VIRGINIA DEPARTMENT OF HEALTH
Office of Licensure and Certification
www.vdh.virginia.gov/licensure-and-certification/

Workgroup: State Health Services Plan Meeting

Agenda
August 9, 2024 at 9:00 a.m.
VIA WEBEX

This meeting has been changed to an all-virtual meeting due to the declared state of emergency for the Commonwealth of Virginia

1. Call to Order and Introductions – Dr. Thomas Eppes Jr., Chair
2. Review of Agenda – Allyson Flinn, Policy Analyst
3. Public Comment Period
4. Approval of July 12 Meeting Minutes
5. Review of July 12 Adopted Recommendations – Allyson Flinn
6. Remaining Expedited Review Projects
    I. Review of DCOPN Options for Recommendation – Erik Bodin, DCOPN Director
    II. Discussion
    III. Voting
7. Wrap Up and Next Steps
8. Meeting Adjournment

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 relocate psychiatric beds within the same planning district through the expedited process.
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.

VDH VIRGINIA DEPARTMENT OF HEALTH

State Health Services Plan Task Force

July 12, 2024 Meeting

Sign-up link for public comment:
https://forms.office.com/g/AhFzf1nLSn

Virtual Meeting Etiquette & Reminders

- You will be considered absent from any portion of the meeting in which your audio or video is disconnected, so please keep your video on for the meeting
- Please mute your microphone when you are not speaking to eliminate any background noises
- If you would like to ask a question, or make a comment, please either:
  - Raise your hand using the “raise hand” function on Webex
  - Send a message into the chat
- Members of the public – please save your comments for the public comment portion of the meeting. To sign up, please use this link: https://forms.office.com/g/AhFzf1nLSn

Roll Call

Review of the Agenda

Agenda
July 12, 2024 at 9:00 a.m.
Via Webex

1. Call to Order and Welcome – Dr. Thomas Eppes, Jr., Chair
2. Roll Call
3. Review of Agenda – Joseph Hilbert, Deputy Commissioner for Governmental & Regulatory Affairs
4. Review of Meeting Materials – Allyson Flinn, Policy Analyst
5. Approval of Prior Meeting Minutes
6. Public Comment Period
7. Task Force Vote on Psychiatric Recommendations
    a. Review of Policy Options
    b. Discussion
    c. Vote

Break

8. Expedited Review Projects & Process Options
    a. Review of remaining projects
    b. Review of potential process options and criteria for consideration
    c. Discussion
9. Wrap-Up and Next Steps
    a. August Meeting
10. Meeting Adjournment

Review of Meeting Materials

Approval of Prior Meeting Minutes

Public Comment Period

Public Comment Period

- There is a two-minute time limit for each person to speak
- We will be calling names of those who signed up using the comment form
- After the two-minute public comment limit is reached, we will let you complete your sentence and move of to the next attendee

Review of Policy Options

Policy Options - Summary

Legislative Changes:

1. Move psychiatric beds from full COPN review to expedited review
2. Move the establishment of a psychiatric facility from full COPN review to expedited review
3. Allow facilities that already provide psychiatric services to add beds using the expedited review process
4. Allow facilities to relocate psychiatric beds through the expedited process
5. Require facilities to request a COPN in order to convert beds from psychiatric beds to non-psychiatric beds
6. Allow facilities that already provide psychiatric services to establish a new psychiatric facility through the expedited review process
7. Move the addition of psychiatric services from full COPN review to expedited review
8. Require the Commissioner to condition psychiatric projects on the acceptance of Temporary Detention Orders

Regulatory Changes:

1. Extend expedited review from 45 days to 90 days
2. Require the Commissioner to condition expedited review applications on providing a specified level of charity care
3. Require any project that is contested to be pulled from expedited review and placed into full review
4. Allow for members of the public to request a hearing for an expedited project

Discussion

Voting Procedures

- VDH Staff will read the policy option
- The Chair will ask for a motion to adopt the policy option
- Upon receiving a second, the Chair will ask if there is any discussion regarding the policy option
  - Option is now in position to be discussed and considered by the Task Force
  - Task Force members may also offer amendments at this time
- If Task Force members would like to offer amendments, those will need to be offered in the form of a motion
- After all discussion is had and motions are moved and seconded, the Chair will call for a roll call vote
- VDH Staff will call the roll and each member will respond with a **Yes, No, or Abstain**

Break

Chapter 423 of the 2024 Acts of Assembly

- Develop recommendations on expedited review of project types subject to certificate of public need (COPN) requirements that are generally non contested and present limited health planning impacts. The Task Force shall also create recommendations regarding:
  - What facilities and projects listed in § 32.1-102.1:3 of the Code of Virginia should be added to the expedited review process;
  - Criteria that should apply to any project types subject to expedited review; and
  - A framework for the application and approval process of such projects.

Expedited Review – Current Projects

- Capital expenditures of $15 million or more by or on behalf of a medical care facility other than a general hospital

Recommendations from the 2021 COPN Study

- Recommend including the following non-competing projects in expedited review for existing facilities increasing capacity in an existing service:
  - Medical-surgical beds
  - Hospice beds
  - Psychiatric beds
  - Rehabilitation beds
  - Cardiac catheterization laboratories
  - Operating rooms
  - CT machines
  - MRI machines
  - PET machines
  - Linear accelerators

Review of Remaining Projects

Discussion

Wrap-Up and Next Steps

Meeting Adjournment

COPN Project Types

Based on COPN Project Definition and Project Sub-Type Within the Definition

Grouped by Service Type	Chapt 1271 Recommendation?	To Include as Expedited Discussion	Reason		
Hospital					
Add Hospital Beds by Relocation of existing hospital beds	when not competing	Yes	Chapt 1271, inventory neutral		
Add new Hospital Beds	when not competing	Yes	Chapt 1271		
Establish a Hospital		No	Maj proj implicatons, high cap cost, new service		
Establish a long term acute care hospital		No	Maj proj implicatons, new service		
Neonatal Intensive Care					
Introduce Neonatal Specialty Care Intermediate Level		No	New service, highly specialized, high acuity pts, regional service		
Introduce Neonatal Specialty Care Specialty Level		No	New service, highly specialized, high acuity pts, regional service		
Imaging					
Add a CT scanner by relocating an existing CT in the planning district	when not competing	Yes	Chapt 1271		
Add a CT scanner in an existing hospital with existing CT services	when not competing	Yes	Chapt 1271		
Add a CT scanner in an existing imaging center	when not competing	Yes	Chapt 1271		
Add a CT scanner in an existing outpatient surgical hospital with existing CT services	when not competing	Yes	Chapt 1271		
Establish an imaging center for CT imaging		No	New service		
Introduce a new CT for radiation therapy simulation in an existing center for radiation therapy		Yes	Not general diagnostic, required adjunct for other reviewable service		
Introduce a new CT service in an existing hospital		No	New service		
Introduce a new CT service in an existing imaging center		No	New service		
Introduce CT by relocating an existing CT in the planning district		Yes	Inventory neutral		
Establish an imaging center for MRI imaging		No	New service		
Add an MRI scanner by relocating an existing MRI in the planning district	when not competing	Yes	Chapt 1271, inventory neutral		
Add an MRI scanner in an existing hospital with existing MRI services	when not competing	Yes	Chapt 1271		
Add an MRI scanner in an existing imaging center	when not competing	Yes	Chapt 1271		
Introduce a new MRI service in an existing hospital		No	New service		
Introduce a new MRI service in an existing imaging center		No	New service		
Add a PET scanner in an existing hospital with existing PET services	when not competing	Yes	Chapt 1271		
Add a PET scanner in an existing imaging center	when not competing	Yes	Chapt 1271		
Establish an imaging center for PET imaging		No	New service		
Introduce a new PET service in an existing hospital		No	New service		
Introduce a new PET service in an existing imaging center		No	New service		
Introduce a new PET service in an existing radiation therapy center		No	New service		
Add a scanner by converting a mobile site to a fixed unit (CT and/or PET and/or MRI)	when not competing	Yes	Chapt 1271, semi-inventory neutral		
Establish an imaging center for 2 or more regulated modalities (Other than Cancer Treatment)		No	New service, complex		
Intermediate Care Facility for Individuals with Intellectual Disability					
Establish an intermediate care facility with 13 or more beds for individuals with intellectual disability[5]		No	Currently in conflict with licensure requirements		
Long Term Care					
Add a distinct part nursing home unit in an existing hospital		No	New service		
Add new nursing home beds in an existing nursing home		No	New beds only available through RFA process		
Add nursing home beds in an existing nursing home by relocating beds from outside the PD		Yes	Inventory neutral		
Add nursing home beds in an existing nursing home by relocating beds within the PD		Yes	Inventory neutral		
Add nursing home beds in an existing nursing home in a CCRC		Yes	Special treatment of CCRC due to need to preserve continuium of care		
Establish a new nursing home		No	New service		
Establish a new nursing home by relocation		Yes	Inventory neutral		
Establish a new nursing home in a CCRC		Yes	Special treatment of CCRC due to need to preserve continuium of care		
Cardiac Catheterization					
Add a cardiac catheterization lab in an existing hospital with cardiac catheterization services	when not competing	Yes	Chapt 1271		
Establish a freestanding cardiac catheterization laboratory		No	New service		
Introduce a new cardiac catheterization service in an existing hospital		No	New service		
Surgical					
Add new operating rooms in an existing hospital	when not competing	Yes	Chapt 1271		
Add new operating rooms in an existing outpatient surgical hospital	when not competing	Yes	Chapt 1271		
Add new operating rooms in an existing outpatient surgical hospital by relocating existing ORs from another hospital	when not competing	Yes	Chapt 1271, inventory neutral		
Introduce a new kidney transplant service in an existing hospital		No	New service, highly specialized, high acuity pts, regional service		
Introduce a new lung transplant service in an existing hospital		No	New service, highly specialized, high acuity pts, regional service		
Introduce a new pancreas transplant service in an existing hospital		No	New service, highly specialized, high acuity pts, regional service		
Introduce a new open heart surgery service in an existing hospital		No	New service, highly specialized, high acuity pts, regional service		
Establish a new outpatient surgical hospital		No	New service		
Psychiatric					
Add new psychiatric beds in an existing hospital	when not competing	Yes	Chapt 1271		
Add new psychiatric beds in an existing hospital with an existing psychiatric unit by converting beds to psychiatric beds	when not competing	Yes	Chapt 1271		
Establish a new inpatient psychiatric hospital		No	New service		
Introduce a new psychiatric service in an existing hospital by adding new beds		No	New service		
Introduce a new psychiatric service in an existing hospital by converting existing beds		No	New service		
Introduce a new psychiatric service in an existing hospital by transfering existing psychiatric beds from another hospital		Yes	Inventory neutral		
Medical Rehabilitation					
Add new rehabilitation beds in a hospital with existing rehabilitation services	when not competing	Yes	Chapt 1271		
Add rehabilitation beds in a hospital with existing rehabilitation services by converting Med/surg beds	when not competing	Yes	Chapt 1271, inventory neutral		
Establish a new rehabilitation hospital		No	New service		
Introduce a new medical rehabilitation service in an existing hospital		No	New service		
Radiation Therapy / Cancer Treatment					
Establish a center for radiation therapy service (brachytherapy)		No	New service		
Introduce a new radiation therapy service (brachytherapy) in an existing hospital		No	New service		

Add a linear accelerator by relocating an existing linear accelerator to a hospital with an existing linear accelerator	when not competing	Yes	Chapt 1271		
Add a linear accelerator in an existing hospital with an existing linear accelerator	when not competing	Yes	Chapt 1271		
Add a linear accelerator in an existing outpatient surgical hospital with an existing linear accelerator	when not competing	Yes	Chapt 1271		
Add a linear accelerator in an existing radiation treatment center with a linear accelerator	when not competing	Yes	Chapt 1271		
Establish a center for radiation therapy service (linear accelerator)		No	New service		
Introduce a new radiation therapy service (linear accelerator) in an existing hospital		No	New service		
Introduce a new radiation therapy service (linear accelerator) in an existing outpatient surgical hospital		No	New service		
Establish a center for proton beam therapy		No	New service, extreme capital cost		
Introduce new proton beam therapy in an existing hospital		No	New service, extreme capital cost		
Add SRS equipment in an existing radiation treatment center with with existing SRS		Yes	Expansion of existing service		
Establish an cancer treatment center for 2 or more regulated modalities		No	New service, complex		
Introduce a new SRS in an existing hospital		No	New service		
Introduce a new SRS in an existing radiation therapy center		No	New service		

Relocation

Establish a medical care facility that is the relocation of existing regulated modality(ies), other than beds, within the PD		Yes	Inventory neutral		

Yes	34
No	41

WestVirginiaUniversity.
JOHN CHAMBERS COLLEGE OF
BUSINESS AND ECONOMICS
KNEE REGULATORY RESEARCH CENTER

Matthew D. Mitchell, Ph.D.
Knee Regulatory Research Center
West Virginia University

August 5, 2024

Dear Dr. Berger:

Thank you for sharing the Virginia Hospital and Health Care Association's (VHHA) letter of June 28, 2024. I read it with great interest and have a few comments below.

Let me begin with the big picture. Since the VHHA is attempting to read and summarize a (very) large body of social scientific literature, please allow me to begin with a few notes on how social scientists attempt to go about their jobs.

First, we try to be humble. Humans are complex. And human systems more so. As a result of this complexity, most researchers prefer to state their results cautiously. We don't accept hypotheses; we fail to reject them. The VHHA has picked up on the fact that many studies of CON are carefully caveated, that they express relationships in terms of correlation rather than causations, and that results are almost always presented as tentative. All of this is true. But, as we will see, this does not mean that we are flying blind. As a result of tireless efforts by hundreds of social scientists, we have quite a bit of information about how CON laws do (and do not) work. In fact, we know more about CON laws than we know about many higher profile regulations. We should not ignore this evidence because good social scientists are careful not to overstate their case.

Second, as social scientists like to say, "we should trust literatures, not studies." If one study finds X is associated with Y, we should take that as *some evidence* that X is associated with Y. But if dozens of studies suggest X is associated with Y, and if sound theory predicts that X is associated with Y, and if there is little reason to believe X is associated with the opposite of Y, then we should take that as *a great deal of evidence* that X is, indeed, associated with Y.

And finally, we should never lose sight of the fact that the subjects of social science are, of course, human beings. Each person has his or her our own preferences, goals, and worth. As a result, we should demand an extremely high level of certainty before we think it prudent to override the decisions of others.

With these preliminaries in mind, allow me to say what we know about CON laws.

To date, there have been 128 academic, peer-reviewed studies of health care CON laws.[1] And together these studies contain 433 empirical tests with obvious normative implications for access, cost, and quality of care. For every one test associating CON with a good outcome such as lower spending, there are more than *four* tests associating CON with a bad outcome such as diminished access or lower quality of care. What's more, this pattern is entirely consistent with standard economic theory which suggests that a supply restriction will tend to restrict access, raise costs, and undermine quality.
On some questions, the evidence is especially lopsided, for example:

[1] For a review of the entire literature, please see Mitchell (2024).

- Forty-five tests have assessed the effects of CON on spending per service rendered. Just 3 of these associate CON with lower spending per service while 27 associate it with higher spending per service. In other words, for every 1 test that finds CON is associated with lower spending per service, 9 associate it with higher spending per service. This is consistent with standard economic theory.
- Eighty-three tests assess the effects of CON on access to care. Just 6 of these associate CON with greater access to care, while 65 associate it with less access to care. In other words, for every 1 test associating CON with greater access, there are more than 10 associating it with less access. This too is consistent with standard economic theory.
- One-hundred-and-fourteen tests assess the effect of CON on quality of care. Of these, 18 associate CON with higher quality of care and 52 associate it with lower quality of care. In other words, for every 1 test associating CON with higher quality care, there are nearly three associating it with lower quality of care. This is consistent with standard economic theory.
- Seventeen tests assess the effect of CON on care for vulnerable or underserved populations. To date, no study has found CON to correlate with more or better care for these groups, while 14 tests associate CON with diminished care for these groups. This is consistent with standard economic theory.

Each of these studies has been peer reviewed. Most employ datasets with hundreds or even thousands of observations. They control for possibly confounding factors, and, when possible, use careful empirical techniques to infer causal relationships.

Does this evidence "prove" that CON fails to achieve its ends? You won't find many social scientists using those words. But the entire body of literature does offer a great deal of evidence to suggest that CON laws do not work as their advocates contend. And given that, by their design, CON laws prevent trained and skilled health care professionals from offering care to patients who want their services, it seems entirely prudent to say that CON advocates have not met their burden of proof.

With these preliminaries in mind, here are a few smaller quibbles with the VHHA's characterization of the evidence.

- Zhang (2008). Here is how the VHHA describes this study: "CON laws increased the number and percent of admissions for the uninsured by non-profit hospitals and are significantly positively related to the percent of admissions for the uninsured by for-profit hospitals."

  The study examined the effect of three regulatory policies—CON laws, uncompensated care pools, and community benefit requirement laws. It found that CON is associated with small increases in uninsured admissions, though the results were small (0.07%) and not statistically significant when the author controlled for endogeneity. Furthermore, he found that in the presence of all three policies, the number of uninsured admissions by nonprofit hospitals fell.

- Campbell and Fournier (1993). The VHHA writes the authors "found evidence that CON laws have been used to promote internal subsidization of indigent care."

  This was not a direct test of CON.[2] The authors did not study whether indigent care was more or less common in CON settings. Instead, they found that in Florida, CONs were more likely to be awarded to hospitals that provide more indigent care. Whether this actually led to more indigent

[2] Similarly, Mitchell (2005), GAO (2003), Guy *et al.* (2014), and Dobson *et al.* (2006) are not direct tests of CON.

care is uncertain. For those who are interested in a direct study of CON and indigent care, I suggest Stratmann and Russ (2014). They find that while patients in CON states have access to fewer hospitals and fewer beds, there is no statistically significant difference in uncompensated care in CON and non-CON settings.

- Interestingly, the VHHA discusses the indirect evidence in Conover and Sloan (1998) that volume is associated with quality but do not mention their direct test of CON, in which they found CON has no effect on total per capita health expenditures and there is no evidence of a surge in spending after repeal.

- Vaughan-Sarrazin, et al. (2002). The VHHA says they "found that unadjusted mortality rates for Medicare patients undergoing CABG surgery was higher in states without CON."

  This is accurate but others have found different results. For example[3]:
  - Robinson et al. (2001) found mortality was unchanged after repeal.
  - DiSesa et al. (2006) found no direct relationship between CON and mortality.
  - Ho, et al. (2009) found procedural CABG mortality declined after repeal, though the difference was not permanent
  - Kolstad (2009) found surgeries were more likely to be performed by high quality surgeons following the Pennsylvania repeal of CON.
  - Cutler, Huckman, and Kolstad (2010) found CON repeal was associated with a shift from standard quality to high quality surgeons.
  - Li and Dor. (2015) found that following CON repeal, entry by new cardiac surgery centers tended to sort high-severity patients into the more invasive CABG procedure and low-severity patients into the less invasive PCI procedures, potentially improving quality of care.

- Ho (2004). The VHHA writes: "found that CON may be marginally effective in improving outcomes for PTCAs."
  - Again, this is not a direct test of CON and quality. She finds CON is associated with higher volume and volume is associated with better outcomes, but she doesn't directly study the relationship between CON and outcomes.

- Ross et al. (2007). The VHHA says: "found CON regulation of cardiac catheterization was associated with the continued delivery of more appropriate care after admission for AMI and reduced delivery of less appropriate care."
  - This is accurately described. It is one of 18 tests that associate CON with better quality of care. But, as noted above, more than twice as many—52 tests—associate CON with lower quality of care.

- Cancienne et al. (2020). The VHHA says this study "found that the rate of decrease in the incidence of knee arthroscopy was significantly greater in CON states than that in non-CON states, CON states also had significantly lower charges at all time points, and overall, compared with non-CON states. There were significantly more high- and mid-volume facilities in CON states than in non-CON states, and there were significantly more low-volume facilities in non-CON states than in CON states. Finally, there were significantly higher rates of emergency room visits within 30 days and infection within 6 months in non-CON states than in CON states.

[3] All of these studies are related to CABG. Of course, others, like Stratmann (2022) associate CON with greater mortality in other settings such as following heart attack, heart failure, and pneumonia.

- Here is a full description of the study: They examine the effect of CON on knee arthroscopy, assessing its effect on:
    1) Charges and reimbursements: in t-tests without controls[4] they found that charges (which are the prices set before any negotiation) were lower in CON states, while reimbursements (which are actual payments) were not statistically significantly different.
    2) Total volume: total volume and growth in total volume was lower in CON states than in non-CON states.
    3) Volume within facilities: CON is associated with the presence of more high-volume facilities, and
    4) Quality: There were more ER visits within 30 days of operation and more infections within 6 months of operation in CON than in non-CON states; there were no differences in in-hospital deaths or readmissions within 30 days of the operation between CON and non-CON states.

- Rosko and Mutter (2014). The VHHA writes that the authors "found that hospitals in states with CON laws that regulate acute care beds were more cost-efficient than hospitals located in other states and suggest that the differences could be driven by greater capital efficiency in CON states. Mean total capital expenses per bed were significantly lower in CON states, coupled with a higher mean occupancy rate in these states."

    - This is one of 4 tests associating CON with more efficient use of capital. Four additional tests, however, associate it with less efficient use of capital.

- Hellinger (2009). The VHHA says he "found that CON laws have reduced the number of hospital beds by about 10%, which has led to a slight reduction in healthcare expenditures in CON states."
    - More precisely, Hellinger found CON is associated with fewer hospital beds, which in turn are associated with slightly slower growth in aggregate health expenditures per capita. But the author actually looked for and found no direct relationship between CON and health expenditures per capita.

Thank you again for the opportunity to review the VHHA's letter. I hope that my remarks are helpful as you and your fellow taskforce members formulate recommendations concerning the fate of CON (COPN) in Virginia.

Please feel free to pass my contact information along to your fellow taskforce members.

Best regards,

Matthew Mitchell, Ph.D.

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[4] To my knowledge, this is the only study to report a finding without using controls.

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August 6, 2024

Karen Shelton, MD
State Health Commissioner
Virginia Department of Health
P.O. Box 2448
Richmond, Virginia 23218-2448

Re: Public Comment to State Health Services Plan Task Force, August 9, 2024, Meeting

Dear Commissioner Shelton,

Thank you for the opportunity to submit this public comment to the State Health Services Plan (SHSP) Task Force in advance of its August 9, 2024, meeting. At the conclusion of the July 12, 2024, Task Force meeting, members of the Task Force were asked to consider whether additional project types, other than various psychiatric services projects already considered, should be moved from full COPN review to expedited review. Subsequently, the Task Force received in meeting materials for the August 9, 2024, meeting, an analysis of project types and their approval and denial rates along with recommendations from the Virginia Department of Health on various project types that should be considered for expedited review. This public comment is submitted in response to VDH's analysis for consideration by the SHSP Task Force as it seeks to finalize its recommendations.

VHHA support for expedited review is limited to certain projects that are non-contested and/or raise comparatively few health planning concerns. Further, as reflected in its legislative mandate, the SHSP Task Force is to develop recommendations on expedited review of project types "that are generally non contested and present limited health planning impacts."

Reviewing the list of VDH recommendations with this criteria in mind, there are several project types that do not appear to be non-contested or raise comparatively few health planning impacts. These include:

- Add new hospital beds
- Add a CT scanner in an existing imaging center
- Add an MRI scanner in an existing imaging center
- Add new operating rooms in an existing hospital
- Establish a medical care facility that is the relocation of existing regulated modality(ies), other than beds, within the PD

Each of these project types have been subject to denials in the past indicating that there was a health planning issue that resulted in the project not being approved. Project types such as these should remain under full COPN review.

We urge the Task Force to proceed cautiously with any recommendations to approve additional project types for expedited review. Allowing expedited review of project types that are contested or that have demonstrable health planning impacts would have unintended consequences that undermine the sound policy rationale of Virginia's COPN program.

Again, we are grateful for the work that you and the Task Force are undertaking to improve Virginia's COPN Program. The COPN Program is a critical policy function of the Commonwealth and reforms to modernize this program present a great opportunity to produce greater efficiencies and generate even better outcomes.

Thank you for your consideration of this public comment.

Sincerely,

R. Brent Rawlings
Senior Vice President & General Counsel

cc: Dr. Thomas Eppes, Chair, SHSP Task Force
Karen Cameron, Vice Chair, SHSP Task Force