conversion of beds. Mr. Desjadon then inquired about receiving a history of past legislative efforts and why the bills had been unsuccessful in the past. Ms. Flinn confirmed that VDH could provide this data, and Ms. Allen further explained that VDH can only provide the public conversations that surrounded the bills.

Val Hornsby then presented a jurisdictional comparison on COPN and psychiatric services and beds in different states to the Task Force. Ms. Dulin inquired about

the combination of psychiatric beds and substance use disorder beds and whether or not this has changed the landscape of the bed need in Virginia. Ms. Allen responded to Ms. Dulin, stating that VDH would try to acquire this data. Ms. Cameron then discussed that substance use disorder patients cannot be placed in a psychiatric bed unless that patient has a psychiatric co-morbidity or dual diagnosis, to which Dr. Shelton confirmed. Ms. Allen then clarified that Ms. Cameron is correct in saying that psychiatric beds require a primary psychiatric diagnosis.

Dr. Eppes requested that VDH provide data regarding states that do not have a COPN equivalent, specifically how these states handle charity care and TDOs. Ms. Cameron requested that VDH create a comparison of Virginia and a state without COPN that is similar in terms of economics, population, and geography. Dr. West requested data from the states that do not have a COPN equivalent and the external landscape that exists that ties in this process. Dr. Berger seconded that request, stating that he would like to know how states operate without a COPN equivalent. Mr. Phillips requested information on how the states without COPN assure that quality is upheld without the COPN guardrails in place. Carrie Davis requested information about TDO discharges, and if there is anything relating to those discharges that is currently contingent on COPN or the conditions imposed.

7.2. Breakout Sessions

Dr. Eppes announced that the Task Force members would be breaking into three smaller groups for breakout sessions. Ms. Allen explained that Task Force members would go across the hall to Training Room 1, which had been partitioned into 3 smaller rooms, according to which group they had been randomly assigned. Ms. Allen also explained that these breakout sessions were open to the public, that seating was available in each partitioned room for the public, and that a member of staff would be in each room to minute the discussions. Dr. Eppes then announced the membership of each group.

Group 1 – Training Room 1A

Group 1 consisted of Dr. Berger, Ms. Davis, Mr. Desjadon, Ms. Dulin, and Mr. Philips.

Mr. Desjadon initiated the discussion by asking what information the Task Force had and what it would need in order to make recommendations. Dr. Berger spoke about his experience applying for a COPN without sucess; he also spoke about other jurisdictions like South Carolina that had repealed or were in the process of repealing COPN requirements and what information those jurisdictions may be about to provide about increases in quality and decreases in cost that resulted from COPN deregulation. Mr. Philips and Mr. Desajadon agreed that more information from non-COPN jurisdictions would be valuable, with Mr. Desjadon specificaly pointing to data about quality, access, and costs. Mr. Philips stated it was important to compare Virginia to jurisdictions with similar demographics. Ms. Davis

questioned what the group meant by access, to which Mr. Desjadon responded it meant people getting what they wanted. Ms. Davis emphasized that access should be leveled across income levels and Mr. Desjadon agreed and further stated that it should be level across geographic location as well.

The group received comments from Curtis Byrd with Chesapeake Regional Healthcare, who stated that certain service lines are not profit centers. Mr. Byrd further stated that there needed to be a mechanism for equitable bed distrubtion because reimbursement is not keeping pace with costs and there are differing levels of investment needed to put beds into service. Mr. Desjadon asked what the overall psychiatric need in Virginia was and how to determine it. Dr. Berger responded that the market should determine need.

Ms. Dulin spoke about the JLARC report's highlights about the different discharge experiences between state and non-state psychiatric hospitals. The group received comments from Bill Elwood of Elwood Consulting, LLC, who stated that already-approved psychiatric inpatient beds are not the issue. Ms. Davis stated that COPN may not be the issue for inpatient psychiatric care and that removing COPN could leave Virginia in the same place as it is today, but that at least that barrier would no longer be present. Mr. Desjadon reiterated his point about what the overall psychiatric need was in Virginia and Ms. Dulin questioned whether Virginia had the resources to treat psychiatric conditions before it became an inpatient issue. Mr. Desjadon asked what has moved the needle for psychiatric care and Dr. Berger responded that perhaps the Task Force should hear from providers. Mr. Philips reminded the group of the narrow assignment that the Task Force has, and Mr. Desjadon read aloud the text of SB277. Ms. Davis questioned whether fulfilling that assignment would move the needle.

Ms. Dulin stated that inpatient beds can freely be exchanged between different use types (e.g., medical-surgical, psychiatric, etc.) without a COPN. The group received comments from Mr. Bodin, who clarified that psychiatric inpatient beds could be converted to a non-psychiatric inpatient beds without a COPN, but that the reverse would require a COPN. Ms. Dulin expressed her concerns about the higher level of care and patient needs in the psychiatric population. Mr. Bodin explained concerns about completely removing psychiatric inpatient beds from COPN without appropriate guardrails on their use or future conversion could become a back-door way for hospitals to increase medical-surgical beds without going through COPN. Ms. Dulin stated that she did not understand the distinction between inpatient psychiatric beds and substance abuse inpatient beds. Mr. Bodin stated that COPN does not apply to beds in residential substance abuse facilities or in intermediate care facilities for individuals with substance abuse.

Ms. Dulin stated that care for TDO patients was paid for by the Commonwealth and Mr. Desjadon noted that it appeared that state hospitals were overburdened with TDO patients. The group received comment from Mr. Elwood, who reminded

everyone of the financial incentive recommendations that JLARC had included in its report regarding TDO patients. Ms. Dulin asked what the effect was of having psychiatric inpatient beds 'attached' to hospital emergency departments. THe group received comment from Sara Heisler from Sentara Healthcare, who stated that patients are often boarded in the emergency department for lack of staffed psychiatric inpatient beds. Ms. Heisler further stated that until the Commonwealth puts more resources towards community service boards, there would be no fix for behavioral health care. Mr. Desjadon agreed that there was a need for community resources before behavioral health issues become acute.

The group received a comment from Mr. Elwood, who questioned what the fix was if overcrowding in state hospitals was an issue. The group also received a comment from Ms. Heisler, who questioned what the state was doing for staffing. Mr. Elwood also reminded the group that SB 277 included the Task Force making recommendations on what could be moved to expedited review. Ms. Dulin stated she thought that psychiatric inpatient beds could be moved to expedited review. Dr. Berger reiterated his desire to see information from jurisdictions without COPN and see what is working for those areas.

The group then wrote down their major questions that they felt needed additional data from staff prior to making recommendations. The group then end its breakout session and returned to Board Room 4.

Group 2 – Training Room 1B

Group 2 consisted of Ms. Adams, Dr. Baker, Mr. Elliott, Dr. Eppes, Ms. Menees, and Ms. Ramos.

Ms. Adams began the conversation inquiring about what the Task Force was able to recommend, and whether or not this was restricted only to expedited review. Dr. Baker discussed the need for the Task Force to be thoughtful of the recommendations made. Dr. Eppes then discussed that a timeline for reevaluation should be set for this process, recommending a reevaluation in approximately 5-10 years. Dr. Baker then discussed the need to know and understand what the outcome of each recommendation may be.

Mr. Elliott then inquired about TDOs, and if a problem was non-compliance with accepting TDOs, why did this problem exist. Dr. Baker responded to Mr. Elliott, stating that the JLARC report was not explicit, but it was possible to make a leap that the level of care provided by a facility may not be appropriate for a TDO patient, and that most TDOs are not accepted because the safety of the staff cannot be maintained. Dr. Eppes then suggested that utilization may be too low, and that police departments do not want to transport a patient across the state for a TDO. Dr. Baker clarified that police are hesitant to remove a patient from their place of home.

Ms. Adams requested data on bed closures. Ms. Menees stated that the issue was not the number of beds in state, but instead the number of beds in the state that are staffed. Ms. Menees further explained that there is a shortage of appropriate workforce numbers, and that removing COPN will further exacerbate this issue by potentially increasing the number of beds that are not staffed.

Dr. Eppes then discussed the JLARC report, discussing the data regarding TDOs and bed utilization rates. Ms. Menees clarified that the issue is an insufficient number of staff, specialization, and equipment. Dr. Baker asked if this Task Force could recommend licensure requirements, including how hospitals manage seclusion and restraints. Ms. Menees discussed the directive of the Task Force, and how this focus is on how beds are allocated in the state.

Ms. Menees then reviewed the questions for consideration. Ms. Ramos stated that the Task Force did not have enough data to answer question one of the questions for consideration. Dr. Eppes agreed, stating that the Task Force needed information about states that have repealed COPN, as well as information about the current psychiatric workforce. Dr. Baker then suggested the group set up a process if the standard COPN process is not used. Ms. Menees responded, stating that the group should focus on utilizing expedited review for facilities that already offer psychiatric services and have reached capacity. Ms. Menees further stated that the group needed to be mindful of applications that may negatively impact providers who already provide services in that area, explaining that the group needs to consider different process for projects that add services and beds in an existing facility versus a project that creates new facilities and services.

Ms. Menees inquired about how the group could devise a recommendation on the two project types mentioned above, stating that removing COPN entirely will remove the ability to require facilities to adhere to charity care conditions. Dr. Eppes discussed the JLARC report and the information regarding the underutilization of private hospitals and whether this was a staffing issue. Ms. Menees responded, stating that it was a staffing issue. Dr. Baker inquired with the group about what data they would need and requested information on COPN conditions and facility adherence to those conditions, bed utilization, and workforce challenges faced by the facilities. Ms. Menees requested data regarding state level psychiatric workforce challenges. Dr. Eppes requested data regarding the operational and licensed bed numbers in private hospitals, to which Ms. Menees requested state hospital data as well in order for the Task Force know the entire bed utilization landscape.

Dr. Eppes requested information on the reality of COPN in Virginia. Ms. Menees inquired about what the problem is if it is not a volume issue, to which Mr. Elliott further inquired whether the problem is staffing or volume. Dr. Eppes then stated that it may be a bed issue, asking if the available beds were really available, to which Ms. Menees answered that the issue is not beds, but that the approved beds

are not readily available to the people who need them. Ms. Menees further stated that the COPN process would not fix this, and that the ask should be how the Task Force can approach the review of additional beds.

Dr. Baker and Dr. Eppes both agreed that if the recommendation was to get rid of COPN, the Task Force would need data from other states without COPN in order to see how these states handle health care facility regulation. Dr. Baker further stated that the Task Force would need to know how other states that have repealed COPN handle their forensic bed inventory. Ms. Menees then stated that no applications for psychiatric beds have really been denied in recent years and that this may indicate that the issue is not that beds cannot be added. Ms. Ramos then suggested that COPN may be potentially keeping businesses out of the state.

Ms. Menees then suggested the group separate the expedited recommendation into two buckets, with one bucket for existing facilities and another for new facilities. The group then debated if this bifurcation is necessary, whether or not conditions should be required for expedited review certificates, and if there should be certain “triggers” that will pull a project out of expedited review and put it into standard. The group the concluded that more data would be necessary before any recommendations could be made.

The group then wrote down their major questions that they felt needed additional data from staff prior to making recommendations. The group then end its breakout session and returned to Board Room 4.

Group 3 – Training Room 1C

Group 3 consisted of Ms. Cameron, Mr. Dreyer, Mr. Hedrick, and Mr. Orsini, Dr. West.

Ms. Cameron stated that the first issue to address would be the need for psychiatric beds and queried about whether part of the demand for beds was that community-based services were not readily available across the Commonwealth, inquiring that if more psychiatric beds are available through the COPN process, would that change the other issues faced by psychiatric facilities, especially workforce issues. Ms. Cameron further stated that there are unseen issues relating to these topics.

Mr. Dreyer reiterated the findings of the JLARC report and the need for more staff in state psychiatric facilities. Mr. Dreyer further stated that the JLARC report emphasized that state psychiatric hospitals take any individual as is their requirement.

Dr. West asked what in the external landscape of psychiatric services is driving the need and what the demographics were of individuals receiving those services. Mr. Hedrick reiterated the need for more information to answer more questions and discussed what substance abuse or residential treatment would look like regarding expanded psychiatric service access.

Ms. Cameron stated that with Medicaid expansion in Virginia, more people have access and queried about whether the issue is that the problem is bigger or more people have access to care which means the volume of people with access to those facilities is larger, further stating that if the Commonwealth can do a good job in community-based care, expanded psychiatric bed capacity would not be as necessary in the future. Mr. Dreyer stated that inpatient psychiatric services would still be a necessity and queried about why bills surrounding COPN were not passing.

Mr. Orsini discussed that when Medicaid was expanded, some providers chose not to take it, to which Ms. Cameron stated this was for the purpose of reaping a profit and not provide charity care and that substance abuse rehabilitation options were more popular and covered more often by insurance in the 1980's. Mr. Orsini then asked if opening more facilities to participate in Medicaid would require more staff.

Dr. West asked what segment of the population we would talking about when we look at psychiatric services and about the adequacy of community-based programs. She further inquired about data on states without a COPN program.

Mr. Dreyer recapped what was written on the groups flipchart thus far which was the necessity for more data, continuum of care, and recognition of health disparities in low-income communities. Ms. Cameron emphasized the value of the public process which cannot be fully deregulated and would require stepwise changes to be made if there are to be changes.

Mr. Orsini stated that if you were to take COPN completely away, there would not be inpatient psychiatric facility in low-income facilities and that the COPN process is still the way to go in Virginia. He further inquired about whether VDH has the staff for the expedited review process. Mr. Hedrick stated that going through the standard review process can be expensive if a lawyer is needed. Dr. West emphasized that low-income populations may be adversely affected and that there may be health disparity issues with changes with COPN.

Ms. Cameron further discussed considerations for rural communities and conditioning issues. Mr. Orsini asked if some level of review would require including charity care and TDOs, to which Ms. Cameron stated that if you get rid of the process, you have no ability to have conditioning.

Ms. Cameron stated that psychiatric beds could be a part of expedited review and that there needs to be some off ramp for addressing concerns and further discussed expedited review for expansion of services. Dr. West then asked if there were psychiatric beds in nursing homes.

Ms. Cameron stated that Medicaid has the data from psychiatric services, and Mr. Hedrick said that VHI has some of the data they need for making

recommendations. Ms. Cameron in reference to expedited review stated that making the process simpler may not be beneficial.

The group then wrote down their major questions that they felt needed additional data from staff prior to making recommendations. The group then end its breakout session and returned to Board Room 4.

7.3. Group Discussion

Dr. Eppes called the Task Force back for a group discussion to review what each breakout group had to recommend. Ms. Cameron then had a clarification about the conversion of psychiatric beds to non-psychiatric beds, deferring to Mr. Bodin, who then explained that you need a certificate to increase the number of psychiatric beds in a facility and that nothing bars you from converting those beds into medical-surgical beds, with one small exception being the RFA process.

Dr. Eppes then requested that group 1 share their recommendations first. Mr. Desjadon presented for group 1, stating that the group consensus was to have more data in order to make a decision. For this data, the group requested information on how states without COPN look like in terms of healthcare quality, cost, and access, information about what the real need or problem is, the relationship between the high-volume emergency departments and the facilities, and information regarding past legislation. The Task Force had no questions for Mr. Desjadon or group 1 at the conclusion of their summary presentation.

Ms. Menees from group 2 then presented the group's summary, stating that they had similar data requests. Group 2 also requested data about operational beds and licensed beds due to the discussions the group had about workforce, and data regarding past COPN projects and whether or not those projects have met the projected occupancy rates. Ms. Menees then concluded with a summary of the bifurcated expedited process, placing emphasis on ensuring conditions and triggers are put in place for these project types. The Task Force had no questions for Ms. Menees or group 2 at the conclusion of their summary presentation.

Mr. Dreyer then presented for group 3, stating that they too had similar data requests. Similarly to group 2, group 3 also placed emphasis on needing conditions. Mr. Dreyer discussed group 3's interest in the unseen issues, stating that the continuum of behavioral health services, staffing limitations, and community resources are all factors of this greater issue. Mr. Dreyer concluded the presentation with the group's data requests, such as the demographic data of psychiatric patients, and information regarding the growth of Medicaid and how this affects the COPN process.

8. Wrap-Up and Next Steps

Dr. Eppes requested that the Task Force utilize the breakout groups during the next meeting in order to continue the current discussions. Dr. Eppes also requested that the Task Force members reach out to him if they have any ideas or recommendations to share before the next meeting on May 17th. Mr. Phillips

inquired whether or not he was able to join remotely next meeting due to his travel schedule, to which Ms. Allen responded that he may, but to keep in mind that he may not be able to participate in the breakout sessions due to the technology being unavailable.

Dr. Shelton then suggested to the group that they request a presentation from the DBHDS in order to gain insight and knowledge about the Right Help, Right Now initiative, as it may apply to some of the questions and data inquiries that the Task Force discussed today. Dr. Eppes requested that VDH staff reach out to DBHDS in order to request a presentation to the Task Force, to which VDH staff confirmed in the positive.

9. Meeting Adjournment

The meeting adjourned at 12:10 p.m.

GROUP 1

QUESTIONS

1. QUALITY: CON VS. NON CON
2. COST: CON VS. NON CON
3. ACCESS: CON VS. NON CON

* BROKEN BY - SDOH, DEMOGRAPHICS, GEOGRAPHY, PAYER

4. WHAT IS NEED?
   - BEDS?
   - STAFF?
   - REIMBURSEMENT?
5. WHAT HAS MOVED NEEDLE?

Specific to SB

- Where is real pressure point?
  - Trend
  - Type (patient / condition)

- Relationship of High Volume ED's to inpatient admissions?

- Resources toward Acute vs Inpatient
  Community

  → Does Coordination Help
  → Is it Beds + Community + Staffing

Needs:

- Private + State } operational vs. licensed Beds
- Success for states w/ No COPN — How has it gone, what's been outcome? Process
- Approved Projects Projected vs. actual occupancy — Did They / Do They meet projections

(A) Existing Facility	(B) New Facility or New service at Existing Facility
* Expedited Process / or NO COPN * Same conditions Required * If Issues / concern move back to standard	→ Expedited unless contested → TBD, more data, more Discussion needed

Unseen Issues/Impacts:

1) Continuum of Behavioral Services – Community Based Programs lacking
2) Staffing is a limitation
3) Value of a public process
4) Segmentation of populations – who serves underserved
5) Health Disparities ⇒ conditioning process

Level of Review:

⇒ Some Level of Review should be required
↳ should include charity + TDO conditions
→ Expedited Review for expansion of existing services
→ with an "off-ramp" to full review if opposed/incomplete
→ should use same review criteria

DCOPN Needs personnel + resources

What we need to know:

1) what is driving psych services need?
2) what are demographics of psych patients?
3) Private vs. Public need / Psych vs. Substance Abuse
4) Growth of Medicaid with expansion

State Health Services Plan Task Force
May 30th, 2024
Time 9:00 a.m.
Perimeter Center, Board Room 2
9960 Mayland Drive
Henrico, VA 23233

Task Force Members in Attendance In-Person – Entire Meeting (alphabetical by last name): Jeannie Adams; Dr. Kathy Baker; Dr. Keith E. Berger; Karen Cameron; Carrie Davis; Michael Desjadon; Paul Dreyer; Amanda Dulin; Dr. Thomas Eppes, Jr.; Paul Hedrick; Shaila Camile Menees.

Task Force Members in Attendance Virtually – Entire Meeting: Rufus Phillips.

Staff in Attendance (alphabetical by last name): –Erik O. Bodin, COPN Director, VDH OLC; Michael Capps, Senior Policy Analyst, VDH Office of Governmental and Regulatory Affairs; Allyson Flinn, Policy Analyst, VDH OLC; Joseph Hilbert, Deputy Commissioner of Governmental and Regulatory Affairs, VDH; Val Hornsby, Policy Analyst, VDH OLC; Dr. Karen Shelton, State Health Commissioner, VDH.

Dr. Marilyn West joined the meeting virtually at 9:07 am and left the meeting at 10:47 am.

1. **Call to Order and Welcome**

   Dr. Thomas Eppes, Jr. called the meeting to order at 9:04 a.m. Dr. Eppes reminded the meeting members that private conversations would be picked up by the microphones in the room.

2. **Roll Call**

   Allyson Flinn called the roll of the members. Ms. Flinn noted that Rufus Phillips had joined the meeting virtually, and that Kyle Elliott and Dr. Marilyn West would be joining the meeting virtually.

3. **Review of Mandate**

   Ms. Flinn reviewed the statutory mandate within § 32.1-102.2:1 of the Code of Virginia and Chapter 423 of the 2024 Acts of Assembly.

4. **Review of Agenda**

   Joseph Hilbert reviewed the agenda.

5. **Approval of Meeting Minutes from March 8 Meeting**

   The minutes from the March 8, 2024 meeting were reviewed. Michael Desjadon made a motion to amend the minutes by changing the adjournment at 12:10 a.m. to p.m.

Page **1** of **4**

Amanda Dulin seconded the amendments and the motion passed unanimously by voice vote. The meeting minutes as amended were approved without objection.

6. **Adoption of Updated Remote Participation Policy**

Ms. Flinn reviewed the amendments to the remote participation policy. Karen Cameron motioned to adopt the updated remote participation policy with Dr. Eppes seconding that motion. The policy was adopted unanimously by voice vote.

7. **Presentation from the Department of Behavioral Health and Developmental Services**

Nelson Smith, Commissioner for the Department of Behavioral Health and Developmental Services presented to the Task Force on the following topics: (i) Governor Youngkin's *Right Help, Right Now Plan* and its Crisis Pillar, (ii) an update on the *Right Help, Right Now* plan, (iii) Public and Private Psychiatric Bed Estimates, (iv) Temporary Detention Orders, (v) Psychiatric Bed Capacity, and (vi) a Nationwide COPN Overview.

There was discussion regarding the licensure of crisis centers, exclusionary criteria, private vs public bed capacity, the effectiveness of crisis centers in keeping people from requiring inpatient care, school education initiatives, the number of crisis stabilization centers and the capacity of those centers, and the 988 number.

8. **Review of Meeting Materials**

Ms. Flinn reviewed the meeting materials with the Task Force, concluding the review with a brief overview of VDH's data observations. There was discussion about the most recent COPN denial for a psychiatric project, and the regulation of state hospitals in Oregon.

9. **Public Comment Period**

Two members of the public signed up to give public comment, Brent Rawlings from the Virginia Hospital and Healthcare Association and Clark Barrineau from the Medical Society of Virginia regarding the Task Force's upcoming votes on recommendations.

10. **Psychiatric Beds and Services & Expedited Review**

10.1. Staff Presentation

Ms. Flinn discussed the break-out session groups with the Task Force and requested that Mr. Desjadon move from Group 1 to Group 3 due to absences, to which Mr. Desjadon agreed.

There was discussion regarding the mandate found in Chapter 423 of the 2024 Acts of Assembly, the future meeting schedule, and the options for consideration by the Task Force.

10.2. Breakout Sessions

Dr. Eppes announced that the Task Force members would be breaking into three smaller groups for breakout sessions. Ms. Flinn explained that Task Force members would go across the hall the hearing rooms according to which group they had been randomly assigned.

Group 1 – Hearing Room 4

Group 1 consisted of Jeannie Adams, Dr. Kathy Baker, and Paul Hedrick.

The breakout group discussions consisted of the interest in closing the loop that allows a psychiatric beds to be converted to a non-psychiatric bed, the ability for members of the public to voice their opinions on expedited projects, the acceptance of TDOs by private hospitals and the potential to condition COPNs on that, the difference between civil TDOs and forensic TDOs, and general discussion regarding the current COPN landscape in Virginia. The group then ended its breakout session and returned to Board Room 2.

Group 2 – Hearing Room 3

Group 2 consisted of Dr. Keith Berger, Carrie Davis, Shaila Camile Menees, and Amanda Dulin

The breakout group discussions consisted of the concerns with psychiatric staffing, the merits of COPN and its ability to regulate the market, COPN deregulation, an increase in the number of application batch cycles, the unregulated conversion of psychiatric beds to non-psychiatric beds, the interest in ensuring expedited projects include a charity care requirement, the complexities of TDOs and the acceptance of them by facilities, and general discussion regarding economic arguments for COPN regulations. The group then ended its breakout session and returned to Board Room 2.

Group 3 – Hearing Room 2

Group 3 consisted of Paul Dreyer, Karen Cameron, Dr. Thomas Eppes, Jr., and Michael Desjadon

The breakout group discussions consisted of the current efforts aimed at addressing the behavioral health crisis in Virginia, whether COPN plays a role in regulating the market, what barrier, if any, COPN introduces for psychiatric care, the staffing of psychiatric beds and potential shortages that may exist, the staff time and resources it takes to review applications, concerns surrounding the current expedited process and its lack of public participation, whether a recommendation should include a request for the General Assembly to fund the regional health planning agencies that have shut down, the addition of a batch cycle for expedited review projects, and the reasons for why a project should be

moved from expedited review into full review. The group then ended its breakout session and returned to Board Room 2.

10.3. Group Discussion

Dr. Eppes called the Task Force back for a group discussion at 11:42 am. Dr. Kathy Baker gave the group 1 report. Option 1 & Option 2 opposed, Option 3 support on caveat of 90-day extension of expedited review, Option 4, 5, and 6 support, Option 7 oppose, Option 8 highly support, Option 9 oppose at face value, but need more information, Option 10 support, but not as a mandate, Option 11 & 12 support, and Option 13 need more information, but had discussion on diagnostic imaging.

Shaila Menees gave the group 2 report. With option 1 3 group members support and 1 would like to repeal COPN, option 2 maybe add another cycle for psychiatric services rather than expedited review, option 3 and 4 similar proposition to option 2, option 5 support, option 6, 7, and 8 3 group members oppose and 1 would like to repeal COPN, option 9 support, option 10 need more information regarding accepting TDOs, option 11 support, option 12 oppose, option 13 need more information and there was further discussion on conversion from psychiatric to medical-surgical beds.

Mr. Desjadon gave the group 3 report with the following options and reasonings – Option 1 support, option 2 table for further discussion, option 3 support, option 4 support with caveat of in the same PD, option 5 support, option 6 support with caveat of in the same PD, option 7 no consensus, option 8 support, options 9 & 10 support, option 11 tabled for further discussion, option 12 support, option 13 tabled, option 14 discussion of addition of batch cycle.

There was discussion regarding the fiscal and staffing impacts the presented options would have, the scope of each proposed change, and potential impacts of the various proposed options.

11. Wrap-Up and Next Steps

Mr. Hilbert requested that the Task Force members fill out the worksheets when they are sent to them in order to prepare them for the next meeting. Dr. Keith E. Berger handed out two documents to the Task Force members for their review (these can be viewed at the end of this document). Dr. Eppes proposed a July 12th all-virtual meeting to vote on the options for recommendation.

12. Meeting Adjournment

The meeting adjourned at 12:22 p.m.

State Health Services Plan Task Force
July 12th, 2024
Time 9:00 a.m.
VIA: Webex

Task Force Members in Attendance – Entire Meeting (alphabetical by last name): Dr. Kathy Baker; Dr. Keith E. Berger; Karen Cameron; Michael Desjadon; Paul Dreyer; Amanda Dulin; Dr. Thomas Eppes, Jr.; Kyle Elliott; Paul Hedrick; Shaila Camile Menees; Rufus Phillips

Staff in Attendance (alphabetical by last name): – Kimberly E. Beazley, Director, VDH OLC; Erik O. Bodin, COPN Director, VDH OLC; Michael Capps, Senior Policy Analyst, VDH Office of Governmental and Regulatory Affairs; Allyson Flinn, Policy Analyst, VDH OLC; Joseph Hilbert, Deputy Commissioner of Governmental and Regulatory Affairs, VDH; Val Hornsby, Policy Analyst, VDH OLC; Dr. Karen Shelton, State Health Commissioner, VDH.

Task Force Members in Attendance – Partial Meeting: Ms. Adams left the meeting at 12:15 p.m.

1. **Call to Order and Welcome**

   Dr. Thomas Eppes, Jr. called the meeting to order at 9:00 a.m.

2. **Roll Call**

   Allyson Flinn reviewed the virtual meeting etiquette and reminders with the Group. Ms. Flinn then called the roll of the members. Ms. Flinn noted that Carrie Davis, Thomas Orsini, Maribel Ramos, and Dr. Marilyn West were absent from the meeting.

3. **Review of Agenda**

4. Joseph Hilbert reviewed the agenda.

5. **Review of Meeting Materials**

   Allyson Flinn reviewed the meeting materials found within the packet shared with the Task Force and uploaded to Townhall. Erik Bodin reviewed document containing the COPN project types by action and by service.

6. **Approval of Prior Meeting Minutes**

   The minutes from the May 30, 2024, meeting were reviewed. The meeting minutes were approved without objection.

7. **Public Comment Period**

   Two members of the public signed up to give public comment, Clark Barrineau from the Medical Society of Virginia and Hannah Coley from the Virginia Hospital

and Healthcare Association regarding the Task Force's upcoming votes on recommendations. Keith Berger gave comment regarding the policy options presented to the Task Force.

8. Task Force Vote on Psychiatric Recommendations

8.1. Review of Policy Options

Mr. Hilbert reviewed the voting process with the Task Force. There was discussion on what the voting options are and where they are located. Ms. Flinn reviewed the policy options being brought before the Task Force for voting.

8.2. Discussion

There was discussion regarding the psychiatric bed availability in the state, and whether psychiatric bed access issues are related to a shortage in the number of beds or the number of staff available to staff those beds.

8.3. Vote

Ms. Flinn reviewed the process for voting with the Task Force. Dr. Eppes requested a motion to adopt policy option #1, "[m]ove psychiatric beds from full COPN review to expedited review" as a recommendation by the Task Force. Michael Desjadon motioned to adopt policy option #1 as a recommendation by the Task Force, with Dr. Berger seconding this motion. There was discussion regarding possible amendments to the policy option, batching cycles, COPN staffing capacity, clarification on what expedited review is, and staffing capacity of psychiatric beds. Ms. Flinn called the roll call of votes to adopt policy option #1 as a recommendation by the Task Force. Three members voted "yes" to adopting policy option #1 as a recommendation by the Task Force: Dr. Eppes, Dr. Berger, and Mr. Desjadon. Nine members voted "no" to adopting policy option #1 as a recommendation by the Task Force: Karen Cameron, Jeannie Adams, Dr. Baker, Paul Dreyer, Amanda Dulin, Kyle Elliott, Paul Hedrick, Shaila Menees, and Rufus Phillips. The motion to adopt policy option #1 as a recommendation by the Task Force failed by a voice vote of 3-Yes to 9-No.

Dr. Eppes requested a motion to adopt policy option #2, "[a]llow facilities that already provide psychiatric services to add beds using the expedited review process" as a recommendation by the Task Force. Dr. Berger motioned to adopt policy option #2 as a recommendation by the Task Force, with Mr. Desjadon seconding this motion. There was discussion regarding what the definition of a psychiatric facility is. Ms. Flinn called the roll call of votes to adopt policy option #2 as a recommendation by the Task Force. Four members voted "yes" to adopting policy option #2 as a recommendation by the Task Force: Dr. Eppes, Dr. Berger, Mr. Desjadon, and Mr. Hedrick. Eight members voted "no" to adopting policy option #2 as a recommendation by the Task Force: Ms. Cameron, Ms. Adams, Dr. Baker, Mr. Dreyer, Ms. Dulin, Mr. Elliott, Ms. Menees, and Mr. Phillips. The motion to

adopt policy option #2 as a recommendation by the Task Force failed by a voice vote of 4-Yes to 8-No.

Dr. Eppes requested a motion to adopt policy option #3, "[a]llow facilities that already provide psychiatric services to add beds using the expedited review process" as a recommendation by the Task Force. Mr. Desjadon motioned to adopt policy option #3 as a recommendation by the Task Force, with Dr. Berger seconding this motion. Mr. Desjadon then motioned to amend policy option #3 to insert the word "psychiatric" before "beds using the expedited review process" with Ms. Adams seconding this motion. Ms. Flinn called the roll call of votes to amend policy option #3. The motion to amend policy option #3 was unanimously approved by voice vote. Dr. Baker proposed a motion to amend policy option #3 by adding language preventing any beds added could not be converted to expedited review. There was clarification that the amendment could not be made to the previous amendment, and that a substitute amendment would need to be offered instead. Dr. Baker introduced a substitute motion to amend policy option #3 by inserting the language "[a] psychiatric bed added using the expedited COPN review process may not be converted to a non-psychiatric bed without COPN review" and was seconded by Ms. Dulin. Ms. Flinn called the roll call of votes for the substitute amendment to policy option #3. The substitute motion to amend policy option #3 was unanimously approved by voice vote. Ms. Cameron motioned to reconsider the substitute amendment to policy option #3, with Mr. Dreyer seconding this motion. There was discussion regarding adding language to prevent more than 10 beds or up to 10% of beds in any two year period using expedited review, the roll of hospital boards in the addition of beds, and where the 10 bed or 10% number is derived from. Ms. Flinn called the roll call of votes to reconsider the substitute amendment to policy option #3. Eight members voted "yes" to reconsidering the substitute amendment to policy option #3: Ms. Cameron, Ms. Adams, Dr. Baker, Mr. Dreyer, Ms. Dulin, Mr. Elliott, Ms. Menees, and Mr. Phillips. Four members voted "no" to reconsidering the substitute amendment to policy option #3: Dr. Eppes, Dr. Berger, Mr. Desjadon, and Mr. Hedrick. The motion to reconsider the substitute amendment to policy option #3 was approved by a voice vote of 8-Yes to 4-No. Ms. Cameron motioned to amend policy option #3 by inserting "up to 10 beds or 10% of beds, whichever is greater, in any two year period" after "...psychiatric services to add psychiatric beds" with Ms. Dulin seconding that motion. Ms. Flinn called the roll call of votes to amend policy option #3. Seven members voted "yes" to amending policy option #3: Ms. Cameron, Ms. Adams, Dr. Baker, Mr. Dreyer, Ms. Dulin, Ms. Menees, and Mr. Phillips. Four members voted "no" to amending policy option #3: Dr. Eppes, Dr. Berger, Mr. Desjadon, and Mr. Hedrick. The motion to amend policy option #3 was approved by a voice vote of 7-Yes to 4-No. Ms. Flinn called the roll call of votes to support the amended policy option #3, "[a]llow facilities that already provide psychiatric services to add psychiatric beds up to 10 beds or 10% of beds, whichever is greater, in any two year period using the expedited process. A psychiatric bed added using the

expedited COPN review process may not be converted to a non-psychiatric bed without COPN review" as a recommendation by the Task Force. The motion was approved unanimously by voice vote, and policy option #3 as it was amended was adopted as a recommendation by the Task Force.

Dr. Eppes requested a motion to adopt policy option #4, "[a]llow facilities to relocate psychiatric beds through the expedited process" as a recommendation by the Task Force. Dr. Baker motioned to adopt policy option #4 as a recommendation by the Task Force, with Dr. Berger seconding that motion. Ms. Cameron motioned to amend policy option #4 by inserting "within the same planning district" after "Allow facilities to relocate psychiatric beds" with Mr. Hedrick seconding that motion. There was discussion regarding the relocation of beds and reasons for that relocation, and the potential effects the added language may have on patients. Ms. Flinn called the roll call of votes to amend policy option #4. Nine members voted "yes" to amending policy option #4: Dr. Eppes, Ms. Cameron, Dr. Berger, Mr. Dreyer, Ms. Dulin, Mr. Elliott, Mr. Hedrick, Ms. Menees, and Mr. Phillips. Three members voted "no" to amending policy option #4: Ms. Adams, Dr. Baker, and Mr. Desjadon. The motion to amend policy option #4 was approved by a voice vote of -Yes to 3-No. Ms. Flinn called the roll call of votes to support the adoption of the amended policy option #4, "[a]llow facilities to relocate psychiatric beds within the same planning district through the expedited process" as a recommendation by the Task Force. The motion was approved unanimously by voice vote, and policy option #4 as it was amended was adopted as a recommendation by the Task Force.

Dr. Eppes requested a motion to adopt policy option #5, "[r]equire facilities to request a COPN in order to convert beds from psychiatric beds to non-psychiatric beds" as a recommendation by the Task Force. Dr. Baker motioned adopt policy option #5 as a recommendation by the Task Force, with Ms. Adams seconding that motion. There was discussion regarding the COPN process that would be used to review these bed conversions, how the process of bed conversion works currently at the hospital-level, and how this recommendation may affect hospitals during a public health emergency. Ms. Cameron motioned to amend policy option #5 to insert "which is allowable through the expedited review process" after "non-psychiatric review" and was seconded by Mr. Desjadon. There was discussion whether this amendment closes the "loop hole." Ms. Cameron withdrew her motion to amend policy option #5. Ms. Flinn called the roll call of votes to adopt policy option #5 as a recommendation by the Task Force. The motion was approved unanimously by voice vote, and policy option #5 was adopted as a recommendation by the Task Force.

Dr. Eppes requested a motion to adopt policy option #6, "[a]llow facilities that already provide psychiatric services to establish a new psychiatric facility through the expedited review process" as a recommendation by the Task Force. Dr. Berger

motioned to adopt policy option #6 as a recommendation by the Task Force, with Mr. Hedrick seconding that motion. Ms. Menees motioned to amend policy option #6 by inserting "within the same planning district" after "establish a new psychiatric facility" with Mr. Dreyer seconding that motion. There was discussion regarding whether this option includes beds to be placed within the facility, and the limitations hospital licensure places on the establishment of these psychiatric facilities by a current psychiatric provider. Ms. Flinn called the roll call of votes to adopt the proposed amendments to policy option #6. The amendments were adopted unanimously by voice vote. Ms. Flinn then called the roll call of votes to adopt the amended policy option #6, "[a]llow facilities that already provide psychiatric services to establish a new psychiatric facility within the same planning district through the expedited review process" as a recommendation by the Task Force. Seven members voted "yes" to adopting the amended policy option #6 as a recommendation by the Task Force: Dr. Eppes, Ms. Adams. Dr. Berger. Mr. Desjadon, Mr. Elliott, Mr. Hedrick, and Mr. Phillips. Four Task Force members voted "no" to adopting the amended policy option #6 as a recommendation by the Task Force: Dr. Baker, Mr. Dreyer, Ms. Dulin, and Ms. Menees. Ms. Cameron voted to abstain from the vote. The motion was supported by a voice vote of 7-Yes, 4-No, and 1-Abstain, and policy option #6 as amended was adopted as a recommendation by the Task Force.

Dr. Eppes requested a motion to adopt policy option #7, "[m]ove the addition of psychiatric services from full COPN review" as a recommendation by the Task Force. Mr. Desjadon motioned to adopt policy option #7 as a recommendation by the Task Force, with Mr. Hedrick seconding that motion. There was discussion regarding what the definition of a psychiatric service is, and what the word addition would mean within this policy option. Ms. Menees motioned to amend policy option #7 by inserting "allow for" after "[m]ove", "introduction" after "the addition", and "to an existing facility to go through the expedited review process" after "psychiatric services", and to strike "[m]ove", "addition", and "from full COPN review to expedited review" with Dr. Baker seconding this motion to amend. Ms. Flinn called the roll call of votes to adopt the amendment to policy option #7. The motion to amend policy option #7 was unanimously adopted by voice vote. There was discussion regarding whether this option is appropriate for expedited review, and the loop-hole language found in policy option #3. Dr. Baker introduced a substitute motion to amend policy option #7 by inserting "[a] psychiatric bed added using the expedited COPN review process may not be converted to a non-psychiatric bed without COPN review", with Ms. Dulin seconding that substitute motion. Ms. Flinn called the roll call of votes to approve the substitute motion to amend policy option #7. The substitute motion to amend policy option #7 was adopted unanimously by voice vote. There was no further discussion regarding policy option #7. Ms. Flinn called the roll call of votes to adopt policy option #7 as amended, "[a]llow for the introduction of psychiatric services to an existing facility to go through the expedited process. A psychiatric bed added using the expedited COPN review

process may not be converted to a non-psychiatric bed without COPN review" as a recommendation by the Task Force. Five Task Force members voted "yes" to adopting the amended policy option #7 as a recommendation by the Task Force: Dr. Eppes, Dr. Berger, Mr. Desjadon, Mr. Hedrick, and Ms. Menees. Seven Task Force members voted "no" to adopting the amended policy option #7 as a recommendation by the Task Force: Ms. Cameron, Ms. Adams, Dr. Baker, Mr. Dreyer, Ms. Dulin, Mr. Elliott, and Mr. Phillips. The motion to adopt policy option #7 as amended as a recommendation by the Task Force failed on a voice vote of 4-Yes to 7-No.

Dr. Eppes requested a motion to adopt policy option #8, "[e]xtend expedited review from 45 days to 90 days" as a recommendation by the Task Force. Ms. Cameron motioned to adopt policy option #8 as a recommendation by the Task Force, with Ms. Dulin seconding that motion. Ms. Cameron then requested the language from policy option #12 be added to policy option #8. There was discussion regarding whether 45 days is a sufficient enough time to review COPN applications, when expedited review applications may be submitted, and public participation during expedited review processes. Mr. Dreyer motioned to amend policy option #8 by inserting "[a]dd four batch cycles per year specifically for expedited review projects", with Ms. Menees seconding this motion. There was discussion regarding where the length of the expedited review applications come from, what reviewing a project consists of, potential time constraints that 45 days may pose regarding the scheduling of Informal Fact-Finding Conferences (IFFCs), the timing of the expedited batch cycles, the conditions for which an IFFC is required to be held, and the needed regulatory changes to the expedited review process. Ms. Flinn called the roll call of votes to adopt the proposed amendments to policy option #8. Ten members voted "yes" to the adoption of the proposed amendments to policy option #8: Dr. Eppes, Ms. Cameron, Dr. Baker, Dr. Berger, Mr. Dreyer, Ms. Dulin, Mr. Elliott, Mr. Hedrick, Ms. Menees, and Mr. Phillips. Two members voted "no" to the adoption of the proposed amendments to policy option #8: Ms. Adams and Mr. Desjadon. The motion to adopt the proposed amendments to policy option #8 was approved by a voice vote of 10-Yes to 2-No. Dr. Eppes motioned to reconsider the proposed amendment to policy option #8, with Dr. Baker seconding that motion. Ms. Flinn called the roll call of votes to reconsider the previous motion to amend policy option #8. The motion to reconsider the previous motion to amend policy option #8 was approved unanimously by voice vote. Ms. Dulin then motioned to amend policy option #8 by inserting "[a]ll expedited review projects will be considered in one of four batch cycles per year specifically for expedited review projects" after "90 days", with Mr. Dreyer seconding this motion. Ms. Flinn called the roll call of votes to adopt the proposed amendments to policy option #8. The motion to adopt the proposed amendments to policy option #8 was approved unanimously by voice vote. There was discussion regarding whether the movement from 45 to 90 days is necessary, and what types of expedited review projects policy option #8 would apply to. Ms. Flinn called the roll call of votes to

adopt policy option #8 as amended as a recommendation by the Task Force. Seven members voted “yes” to the adoption of the amended policy option #8 as a recommendation by the Task Force: Ms. Cameron, Ms. Adams, Dr. Baker, Mr. Dreyer, Ms. Dulin, Ms. Menees, and Mr. Phillips. Five members voted “no” to the adoption of the amended policy option #8 as a recommendation by the Task Force: Dr. Eppes, Dr. Berger, Mr. Desjadon, Mr. Elliott, and Mr. Hedrick. The motion to adopt policy option #8 as amended as a recommendation by the Task Force was approved on a voice vote of 7-Yes to 5-No.

Dr. Eppes requested a motion to adopt policy option #9, “[r]equire the Commissioner to condition expedited review applications on providing a specified level of charity care” as a recommendation by the Task Force. Dr. Baker motioned to adopt policy option #9 as a recommendation by the Task Force, with Ms. Dulin seconding that motion. Mr. Bodin informed the Task Force that according to the Code of Virginia, the Commissioner is already required to condition an expedited review certificate. Dr. Eppes requested the Task Force does not vote on policy option #9 with no objections.

Dr. Eppes requested a motion to adopt policy option #10, “[r]equire the Commissioner to condition psychiatric projects on the acceptance of Temporary Detention Orders (TDOs)” as a recommendation by the Task Force. Ms. Cameron motioned to amend policy option #10 by replacing “require” with the word “allow” as follows, “[a]llow the Commissioner to condition psychiatric projects on the acceptance of Temporary Detention Orders (TDOs)”, with Ms. Dulin seconding that motion. There was discussion regarding the nature of TDOs, and ensuring that facility capability to accept TDOs be considered. Ms. Flinn called the roll call of votes to adopt policy option #10 as a recommendation by the Task Force. 10 members voted “yes” to adopting policy option #10 as a recommendation by the Task Force: Dr. Eppes, Ms. Cameron, Dr. Baker, Dr. Berger, Mr. Dreyer, Ms. Dulin, Mr. Elliott, Mr. Hedrick, Ms. Menees, and Mr. Phillips. Mr. Desjadon voted “no” to adopting policy option #10 as a recommendation by the Task Force. The motion to adopt the amended policy option #10 as a recommendation by the Task Force was approved on a voice vote of 10-Yes to 1-No.

Dr. Eppes requested a motion to adopt policy option #11, “[r]equire any project that is contested to be pulled from expedited review and placed into full review” as a recommendation by the Task Force. Mr. Dreyer motioned to adopt policy option #11 as a recommendation by the Task Force, with Ms. Menees seconding that motion. There was discussion regarding the time frame on contesting a project, the role of regulations in determining the timelines for contesting a project, and the appropriateness of certain projects for expedited review vs full review. Ms. Flinn called the roll call of votes to adopt policy option #11 as a recommendation by the Task Force. 3 members voted “yes” to adopting policy option #11 as a recommendation by the Task Force: Mr. Dreyer, Ms. Dulin, and Ms. Menees. 7

members voted “no” to adopting policy option #11 as a recommendation by the Task Force: Dr. Eppes, Dr. Baker, Dr. Berger, Mr. Elliott, Mr. Hedrick, and Mr. Phillips. Ms. Cameron abstained from the vote. The motion to adopt policy option #11 as a recommendation by the Task Force failed on a voice vote of 3-Yes, 7-No, and 1-Abstain.

Dr. Eppes requested a motion to adopt policy option #12, “[a]llow for members of the public to request a hearing for an expedited project” as a recommendation by the Task Force. Ms. Cameron motioned to adopt policy option #12 as a recommendation by the Task Force, with Mr. Desjadon seconding that motion. There was no discussion regarding this policy option. Ms. Flinn called the roll call of votes to adopt policy option #12 as a recommendation by the Task Force. 7 members voted “yes” to adopted policy option #12 as a recommendation by the Task Force: Ms. Cameron, Dr. Baker, Mr. Dreyer, Ms. Dulin, Mr. Hedrick, Mr. Menees, and Mr. Phillips. 4 members voted “no” to adopting policy option #12 as a recommendation by the Task Force: Dr. Eppes, Dr. Berger, Mr. Desjadon, and Mr. Elliott. The motion to adopt policy option #12 as a recommendation by the Task Force was approved on a voice vote of 7-Yes to 4-No.

The recommendations adopted by the Task Force as recommendations are as follows:

1. Allow facilities that already provide psychiatric services to add psychiatric beds up to 10 beds or 10% of beds, whichever is greater, in any two year period using the expedited review process. A psychiatric bed added using the expedited COPN review process may not be converted to a non-psychiatric bed without COPN review.
2. Allow facilities to relocate psychiatric beds within the same planning district through the expedited process.
3. Require facilities to request a COPN in order to convert beds from psychiatric beds to non-psychiatric beds.
4. Allow facilities that already provide psychiatric services to establish a new psychiatric facility within the same planning district through the expedited review process.
5. Extend expedited review from 45 days to 90 days. All expedited review projects will be considered in one of four batch cycles per year specifically for expedited review projects.
6. Allow the Commissioner to condition psychiatric projects on the acceptance of Temporary Detention Orders.
7. Allow members of the public to request a hearing for an expedited project.

9. Expedited Review Projects & Process Options

9.1. Review of Remaining Projects

Mr. Bodin reviewed the remaining projects for consideration with the Task Force.

9.2. Review of Potential Process Options and Criteria for Consideration

The Task Force discussed strategies for addressing the remainder of the projects for consideration, determining that reviewing the projects by service and action is the most effective way to review the projects.

9.3. Discussion

There was no further discussion regarding the remainder of the projects for consideration.

10. Wrap-Up and Next Steps

Dr. Eppes informed the Task Force that there will be an upcoming poll to determine the availability for future in-person meetings.

11. Meeting Adjournment

The meeting adjourned at 1:00 p.m.

State Health Services Plan Task Force
August 9, 2024
Time 9:00 a.m.
VIA: Webex

NOTICE: The August 9, 2024 meeting was changed from an in-person meeting to an all-virtual meeting due to the declared state of emergency for the Commonwealth of Virginia

Task Force Members in Attendance – Entire Meeting (alphabetical by last name): Jeannie Adams; Dr. Kathy Baker; Dr. Keith E. Berger; Karen Cameron; Michael Desjadon; Paul Dreyer; Amanda Dulin; Dr. Thomas Eppes, Jr.; Paul Hedrick; Thomas Orsini; Rufus Phillips; Dr. Marilyn West.

Staff in Attendance (alphabetical by last name): – Kimberly E. Beazley, Director, VDH OLC; Erik O. Bodin, COPN Director, VDH OLC; Michael Capps, Senior Policy Analyst, VDH Office of Governmental and Regulatory Affairs; Allyson Flinn, Policy Analyst, VDH OLC; Joseph Hilbert, Deputy Commissioner of Governmental and Regulatory Affairs, VDH; Val Hornsby, Policy Analyst, VDH OLC; Dr. Karen Shelton, State Health Commissioner, VDH.

1. **Call to Order and Welcome**

   Dr. Thomas Eppes, Jr. called the meeting to order at 9:05 a.m.

2. **Roll Call**

   Allyson Flinn reviewed the virtual meeting etiquette and reminders with the group. Ms. Flinn then called the roll of the members. Ms. Flinn noted that Ms. Davis, Mr. Elliott, Ms. Menees, and Ms. Ramos were absent from the meeting.

3. **Review of Agenda**

   Ms. Flinn reviewed the agenda with the Task Force members.

4. **Approval of Prior Meeting Minutes**

   The minutes from the July 12, 2024 meeting were reviewed. Jeannie Adams requested clarification to the recommendations within the minutes, to which Ms. Flinn affirmed that there was a mistake in the minutes. Ms. Flinn amended the July 12 meeting minutes to accurately reflect the correct language of the recommendations. The amended meeting minutes were approved without objection.

5. **Public Comment Period**

   One member of the public signed up to give public comment, Clark Barrineau from the Medical Society of Virginia. Mr. Barrineau gave comment regarding the Task Force's upcoming votes on projects to recommend for expedited review.

6. Review of July 12 Adopted Recommendations

Ms. Flinn reviewed the adopted recommendations from the July 12, 2024 meeting with the Task Force. There was discussion regarding the timelines for expedited review, when an LOI can be contested, the posting of LOIs on the VDH website, the regulatory process and the length of time it takes to update regulations, and the expedited review process.

7. Remaining Expedited Review Projects

7.1. Review of Policy Options

Mr. Bodin reviewed the remaining expedited review projects with the Task Force members.

7.2. Discussion

There was discussion regarding the mandate within Chapter 423 of the 2024 Acts of Assembly, the voting procedures for block voting, the definition of contested, the structure for the expedited review process, and the asks from the VDH staff members for the next meeting.

7.3. Vote

Dr. Eppes announced that the Task Force members will not be voting on the blocks today and will address the block votes at the August 23, 2024 meeting.

8. Wrap-Up and Next Steps

Ms. Flinn reminded the Task Force members that the next meeting will be in-person on August 23, 2024.

9. Meeting Adjournment

The meeting adjourned at 11:04 a.m.

State Health Services Plan Task Force
August 23, 2024
Time 9:00 a.m.
Board Room 2. 9960 Mayland Drive
Henrico, Virginia 23233

Task Force Members in Attendance (alphabetical by last name): Jeannie Adams; Dr. Kathy Baker; Dr. Keith E. Berger; Karen Cameron; Michael Desjadon; Paul Dreyer; Amanda Dulin; Dr. Thomas Eppes, Jr.; Paul Hedrick; Thomas Orsini; Rufus Phillips.

Staff in Attendance (alphabetical by last name): – Kimberly E. Beazley, Director, VDH OLC; Erik O. Bodin, COPN Director, VDH OLC; Allyson Flinn, Policy Analyst, VDH OLC; Joseph Hilbert, Deputy Commissioner of Governmental and Regulatory Affairs, VDH; Val Hornsby, Policy Analyst, VDH OLC; Dr. Karen Shelton, State Health Commissioner, VDH.

1. Call to Order and Welcome

Dr. Thomas Eppes, Jr. called the meeting to order at 9:02 a.m.

2. Roll Call

Allyson Flinn called the roll of the Task Force members. Ms. Flinn noted that Ms. Davis, Mr. Elliott, Ms. Menees, Ms. Ramos, and Dr. West were absent from the meeting. Ms. Menees was not given the opportunity to participate remotely and would not have voted in favor of the recommendation to put imaging services into the expedited review process.

3. Review of Agenda

Ms. Flinn reviewed the agenda with the Task Force members.

4. Review of Meeting Materials

Ms. Flinn reviewed the meeting materials with the Task Force members.

5. Approval of Prior Meeting Minutes

The minutes from the August 9, 2024, meeting were reviewed and approved without objection.

6. Public Comment Period

One member of the public signed up to give public comment, Scott Castro from the Medical Society of Virginia. Mr. Castro gave comment regarding the Task Force's upcoming votes on projects to recommend for expedited review.

7. Remaining Expedited Review Projects

7.1. Review of Policy Options

Mr. Bodin reviewed the remaining expedited review projects with the Task Force members.

7.2. Discussion

There was discussion regarding the timelines for the current standards and expedited COPN process, whether the COPN process can move quicker than 190 days, who the current challengers are for projects, the process of moving all projects to expedited review, the role community grassroots organizations play in the COPN process, and health care planning and the process followed outside of the COPN process.

7.3. Vote

Mr. Desjadon made a motion to recommend moving all projects subject to COPN review into expedited review, with Dr. Berger seconding this motion. There was discussion regarding the workload burden on VDH staff. Dr. Baker motioned to amend Mr. Desjadon's motion to only include the VDH OLC staff "yes" options to expedited review, with Mr. Desjadon seconding that motion. There was discussion regarding long-term care projects. Dr. Baker withdrew the amended motion. The Task Force voted on the motion to recommend moving all projects subject to COPN review into expedited review, and the motion failed on a vote of 3 – Yes and 8 – No.

The Task Force members unanimously removed the psychiatric service block from the voting.

Ms. Adams made a motion to exclude all long-term care services and intermediate care facility for individuals with intellectual disability services from the expedited review recommendations, with Ms. Cameron seconding that motion. There was discussion regarding the involvement of Medicaid in the long-term care setting. The Task Force voted on the motion to exclude all long-term care projects from the expedited review recommendations, and the motion was approved on a vote of 6 – Yes and 5 – No.

Mr. Dreyer made a motion to exclude the addition of new hospital beds from the expedited review recommendations, with Ms. Dulin seconding that motion. There was discussion regarding uncontested projects. The Task Force voted on the motion to exclude the addition of new hospital beds from the expedited review recommendations, and the motion was approved on a vote of 6 – Yes and 4 – No.

Ms. Adams made a motion to include all imaging projects into the expedited review recommendations, with Dr. Berger seconding that motion. There was discussion regarding the difference between "addition" and "introduction", CT scanners in radiation centers, the implications of moving all imaging services into expedited

review, inventory neutral services, service utilization, the number of imaging services that may be contested, and what contesting a project may consist of. The Task Force voted on the motion to include all imaging projects in the expedited review recommendations, and the motion was approved on a vote of 6 – Yes and 5 – No.

Ms. Cameron made a motion to include the VDH OLC staff "yes" options for cardiac catheterization services in the expedited review recommendations, with Dr. Baker seconding that motion. There was discussion regarding the difference between "establish" and "introduce." The Task Force voted on the motion to include the VDH OLC staff "yes" options for cardiac catheterization services in the expedited review recommendations, the timeliness of the COPN review process, and the motion was approved unanimously.

Mr. Dreyer made a motion to exclude the addition of new operating rooms in an existing hospital and the addition of new operating rooms in an existing outpatient surgical hospital from the expedited review recommendations, with Ms. Cameron seconding that motion. There was discussion regarding COPN and institutional need, COPN review criteria, and inventory neutral projects. The Task Force voted on the motion to exclude the addition of new operating rooms in an existing hospital and the addition of new operating rooms in an existing outpatient surgical hospital from the expedited review recommendations, and the motion was approved on a vote of 6 – Yes and 5 – No.

Rufus Phillips made a motion to include the remaining VDH OLC staff "yes" options for Surgical services in the expedited review recommendations, with Ms. Adams seconding that motion. Dr. Berger then motioned to amend Mr. Phillips' motion by removing the establishment of a new outpatient surgical hospital from the block, with Mr. Desjadon seconding that motion. There was discussion regarding the IFFC rate of outpatient surgical hospital projects, the difference between Virginia licensure and the Centers for Medicare and Medicaid Services certification of outpatient surgical hospitals. The Task Force voted on the motion to amend Mr. Phillips' motion by removing the establishment of a new outpatient surgical hospital from the block, and the Task Force unanimously adopted the amendment. The Task Force then voted on the amended motion to include the remaining VDH OLC staff "yes" options for surgical services in the expedited review recommendations, excluding the establishment of a new outpatient surgical hospital, and the motion was approved unanimously.

Dr. Berger made a motion to include the establishment of a new outpatient surgical hospital in the expedited review recommendations, with Mr. Desjadon seconding that motion. There was discussion regarding the number of IFFCs held for outpatient surgical hospital establishment projects, and the complexity of

outpatient surgical hospital project applications, staffing and COPN applications. The Task Force then voted on the motion to include the establishment of a new outpatient surgical hospital in the expedited review recommendations, and the motion failed on a vote of 5 – Yes and 6 – No.

Ms. Cameron made a motion to exclude the establishment of a new outpatient surgical hospital from the expedited review recommendations, with Mr. Dreyer seconding that motion. The Task Force then voted on the motion to exclude the establishment of a new outpatient surgical hospital from the expedited review recommendations, and the motion was approved on a vote of 7 – yes and 4 – No.

Mr. Dreyer made a motion to include the VDH OLC staff "yes" options for medical rehabilitation services in the expedited review recommendations, with Ms. Adams seconding that motion. The Task Force then voted on the motion to include the VDH OLC staff "yes" options for medical rehabilitation services in the expedited review recommendations, and the motion was approved unanimously.

Ms. Cameron made a motion to include the VDH OLC staff "yes" options for radiation therapy and cancer treatment services in the expedited review recommendations, with Dr. Berger seconding that motion. There was discussion regarding whether SRS is still requires a COPN. The Task Force then voted on the motion to include the VDH OLC staff "yes" options for radiation therapy and cancer treatment services in the expedited review recommendations, and the motion was approved unanimously.

Ms. Dulin made a motion to exclude the establishment of a medical care facility that is the relocation of existing regulated modalities other than beds within the planning district from the expedited review recommendations, with Ms. Adams seconding that motion. There was discussion regarding the definition of a medical care facility, the complexities of moving locations within the same planning district, and the number of contested applications, the difference between expansion and relocation. The Task Force then voted on the motion to exclude the establishment of a medical care facility that is the relocation of existing regulated modalities other than beds within the planning district, and the motion was approved on a vote of 6 – Yes and 5 – No.

Mr. Hilbert then reminded the Task Force of the remaining projects to be addressed. Ms. Cameron made a motion to include the VDH OLC staff "yes" options for hospital services and neonatal intensive services, excluding the addition of new hospital beds, in the expedited review recommendations, with Dr. Baker seconding that motion. There was discussion regarding the relocation of hospital beds. The Task Force then voted on motion to include the VDH OLC staff "yes" options for hospital services and neonatal intensive services, excluding the

addition of new hospital beds, in the expedited review recommendations, and the motion was approved on a vote of 10 – Yes and 1 – No.

The Task Force recommendations for expedited review are as follows:

Hospital

- Add new hospital beds by relocation of existing hospital beds

Imaging

- Add a CT scanner by relocating an existing CT in the planning district
- Add a CT scanner in an existing hospital with existing CT services
- Add a CT scanner in an existing imaging center
- Add a CT scanner in an existing outpatient surgical hospital with existing CT services
- Establish an imaging center for CT imaging
- Introduce a new CT for radiation therapy simulation in an existing center for radiation therapy
- Introduce a new CT service in an existing hospital
- Introduce a new CT service in an existing imaging center
- Introduce CT by relocating an existing CT in the planning district
- Establish an imaging center for MRI imaging
- Add an MRI scanner by relocating an existing MRI in the planning district
- Add an MRI scanner in an existing hospital with existing MRI services
- Add an MRI scanner in an existing imaging center
- Introduce a new MRI service in an existing hospital
- Introduce a new MRI service in an existing imaging center
- Add a PET scanner in an existing hospital with existing PET services
- Add a PET scanner in an existing imaging center
- Establish an imaging center for PET imaging
- Introduce a new PET service in an existing hospital
- Introduce a new PET service in an existing imaging center
- Introduce a new PET service in an existing radiation therapy center
- Add a scanner by converting a mobile site to a fixed unit (CT and/or PET and/or MRI)
- Establish an imaging center for 2 or more regulated modalities (Other than Cancer Treatment)

Cardiac Catheterization

- Add a cardiac catheterization lab in an existing hospital with cardiac catheterization services

Surgical

- Add new operating rooms in an existing outpatient surgical hospital by relocating existing ORs from another hospital

Medical Rehabilitation

- Add new rehabilitation beds in a hospital with existing rehabilitation services
- Add rehabilitation beds in a hospital with existing rehabilitation services by converting medical-surgical beds

Radiation Therapy & Cancer Treatment

- Add a linear accelerator by relocating an existing linear accelerator to a hospital with an existing linear accelerator
- Add a linear accelerator in an existing hospital with an existing linear accelerator
- Add a linear accelerator in an existing outpatient surgical hospital with an existing linear accelerator
- Add a linear accelerator in an existing radiation treatment center with a linear accelerator
- Add SRS equipment in an existing radiation treatment center with existing SRS

8. Wrap-Up and Next Steps

The Task Force then discussed the Next Steps for the Task Force. There was discussion regarding the services for discussion, the data submitted by hospitals and the reliability, the date of the last revision of the SMFP, the timeline for updating the SHSP, and email etiquette reminders. Ms. Flinn reminded the Task Force members that the next meeting will be in-person on September 6, 2024.

9. Meeting Adjournment

The meeting adjourned at 11:24 a.m.

State Health Services Plan Task Force
September 6, 2024
Time 9:00 a.m.
Board Room 4, 9960 Mayland Drive
Henrico, Virginia 23233

Task Force Members in Attendance (alphabetical by last name): Dr. Kathy Baker; Karen Cameron; Carrie Davis; Michael Desjadon; Paul Dreyer; Amanda Dulin; Dr. Thomas Eppes, Jr.; Paul Hedrick; Shaila Menees; Rufus Phillips; Thomas Orsini.

Staff in Attendance (alphabetical by last name): –Erik O. Bodin, COPN Director, VDH OLC; Allyson Flinn, Policy Analyst, VDH OLC; Joseph Hilbert, Deputy Commissioner of Governmental and Regulatory Affairs, VDH; Val Hornsby, Policy Analyst, VDH OLC; Dr. Karen Shelton, State Health Commissioner, VDH.

1. **Call to Order and Welcome**

   Dr. Thomas Eppes, Jr. called the meeting to order at 9:02 a.m.

2. **Roll Call**

   Allyson Flinn called the roll of the Task Force members. Ms. Flinn noted that Ms. Adams, Mr. Elliott, Ms. Ramos, and Dr. West were absent from the meeting.

3. **Review of § 32.1-102.2:1 of the Code of Virginia**

   Ms. Flinn reviewed the mandate for the Task Force in § 32.1-102.2:1 of the Code of Virginia with the group. There was discussion regarding the timeline for completion of the mandate, VDH's budget for hiring consultants, information sources available to the Task Force, and the length of the upcoming process.

4. **Review of Agenda**

   Ms. Flinn reviewed the agenda with the Task Force members. There was discussion regarding the official recommendations, the upcoming Commissioner's report of the Task Force, the framework for the recommended expedited process, the items that will be included in the upcoming report, the pathways in which the recommendations made by the Task Force can be achieved, the differences in the two mandates of the Task Force, and the criteria for review of all Certificate of Public Need (COPN) projects within the State Medical Facilities Plan (SMFP).

5. **Review of Meeting Materials**

   Ms. Flinn reviewed the meeting materials with the Task Force members. There was discussion regarding the regulatory process in Virginia.

6. **Approval of Prior Meeting Minutes**

   The Task Force reviewed the meeting minutes from the August 23, 2024 meeting. Ms. Menees motioned to amend the meeting minutes to include

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mention of her absence from the August 23 meeting as follows, "Ms. Menees was not given the opportunity to participate remotely and would not have voted in favor of the recommendation to put imaging services into the expedited review process." The motion to amend the meeting minutes was unanimously approved by roll call vote. There was discussion regarding the importance of using a roll call vote, and concern regarding the lack of roll call vote used at the August 23 meeting. Mr. Desjadon then moved to adopt the minutes as amended, with Ms. Davis seconding that motion. The minutes from the August 23, 2024 meeting were approved as amended by a roll call vote of 6 – Yes and 5 – No, with the following members voting Yes: Dr. Baker, Ms. Davis, Mr. Desjadon, Mr. Hedrick, Mr. Orsini, and Dr. Eppes, and the following members voting No: Ms. Cameron, Mr. Dreyer, Ms. Dulin, Ms. Menees, and Mr. Phillips.

Mr. Dreyer made a motion to rescind the Task Force's previous vote on the inclusion of imaging services in the recommendations for inclusion in an expedited review process, with Ms. Menees seconding that motion. There was discussion regarding the competition in the healthcare market, staffing shortages, and the time needed to conduct in-depth discussions regarding imaging projects and expedited review. The Task Force then voted on the motion to rescind the Task Force's previous vote on the inclusion of imaging services in the recommendations for inclusion in an expedited review process; the vote was approved by a roll call vote of 7 – Yes and 4 – No, with the following members voting Yes: Dr. Baker, Ms. Cameron, Mr. Dreyer, Ms. Dulin, Ms. Menees, Mr. Phillips, and Mr. Orsini, and the following members voting No: Ms. Davis, Mr. Desjadon, Mr. Hedrick, and Dr. Eppes.

7. Public Comment Period

Two members of the public signed up to give public comment, Scott Castro from the Medical Society of Virginia and Brent Rawlings from the Virginia Hospital & Healthcare Association. Mr. Castro gave comment regarding the Task Force's previous votes regarding expedited review and requested the Task Force to not rescind any other recommendations. Mr. Rawlings gave comment regarding the public comments submitted by hospital systems in the state and the importance of the non-contested language.

8. The State Health Services Plan

8.1. Review of the projects currently within the SMFP

Mr. Bodin reviewed the current SMFP with the Task Force and the projects subject to the SMFP. There was discussion regarding the eight criteria the Commissioner is required to consider while reviewing COPN applications, the potential to create "guiding principles" for the Task Force, and the data needed to fulfill the the remainder of the mandate.

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8.2. Planning to address the mandate within § 32.1-102.2:1 of the Code of Virginia

Mr. Bodin reviewed the project types the Task Force will need to discuss for the development of the SHSP. There was discussion regarding the data needed to evaluate the project types, and the considerations for innovation.

8.3. Discussion

The Task Force discussed the methods for addressing the remainder of the mandate in the Code of Virginia.

9. Wrap-Up and Next Steps

The Task Force discussed the meeting cadence and project order for the remaining mandate. The Task Force chose to address Batch Group C first, the Batch Group D/F, then A, B, E, and G. The Task Force also discussed holding monthly meetings, deciding on October 10th to be the date of the next meeting of the Task Force.

10. Meeting Adjournment

The meeting adjourned at 10:57 a.m.

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APPENDIX F – FEEDBACK FROM MEMBERS

Task Force members and their organizations were given the opportunity to submit public comment to be shared within this report; the submissions can be seen below.

Docusign Envelope ID: 5F8B373F-608F-4D7C-A383-B0445F59288C

September 4, 2024

Karen Shelton, MD
State Health Commissioner
Virginia Department of Health
P.O. Box 448
Richmond Virginia, 24218

Re: Comment to be Included in Commissioner's Report to Legislature/Senator Hashmi

Commissioner Shelton, Senator Hashmi & Members of the Legislature,

Thank you for the opportunity to address you via this letter, and for the opportunity to support our collective efforts through the State Health Services Plan Task Force to ensure we're providing high quality healthcare services at a fair cost to Virginians. I'm proud of our Task Force's efforts and I am confident each representative of the task force is lending their expertise with the very best of intentions for all Virginians in mind. To work alongside them continues to be an honor.

I represent "Self Insured and Fully Insured Employers" on the task force, which means I represent the voice of Virginia's customers of healthcare. Many of the tenets of the Certificate of Public Need (COPN) have been long disputed by many groups, but what isn't in dispute is the high and rising cost of healthcare. Costs have continued to rise across all care services, compromising our ability to afford reasonable coverage for employees. A research report from Altarum[1] reported an 89 percent increase in the cost of healthcare in Virginia from 2008-2022 (including both premium and deductible). COPN itself isn't part of our mandate, but innovation is and we do have an opportunity in front of us to offer relief in the form of expediting our reviews for services under COPN. This would have the effect of reducing the time to bring new services online, increasing the amount of services available to a given market and reducing the cost of these services through enhanced competition within that market.

The Task Force acted to make this possible by compromising to recommend we extend the expedited review process from 45 days to 90 days, in order to facilitate more services being added to expedited review while maintaining appropriate time for necessary review and public comment. I voted in favor of this and encourage its consideration and adoption. We further acted to recommend a large swath of services be included in expedited review, starting with Mental/Behavioral Health as requested, and extending across other services, including imaging. I moved to include all care in expedited review, a bold position for sure, but with COPN itself not at issue, merely the time it takes for review, I felt it a fair push toward innovation. That motion failed, but we were ultimately satisfied with the compromised items we'd moved into expedited review.

Much like the legislature, our task force is not immune to outside pressure from incumbent interests focused on maintaining the status quo, where a small number of large health systems enjoy protected market share under COPN. This was on display in our now reversed vote over whether or not to include Imaging services under expedited review. I would encourage you to look beyond our two narrow votes, one for and one against, and into the substance of the dialogue as you consider whether or not decisions can and should be made faster to bring relief to Virginia as you act at the legislative level.

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I spent a great deal of time wondering what interests would be served that would drive a lobbying effort directed at overturning our vote on this innovation. In reading each and every contested COPN application, the answer became clear. Imaging is a revenue generating service and these organizations are acting to protect their market share advantage. An average MRI scan in Richmond costs $2,877[2]. The number of scans per machine per day vary widely, but taking a low number of 10 per day a machine yields at least $28,770 every day it's in operation. An incumbent provider with an existing MRI machine knows that in Virginia, with a 190 full review batch cycle for COPN they will have at the very least, 190 uncontested days of operation per machine while the decision making process works, yielding $5,466,300 for that single machine. For a large system that operates 10 machines or more (each of which submitted a letter in asking us to rescind our innovation), that is more than $54M in uncontested run time ($28,770 x 10 machines x 190 days). If we reduce that by 100 days to the proposed 90 day expedited review, they would stand to potentially lose protected operation of $2.8M per machine, or $28M per 10 machines. It became much clearer why our task force received these letters, and why a vote taken in good faith was rescinded under pressure.

I write today in the hope that the good work we're doing on the task force will help you all who have to decide how best to bring innovation to Virginians in the form of lower costs for care and greater access. I hope you consider the recommendations we've made, but also the deliberation that went into the recommendations that didn't win a vote, as the votes do not all represent the unanimous views of the task force. We took seriously your mandate to review "generally uncontested" services, but I fear that language may have been unintentionally read to mean "completely uncontested" and therefore held us back from pushing forward in recommending bolder innovation due to pressure from business interests that may not necessarily reflect the interests of the State or of its residents looking for better access and lower cost services.

Kind Regards,
Mike Desjadon
State Health Services Plan Task Force

Footnotes:

1. https://altarum.org/sites/default/files/2024-01/Tracking_Virginia_Health_Spending_2022.pdf
2. https://www.vdh.virginia.gov/content/uploads/sites/96/2024/08/COPN-Request-Nos-VA-8755-VA-8756-Staff-Report.pdf

New Information on COPN for next SHSP Task Force Sept 6, 2024

Keith Berger <keberger2@verizon.net>
Mon 9/2/2024 2:01 PM
To:Flinn, Allyson (VDH) <Allyson.Flinn@vdh.virginia.gov>
Cc:THOMAS EPPES, JR. <famlymd@aol.com>

1 attachments (981 KB)
2024 Virginia_con_law-a_comparison_with_other_states_20180419.pdf;

Hello Allyson and all SHSP Task Force Members:

I wanted to let everyone know that they may be interested in hearing about some recent data on the impact of Florida's 2019 repeal of their CON laws on in-patient psychiatric beds. Portions of this email will also serve as part of my official comments to the commissioner requested by September 6th.

PS. unfortunately, due to a schedule conflict, I am unable to attend the Richmond Sept 6 meeting. I've asked Dr. Eppes to facilitate any discussion regarding these issues. KEB

So here are the new findings:

Florida experienced a significant increase in adult inpatient psychiatric beds after CON repeal as follows **(Florida reports the number of inpatient adult psych beds annually. The Florida legislature repealed CON for adult psych beds (and other things) effective 2019):**

In 2019, the reported number of beds was 4,475. By 2023, the reported number was 6,777!

From 2014–2019, with CON laws in place, the number of adult psych beds only increased by 507 (around 100 beds/year). After CON repeal, the number of beds increased by 2,302 (about 575 beds/year).

These numbers are available here and are provided by the Florida Department of Health.

"…this tells us a lot about the rapid increase in access that follows CON reform!"

I would also like to make the following points:

1. Arguments that COPN laws improve access, cost and quality of healthcare have long been disproven by over (120) peer reviewed studies. In fact, the

data consistently show a significant negative impact on access and cost with no change to underserved populations. Florida appears to be no exception. I have previously circulated to the task force the April 2024 summary published by economist Matthew Mitchell reviewing the ENTIRE literature on CON studies throughout the US, repeatedly confirming these findings (everyone on the Task Force should have previously received a copy of his paper).

2. With regard specifically to the state of Virginia, Virginia as compared to neighboring non-CON states has FAR FEWER hospital, rural, and ASC beds per capita than the comparison states. To see this graphically take a look at the attached brief summary of testimony Mr. Mitchell gave here in committee in Richmond in 2018. See the (4) graphs comparing Virginia to non-CON states in pages 6-9 in his article. The graphs speak for themselves.
3. Attached: testimony by Matt Mathews*, Virginia's Certificate-of-Public-Need Law: A Comparison with Other States from April8, 2018.*Excellent assessment on Virginia's situation.

TESTIMONY

Virginia's Certificate-of-Public-Need Law: A Comparison with Other States

Matthew D. Mitchell, PhD
Senior Research Fellow
Director, Project for the Study of American Capitalism
Mercatus Center at George Mason University

Virginia House of Delegates
Health, Welfare, and Institutions Committee

April 18, 2018

Chairman Orrock, Vice Chairman Garrett, and distinguished members of the House of Delegates Health, Welfare, and Institutions Committee:

My name is Matthew Mitchell. I am an economist at the Mercatus Center at George Mason University where I am an adjunct professor of economics. In recent years, my colleagues and I have been studying certificate-of-need laws in healthcare. I am grateful for the opportunity to discuss our findings with you today.

INTRODUCTION TO CON LAWS

Certificate-of-need (CON) laws—or certificate-of-public-need (COPN) laws, as they are called in Virginia—require healthcare providers wishing to open or expand a healthcare facility to first prove to a regulatory body that their community needs the services the facility would provide. The regulations are typically *not* designed to assess a provider's qualifications or safety record. Other regulations such as occupational licensing aim to do that. Instead, the process aims to determine whether or not a service is economically viable and valuable. The process for obtaining a CON or COPN can take years and tens or even hundreds of thousands of dollars in preparation costs.[1] While these regulations appear to benefit incumbent providers by limiting their competition, their effects on patients and taxpayers have generally been found to be negative. This helps explain why antitrust authorities at the Federal Trade Commission (FTC) and at the US Department of Justice (DOJ) have long taken the position that these rules are anticompetitive. In a joint report from 2004, for example, the FTC and DOJ declared,

> The Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits.[2]

[1] Kent Hoover, "Doctors Challenge Virginia's Certificate-of-Need Requirement," *Business Journals*, June 5, 2012.
[2] Federal Trade Commission and US Department of Justice, *Improving Health Care: A Dose of Competition*, July, 2004, 22. For more recent examples, see *Competition in Healthcare and Certificates of Need, Hearing before a Joint Session of the Health and Human Services Committee of the State Senate and the CON Special Committee of the State House of Representatives of the General Assembly of the State of Georgia*, 149th Gen. Assemb. (2007) (statement of Mark J. Botti, Chief, Litigation I Section, US

For more information or to meet with the scholar, contact
Mercatus Outreach, 703-993-4930, mercatusoutreach@mercatus.gmu.edu
Mercatus Center at George Mason University, 3434 Washington Blvd., 4th Floor, Arlington, Virginia 22201

The ideas presented in this document do not represent official positions of the Mercatus Center or George Mason University.

In the remainder of my testimony today, I will offer a brief history of CON laws and an overview of the economic evidence that has led many, including the FTC and DOJ, to conclude that these laws pose anticompetitive risks to consumers and taxpayers. Finally, I compare Virginia's COPN program to the CON programs in surrounding states.

A BRIEF HISTORY OF CERTIFICATE-OF-NEED REGULATION

More than four decades ago, Congress passed and President Ford signed the National Health Planning and Resources Development Act of 1974.[3] The statute enabled the federal government to withhold federal funds from states that failed to adopt CON regulations in healthcare.

New York had already enacted the first CON program in 1964; by the early 1980s, with the federal government's encouragement, every state except Louisiana had implemented some version of a CON program.[4] Policymakers hoped these programs would restrain healthcare costs, increase healthcare quality, and improve access to care for poor and underserved communities.

In 1986—after Medicare changed its reimbursement practices and as evidence mounted that CON laws were failing to achieve their stated goals—Congress repealed the federal act, eliminating federal incentives for states to maintain their CON programs.[5] Since then, 15 states, representing about 40 percent of the US population, have done away with their CON regulations, and many have pared them back.[6] A majority of states still maintain CON programs, however, and vestiges of the National Health Planning and Resources Development Act can be seen in the justifications that state legislatures offer in support of these regulations.[7]

THE ECONOMICS OF CERTIFICATE-OF-NEED REGULATION

Unfortunately, by limiting supply and undermining competition, CON laws may undercut each of the laudable aims that policymakers desire to achieve with CON regulation. In fact, research shows that CON laws *fail* to achieve the goals most often given when enacting such laws. These goals include

1. ensuring an adequate supply of healthcare resources,
2. ensuring access to healthcare for rural communities,
3. promoting high-quality healthcare,
4. ensuring charity care for those unable to pay or for otherwise underserved communities,

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Department of Justice, Antitrust Division); Federal Trade Commission and US Department of Justice, *Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice to the Virginia Certificate of Public Need Working Group*, October 2015; Federal Trade Commission and US Department of Justice, *Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250*, January 2016; *Statement of the Federal Trade Commission to the Alaska Senate Committee on Labor & Commerce on Certificate-of-Need Laws and Alaska Senate Bill 62, Hearing before the Senate Labor and Commerce Standing Committee*, 30th Leg. (2018) (statement of Daniel Gilman, Attorney Advisor, Federal Trade Commission, Office of Policy Planning).

[3] National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k–300n-5), repealed by Pub. L. No. 99-660, § 701, 100 Stat. 3799 (1986).

[4] Matthew D. Mitchell and Christopher Koopman, "40 Years of Certificate-of-Need Laws across America," Mercatus Center at George Mason University, September 27, 2016.

[5] Patrick John McGinley, "Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a 'Managed Competition' System," *Florida State University Law Review* 23, no. 1 (1995).

[6] New Hampshire is the state that most recently repealed its CON program, which it did in the summer of 2016. Mitchell and Koopman, "40 Years of Certificate-of-Need Laws across America."

[7] According to Virginia's CON website, "The program seeks to contain health care costs while ensuring financial viability and access to health care for all Virginia at a reasonable cost." Virginia Department of Health, Licensure and Certification, "Certificate of Public Need Program," accessed April 6, 2018, http://www.vdh.virginia.gov/licensure-and-certification/the-certificate-of-public-need-program/.

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5. encouraging appropriate levels of hospital substitutes and healthcare alternatives, and
6. restraining the cost of healthcare services.[8]

We have quite a bit of information to help us predict what would happen if other states such as Virginia were to repeal their laws because 15 states have repealed their CON programs. Economists have been able to use modern statistical methods to compare outcomes in CON and non-CON states to estimate the effects of these regulations. These methods control for factors such as socioeconomic conditions that might confound the estimates. Table 1 summarizes some of this research. It is organized around the stated goals of CON laws.

TABLE 1. SUMMARY OF RESEARCH ADDRESSING THE GOALS OF CERTIFICATE-OF-NEED (CON) LAWS IN HEALTHCARE

Question	Answer	Research
1. Do CON programs help ensure an adequate supply of healthcare resources?	No. CON regulation explicitly limits the establishment and expansion of healthcare facilities and is associated with fewer hospitals, ambulatory surgical centers, dialysis clinics, and hospice care facilities. It is also associated with fewer hospital beds and decreased access to medical imaging technologies. Residents of CON states are more likely than residents of non-CON states to leave their counties in search of medical services. Regression analysis by Stratmann and Koopman (2016) suggests that a Virginia without COPN would have 42 percent more hospitals than it currently has.	Ford and Kaserman (1993); Carlson et al. (2010); Stratmann and Russ (2014); Stratmann and Baker (2017); and Stratmann and Koopman (2016)
2. Do CON programs help ensure access to healthcare for rural communities?	No. CON programs are associated with fewer hospitals overall, but also with fewer rural hospitals, rural hospital substitutes, and rural hospice care facilities. Residents of CON states must drive farther to obtain care than residents of non-CON states. Stratmann and Koopman's research suggests that a Virginia without COPN would have 44 percent more rural hospitals than it currently has.	Cutler, Huckman, and Kolstad (2010); Carlson et al. (2010); and Stratmann and Koopman (2016)
3. Do CON programs promote high-quality healthcare?	Most likely not. While early research was mixed, more recent research suggests that deaths from treatable complications following surgery and mortality rates from heart failure, pneumonia, and heart attacks are all statistically significantly higher among hospitals in CON states than hospitals in non-CON states. Also, in states with especially comprehensive programs such as Virginia, patients are less likely to rate hospitals highly.	Stratmann and Wille (2016)
4. Do CON programs help ensure charity care for those unable to pay or for otherwise underserved communities?	No. There is no difference in the provision of charity care between states with CON programs and states without them, and CON regulation is associated with greater racial disparities in access to care.	DeLia et al. (2009) and Stratmann and Russ (2014)
5. Do CON programs encourage appropriate levels of hospital substitutes and healthcare alternatives?	No. CON regulations have a disproportionate effect on new hospitals and nonhospital providers of medical imaging services. Research also finds that states such as Virginia that have an ambulatory surgical center-specific CON (COPN) have, on average, 14 percent fewer total ambulatory surgical centers.	Stratmann and Baker (2017) and Stratmann and Koopman (2016)

[8] Each of these goals was first articulated in the National Health Planning and Resources Development Act of 1974.

3

6. Do CON programs help restrain the cost of healthcare services?	No. By limiting supply, CON regulations increase per-service and per-procedure healthcare costs. Even though CON regulations might reduce overall healthcare spending by reducing the quantity of services that patients consume, the balance of evidence suggests that CON laws actually increase total healthcare spending.	Mitchell (2016) and Bailey (2016)

Sources: James Bailey, "Can Health Spending Be Reined In through Supply Constraints? An Evaluation of Certificate-of-Need Laws" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, August 2016); Melissa D. A. Carlson et al., "Geographic Access to Hospice in the United States," *Journal of Palliative Medicine* 13, no. 11 (2010); David M. Cutler, Robert S. Huckman, and Jonathan T. Kolstad, "Input Constraints and the Efficiency of Entry: Lessons from Cardiac Surgery," *American Economic Journal: Economic Policy* 2, no. 1 (2010); Derek DeLia et al., "Effects of Regulation and Competition on Health Care Disparities: The Case of Cardiac Angiography in New Jersey," *Journal of Health Politics, Policy and Law* 34, no. 1 (2009); Jon M. Ford and David L. Kaserman, "Certificate-of-Need Regulation and Entry: Evidence from the Dialysis Industry," *Southern Economic Journal* 59, no. 4 (1993); Matthew D. Mitchell, "Do Certificate-of-Need Laws Limit Spending?" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, September 2016); Thomas Stratmann and Matthew C. Baker, "Barriers to Entry in the Healthcare Markets: Winners and Losers from Certificate-of-Need Laws" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, August 2017); Thomas Stratmann and Christopher Koopman, "Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, February 2016); Thomas Stratmann and Jacob W. Russ, "Do Certificate-of-Need Laws Increase Indigent Care?" (Working Paper No. 14-20, Mercatus Center at George Mason University, Arlington, VA, July 2014); Thomas Stratmann and David Wille, "Certificate-of-Need Laws and Hospital Quality" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, September 2016).

CERTIFICATE-OF-PUBLIC-NEED REGULATION IN VIRGINIA

Virginia's COPN program is one of the more comprehensive CON programs in the country. Among many other things, Virginia's program regulates acute hospital beds, ambulatory surgical centers, medical imaging technologies, rehabilitation centers, and psychiatric care facilities. Table 2 shows the number of technologies and procedures regulated by Virginia and surrounding states. Nationally, the average number of technologies and procedures regulated is 12, among CON states the number is 16, and among states in the Mid-Atlantic region it is 18. Virginia regulates 20 technologies and procedures.

TABLE 2. CERTIFICATE-OF-PUBLIC-NEED IN VIRGINIA AND CERTIFICATE-OF-NEED IN SURROUNDING STATES

State	Number of Technologies and Procedures Regulated
Delaware	8
Kentucky	21
Maryland	17
New Jersey	26
North Carolina	25
Ohio	1
Pennsylvania	0
South Carolina	22
Tennessee	23
Virginia	20
West Virginia	20
District of Columbia	28

Regional average	18
National average among CON states	16
National average among all states	12

Source: Christopher Koopman and Anne Philpot, "Certificate of Need Laws in 2016," Mercatus Center at George Mason University, September 27, 2016. West Virginia's number was updated by the author to reflect changes in 2017.

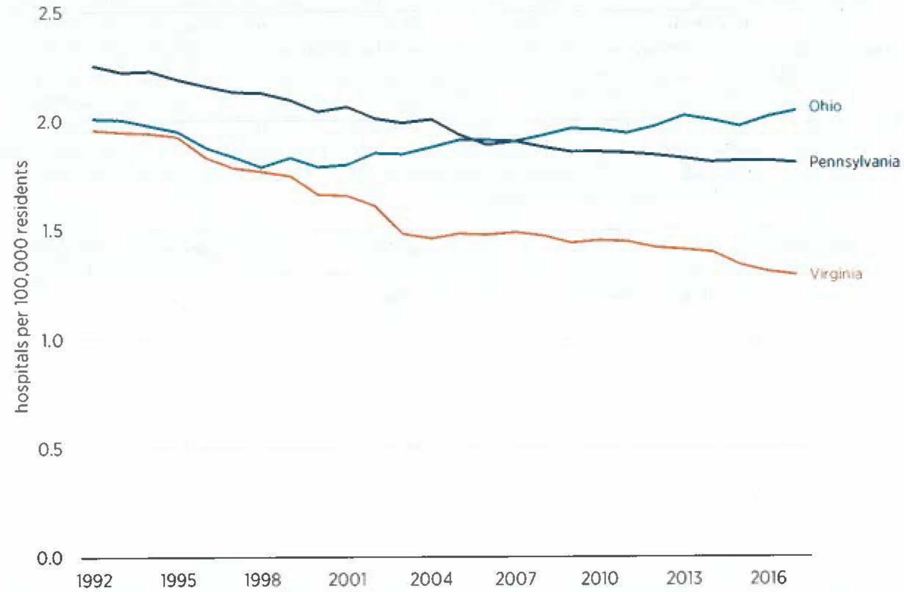
All of the evidence reviewed in table 1 was derived from point estimates in regression analyses. Though a regression is one of the best ways to assess the effect of a policy while controlling for other factors, it is not an intuitive concept for many. So to better illustrate the data behind these results, I have created four charts that show changes over time in healthcare facilities per capita in Virginia and the two states in the region with limited or no CON programs, Ohio and Pennsylvania. These states are illustrative because they are comparable in location, size, and socioeconomic makeup. The differences that do exist between these states would lead one to believe that Virginia has the advantage. For example, per capita personal income is higher in Virginia than in either Ohio or Pennsylvania, while poverty rates are lower in Virginia than in either of the other two states.[9]

As I have mentioned, Virginia regulates 20 different procedures and technologies. In contrast, Ohio's CON program regulates just one item, nursing home and long-term care beds, while Pennsylvania has no CON program at all, having repealed its program in 1996.

[9] For per capita income, see Bureau of Economic Analysis, "Personal Income, Population, Per Capita Personal Income, Disposable Personal Income, and Per Capita Disposable Income (SA1, SA51)," accessed April 10, 2018, https://www.bea.gov/iTable/iTable.cfm?reqid=70&step=1&isuri=1&acrdn=6#reqid=70&step=1&isuri=1&7022=21&7023=0&7033=-1&7024=non-industry&7025=0&7026=39000,42000,51000&7001=421&7027=2017,2016,2015,2014,2013,2012,2011,2010,2009,2008,2007,2006,2005,2004,2003,2002,2001,2000,1999,1998,1997,1996,1995,1994,1993,1992&7028=-1&7031=0. For poverty rates, see Jessica L. Semega, Kayla R. Fontenot, and Melissa A. Kollar, *Income and Poverty in the United States: 2016*, (Washington, DC: US Census Bureau, 2017).

Figure 1 shows hospitals per 100,000 residents. In Ohio, the number of hospitals per 100,000 residents rose slightly. Over the same period, in both Virginia and Pennsylvania, the number has fallen. In Virginia, however, the decline was sharper, falling 34 percent, compared with a 20 percent decline in Pennsylvania. On a per-resident basis, Virginia now has seven-tenths as many hospitals as Pennsylvania and a little more than six-tenths as many as Ohio.

FIGURE 1. HOSPITALS PER 100,000 RESIDENTS



Sources: Provider Data: US Centers for Medicare & Medicaid Services, "Provider of Services Current Files," accessed April 10, 2018, https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/. Population Data: US Census Bureau, "State Population Totals and Component of Change: 2010–2017," accessed April 20, 2018, https://www.census.gov/data/tables/2017/demo/popest/state-total.html.

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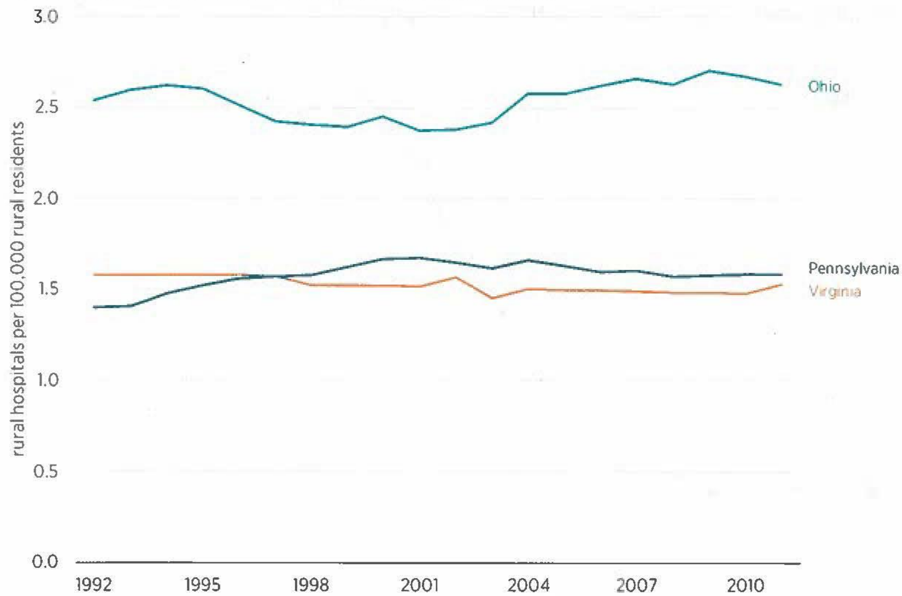
Figure 2 shows rural hospitals per 100,000 rural residents. Virginia not only has fewer rural hospitals per rural resident than either of the other two states; it is the only one of the three that has seen a decline in that figure over time.

FIGURE 2. RURAL HOSPITALS PER 100,000 RURAL RESIDENTS



Sources: Provider Data: US Centers for Medicare & Medicaid Services, "Provider of Services Current Files," accessed April 10, 2018, https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/. Population Data: US Census Bureau, "Population and Housing Unit Estimates Tables," accessed April 10, 2018, https://www.census.gov/programs-surveys/popest/data/tables.html.

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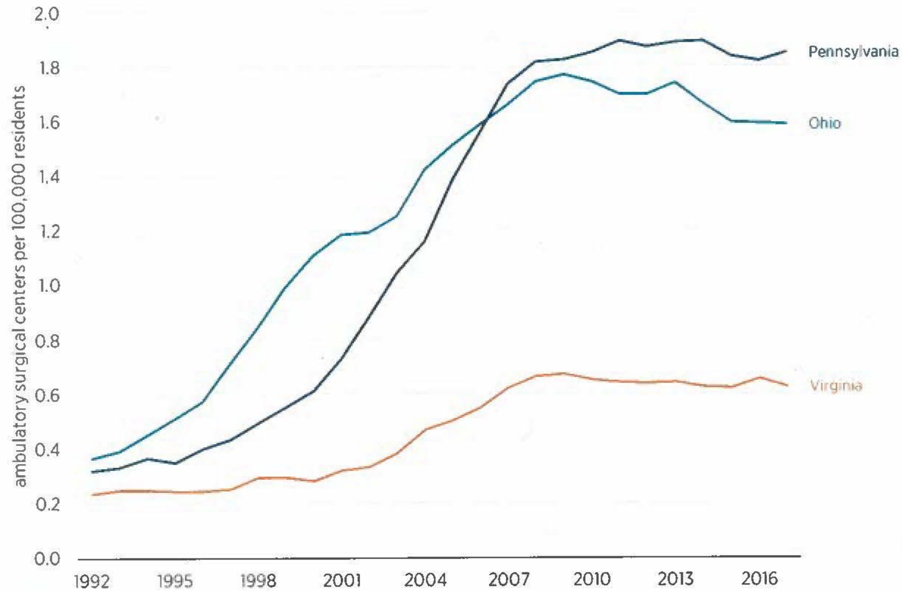
Figure 3 shows ambulatory surgical centers (ASCs) per 100,000 residents over time. In all three states, the number of these centers per resident has been rising. In Virginia—the only state of the three that regulates ASCs through COPN—the rise has been the most modest. On a per capita basis, Virginia has about one-third as many ASCs as Pennsylvania and four-tenths as many as Ohio.

FIGURE 3. AMBULATORY SURGICAL CENTERS PER 100,000 RESIDENTS



Sources: Provider Data: US Centers for Medicare & Medicaid Services, "Provider of Services Current Files," accessed April 10, 2018, https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/. Population Data: US Census Bureau, "State Population Totals and Component of Change: 2010–2017," accessed April 20, 2018, https://www.census.gov/data/tables/2017/demo/popest/state-total.html.

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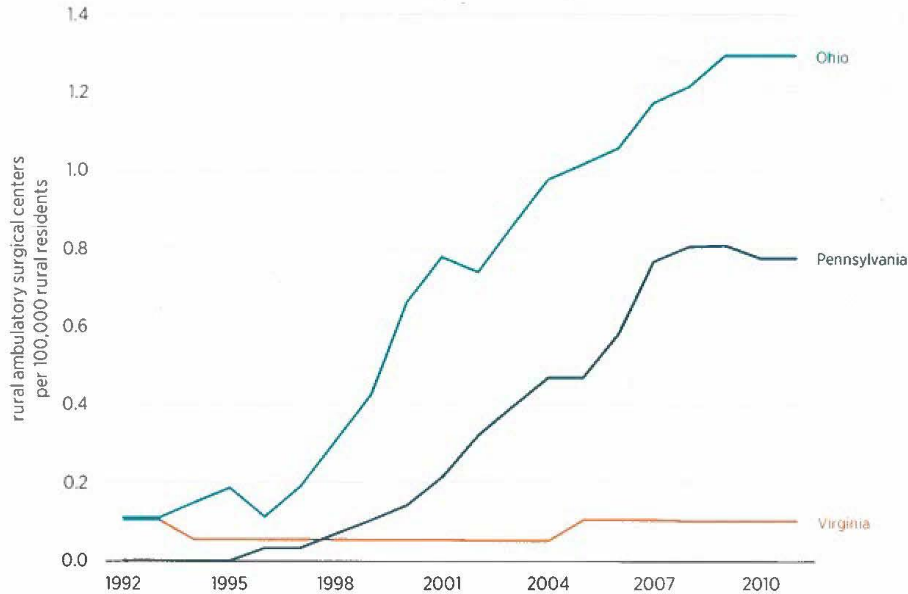
Figure 4 shows rural ASCs per 100,000 rural residents. Virginia is the only state of the three that has seen a decline in this figure over time. On a per-rural-resident basis, Virginia has one-eighth as many rural ASCs as Pennsylvania and one-twelfth as many as Ohio.

FIGURE 4. RURAL AMBULATORY SURGICAL CENTERS PER 100,000 RURAL RESIDENTS



Sources: Provider Data: US Centers for Medicare & Medicaid Services, "Provider of Services Current Files," accessed April 10, 2018, https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Provider-of-Services/. Population Data: US Census Bureau, "Population and Housing Unit Estimates Tables," accessed April 10, 2018, https://www.census.gov/programs-surveys/popest/data/tables.html.

None of these results should be surprising. CON laws are a restriction on the supply of facilities and services, and economic theory suggests that supply restrictions limit access to services while raising costs and undermining quality. Indeed—as shown in table 1—that is exactly what empirical studies of CON have consistently found.

CONCLUDING REMARKS

Given the substantial evidence that CON laws do not achieve their stated goals, one may wonder why these laws continue to exist in so much of the country. The explanation seems to lie in the special-interest theory of regulation.[10] Specifically, CON laws perform a valuable function for incumbent providers of healthcare services by limiting their exposure to new competition. Indeed, recent evidence

[10] This theory holds that regulations exist as a way to limit competition or raise rivals' costs, or both. See George J. Stigler, "The Theory of Economic Regulation," *Bell Journal of Economics and Management Science* 2, no. 1 (April 1, 1971): 3–21; Ernesto Dal Bó, "Regulatory Capture: A Review," *Oxford Review of Economic Policy* 22, no. 2 (June 20, 2006): 203–25; Matthew D. Mitchell, *The Pathology of Privilege: The Economic Consequences of Government Favoritism* (Arlington, VA: Mercatus Center at George Mason University, 2014).

suggests that special interests are able to use political donations to increase the odds that their CON requests will be granted.[11] This aspect of CON laws helps explain why economists as well as antitrust authorities have long argued that these regulations are anticompetitive and harmful to consumers.

For those who are interested in further details on the effects of CON on spending patterns, I have also attached my paper, "Do Certificate-of-Need Laws Limit Spending?" Like all Mercatus Center research, it has been through a rigorous, double-blind peer review process.

Thank you again for the opportunity to share my research with you. I look forward to answering any questions you may have.

Sincerely,

Matthew D. Mitchell, PhD

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Director, Project for the Study of American Capitalism
Mercatus Center at George Mason University

ATTACHMENT
"Do Certificate-of-Need Laws Limit Spending?" (Mercatus Working Paper)

[11] Thomas Stratmann and Steven Monaghan, "The Effect of Interest Group Pressure on Favorable Regulatory Decisions: The Case of Certificate-of-Need Laws" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, 2017).

Do Certificate-of-Need Laws Limit Spending?

Matthew D. Mitchell

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Matthew D. Mitchell. "Do Certificate-of-Need Laws Limit Spending?" Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, September 2016.

Abstract

In 35 states, certificate-of-need (CON) laws in health care restrict the supply of medical services. These regulations require providers hoping to open a new healthcare facility, expand an existing facility, or purchase certain medical equipment such as an MRI machine or a hospital bed to first prove to a regulatory body that their community needs the service in question. The approval process can be time consuming and expensive, and it offers incumbent providers an opportunity to oppose the entrance of new competitors. However, it was originally hoped that these laws would, among other things, reduce healthcare price inflation. In this brief, I review the basic economic theory of a supply restriction like CON, then summarize four decades of empirical research on the effect of CON on healthcare spending. There is no evidence that CON regulations limit healthcare price inflation and little evidence that they reduce healthcare spending. In fact, the balance of evidence suggests that CON laws are associated with higher per unit costs and higher total healthcare spending.

JEL codes: D72, D78, H75, I1, L51

Keywords: economics of regulation, certificate of need, supply constraints, regulatory capture, special interests, rent-seeking

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Do Certificate-of-Need Laws Limit Spending?

Matthew D. Mitchell

Economic Theory and the Original Rationale for Certificate of Need

Thirty-five states and the District of Columbia currently impose certificate-of-need (CON) restrictions on the provision of health care.[1] These rules require those hoping to open or expand specific types of healthcare facilities to first prove to a state regulator that their community "needs" the particular service. For example, Virginia providers wishing to open a neonatal intensive care unit, start a rehabilitation center, or even purchase a new CT scanner for an existing practice must first prove to the state health commissioner that their community needs the service in question.[2] Providers wait years and spend tens or even hundreds of thousands of dollars convincing CON authorities to approve their projects.[3] In the process, incumbent providers are often invited to testify against their would-be competitors. It was originally hoped that the CON process would reduce healthcare price inflation, though over the years, the rationale in favor of CON has shifted a number of times.

In 1964, New York implemented the first CON program.[4] A decade later, Congress enacted the National Health Planning and Resources Development Act, thereby withholding

[1] In some states, such as Virginia, these restrictions are known as a Certificate of Public Convenience and Necessity. In July 2016, New Hampshire eliminated its CON program. For more details about the history of CON programs in the states, see Matthew Mitchell and Christopher Koopman, "40 Years of Certificate-of-Need Laws across America," Mercatus Center at George Mason University, Arlington, VA, October 14, 2014.
[2] "CON—Certificate of Need State Laws" (Washington, DC: National Conference of State Legislatures, August 2016), http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx.
[3] Virginia's Dr. Mark Monteferrante spent five years and $175,000 seeking permission to add a second MRI machine to his practice. Kent Hoover, "Doctors Challenge Virginia's Certificate-of-Need Requirement," *Washington Bureau*, *Business Journals*, June 5, 2012.
[4] Mitchell and Koopman, "40 Years of Certificate-of-Need Laws across America."

federal healthcare dollars from any state that failed to implement its own CON program.[5] By 1979, every state except Louisiana had responded to this incentive and implemented a CON program.[6] The federal incentive was repealed in 1987 following a change in Medicare reimbursement practices, and more than a dozen states have since repealed their CON programs. But in 35 states and the District of Columbia, CON laws still restrict the supply of some healthcare services.

The rationale behind the 1974 federal legislation was clear. Under a section titled "Findings and Purpose," Congress declared,

> The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the *cost* of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.[7]

Note the emphasis on cost. From the beginning, a primary goal of CON programs was to rein in the excessive growth of healthcare costs.[8] Then, as now, healthcare price inflation was a perennial concern. Note also that the authors of this legislation believed healthcare price inflation to be a result of other federal policies. In what way might a law restricting supply reduce cost? I begin with a simple economic model of supply and demand and then consider three slightly more elaborate models.

[5] National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641 (1975).
[6] Mitchell and Koopman, "40 Years of Certificate-of-Need Laws across America."
[7] Pub. L. No. 93-641, emphasis added.
[8] For research testing CON's ability to meet the other goals of the National Health Planning and Resources Development Act, see Thomas Stratmann and Jacob Russ, "Do Certificate-of-Need Laws Increase Indigent Care?," Mercatus Working Paper No. 14-20, Mercatus Center at George Mason University, Arlington, VA, July 2014; Thomas Stratmann and Matthew C. Baker, "Are Certificate-of-Need Laws Barriers to Entry? How They Affect Access to MRI, CT, and PET Scans," Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, January 2016; Thomas Stratmann and Christopher Koopman, "Entry Regulation and Rural Health Care: Certificate-of-Need Laws, Ambulatory Surgical Centers, and Community Hospitals," Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, February 2016.

The Simple Model of Supply and Demand

In everyday language, we speak of cost in *per unit* terms: How much does one slice of pizza cost? What is the going rate for a gallon of unleaded gasoline? Simple economic theory offers a straightforward answer to the question of how a supply restriction might reduce this sort of cost: it can't. In a supply-and-demand model, there is no way that a supply restriction can reduce per unit cost. It *might* reduce overall healthcare expenditures—the total amount that people spend on health care in a given time period. But although reducing per unit cost is a worthy goal, it is far from obvious that reducing overall expenditures is desirable. Figure 1 explains why.

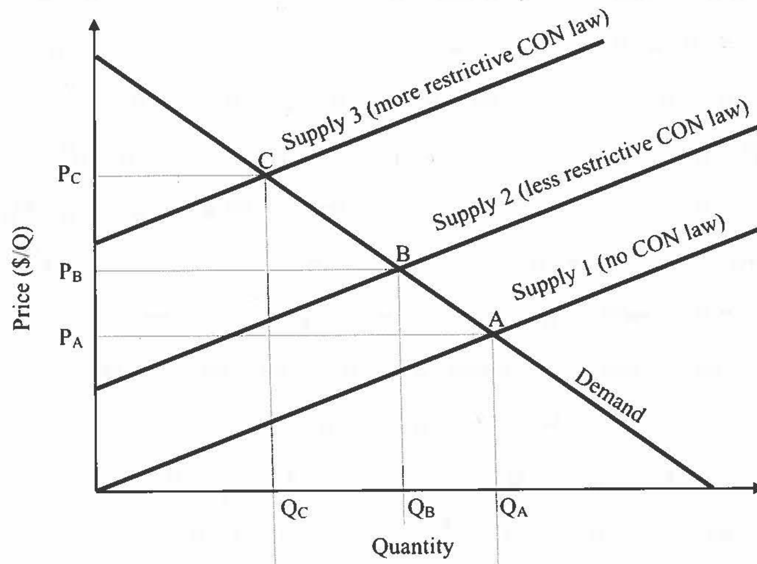
Panel A of figure 1 shows a demand curve intersected by three different supply curves. The market supply of health care without a CON law is indicated by Supply 1. The restricted supply of health care with a CON law is indicated by *either* Supply 2 or Supply 3, with the difference depending on how restrictive the CON process is. Consistent with standard practice, the supply restriction is modeled as a leftward shift in the supply curve; by limiting entry, CON laws ensure that a smaller quantity of services is available at any given price.

Note that as supply is restricted, the per unit price unambiguously rises, and the quantity consumed unambiguously falls. Because the supply restriction causes consumers to pay more and consume less, it unambiguously reduces what economists call "consumer surplus," which is the value that consumers derive from a product in excess of its price.[9]

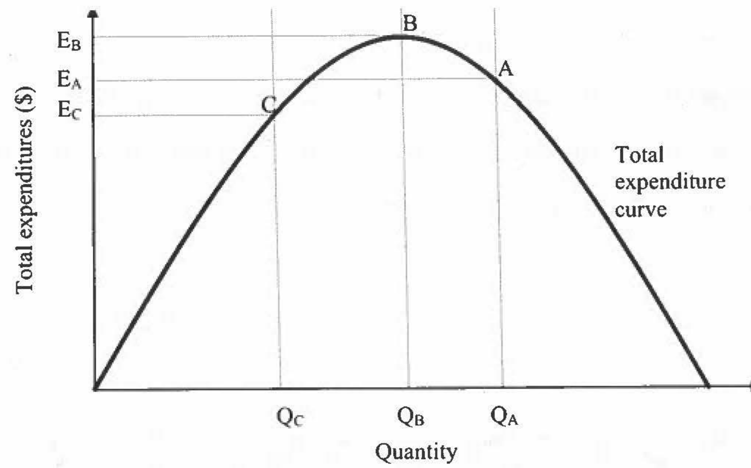
[9] Consumer surplus is measured by the area above the price line and below the demand curve. It gets smaller as supply decreases (shifts leftward). Total producer surplus, measured by the area below the price line and above the supply curve, is also reduced. However, a supply restriction may make a few firms better off by allowing them to capture a larger *portion* of the producer surplus at the expense of other producers. This artificially large portion of producer surplus is known as rent.

Figure 1. A Supply Restriction

Panel A. The Effect of a Supply Restriction on Price



Panel B. The Effect of a Supply Restriction on Total Expenditures



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However, because of the third-party-payer problem in health care, patients may not directly pay the higher prices. They and others will indirectly pay higher prices through higher insurance premiums, higher taxes, or both. Patients will, of course, be directly affected by the diminished quantity of healthcare services available to them. That is, they will experience a reduction in welfare resulting from the leftward shift in the quantity of services.

Note, however, that the supply restriction has an *ambiguous* effect on total expenditures. This is because total expenditures—depicted in panel B of figure 1—are equal to the price per unit multiplied by the number of units sold. Because the supply restriction raises the price per unit but lowers the number of units sold, it has an ambiguous effect on total expenditure.

As shown in panel B, total expenditures might rise to E_B or fall to E_C, depending on whether the price increase or the quantity decrease dominates.[10] Note also that if consumers are less price sensitive and the demand curve is steeper (less elastic), the price-increasing effect is likely to dominate, and the supply restriction is likely to increase total expenditures.

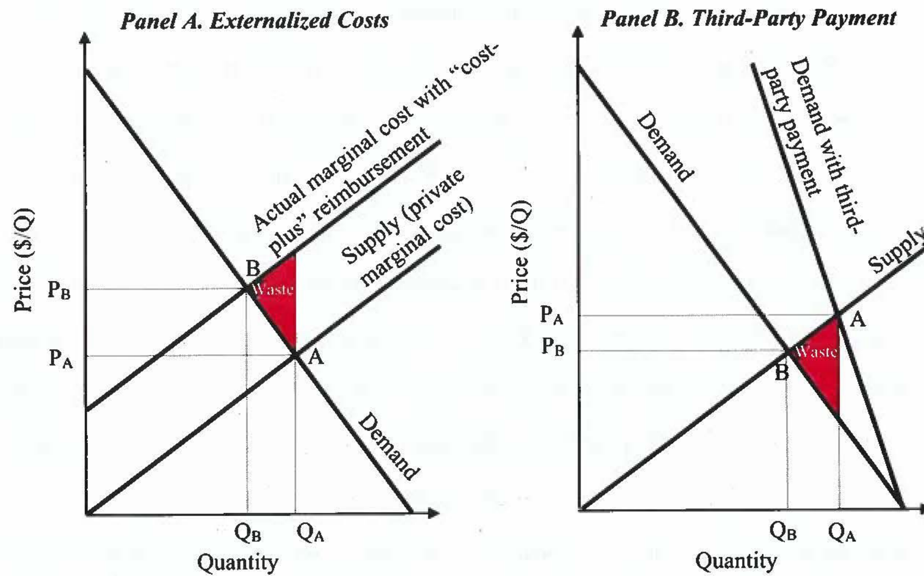
Despite the stated objective of the federal legislation promoting CON, this simple model suggests that CON laws cannot reduce cost in the per unit sense in which most people think of it. Instead, CON laws are expected to increase the per unit cost of healthcare services, although they *might* reduce total expenditures if they restrict consumption enough to outweigh the higher per unit cost. It is important to note, however, that if CON laws do succeed in reducing overall expenditures, they do so only by restricting the availability of services, limiting consumer choice, and reducing consumer welfare.

[10] The answer depends on whether the original, nonrestricted supply curve intersects the demand curve in the elastic portion, above and to the left of B, or in the inelastic portion, below and to the right of B.

Externalities

A more complex model might account for the fact that other public policies have distorted the healthcare market so that market participants are divorced from the true marginal costs of their decisions. In this case, a CON regulation might counteract the harm of such policies, but as we will see, it is hardly the most efficient means of doing so. Figure 2 depicts two ways that public policies might distort the healthcare market by creating an externality. I will consider each in turn.

Figure 2. Externalities



Cost-plus reimbursement. In panel A of figure 2, the equilibrium is at point A, where supply and demand intersect. If providers internalized all their costs, this equilibrium would be efficient because marginal cost would equal marginal benefit. But at the time that many states adopted

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CON, Medicare reimbursed hospitals for their costs on a "retrospective" basis. Healthcare researchers Stuart Guterman and Allen Dobson described this reimbursement practice in 1986: "Under this system, hospitals were paid whatever they spent; there was little incentive to control costs, because higher costs brought about higher levels of reimbursement."[11]

This reimbursement method was often referred to as a "cost-plus" system because it encouraged hospitals to overinvest in certain inputs. In other words, hospitals were able to externalize some of their costs of care and to pass them on to taxpayers. As a result, *actual* marginal costs were higher than the private marginal costs of hospitals.

These actual marginal costs are indicated by the marginal cost curve that sits above the supply curve in the left panel of figure 2. With this sort of reimbursement system, the efficient production point would be at point B, where true marginal cost equals marginal benefit. But because firms fail to internalize all costs, the actual equilibrium is at point A, resulting in what economists call a "deadweight loss." This deadweight loss is depicted by the red triangle and is labeled "Waste." It indicates that for the quantity of units of health care between Q_B and Q_A, marginal cost exceeds marginal benefit.

Under this type of reimbursement system, CON laws—by restricting supply—might be one way to move the market toward the more efficient outcome (Q_B). A more straightforward solution, however, would be to change the way Medicare reimburses hospitals. Indeed, Congress pursued this straightforward solution more than 30 years ago with the adoption of Public Law 98-21.[12]

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[11] Stuart Guterman and Allen Dobson, "Impact of the Medicare Prospective Payment System for Hospitals," *Health Care Financing Review* 7, no. 3 (Spring 1986): 97–114.
[12] Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65 (1983).

That legislation phased in Medicare's Prospective Payment System, thus ending retrospective, cost-plus reimbursement. Therefore, the externalized-costs rationale for CON has not been relevant for decades. As Mark Botti, an official in the Antitrust Division of the Department of Justice, noted in 2007 testimony before the Georgia State Assembly,

> We [antitrust officials at the Department of Justice and the Federal Trade Commission] made that recommendation [that states rethink their CON laws] in part because the original reason for the adoption of CON laws is no longer valid. Many CON programs trace their origins to a repealed federal mandate, the National Health Planning and Resources Development Act of 1974, which offered incentives for states to implement CON programs. At the time, the federal government and private insurance reimbursed healthcare expenses predominantly on a "cost-plus basis." This is a very important point. The original reason for CON laws was not, as some have argued, that competition inherently does not work in healthcare or that market forces promote over-investment. Instead, CON laws were desired because the reimbursement mechanism, i.e., cost-plus reimbursement, incentivized over-investment. The hope was that CON laws would compensate for that skewed incentive. . . . CON laws appear not to have served well even their intended purpose of containing costs. Several studies examined the effectiveness of CONs in controlling costs. The empirical evidence on the economic effects of CON programs demonstrated near-universal agreement among health economists that CON laws were unsuccessful in containing healthcare costs.
>
> In addition to the fact that CON laws have been ineffective in serving their original purpose, CON laws should be reexamined because the reimbursement methodologies that may in theory have justified them initially have changed significantly since the 1970s. The federal government no longer reimburses on a cost-plus basis.[13]

Indeed, it is instructive to note that Congress eliminated the incentive for states to implement CON regulations in 1987, one year after Medicare's new reimbursement practice was fully phased in.

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[13] Mark J. Botti, "Competition in Healthcare and Certificates of Need" (Testimony before a Joint Session of the Health and Human Services Committee of the State Senate and the CON Special Committee of the State House of Representatives of the General Assembly of the State of Georgia, US Department of Justice Antitrust Division, Washington, DC, February 23, 2007). In support of his claim that economists were in "near-universal agreement" that CON laws failed to contain healthcare costs, Botti cites David S. Salkever, "Regulation of Prices and Investment in Hospitals in the United States," in *Handbook of Health Economics*, ed. A. J. Culyer and J. P. Newhouse, vol. 1B (New York: Elsevier, 2000), 1489–1535.

The third-party-payer problem. Although policymakers long ago addressed the problem of externalized costs by abandoning cost-plus reimbursement, market participants might be divorced from true marginal cost in another way. Third parties such as governments and insurance companies cover some or all of the costs of decisions made by patients and their providers, and because patients fail to pay the full costs of their decisions, their demand for healthcare services is greater and less price sensitive than it otherwise would be.

Governments currently pay about 64 cents out of every healthcare dollar spent in the United States.[14] But even when taxpayers don't pick up the bill, public policy encourages third-party payment through private insurance. During World War II, wage and price controls prevented employers from paying their employees the prevailing market wage. To attract talented workers, some employers offered fringe benefits such as health insurance because those benefits were not limited by the wage controls. After the controls were lifted, Congress found it difficult to remove the favorable tax treatment of health insurance, and it has remained untaxed ever since.[15]

This favorable tax treatment of health insurance encourages employers to compensate their employees with more (untaxed) benefits and less (taxed) cash. And this arrangement has long been blamed for introducing various distortions to the healthcare market.[16] Among other things, this policy has exacerbated the third-party-payer problem by changing the nature of health insurance. Traditionally, insurance covers low-probability, high-cost events such as death,

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[14] David U. Himmelstein and Steffie Woolhandler, "The Current and Projected Taxpayer Shares of US Health Costs," *American Journal of Public Health* 106, no. 3 (March 1, 2016): 449–52.
[15] Rexford E. Santerre and Stephen P. Neun, *Health Economics: Theory, Insights, and Industry Studies*, 5th ed. (Mason, OH: South-Western Publishing, 2010), 316; Milton Friedman, "Pricing Health Care: The Folly of Buying Health Care at the Company Store," *Wall Street Journal*, February 3, 1993.
[16] Martin Feldstein and Bernard Friedman, "Tax Subsidies, the Rational Demand for Insurance and the Health Care Crisis," *Journal of Public Economics* 7, no. 2 (April 1, 1977): 155–78; Jonathan Gruber, "The Tax Exclusion for Employer-Sponsored Health Insurance," *National Tax Journal* 64, no. 2 (2011): 511–30; Jeremy Horpedahl and Harrison Searles, "The Tax Exemption of Employer-Provided Health Insurance," Mercatus on Policy, Mercatus Center at George Mason University, Arlington, VA, September 2013.

accidents, or disease. But in the case of health insurance, favorable tax treatment and various regulatory mandates have caused health insurers to cover entirely predictable expenses such as checkups, screenings, immunizations, diet counseling, breastfeeding consultation, nutritional supplements, and much more.[17]

As a result, patients are able to purchase routine and entirely foreseeable health services while pushing some portion of the cost off onto others who pay insurance premiums. This arrangement has caused the effective demand for healthcare services to be greater and less price sensitive than it otherwise would be, thereby pivoting the demand curve out to the right.[18] This situation is depicted in panel B of figure 2. Here, the equilibrium is at point A, where the "Supply" curve intersects the "Demand with Third-Party Payment" curve. As in the case of externalized costs, the equilibrium is inefficient because marginal cost exceeds the marginal benefit, as indicated by the demand curve.

As in the case of externalized costs, policymakers *might* be able to correct this problem by restricting supply through CON programs, thus raising the price and getting consumers to internalize more of the cost. Note, however, that if this is the goal of CON regulation, it contradicts the *named* goal of reducing cost. Moreover, to do this properly, policymakers would need to estimate how much of the cost is externalized, as well as the degree to which private arrangements such as cost-sharing already correct for this problem.[19] Then they would need to shift the supply curve up by the exact amount of the externalized cost; if the shift were too little or too great, wasteful inefficiencies would remain.

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[17] Maureen Buff and Timothy Terrell, "The Role of Third-Party Payers in Medical Cost Increases," *Journal of American Physicians and Surgeons* 19, no. 2 (Summer 2014): 75–79.
[18] Santerre and Neun, *Health Economics: Theory, Insights, and Industry Studies*, 115–35.
[19] John V. C. Nye, "The Pigou Problem: It Is Difficult to Calculate the Right Tax in a World of Imperfect Coasian Bargains," *Regulation* 31, no. 2 (Summer 2008).

It is not clear that policymakers have the knowledge or the expertise to make this assessment—especially because their decisions are unguided by market signals.[20] Nor is it clear that CON is a precise enough tool to allow them to shift the supply curve the proper amount.

Those considerations aside, CON is hardly the most efficient or equitable way to address the third-party-payer problem. A far more direct approach would be to address the policies that encourage third-party payment in the first place, just as Congress once addressed the externalized cost problem by changing Medicare reimbursement practices.

If, for example, policymakers are concerned that patients are spending too much on health care, a straightforward approach would be to eliminate the tax privilege for employer-provided health insurance and to repeal the insurance mandates that require insurers to cover routine and foreseeable procedures. Doing so would cause the effective demand for health care to more closely resemble patients' actual marginal benefits.

In contrast, CON regulations restrict the ability of everybody to access medical services such as psychiatric care (regulated by CON procedures in 26 states), neonatal intensive care (regulated by 23 states), and MRI scans (regulated by 16 states).[21] This restriction means that all patients—even those who pay out of pocket and don't push costs onto third parties—have less access to valuable medical services.

Before I move on to the third theoretical model, one more point is worth emphasizing. Recall that in the previous section, I noted that a supply restriction would be more likely to increase total expenditures when demand was less elastic. Because the third-party-payer problem

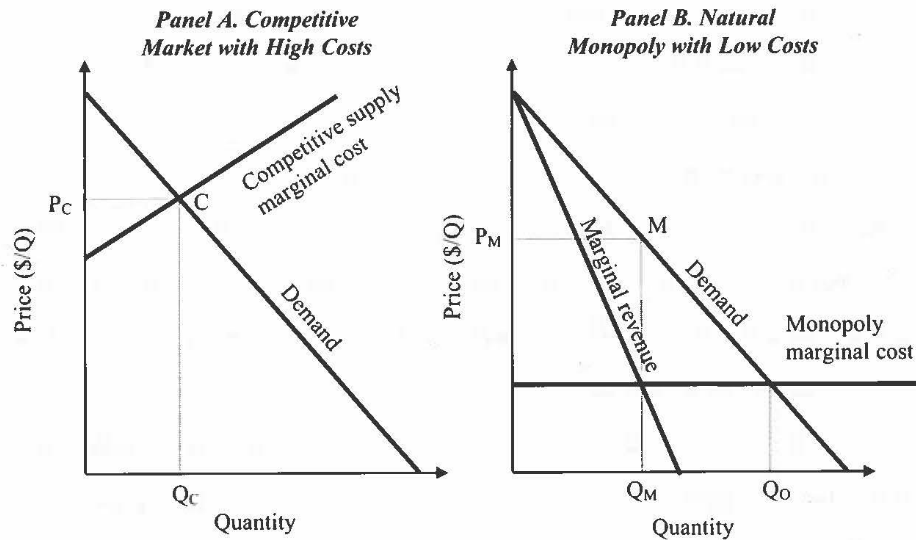
[20] F. A. Hayek, "The Use of Knowledge in Society," *American Economic Review* 35, no. 4 (September 1, 1945): 519–30; F. A. Hayek, "Competition as a Discovery Procedure," trans. Marcellus Snow, *Quarterly Journal of Austrian Economics* 5, no. 3 (Fall 2002): 9–23.
[21] For state CON regulations, see "CON—Certificate of Need State Laws."

tends to cause the effective demand curve to be less elastic than it otherwise would be, this model suggests that CON is likely to increase rather than decrease total expenditures.

Economies of Scale

Another slightly more complex model might posit that there are economies of scale in the provision of medical services and that a few hospitals or even one large hospital might be able to deliver care with a lower cost than can many smaller ones. This situation is depicted in figure 3.

Figure 3. Competition vs. Natural Monopoly



Panel A shows a competitive industry with comparatively high production costs. Because the industry is competitive, firms are unable to mark up the price. Therefore, they set the price at marginal cost P_C.

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Panel B shows a monopolist with comparatively low production costs. The monopolist uses its pricing power to set price above marginal cost, at P_M, but even this marked-up price is lower than that charged by the competitive firms, because the monopolist enjoys economies of scale in production.

It is possible that policymakers have this sort of model in mind. Perhaps by channeling more patients to a few hospitals, regulators may allow these individual hospitals to achieve some economies of scale. Relatedly, some policymakers have recently begun to argue that CON might allow these hospitals to increase the quality of their care by becoming more proficient in certain procedures.[22]

As health economists Robert Ohsfeldt and John Schneider observe, however, CON "is an unacceptably blunt instrument for quality enhancement in a sector as innovative and dynamic as health care," especially when there are more direct and effective ways to achieve the same end.[23] In any case, the most recent evidence suggests that, if anything, CON is associated with lower, not higher, quality.[24]

This natural monopoly theory has problems. For one thing, the model is most appropriate in industries such as power production that require large fixed-cost investments in plant but have low marginal costs of operation. This model is only somewhat descriptive of the healthcare

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[22] Mary S. Vaughan-Sarrazin et al., "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States with and without Certificate of Need Regulation," *Journal of the American Medical Association* 288, no. 15 (October 16, 2002): 1859–66.

[23] Robert L. Ohsfeldt and John E. Schneider, *The Business of Health: The Role of Competition, Markets, and Regulation* (Washington, DC: AEI Press, 2006), 39.

[24] More recent work, using better data and methods, fails to find a link between CON and quality. See Iona Popescu, Mary S. Vaughan-Sarrazin, and Gary E. Rosenthal, "Certificate of Need Regulations and Use of Coronary Revascularization after Acute Myocardial Infarction," *Journal of the American Medical Association* 295, no. 18 (May 10, 2006): 2141–47. For an overview, see Vivian Ho, Meei-Hsiang Ku-Goto, and James G. Jollis, "Certificate of Need (CON) for Cardiac Care: Controversy over the Contributions of CON," *Health Services Research* 44, no. 2, pt. 1 (April 2009): 483–500. Finally, for one of the best attempts to get at causation, see Thomas Stratmann and David Wille, "Certificate-of-Need Laws and Hospital Quality," Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, September 2016. They find that CON is associated with lower-quality care.

industry, where the marginal cost of healthcare providers' salaries is significant. Additionally, there is reason to believe that when firms are protected from competition, they will have higher, not lower, production costs because administrators will tend to be less disciplined about cost minimization.[25] These factors explain why hospital prices in monopoly markets are more than 15 percent higher than those in markets with four or more competitors.[26]

Most important, however, even if the natural monopoly model did describe the healthcare market, artificial restrictions on entry would be unlikely to improve conditions. The economist David Henderson explains why:

> Economists tend to oppose regulating entry. The reason is as follows: If the industry really is a natural monopoly, then preventing new competitors from entering is unnecessary because no competitor would want to enter anyway. If, on the other hand, the industry is not a natural monopoly, then preventing competition is undesirable. Either way, preventing entry does not make sense.[27]

In other words, as the name implies, a natural monopoly occurs naturally. If the market will bear only one firm, then policymakers need not artificially restrict entry.

The Interest-Group Model for CON

The preceding models have all been normative: they've focused on whether or not CON laws are desirable in the sense that they increase consumer welfare and efficiency. But perhaps the most informative models of CON are positive in the sense that they explain why CON programs exist irrespective of their desirability.

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[25] This finding is known as x-inefficiency. For more details, see Harvey Leibenstein, "Allocative Efficiency vs. 'X-Efficiency,'" *American Economic Review* 56, no. 3 (June 1, 1966): 392–415.
[26] Zack Cooper, Stuart V. Craig, Martin Gaynor, and John Van Reenen, "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured," NBER working paper, National Bureau of Economic Research, Cambridge, MA, December 2015.
[27] David R. Henderson, "Natural Monopoly," ed. David R. Henderson, *The Concise Encyclopedia of Economics* (Indianapolis, IN: Liberty Fund Inc., 2008).

Positive models stress that a CON law is a special privilege afforded to a particular interest group, namely the incumbent provider who benefits from a lack of competition. A large body of literature suggests that interest groups seeking special privileges through the political process have an advantage over the consumers and taxpayers who bear the costs of those privileges.

First, it takes time, money, and effort to get politically engaged. But, being few in number, the members of a special interest group typically find it easier than large, diffuse interests to organize for political action.[28]

Second, such groups tend to be well informed about their industry. Often, they are able to capitalize on voter ignorance and irrationality[29] or to use their superior knowledge of the industry to dominate the regulatory process, or both.[30]

Third, concentrated interest groups are often able to control the agenda, thus allowing them to steer committee outcomes to their benefit.[31]

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[28] Mancur Olson, *The Logic of Collective Action: Public Goods and the Theory of Groups*, Second Printing with New Preface and Appendix, Revised (Cambridge, MA: Harvard University Press, 1965); Jonathan Rauch, *Government's End: Why Washington Stopped Working* (New York: PublicAffairs, 1999).

[29] On voter ignorance, see Anthony Downs, *An Economic Theory of Democracy* (New York: Harper & Row, 1957); Geoffrey Brennan and Loren E. Lomasky, *Democracy and Decision: The Pure Theory of Electoral Preference* (Cambridge, UK: Cambridge University Press, 1997). On voter irrationality, see Bryan Caplan, *The Myth of the Rational Voter: Why Democracies Choose Bad Policies* (Princeton, NJ: Princeton University Press, 2008).

[30] George J. Stigler, "The Theory of Economic Regulation," *Bell Journal of Economics and Management Science* 2, no. 1 (April 1, 1971): 3–21; Richard A. Posner, "Theories of Economic Regulation," *Bell Journal of Economics and Management Science* 5, no. 2 (October 1, 1974): 335–58; Sam Peltzman, "Toward a More General Theory of Regulation," *Journal of Law and Economics* 19, no. 2 (August 1, 1976): 211–40; Ernesto Dal Bó, "Regulatory Capture: A Review," *Oxford Review of Economic Policy* 22, no. 2 (June 20, 2006): 203–25; Patrick A. McLaughlin, Matthew Mitchell, and Ethan Roberts, "When Regulation Becomes Privilege," Mercatus Center at George Mason University, Arlington, VA, forthcoming.

[31] On using control of the agenda to determine the outcome, see Duncan Black, "On the Rationale of Group Decision-Making," *Journal of Political Economy* 56, no. 1 (February 1, 1948): 23–34; Kenneth Joseph Arrow, *Social Choice and Individual Values* (New Haven: Yale University Press, 1951); Richard D McKelvey, "Intransitivities in Multidimensional Voting Models and Some Implications for Agenda Control," *Journal of Economic Theory* 12, no. 3 (June 1976): 472–82. On keeping certain items off the agenda, see Peter Bachrach and Morton S. Baratz, "Two Faces of Power," *American Political Science Review* 56, no. 4 (December 1, 1962): 947–52.

Fourth and finally, firms tend to get better at political activity the more they engage in it, giving incumbents a marked advantage over new entrants.[32]

All these factors explain why the CON process seems to favor incumbent firms through features such as steep application fees, long wait periods, and a notice-and-comment process that allows incumbents to argue against competition. They also explain why hospital lobbies typically support CON laws while federal antitrust authorities at the Justice Department and the Federal Trade Commission have long opposed them.[33]

If, as the interest group models imply, CON laws exist to serve special interests rather than the general interest, then those laws are especially costly. Figure 4 demonstrates why. The model assumes, for simplicity, that marginal costs are identical under competitive and monopolistic conditions. (This assumption is made for ease of explanation; it does not drive the analysis.)

Without CON, the market equilibrium would be at A, where marginal cost equals marginal benefit. If an incumbent provider is able to obtain a monopoly privilege through CON, however, then the provider will limit the quantity supplied and will charge a higher price. Standard economic theory predicts that the monopolist will charge price P_B because at that price, marginal revenue is equal to marginal cost, thus maximizing profit. This pricing results in a traditional monopoly deadweight loss, indicated by the red triangle.[34]

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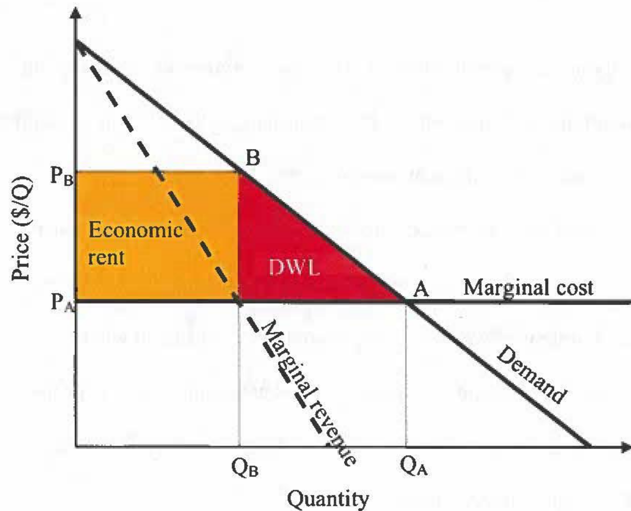
[32] Lee Drutman, *The Business of America Is Lobbying: How Corporations Became Politicized and Politics Became More Corporate* (New York: Oxford University Press, 2015).
[33] For one recent example, see Federal Trade Commission and US Department of Justice, "Joint Statement of the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250," January 2016, https://www.ftc.gov/policy/policy-actions/advocacy-filings/2016/01/joint-statement-federal-trade-commission-antitrust.
[34] Economists consider this an economic loss because consumers and would-be competitors lose more than the monopolist gains. For more details, see James R. Hines, "Three Sides of Harberger Triangles," NBER Working Paper 6852, National Bureau of Economic Research, Cambridge, MA, December 1998.

Figure 4. CON as a Special Interest



But there is a potential for further social losses. The monopolist's profit—which comes at the expense of consumers and would-be competitors—is indicated by the yellow rectangle and is known as "economic rent." Because this rent can represent a substantial economic profit, firms will be willing to invest scarce resources seeking it.[35] They will lobby, donate to political action committees, and alter their business models to satisfy political preferences. Not all those activities are legal. For example, according to federal prosecutors, former HealthSouth CEO Richard Scrushy paid former Alabama Governor Don Siegelman more than $500,000 for a seat

[35] Gordon Tullock, "The Welfare Costs of Tariffs, Monopolies, and Theft," *Western Economic Journal [Economic Inquiry]* 5, no. 3 (June 1, 1967): 224–32; Anne O. Krueger, "The Political Economy of the Rent-Seeking Society," *American Economic Review* 64, no. 3 (1974): 291–303.

on the state's certificate-of-need board. Both men were convicted of bribery (among other crimes) in June 2006.[36]

Illegal or not, this activity has an opportunity cost. This cost is known as "rent-seeking," and it can be enormously wasteful. Indeed, under the right circumstances, firms might be willing to invest more resources in rent-seeking than the rent is even worth.[37]

But this is only one of several costs of special-interest privilege.[38] For example, when firms can obtain anticompetitive privileges, entrepreneurial talents will be directed at seeking those privileges rather than developing new ways to please customers, resulting in what economists call "unproductive entrepreneurship."[39] This practice is especially costly over the long run because it robs an industry of the sort of entrepreneurial dynamism that characterizes healthy growth and because it locks in outdated business models.[40]

For these reasons, the special-interest theory of CON regulation suggests that CON laws will result in higher costs, lower quality, and less innovation.

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[36] Kyle Whitmire, "Ex-Governor and Executive Convicted of Bribery," *New York Times*, June 30, 2006.

[37] Known as "overdissipation," this outcome is possible when there are many rent-seekers and when there are increasing returns to political activity. Gordon Tullock, "Efficient Rent Seeking," in *Toward a Theory of the Rent-Seeking Society*, ed. James M. Buchanan, Robert D. Tollison, and Gordon Tullock (College Station: Texas A&M University Press, 1980), 97–112; Dennis C. Mueller, *Public Choice III*, 3rd ed. (Cambridge, UK: Cambridge University Press, 2003), 331–37. For evidence that there are increasing returns to political activity, see Drutman, *The Business of America Is Lobbying*; Matthew Mitchell, "Of Rent-Seekers and Rent-Givers," review of *The Business of America Is Lobbying*, by Lee Drutman, Library of Law and Liberty, December 14, 2015.

[38] Matthew Mitchell, *The Pathology of Privilege: The Economic Consequences of Government Favoritism* (Arlington, VA: Mercatus Center at George Mason University, 2012).

[39] William J. Baumol, "Entrepreneurship: Productive, Unproductive, and Destructive," *Journal of Political Economy* 98, no. 5 (October 1, 1990): 893–921.

[40] Kevin M. Murphy, Andrei Shleifer, and Robert W. Vishny, "The Allocation of Talent: Implications for Growth," *Quarterly Journal of Economics* 106, no. 2 (May 1, 1991): 503–30; Kevin Murphy, Andrei Shleifer, and Robert Vishny, "Why Is Rent-Seeking So Costly to Growth?," *American Economic Review Papers and Proceedings* 83, no. 2 (1993): 409–14; Stephen L. Parente and Edward C. Prescott, *Barriers to Riches*, repr. ed. (Cambridge, MA: MIT Press, 2002); Adam Thierer, *Permissionless Innovation: The Continuing Case for Comprehensive Technological Freedom* (Arlington, VA: Mercatus Center at George Mason University, 2014).

Summary of the Economic Theory

In this section, I have reviewed several economic models of a supply restriction such as CON. None of those theories suggest that a CON regulation will decrease healthcare prices. Instead, theory predicts that a CON regulation will raise per unit cost, limit the supply of healthcare services, reduce consumer welfare, and lead to the misallocation of resources in rent-seeking activity.

Theory suggests that CON laws might reduce healthcare expenditures if the effects of the quantity reduction outweigh the effects of the price increases. But this theory would only hold if the demand for health care were relatively elastic, which is unlikely given the third-party-payer problem. CON regulations might mitigate a policy-induced externality, but they are hardly the most efficient or equitable means of doing so.

In the next section, I turn to the data and examine 40 years of empirical studies on the effects of CON on spending.

What Do the Data Show?

Table 1 reports the empirical literature assessing the effect of CON on various spending outcomes. For ease of reference, the studies are divided into four categories: (1) the effect of CON on cost per procedure, price, or charge; (2) the effect of CON on total expenditures; (3) the effect of CON on efficiency; and (4) the effect of CON on investment. Studies that assess CON along multiple spending outcomes appear more than once in the table. The scope of the analysis is limited to only published, peer-reviewed papers, and it encompasses 20 studies spanning the course of 40 years.[41]

[41] Being focused on published, peer-reviewed papers, the table omits some high-quality government reports that were prepared by academics. Those reports are consistent with the findings reported in the table. See, for example, Daniel Sherman, "The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis," Staff Report of the Bureau of Economics, Federal Trade Commission, Washington, DC, January 1988; Christopher J. Conover and Frank A. Sloan, "Evaluation of Certificate of Need in Michigan," Report to the Michigan Department of Community Health (Durham, NC: Duke University Center for Health Policy, Law, and Management, May 2003), http://ushealthpolicygateway.com/wp-content/uploads/2009/07/mi-con-intro-iii.pdf.

Table 1. Empirical Studies of CON and Spending

Author(s)	Year	Title	Publication	Effect of CON on cost/price/investment/efficiency	Quotes
Effect of CON on per unit costs, prices, or charges					
Noether	1988	"Competition among Hospitals"	*Journal of Health Economics*	CON increases the average price for specific disease categories such as congestive heart failure and pneumonia.	"CON's strongest effect is that it creates cost-raising inefficiencies which are passed on in higher prices."
Grabowski, Ohsfeldt, and Morrisey	2003	"The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures"	*Inquiry: The Journal of Medical Care Organization, Provision, and Financing*	CON repeal has no statistically significant effect on per diem Medicaid nursing home charges or per diem Medicaid long-term-care charges.	"The results . . . show that regulatory change did not have a statistically significant effect on either Medicaid payment rates or overall days."
Ho and Ku-Goto	2013	"State Deregulation and Medicare Costs for Acute Cardiac Care"	*Medical Care Research and Review*	Removing CON decreases the cost of some procedures.	"We found that states that dropped CON experienced lower costs per patient for coronary artery bypass grafts (CABG) but not for percutaneous coronary intervention (PCI)."
Bailey	2016	"Can Health Spending Be Reined In through Supply Constraints? An Evaluation of Certificate of Need Laws"	Mercatus Working Paper, Mercatus Center at George Mason University	Removing CON reduces hospital charges by 5.5% five years after repeal.	"CON repeal . . . is associated with . . . a statistically significant 1.1% reduction in average hospital charges per year (a 5.5% reduction for a mature CON repeal)."
Effect of CON on expenditures					
Sloan and Steinwald	1980	"Effects of Regulation on Hospital Costs and Input Use"	*Journal of Law and Economics*	Comprehensive CON programs have no effect on hospital expenditures per patient day, while noncomprehensive programs increase hospital expenditures per patient day.	"The short-run effect of a mature, noncomprehensive program is to raise total expense per adjusted patient day by nearly 5 percent; the long-run effect is over twice this."
Sloan	1981	"Regulation and the Rising Cost of Hospital Care"	*Review of Economics and Statistics*	CON has no effect on hospital expenditures per admission, per patient day, or per adjusted patient day.	"The certificate-of-need coefficients imply CON has had no impact on costs."
Lanning, Morrisey, and Ohsfeldt	1991	"Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures"	*Journal of Regulatory Economics*	CON increases per capita hospital, nonhospital, and total health expenditures.	". . . the coefficient of CON is positive and statistically significant in all three expenditure equations. The most pronounced effect is on hospital expenditures, where CON appears to add 20.6 percent to per capita hospital expenditures in the long run. This is consistent with the view that CON programs act to protect inefficient hospitals from competition."

Antel, Ohsfeldt, and Becker	1995	"State Regulation and Hospital Costs"	*Review of Economics and Statistics*	CON increases per-day and per-admission hospital expenditures but has no relationship to per capita hospital expenditures.	"CON investment controls imply higher per day and per admission costs, but have no statistically significant effect on per capita cost."
Conover and Sloan	1998	"Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?"	*Journal of Health Politics, Policy, and Law*	CON has no effect on total per capita health expenditures; there is no evidence of a surge in spending after repeal.	"Mature CON programs are associated with a modest (5 percent) long-term reduction in acute care spending per capita, but not with a significant reduction in total per capita spending. There is no evidence of a surge in acquisition of facilities or in costs following removal of CON regulations."
Miller, Harrington, and Goldstein	2002	"Access to Community-Based Long-Term Care: Medicaid's Role"	*Journal of Aging and Health*	CON increases per capita Medicaid community-based care expenditures.	"Use of a nursing home CON or combined CON/moratorium was associated with increased community-based care expenditures."
Grabowski, Ohsfeldt, and Morrisey	2003	"The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures"	*Inquiry: The Journal of Medical Care Organization, Provision, and Financing*	CON repeal has no statistically significant effect on either aggregate Medicaid nursing-home or aggregate Medicaid long-term-care expenditures.	"Using aggregate state-level data from 1981 through 1998, this study found that states that repealed their CON and moratorium laws had no significant growth in either nursing home or long-term care Medicaid expenditures"
Rivers, Fottler, and Younis	2007	"Does Certificate of Need Really Contain Hospital Costs in the United States?"	*Health Education Journal*	CON laws increase hospital expenditures per adjusted admission.	"The results indicate that CON laws had a positive, statistically significant relationship to hospital costs per adjusted admission. . . .These findings suggest not only that CON do not really contain hospital costs, but may actually increase them by reducing competition."
Hellinger	2009	"The Effect of Certificate-of-Need Laws on Hospital Beds and Healthcare Expenditures: An Empirical Analysis"	*American Journal of Managed Care*	CON is associated with fewer hospital beds, which in turn are associated with slower growth in aggregate health expenditures per capita. But there is no direct relationship between CON and health expenditures per capita.	"Certificate-of-need programs did not have a direct effect on healthcare expenditures. . . . Certificate-of-need programs have limited the growth in the supply of hospital beds, and this has led to a slight reduction in the growth of healthcare expenditures."
Rivers, Fottler, and Frimpong	2010	"The Effects of Certificate of Need Regulation on Hospital Costs"	*Journal of Health Care Finance*	Stringent CON programs increase hospital expenditures per admission.	"Implications from these results include the inability of CNR [CON] to contain HC [hospital costs] as assumed or expected, and the possibility that CNR [CON] may actually increase HC [hospital costs], while reducing competition."
Rahman et al.	2016	"The Impact of Certificate-of-Need Laws on Nursing Home and Home Health Care Expenditures"	*Medical Care Research and Review: MCRR*	CON increases the growth in Medicare and Medicaid expenditures on nursing home care but decreases growth in home healthcare expenditures.	"Compared with states without CON laws, Medicare and Medicaid spending in states with CON laws grew faster for nursing home care and more slowly for home health care."

Bailey	2016	"Can Health Spending Be Reined In through Supply Constraints? An Evaluation of Certificate of Need Laws"	Mercatus Working Paper, Mercatus Center at George Mason University	CON is associated with higher overall per capita healthcare expenditures and with higher per capita Medicare expenditures.	"CON increases total health spending [per capita] by a statistically significant 3.1%. Increases are especially high for spending on physician care—a statistically significant 5.0%. . . . CON is estimated to increase overall Medicare spending [per capita] by a statistically significant 6.9%."
Effect of CON on Hospital Efficiency					
Eakin	1991	"Allocative Inefficiency in the Production of Hospital Services"	*Southern Economic Journal*	CON hospitals are less efficient than non-CON hospitals.	". . . hospitals subject to CON regulations have a greater measure of allocative inefficiency by .88 to 1.03 percentage points."
Bates, Mukherjee, and Santerre	2006	"Market Structure and Technical Efficiency in the Hospital Services Industry: A DEA Approach"	*Medical Care Research and Review*	CON hospitals are not any less efficient than non-CON hospitals.	"Evidence also implies that the presence of a state certificate-of-need law was not associated with a greater degree of inefficiency in the typical metropolitan hospital services industry."
Ferrier, Leleu, and Valdmanis	2010	"The Impact of CON Regulation on Hospital Efficiency"	*Health Care Management Science*	CON hospitals are more efficient than non-CON hospitals.	"In general, we found that the hospital sector in states with active CON regulations performed better in terms of aggregate technical and mix efficiency, irrespective of the stringency or laxness of this oversight."
Rosko and Mutter	2014	"The Association of Hospital Cost-Inefficiency with Certificate-of-Need Regulation"	*Medical Care Research and Review*	CON hospitals are more efficient than non-CON hospitals.	"Average estimated cost-inefficiency was less in CON states (8.10%) than in non-CON states (12.46%)."
Effect of CON on Investment					
Salkever and Bice	1976	"The Impact of Certificate of Need Controls on Hospital Investment"	*Milbank Memorial Fund Quarterly: Health and Society*	CON does not decrease investment but does change its composition.	"CON did not reduce the total dollar volume of investment but altered its composition, retarding expansion in bed supplies but increasing investment in new services and equipment."
Hellinger	1976	"The Effect of Certificate-of-Need Legislation on Hospital Investment"	*Inquiry: The Journal of Medical Care Organization, Provision, and Financing*	CON legislation induced hospitals to increase investments.	"The empirical results support the hypotheses that [CON] legislation has not significantly lowered hospital investment and that hospitals anticipated the effect of [CON] legislation by increasing investment in the period preceding the enactment of the legislation."

Per Unit Costs, Prices, and Charges

The first four studies summarized in table 1 address the idea of cost as it is commonly used in everyday language.[42] Those studies assess the effect of CON on *per unit* costs, prices, or charges (a charge is the initial amount that the payer is billed, whereas a price is the amount that the payer actually pays after negotiation).[43]

As noted in the previous section, economic theory suggests that a supply restriction is likely to increase per unit costs and prices. And, indeed, the empirical evidence is consistent with this prediction. Three of these four studies found CON to be associated with higher per unit prices, costs, or charges, while the fourth—which focused only on per diem Medicaid charges for nursing-home and long-term care—found that repeal of CON had no statistically significant effect on those charges.[44]

One study found that "CON's strongest effect is that it creates cost-raising inefficiencies which are passed on in higher prices."[45] Another found that removing CON decreased the per unit cost of coronary artery bypass grafts, though not the cost of percutaneous coronary intervention.[46] The most recent study found that average hospital charges fell 1.1 percent per

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[42] Monica Noether, "Competition among Hospitals," *Journal of Health Economics* 7, no. 3 (September 1988): 259–84; David C. Grabowski, Robert L. Ohsfeldt, and Michael A. Morrisey, "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures," *Inquiry: The Journal of Medical Care Organization, Provision, and Financing* 40, no. 2 (2003): 146–57; Vivian Ho and Meei-Hsiang Ku-Goto, "State Deregulation and Medicare Costs for Acute Cardiac Care," *Medical Care Research and Review* 70, no. 2 (April 2013): 185–205; James Bailey, "Can Health Spending Be Reined In through Supply Constraints? An Evaluation of Certificate-of-Need Laws," Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, July 2016.

[43] Although prices are more important, economically, charges are easier to observe. For more details, see Bailey, "Can Health Spending Be Reined In through Supply Constraints?"

[44] The three studies that found CON increases prices, charges, or per unit costs were Noether, "Competition among Hospitals"; Ho and Ku-Goto, "State Deregulation and Medicare Costs for Acute Cardiac Care"; and Bailey, "Can Health Spending Be Reined In through Supply Constraints?" The study that failed to find any statistically significant effect was Grabowski, Ohsfeldt, and Morrisey, "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures."

[45] Noether, "Competition among Hospitals."

[46] Ho and Ku-Goto, "State Deregulation and Medicare Costs for Acute Cardiac Care."

year for each of the five years following repeal of CON; in other words, five years following repeal, the charges were 5.5 percent lower than they would otherwise have been.[47]

Expenditures

The next 12 studies in table 1 assess the effect of CON on healthcare expenditures or on the growth of those expenditures, usually measured on a per capita basis.[48] In other words, the studies assess the effect of CON on the total amount that is spent on a patient or state resident, rather than on the price per unit of service. In this sense, those studies are comparable to the effect described in panel B of figure 1.[49] As noted previously, that theoretical framework shows that a supply restriction such as CON might lead to either more spending or less spending, depending on whether the price-raising effect or quantity-reducing effect of the supply restriction dominates.

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[47] Bailey, "Can Health Spending Be Reined In through Supply Constraints?"

[48] Frank A. Sloan and Bruce Steinwald, "Effects of Regulation on Hospital Costs and Input Use," *Journal of Law and Economics* 23, no. 1 (1980): 81–109; Frank A. Sloan, "Regulation and the Rising Cost of Hospital Care," *Review of Economics and Statistics* 63, no. 4 (1981): 479–87; Joyce A. Lanning, Michael A. Morrisey, and Robert L. Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures," *Journal of Regulatory Economics* 3, no. 2 (June 1991): 137–54; John J. Antel, Robert L. Ohsfeldt, and Edmund R. Becker, "State Regulation and Hospital Costs," *Review of Economics and Statistics* 77, no. 3 (1995): 416–22; Christopher J. Conover and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?," *Journal of Health Politics, Policy, and Law* 23, no. 3 (June 1, 1998): 455–81; Nancy A. Miller, Charlene Harrington, and Elizabeth Goldstein, "Access to Community-Based Long-Term Care: Medicaid's Role," *Journal of Aging and Health* 14, no. 1 (February 2002): 138–59; Grabowski, Ohsfeldt, and Morrisey, "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures"; Patrick A. Rivers, Myron D. Fottler, and Mustafa Zeedan Younis, "Does Certificate of Need Really Contain Hospital Costs in the United States?," *Health Education Journal* 66, no. 3 (September 1, 2007): 229–44; Fred J. Hellinger, "The Effect of Certificate-of-Need Laws on Hospital Beds and Healthcare Expenditures: An Empirical Analysis," *American Journal of Managed Care* 15, no. 10 (October 2009): 737–44; Patrick A. Rivers, Myron D. Fottler, and Jemima A. Frimpong, "The Effects of Certificate of Need Regulation on Hospital Costs," *Journal of Health Care Finance* 36, no. 4 (2010): 1–16; Momotazur Rahman et al., "The Impact of Certificate-of-Need Laws on Nursing Home and Home Health Care Expenditures," *Medical Care Research and Review: MCRR* 73, no. 1 (February 2016): 85–105; Bailey, "Can Health Spending Be Reined In through Supply Constraints?"

[49] It is not uncommon for such papers to use the term *cost*, but their focus is on expenditure in the sense that they are looking at total spending and not at the cost per service.

Of those 12 studies, only one suggests that CON is associated with reduced expenditures.[50] And even in that case, the connection was tenuous. The author found CON to be associated with fewer hospital beds, and he found that fewer hospital beds were associated with slightly slower growth in aggregate healthcare expenditures per capita. Importantly, however, he found that "certificate-of-need programs did not have a direct effect on healthcare expenditures."[51]

Of the remaining 11 studies that assess the effect of CON on expenditures, 7 found evidence that CON increases expenditures,[52] 2 found no statistically significant effect,[53] and 2 found that CON increased some expenditures while reducing others.[54]

Hospital Efficiency

The next four studies in table 1 assess the effect of CON on hospital efficiency.[55] Essentially, those studies examine how cost-effectively hospitals transform inputs into outputs.[56] Economic theory offers no clear prediction for how CON might affect an individual hospital's efficiency.

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[50] Hellinger, "The Effect of Certificate-of-Need Laws on Hospital Beds and Healthcare Expenditures."
[51] Ibid., 737.
[52] Sloan and Steinwald, "Effects of Regulation on Hospital Costs and Input Use"; Lanning, Morrisey, and Ohsfeldt, "Endogenous Hospital Regulation and Its Effects on Hospital and Non-Hospital Expenditures"; Antel, Ohsfeldt, and Becker, "State Regulation and Hospital Costs"; Miller, Harrington, and Goldstein, "Access to Community-Based Long-Term Care"; Rivers, Fottler, and Younis, "Does Certificate of Need Really Contain Hospital Costs in the United States?"; Rivers, Fottler, and Frimpong, "The Effects of Certificate of Need Regulation on Hospital Costs"; Bailey, "Can Health Spending Be Reined In through Supply Constraints?"
[53] Sloan, "Regulation and the Rising Cost of Hospital Care"; Grabowski, Ohsfeldt, and Morrisey, "The Effects of CON Repeal on Medicaid Nursing Home and Long-Term Care Expenditures."
[54] Conover and Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?"; Rahman et al., "The Impact of Certificate-of-Need Laws on Nursing Home and Home Health Care Expenditures."
[55] B. Kelly Eakin, "Allocative Inefficiency in the Production of Hospital Services," *Southern Economic Journal* 58, no. 1 (1991): 240–48; Laurie J. Bates, Kankana Mukherjee, and Rexford E. Santerre, "Market Structure and Technical Efficiency in the Hospital Services Industry: A DEA Approach," *Medical Care Research and Review* 63, no. 4 (August 2006): 499–524; Gary D. Ferrier, Hervé Leleu, and Vivian Valdmanis, "The Impact of CON Regulation on Hospital Efficiency," *Health Care Management Science* 13, no. 1 (March 2010): 84–100; Michael D. Rosko and Ryan L. Mutter, "The Association of Hospital Cost-Inefficiency with Certificate-of-Need Regulation," *Medical Care Research and Review* 71, no. 3 (January 22, 2014): 280–298.
[56] For more details see Bates, Mukherjee, and Santerre, "Market Structure and Technical Efficiency in the Hospital Services Industry."

Although most of the theoretical models reviewed in the previous section suggest that CON will increase per unit prices and reduce the quantity of healthcare services, it is possible that by forcing more services to take place in a few large hospitals, CON might allow those hospitals to achieve economies of scale, even if this reduction comes at the price of reduced services elsewhere. Indeed, the empirical literature is mixed on CON and particular hospital efficiency. Two studies find that CON increases some measures of hospital efficiency,[57] one study finds no effect,[58] and one study finds that CON reduces hospital efficiency.[59]

Hospital Investment

Two early studies assessed the effect of CON on investment. Those studies reflect the goal of reducing unnecessary capital expenditures. One of the studies found that CON failed to reduce investment, though it did change the composition of the investment.[60] The other study found that CON backfired, causing hospitals to increase investment immediately before CON was implemented in anticipation that it would make future investments more difficult.[61]

Conclusion

In most industries, the economic viability of a new product or service is determined by the market signals of prices, profit, and loss. These signals are governed by the values of consumers and producers. If market participants do not deem a product or service to be worth

[57] Ferrier, Leleu, and Valdmanis, "The Impact of CON Regulation on Hospital Efficiency"; Rosko and Mutter, "The Association of Hospital Cost-Inefficiency with Certificate-of-Need Regulation."
[58] Bates, Mukherjee, and Santerre, "Market Structure and Technical Efficiency in the Hospital Services Industry."
[59] Eakin, "Allocative Inefficiency in the Production of Hospital Services."
[60] David S. Salkever and Thomas W. Bice, "The Impact of Certificate-of-Need Controls on Hospital Investment," *Milbank Memorial Fund Quarterly: Health and Society* 54, no. 2 (1976): 185–214.
[61] Fred J. Hellinger, "The Effect of Certificate-of-Need Legislation on Hospital Investment," *Inquiry: The Journal of Medical Care Organization, Provision, and Financing* 13, no. 2 (1976): 187–93.

the opportunity cost of producing it, the product or service will not be economically viable and will soon disappear.

In the healthcare markets of 35 states and the District of Columbia, however, many of the decisions are not left to market participants. Instead, they are governed by regulators empowered to permit—or refuse to permit—new and expanded services. Those laws are called certificate-of-need laws because regulators are supposed to determine whether or not consumers need the services in question.

Providers seeking permission to operate can spend years and tens or even thousands of dollars attempting to obtain permission. During this process, incumbent providers are often invited to offer their own opinion about the desirability of competition.

Although CON regulations were once promoted by the federal government as a way to limit healthcare costs, economic theory offers little reason to suppose they work as intended. Instead, economic theory predicts that a supply restriction such as CON will increase per unit costs and decrease the quantity of services. Furthermore, it predicts that CON laws may lead to either increases or decreases in total healthcare spending, depending on whether the price-increasing or the quantity-reducing effects of CON dominate.

Although CON laws may help internalize externalities created by other public policies such as insurance mandates and public funding, a more efficient and equitable way to address these externalities would be to reform the policies that cause them. Even though CON laws might allow individual hospitals to increase efficiency by channeling more patients to one location, thus achieving economies of scale, these laws might alternatively decrease hospital efficiency by making administrators less cost conscious. Finally, economic theory predicts that

CON laws will allow small but concentrated special interests to profit at the expense of consumers and other providers.

A review of 20 peer-reviewed academic studies finds that CON laws have worked largely as economic theory predicts and that they have failed to achieve their stated goal of cost reduction. The overwhelming weight of evidence suggests that CON laws are associated with both higher per unit costs and higher total expenditures. The evidence is mixed on whether CON laws have increased the efficiency of particular hospitals by channeling more patients through fewer facilities, and there is no evidence that CON decreased overall investment as its proponents had hoped. The weight of evidence suggests that CON regulations persist because they protect politically potent special interests from competition.

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August 30, 2024

Karen Shelton, MD
State Health Commissioner
Virginia Department of Health
P.O. Box 2448
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Re: COPN Expedited Review

Dear Commissioner Shelton and SHSP Task Force members:

Chesapeake Regional Healthcare ("CRH") submits this public comment to the State Health Services Plan (SHSP) Task Force in advance of its September 6, 2024, meeting, addressing SHSP Task Force recommendations approved at the August 23, 2024 meeting. CRH believes that the use of expedited review using the current COPN regulations should be limited to uncontested projects that present few health planning concerns. The wholesale use of expedited review for one entire category of projects (CT, MRI and PET imaging services), regardless of project scope, is inconsistent with comparative review requirements and the purpose of expedited review.

For the reasons set forth in this letter and in the Virginia Hospital and Healthcare Association public comment letter, CRH is opposed to the recommendation to include all imaging service project types under expedited review. The Task Force should revisit the issue before the SHSP Task Force releases its recommendations to the General Assembly.

Imaging projects are among the most competitive COPN reviews, resulting in more comparative reviews than any other project classification. There were 19 competitive reviews on imaging projects reflected on the DCOPN website over the last 5 years, more than the 13 competitive reviews on all other project classifications combined.[1]

CRH was involved in multiple competitive reviews on imaging projects over that timeframe. There was nothing uncontested about those projects, which involved relocations of CTs and MRIs across PD 20 and the approval of new project sites. Several of the projects received negative staff recommendations and went through the informal fact-finding process before the Commissioner's decision. One applicant claimed that it was bringing COPN authorized projects back to life after an operating hiatus and sought COPN approval to relocate several services dozens of miles across the planning district. The expedited review of all imaging projects in a 45-90 day timeframe would not provide sufficient safeguards for public comment in these cases.

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[1] See Staff Reports - Licensure And Certification (virginia.gov).

Expedited review was never designed for the consideration of an entire classification of reviewable services. Prior studies of the COPN process identified strict limitations on the use of expedited review. The 2015 HHR Secretary's COPN Work Group report[2] included a recommendation for potential approaches to greater use of expedited review. Recommendation 3c stated:

> VDH should: i) assess projects that may be appropriate for a 45-day expedited review process, which may include projects that are generally non-contested and/or raise comparatively few health planning concerns; ii) develop a process for reviewing such applications in a 45-day review period and identify the conditions under which such applications would require transition to a standard review cycle, and; iii) establish requirements for COPNs issued pursuant to a 45-day expedited review process, including conditions for indigent care and quality assurance.

CRH representatives have attended and have observed the care which the SHSP Task Force has taken in its efforts to develop a sound expedited review process. CRH remains concerned that the use of expedited review should be limited to projects identified by DCOPN which fit the uncontested profile, e.g., additional on-site iterations of COPN reviewable services based on institutional need. COPN decisions on where to place new COPN reviewable projects, including off-site expansions of COPN reviewable services within a planning district, should remain subject to the full administrative review process.

In addition to the practical aspects of considering the health planning effects of all imaging projects in a 45-90 day period, there are the legal considerations requiring comparative review by administrative agencies of applications for the same or similar service.[3] As the Richmond Circuit Court found in the *Charter Hospital of Charlottesville, Inc. v. Kenley* matter,[4] there are legal principles requiring comparative review of similar applications filed in the same time period. However, it is up to the agency to decide how to compare.

The requirement for comparative review led prior Virginia Department of Health commissioners and their staff to establish batching cycles for standard review applications and to limit changes to the letter of intent.[5] And, where standard review applications were being reviewed at the same time as applications under expedited review, the Department elected to review and make decisions on both types of applications at the same time, noting that "the Ashbacker doctrine appears to require such" and that "the fact that regulations for the administrative review process provide for expedited review of certain qualified projects cannot supersede the principle that comparative review be

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[2] The full report from this 2015 Secretary's COPN Work Group (the ("COPN Work Group") is available online at PDF (virginia.gov).

[3] See *Ashbaker Radio Corp. v. FCC*, 326 U.S. 327 (1945).

[4] In chancery, case no. N-2275-2 (August 1985).

[5] *See, e.g., Lewis-Gale Hosp. v. Stroube*, 31 Va. Cir. 263, 270 (July 1993) (noting that the "primary purpose of 'batching' related health care projects is to allow the health care planning agency to consider applications for identical (or even nearly identical) projects serving identical regions with an eye toward which project most effectively and efficiently serves the public health interest"); see also March 16, 1999 letter from Paul Parker, DCOPN Director, to Thomas W. McCandlish re: letter of intent by Cataract Center, LLC (limiting changes to letters of intent); April 17, 2001 letter from Erik Bodin, DCOPN Director, to Paul Boynton, EVHSA Director, re: Change in Applicant triggering new application (same).

made of opposing applications filed in a contemporaneous period of time for a similar limited service."[6]

The use of expedited review in COPN decisions involving allocation of resources to meet public needs should be limited to situations where the location and type of service is uncontested and does not adversely affect the allocation of needed resources across a planning district. The wholesale review of one group of COPN reviewable services in an expedited review process does not accomplish that goal and should be reconsidered. CRH also supports the previous public comments submitted by the Virginia Hospital & Healthcare Association, and we generally support its recommendations on other expedited review matters.

Sincerely,

Reese Jackson, President/CEO

[6] February 14, 1985 letter from James B. Kenley, State Health Commissioner, to Greg Luce, Esq. re: nursing home applications in PD 20 (requiring comparative review of expedited and standard review applications).