

COPN Workgroup - Update

Presentation to JCHC Healthy Living/Health
Services Subcommittee

Joe Hilbert

Director of Governmental and Regulatory
Affairs

October 7, 2015

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Presentation Outline

Workgroup Activities To-Date

Overview of Information Presented to Workgroup

Next Steps

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Study Mandate - Item 278D 2015 Appropriations Act

The Secretary of Health and Human Resources shall convene a stakeholder work group to review the current certificate of public need process and the impact of such process on health care services in the Commonwealth, and the need for changes to the current certificate of public need process.

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Workgroup Members

Eva Hardy - Retired Executive Vice President, Dominion Resources, Inc, *Chair*
 David H. Trump, MD, MPH - Chief Deputy Commissioner, Virginia Department of Health
 Pamela Sutton-Wallace - CEO, UVA Medical Center
 Mary Mannix - President & CEO, Augusta Health
 Richard M. Hamrick, III, MD - Chief Medical Officer, HCA Virginia Health System
 Douglas Suddreth - VP of Development, Autumn Corporation
 J. Abbott Byrd, III, MD - Orthopaedic Surgeon, Atlantic Orthopaedic Specialists
 Richard A. Szucs, MD -Radiologist, Commonwealth Radiology PC
 C. Burke King - President, Anthem Blue Cross & Blue Shield Virginia
 Brian Keefe - CFO of Capitol Market, Aetna, Inc
 Robert Cramer - Former Manager of HR Services, Norfolk Southern Corporation
 Carol Armstrong - Manager of Benefits Administration, Southern States Cooperative
 Jill Lobb - Corporate Director of Benefits, Huntington Ingalls Industries
 Karen Cameron - Director, Virginia Consumer Voices for Health Care
 Debbie Oswalt - Executive Director, Virginia Health Care Foundation
 Kim Horn - President, Kaiser Foundation Health Plan of Mid-Atlantic States
 William A. Hazel, Jr, MD - Secretary of Health and Human Resources, Commonwealth of Virginia, *ex officio*
 Jamie Baskerville Martin - Attorney, McCandlish Holton, *non-voting advisor*

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Initial Meeting - July 1

Secretary Hazel's Initial Remarks and Charge to the Workgroup

COPN Program in Virginia

Joint Commission on Health Care's 2001 COPN Deregulation Plan

COPN Program in Other States

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Second Meeting - August 19

Development of Virginia State Health Improvement Plan - Status Report

COPN and State Medical Facilities Plan - Statutory and Regulatory Provisions

COPN in Other States - Follow-up Information

Comments of Koren Wong-Ervin - Federal Trade Commission

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Third Meeting - September 28

[Denial of COPN Applications Case Study](#)

[American Health Planning Association
Perspective on Certificate of Need](#)

[A Review of Certain Health-Care System
Characteristics in States with and without
Certificate of Need](#)

[Framework of Potential Ideas for
Recommendations](#)

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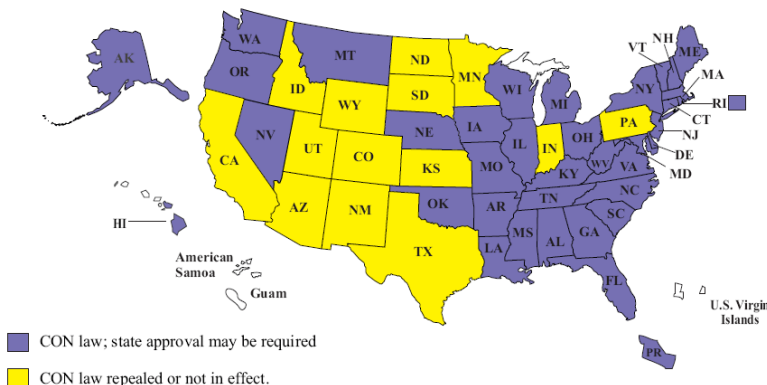
History of COPN in Virginia

- 1973 Virginia enacts COPN program
- 1974 Federal law passed encouraging states to adopt COPN programs
- 1987 Baliles COPN study commission
- 1988 Federal law allowed to expire
- 1989 Partial deregulation approved; postponed in 1991 and repealed in 1992
- 1996 Joint Commission on Health Care study
- 1998-1999 Special Joint Subcommittee study
- 2000 JCHC deregulation plan; rejected by 2001 General Assembly

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State Certificate of Need Laws

State Certificate of Need (CON) Health Laws, 2013



Compiled by NCSL November 2013; based on data from AHPA & State Agencies.

State by State: What is Regulated?

Regulated Services	Number of States
Nursing Home Beds/Long Term Care Beds	35 + DC (including VA)
Acute Hospital Beds	28 (including VA)
Ambulatory Surgical Centers	27 (including VA)
Long Term Acute Care	26 + DC (including VA)
Cardiac Catheterization	26 (including VA)
Psychiatric Services	26 (including VA)
Rehabilitation	25 (including VA)
Open Heart Surgery	25 (including VA)
Radiation Therapy	23 (including VA)
Neo-Natal Intensive Care	23 (including VA)

Medical Care Facilities and Projects Subject to COPN Review in Virginia

9 categories of "Medical Care Facilities" are subject to COPN

Within Medical Care Facilities, 7 categories of "Projects" require COPN approval

5 Guiding Principles for State Medical Facilities Plan (Development of Project Review Criteria and Standards)

State Medical Facilities Plan

2008 - SMFP Task Force established by legislation

- Review SMFP updating or validating existing criteria at least every four years

2009 - Comprehensive Revision

SMFP updated following the standard process for the promulgation of regulations

2015 - NOIRA stage complete for cardiac catheterization and long term care

Consideration and Review of COPN Applications

Pre-Application Phase

Letter of Intent and Completeness Review

Application Review Phase

190-day batched review cycle for each type of project

Public Hearing

8 Statutorily-Required Considerations

Decision Phase

May require Informal Fact Finding Conference

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COPN Decisions

FY 2000 - FY 2015

- 1,168 Decisions
 - 1,021 Approved
 - 147 Denied
 - 15-year average 12.6% denied
 - 15-year median 10.9% denied
 - Range 5.3% - 21.7% denied annually

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Conditions Placed on a COPN

State Health Commissioner has the authority to condition the issuance of a COPN on the applicant's agreement to certain conditions:

- Provision of indigent care
- Facilitation of the development and operation of primary care services
- Accept patients requiring specialized care

Conditions

- 655 Conditioned COPNs Issued
- 195 Conditioned COPNs Active
- 108 Conditioned COPNs not yet completed

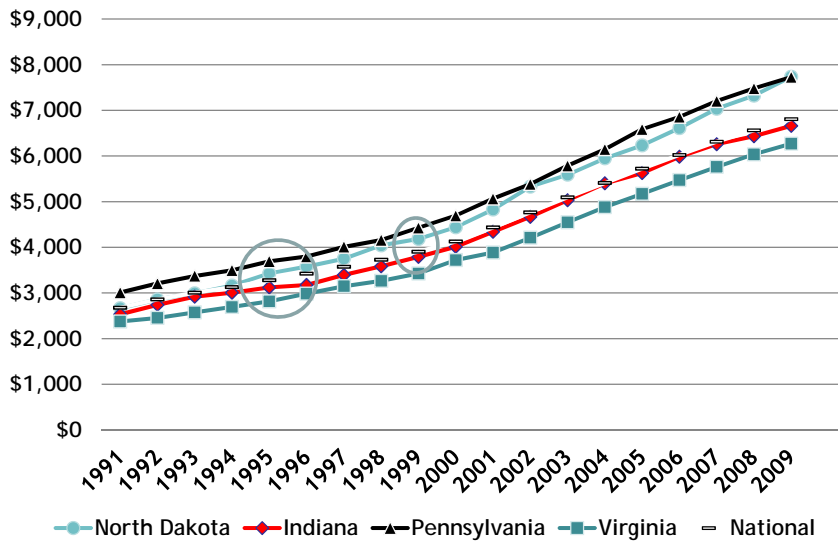
State by State: Application Fees

State(s)	Maximum Fee
South Carolina	\$7,000
Delaware	\$10,000
New Hampshire & Alabama	\$12,000
Michigan	\$15,000
Ohio, Vermont, Virginia	\$20,000
Iowa	\$21,000
Kentucky	\$25,000
Tennessee	\$45,000
Washington	\$46,253
Florida, Georgia, & North Carolina	\$50,000
Mississippi & Alaska	\$75,000
Oregon	\$90,000
Illinois & West Virginia	\$100,000
Maine	\$250,000
D.C.	\$300,000

COPN Program Staffing

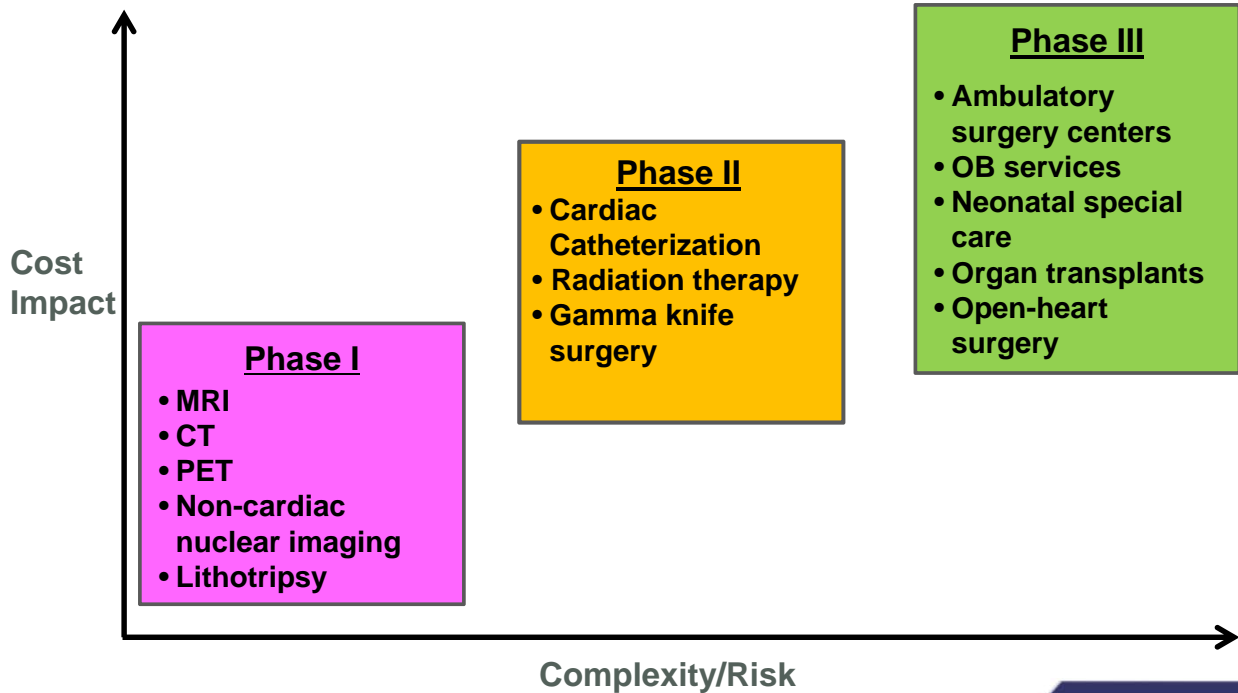
	<u>2010</u>	<u>2015</u>
Director	1.0	0.5
Supervisor	1.0	0.5
Analysts	4.5	3.0
<u>Adjudication Officer</u>	<u>1.0</u>	<u>1.0</u>
Total FTEs	7.5	5.0

North Dakota, Indiana and Pennsylvania per capita health expenditures before and after the CON programs were eliminated



The graph to the left indicates that both North Dakota's (1995) and Pennsylvania's (1996) per capita health expenditures were above the national average at the time they ended their CON programs and there was no marked change in the growth or decline rates of the per capita expenditures after the CON programs were eliminated. Indiana's per capita health expenditures mirror the national per capita health expenditure trend line.

2001 JCHC COPN Deregulation Plan



Health Care Cost: Background

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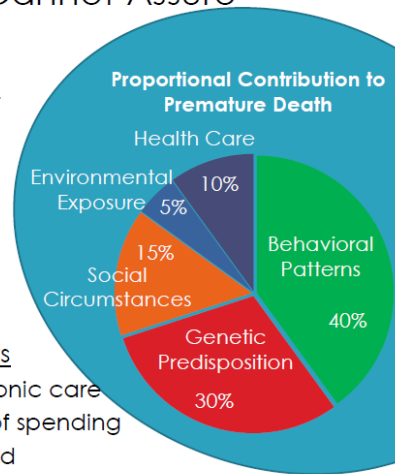
Excellent Health Care Cannot Assure an Individual's Health

Health Is Influenced by 5 Factors

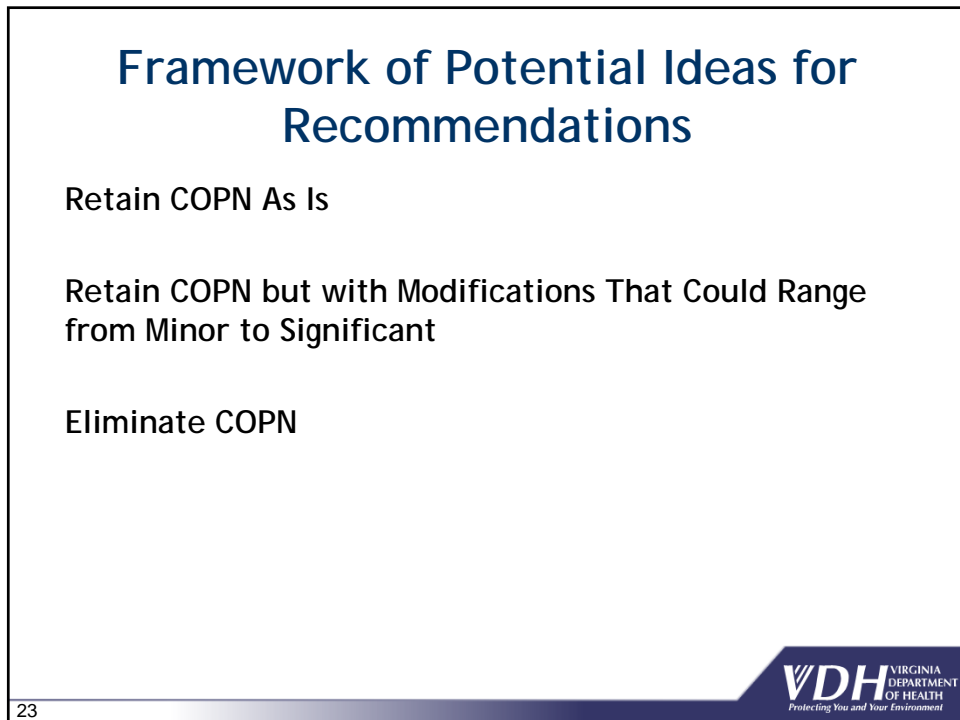
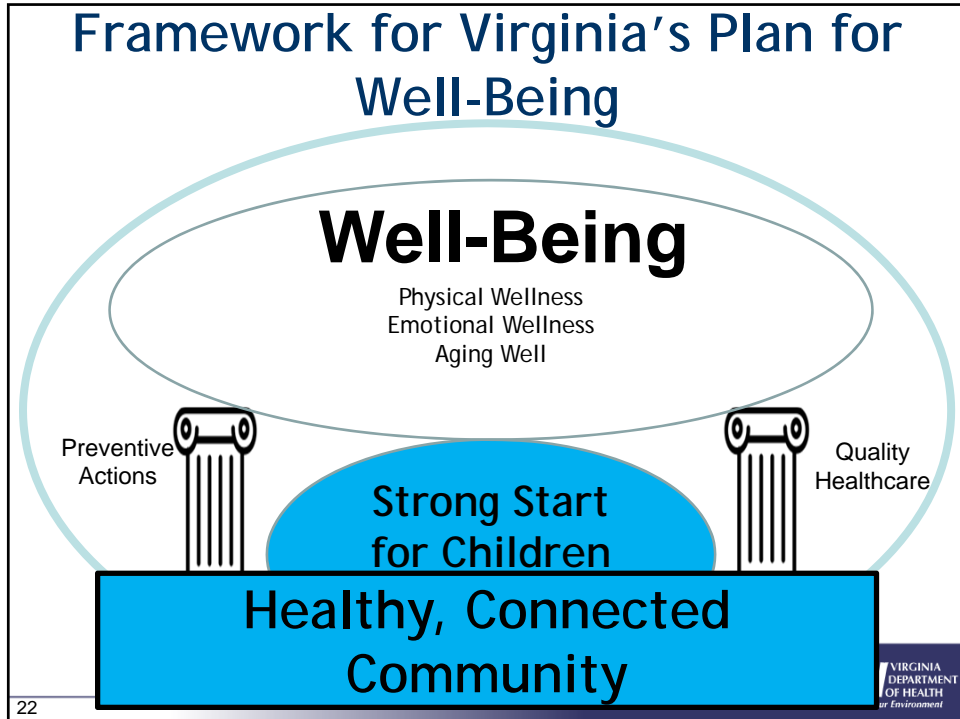
- Genetic predisposition
- Social circumstances
- Environmental exposures
- Behavioral patterns, and
- Health care

U.S. Health Care Expenditure Facts

- 75% of expenditures related to chronic care
- 5% of individuals account for 50% of spending
- 3.5% is spent toward prevention and public health services



Sources: Steven A. Schroeder M.D., We Can Do Better-Improving the Health of American People, N Engl J Med 2007; 357:1221-8, GAO, Preventive Health Activities, December 2012 at <http://www.gao.gov/assets/660/650617.pdf>, and American Public Health Association, Issue Brief: The Prevention and Public Health Fund, July 2012 at http://www.apha.org/NR/tدونلres/8FA13774-AA47-43F2-8388-180757D111C6/0/APHA_PrevFundBrief_June2012.pdf.



Next Steps

Workgroup Meeting - October 27, 1:00 pm, HR C

Workgroup Meeting - November 16, 1:00 pm, HR D

Final Report Due - December 1

COPN Workgroup Website

<http://www.vdh.virginia.gov/Administration/COPN.htm>

Questions?