DESERTCOM Committee
Agenda

August 19th, 2026, at 1:00 p.m.

Virtual Meeting

- Call to Order and Welcome
- Roll Call
- Public Comment Period
- Review Meeting Minutes of July 23rd, 2026
- Review Materials
    - Expedited Review Process
    - Definitions and Preference Language
- Next Steps and Wrap Up
    - Report Out
- Meeting Adjournment

Meeting Minutes
SHSP TF – DESERT Committee
July 23, 2026, 1:00 p.m.
Training Room 2, Perimeter Center

Task Force Members in Attendance (alphabetical by last name): Mr. Jim Beckner; Ms. Karen Cameron (chair); Ms. Carrie Davis; Mr. Deepak Madala ; Mr. Marcus Stone

Staff in Attendance (alphabetical by last name): Ms. Mikayla Ferguson, SHSP-TF Planner; Mr. Geoff Garner, Senior Policy Analyst; Mr. Antwon Jacobs, DCOPN Supervisor

Ms. Cameron welcomed the committee and called the meeting to order at 1:03 p.m.

Ms. Ferguson called the roll.

Mr. Rufus Phillips was absent.

Quorum was established.

Ms. Cameron reviewed the agenda.

The committee reviewed the meeting minutes from the previous meeting, May 15, 2026. The committee noted changes to the bottom of page three of the minutes changing “Mr. Rufus” to “Mr. Phillips”. Ms. Davis motioned to approve the minutes, Mr. Stone seconded the motion, and the committee approved the minutes unanimously.

Ms. Cameron called for public comment and there were none presented.

Mr. Garner led the discussion to the review of the updated maps and methodology produced by the social-epi team at Virginia Department of Health ‘s Office of Health Equity.

Ms. Cameron introduced questions related to the population totals and census tracts for highlighted portions of the maps provided. The SHSP-TF team was able to provide the data requested by county totals.

The committee was able to deduce from the data that approximately 5% of the state meets all 4 standards listed in the criteria.

Mr. Madala pointed out that it was not clear if the maps showed the independent cities that lay in pockets within the counties shown.

Mr. Stone commented about the difference of population density between cities and counties.

Ms. Cameron agreed that cities have different population sizes.

Mr. Garner stated that the map with four proposed criteria does not have a scale which allows for all of the census tracts to be shown clearly on one page. He stated that the task force's task is to look at the macro level, while COPN analysts will determine the micro level need based on criteria in the location. Expedited review will be determined by the micro analysis at the time of the application.

Ms. Cameron stated that expedited review will not address the need of the areas as it will put up facilities and not address root causes. Expedited review speeds up the review process of facilities, but does not address route causes. She is open to addressing the review criteria and discussing wording over addressing the needs of barriers to COPN services.

Mr. Beckner asked if preference is given to applicants which made a preference to serve "red" or "orange" services (in reference to the 4 criteria map).

Mr. Stone stated that there are several factors to consider, including population/poverty/insurance changes.

Mr. Garner restated the assignment of the task force is two-fold: the 2025 request for an expedited review, and the 2026 medical desert definition. The maps are in relation to the 2025 bill (HB 2119) which required expedited application and review process when 2 criteria are met. In addition, the 2026 (HB1337) required the development of criteria for when the review will apply to facilities in the areas.

Ms. Davis stated that space was being left for the individuals committees to for specific services. She stated that they are working on the finding the criteria for when expedited review occurs, such in the psychiatric facilities. The issue at hand is to work on the verbiage of how organizations/applicants are going to sustain services received in the expedited reviews.

Ms. Cameron emphasized that services should be established in areas where a demonstrated need exists and should not be relocated later due to low service volumes. She advised that the language presented to the General Assembly includes provisions that restrict relocation and reinforce the commitment to serving the population effectively. She

further noted that incorporating two or more eligibility criteria would diminish the effectiveness of the COPN process, as it would apply to most regions across the state. Ms. Cameron also expressed concern that, with additional review requirements, there could be increased pressure on DCOPN to evaluate projects beyond the intended scope.

Mr. Jacobs stated reviews would be considered, but there was a misconception with projects.

Mr. Beckner stated that resources- human and monetary- were needed upon review of the projects to ensure that the projects are sustainable.

Ms. Cameron asked about the preference language for projects that would meet all 4, or 3 of the 4, of the criteria.

Mr. Jacobs stated that it has to be more than 2 criteria.

Mr. Stone stated that 3 or more would address some concerns, but would not address all as it still covers a good portion of the Commonwealth.

Ms. Camerons stated preference would apply to those serving 3 or 4 of the criteria. She stressed that it would be preference, and not automatic approval.

Mr. Garner posed the question of if there is an area which meets 4 criteria, may it be a location where that is not currently population.

Ms. Cameron stated that there would be people there, and referenced the population chart.

Mr. Garner stated that if there is wording to provide greater preference to areas meeting more of the criteria, could this put the Health Commissioner in a position where he must approve a project where there is not a need due to low population numbers.

Ms. Cameron stated that the preference language is to guide and not to promote automatic acceptance of projects. She suggested applying the language currently at the site to the continuum of care.

Mr. Beckner stated that the preference is servicing an “orange” or “red” area, not to implement a facility in that area.

Mr. Stone noted that services could be located within a reasonable drive-time if they address a demonstrated need. He emphasized that most facilities understand their populations and typically will not pursue an application without a sustainable service base,

unless there is an intention to relocate the service in the future. He reiterated that the task force's purpose is to expand the applicability of COPN certifications and added that applicants genuinely aiming to support the community would move through the review process more quickly.

Ms. Davis stated that if there is support (ex: transportation, education, etc.) provided in an area "red" or "orange", this would meet the criteria, without putting the specific facility within the area. This would make the process more appealable and provide care for providers.

Mr. Beckner stated that there is a fear that the certificate would be received and then stop the additional services in the area. He posed the question of the certificate being contingent upon the provision of additional services.

Ms. Cameron questioned contingency standards as that in her experience it is rare for certificate removal to happen.

Mr. Jacobs stated that certificates are withdrawn.

Ms. Cameron responded that she was speaking of the state taking away certificates from the applicants per services not being provided as proposed.

Mr. Jacobs clarified that DCOPN actively follows up on certificates by reaching out to applicants and requesting additional information as needed.

Mr. Madala noted that the data under review reflects information from 2024, which is typically two years old. He explained that relying on data with this lag may distort the classification of rural areas, as population shifts over that period can significantly change local demographics.

Mr. Garner noted that the referenced maps do not provide actionable intelligence, but rather a general overview. He recommended including regulatory provisions that impose penalties if an applicant later removes approved services. He also stated that applicants should be required to submit documentation demonstrating that two or more eligibility criteria are met.

Ms. Cameron clarified that they would need to address 2 or more of the areas.

Mr. Garner stated that the application could put the burden on the applicant to show the poverty level, resources available, and how the need is met.

Mr. Stone explained that, in the Federal Grant Process, a mapping system is used to identify all rural facilities and providers. He asked whether a similar tool could support this process, noting that grant applications require review of key data, such as population and facility distribution, along with a plan for addressing local needs. This review must occur both at initial application and at renewal for new or existing facilities.

He further stated that, within the COPN process, applicants would need to evaluate and address the socioeconomic characteristics of the area to demonstrate how community needs will be met. He added that COPN applicants should periodically renew their submissions to show how services continue to support the population.

Mr. Beckner stated that accountability is essential.

Mr. Jacobs stated that charity care is able to address this as well. There is a second part of the conditioning that discusses addressing primary care/maternity care within areas.

Ms. Cameron stated that charity care used to be paid. There is now a list of agencies where the money can be sent in order to meet the charity conditions. Then there was a language change which reduced the paying of charity care further.

Mr. Beckner stated this was due to the data change and slow in return of financial change to VHI. VHI should now receive charity care within the same year so that the conditions can be met.

Ms. Cameron stated that the change back will be helpful and will allow for the funds to be distributed.

Mr. Beckner stated the point of charity care is to provide charity to persons.

Ms. Cameron noted that the gross-to-gross approach ensures services are delivered at the most accurate and appropriate level. She explained that this methodology prompted hospitals to open free clinics and effectively incentivizes providers to deliver the services for which they are authorized.

Mr. Beckner stated that free clinics and physicians partner to provide further assistance to patients.

Ms. Cameron stated that due to the nature of COPN, placement of facilities in the underserved areas is not always feasible, but there are facilities which are currently serving the areas (and more wanting to) and there should be preference language for the areas

Ms. Davis stated that sustainment of services is also a goal of what the taskforce is requesting.

Mr. Beckner stated that there should be specific plans of how to reach patients and residents of the area.

Ms. Davis proposed that applicants should have the opportunity to justify their chosen service area, and that this justification should be incorporated as part of the COPN analysis and consideration.

Mr. Stone stated that there could be wording that it is expected for applicants to present socioeconomic factors of the area and how the needs will be address. Based on the nature of the approval process, there will be a report/update on the continuing of the care.

Ms. Cameron stated that it should be a bi-annual report on how the needs are met.

Mr. Stone requested that the four criteria should be listed to determine the specific needs being met.

Ms. Davis asked if the population changes, with the evidence and plans shown, what happens to the application? She requested for difference between expedited verses regular application. If the criteria changes, what is the difference?

Mr. Jacobs suggested alternative methods to determine population changes, but did not know specifics.

Mr. Garner stated that if the application is approved and then a few years later there is significant changes, the default is shutting the facility down but this may not be the most appropriate method.

Ms. Davis asked what measures would be taken to address situations in which guardrails are in place to maintain continuity of care, but changes in the area mean those conditions are no longer applicable. She inquired specifically about how such circumstances would be reflected in the bi-annual reports.

Mr. Garner stated that the ultimate goal is for the population's conditions to improve as a result of receiving appropriate care.

Mr. Stone suggested that there is long-term evaluation for charity care for all certificates, not just those within the expedited review cycles. There should be a way to track the

process and how to improve based on the authorized certificate. There would need to be legislative changes for the report cycle to be changed.

Ms. Cameron asked whether current application language already requires applicants to address socio-economic factors. She requested adding a recommendation for applicants to provide more detailed information so that staff can conduct more thorough evaluations.

Mr. Jacobs stated that poverty level of the relevant planning district is currently included in staff reports.

Ms. Cameron asked if it could be changed for primary and secondary service area that would be served by the projects.

Ms. Davis proposed the idea that applicants do not build a physical building and instead provide additional services need in the area.

Mr. Becker stated that many "orange" areas have an adjacent "blue" data.

Mr. Stone confirmed and stated that the concentrated poverty areas are adjacent to more economically advantaged areas.

Ms. Davis agreed that facilities located in the "blue" areas are positioned to support care in neighboring regions. She noted that their proximity enables these facilities to meet needs in areas with lower populations while still serving the broader community effectively.

Mr. Jacobs stated that applicant's staffing is already a concern in primary areas.

Ms. Davis agreed that staffing is a concern, but there needs to be a way to meet the intent of the legislature. The wording needs to be preferences and not automatic as it does not need to force approval/services unneeded.

Ms. Cameron proposed "Applications that are claiming preference, provide detailed socioeconomic status gathered to support that preference". She questioned if the language needs to be voted on.

Mr. Garner stated that there does not need to be a vote on specific language as the regulations will be drafted separately. Voting on the language would allow for further guidelines, but is not needed. He also clarified that the language would be requiring the submission from the applicant to meet criteria.

All members of the task force agreed to the clarification.

Ms. Cameron additionally asked about the biannual reports.

Mr. Jacobs stated that this would be a difficult achievement as there is difficulty in collecting reported data currently.

Mr. Garner asked about additional demands placed on certificate holder, additional demands on COPN staff, and how the reports would change with population changes should the requirements not be met.

Mr. Madala asked about certificate language.

Mr. Stone stated that the majority of the process is for the identification of need and once a certificate is determined.

Ms. Cameron stated that non-compliance would place a significant burden on future applicant projects. She noted that existing language already permits revocation of a certificate in cases of "willful negligence."

Ms. Davis stated that if the applicant does not comply with the regulations there is nothing that can be done short of revoking the certificate.

Mr. Jacobs stated that it is not DCOPN's goal to revoke certificates as that is taking away needed medical care.

Ms. Cameron stated that there is a preference for reviewable services for applicants who provide additional care for areas in need. There are six points identified previously which would be included in the preference, in line with the service's patient population. This can be accomplished through partnerships with community based providers. Each of the six services will be added to the preferential language.

Ms. Davis stated it will be beneficial for preference verses expedited as preferential.

Mr. Beckner stated that there is a narrative being told about the COPN takes millions of dollars from applicants.

Ms. Cameron stated that this narrative is not true for projects where there is a legitimate need.

Mr. Garner stated that in reading the wording of the 2026 bill, it would be inappropriate and futile to try to craft any paradigm for the commissioner to rigidly adhere. There needs to be discretion and reasonable alternatives. It is important to note considerations for the

commissioner, but not a rigid formula for each applicant. The question of expedited review can be objective, but application consideration is subjective.

Ms. Cameron noted that expedited reviews had previously been viewed as a simple "checkmark" process due to the absence of public notice. She added that the current regulations now allow community members to apply for participation or input, strengthening the transparency and accountability of the review process.

Motioned by Ms. Cameron: to adopt preference language stemming from psych beds to all services currently regulated by DCOPN;

- General Hospital
- Neonatal Care
- Open Heart, Transplants, and Cardiac Catheterization
- Outpatient Surgical Hospital and OR Additions
- Substance Abuse Tx., ICF/IIDs, and Medical Rehab Beds
- Radiation Therapy Services

Seconded by Mr. Beckner.

5 Ayes. No opposed.

Mr. Garner stated that there would be a preference for projects meeting 3 of the criteria outlined in HB 2119

Mr. Beckner moved for adoption:

Mr. Stone seconded.

Discussion:

Ms. Davis asked whether recommending three criteria would conflict with existing language requiring two.

Mr. Garner clarified that the task force's wording reflects a preference for projects meeting three criteria, not a requirement.

Ms. Davis noted the need to address both the 2025 bill, which mandates expedited review for proposals meeting two criteria, and the 2026 bill, which provides broader guidance.

Mr. Garner emphasized that the 2026 bill directs the task force to develop specific criteria while the Board of Health establishes regulations, creating two separate processes.

Ms. Cameron stated that the recommendation should remove expedited review, though Ms. Davis pointed out that the 2025 requirements remain in effect.

Mr. Beckner confirmed that the proposal under discussion would satisfy both bills.

Mr. Garner restated the proposed preference for projects meeting at least three criteria, after which Ms. Cameron asked whether further discussion was needed.

Motion carried.

5 Ayes, no opposed.

Mr. Garner brought up the requirement for applicants to submit socioeconomic information in the application prior to staff analysis. The proposed language is as follows:

"In order to avail themselves of these preferences that an applicant submit documentation showing how the service population meets the criteria."

Ms. Davis motioned for adoption.

Mr. Stone seconded.

5 ayes. No opposed.

Mr. Garner clarified if the committee wanted to recommend further about how the 4 criteria are met, degree to which they are met, or any other requests for the commissioner.

Mr. Stone asked if there were areas in which staff found to be problematic in the current or proposed review process that the committee were able to address.

Mr. Beckner asked if this was the opportunity to create resources to strengthen COPN reinforcement.

Ms. Cameron and Mr. Stone recommended providing additional resources to support the process.

Ms. Davis suggested additional charity care restrictions and regulations. She asked about additional resources or staff to determine charity care need and enforce the regulation of the requirements.

Mr. Beckner stated that this is step 2 of the plan after changing the language.

Ms. Cameron asked about charity care language when the money was reported that there would be a fee for an additional staff person to monitor charity care regulation. She

suggested a recommendation for the commissioner to investigate staff resources into charity care conditioning. A percentage of the fees would go to the supporting of the staff.

Mr. Stone added the wording of monitoring and tracking charity care.

Mr. Beckner further clarified that this could be finding funds or finding additional staff.

Mr. Stone expressed concern that the regulations and suggestions being created will be able to be enforced to ensure charity care is provided.

Ms. Cameron stated that this is part of the provider assessment to determine taxation in resources. This is a recommendation, but not a requirement.

Mr. Stone restated the wording that "recommend additional resources to evaluate or track charity care and the COPN preference"

Ms. Cameron added "charity care and other conditions" as primary care can be included. She also stated this recommendation would be to the GA in cooperation with the department of health.

Mr. Garner clarified that this would be a separate recommendation and not part of the specific task force recommendation.

Mr. Beckner stated that this is important and needed for the continuing of charity care. Reporting and monitoring is important and there needs to be resources put aside to ensure this.

Mr. Stone stated the recommendation to the board of health is that:

The task force recognized a significant shortage of resources needed to monitor and track charity care obligations and COPN conditions. It recommended that additional resources be identified and that the General Assembly, in conjuncture or partnership with the Commissioner of Health, provide the staffing necessary to support effective oversight of charity care, COPN preferences, and other related conditions.

Ms. Davis motioned for adoption.

Mr. Stone seconded.

5 ayes. No opposed.

Mr. Garner also stated the importance of new jobs created by proposed projects- including salary and recruitment.

Ms. Davis stated that that was asking too much of the applicant and already included on a basic level in the application.

Ms. Cameron stated that the "betterment" of the community would improve the quality of life of community members.

Ms. Garner asked Mr. Jacobs if recruitment from the community is already being reported.

Mr. Jacobs and Ms. Cameron clarified that the level is "high-level" and states what positions are needed, but not specifics.

Mr. Madala questioned if the level of investment is outlined in each application.

Ms. Davis stated that the over-reaching type of FTEs are outlined in the application. The salary of the employees were included in job positions, but it is not reasonable to require for all staff to originate from the area.

Ms. Cameron stated that there could be a question about promoting recruitment from "medical deserts".

Mr. Garner stated that he did not want to burden the applicant or COPN staff, but a statement of the impact of the application could include the different populations being recruited.
Ms. Cameron requested language from staff prior to the final presentation of the task force meeting.

Mr. Garner stated this would have to be done prior to the presentation on August 28th, but the redline minutes can be voted upon and can include the changes.

Ms. Davis suggested a meeting the week of August 17th. It was determined Wednesday, August 19th in the afternoon for a virtual meeting.

Ms. Cameron left a 2:58pm for a prior commitment.

The time for the next meeting was determined to be 1:00 pm virtually on August 19th.

There were no objections to adjourning the meeting at 3:00 pm.

Expedited Review Process & Subcommittee Recommendation Summary

- *Proposed Recommendation on Expedited Review Process*

*******PLEASE NOTE this is proposed regulation currently under review*******

Project 8366 - Fast-Track

Fast Track Project - COPN Expedited Review Process

12VAC5-220-280. Applicability.

A. Capital expenditures as contained in subdivision 8 of "project" as defined in § 32.1-102.1 of the Code of Virginia or projects that involve relocation at the same site of 10 beds or 10% of the beds, whichever is less, from one existing physical facility to another, when the cost of such relocation is less than $5 million, shall be subject to an expedited review process.

B. The following projects shall also be subject to an expedited review process:

1. The establishment of a new medical care facility described in subdivision A 2 of § 32.1-102.1:3 by an existing medical care facility described in subdivision A 1 or 2 of § 32.1-102.1:3 that has an existing certificate to provide psychiatric services pursuant to subdivision B 6 of § 32.1-102.1:3, provided such new medical care facility is located in the same planning district as the existing medical care facility;

2. The addition of psychiatric beds at an existing medical care facility described in subdivision A 1 or 2 of § 32.1-102.1:3 that has an existing certificate to provide psychiatric services pursuant to subdivision B 5 of § 32.1-102.1:3, not to exceed 10 beds or 10 percent of all beds at the medical care facility, whichever is greater, and provided that the applicant has not been awarded a certificate for the addition of psychiatric beds pursuant to this provision in the previous two-year period;

3. The relocation of psychiatric beds to an existing medical care facility described in subdivision A 1 or 2 of § 32.1-102.1:3 that has had an existing certificate to introduce a psychiatric service for at least the previous 12 months pursuant to subdivision B 5 of § 32.1-102.1:3 and that is within the same planning district; and

4. Any capital expenditure of $15 million or more, not defined as reviewable in subdivisions 1 through 7 of § 32.1-102.1:3, by or on behalf of a medical care facility described in subsection A other than a general hospital.

12VAC5-220-285. Ninety-Day Review Cycle.

A. The department shall review completed applications which qualify for expedited review pursuant to 12VAC5-220-280 in accordance with the following 90-day scheduled expedited review cycles.

Batch Group	*Due Date for Complete Applications*	*Review Cycle*	
		Begins	*Ends*
A	*February 5*	*Feb. 10*	*May 10*
B	*May 7*	*May 12*	*Aug. 9*
C	*August 6*	*Aug. 11*	*Nov. 8*
D	*November 5*	*Nov. 10*	*Feb. 7*

12VAC5-220-290. Application forms.

A. Obtaining application forms. Application forms for an expedited review shall be available from the department upon the request of the applicant. The department shall transmit application forms to the applicant within seven days of receipt of such request.

B. Application fees. The department shall collect application fees for applications that request a certificate of public need under the expedited review process. No application will be reviewed until the required application fee is paid as provided in 12VAC5-220-180 B.

C. Filing application forms. Complete applications for review under the expedited review process must be received by the Department and the appropriate regional health planning agency by the close of business at least five days before the start of the batch review cycle. All requests for a certificate of public need in accordance with the expedited review process shall be reviewed by the department and the regional health planning agency which shall each forward a recommendation to the commissioner within 40 60 days from the start date of the relevant batch cycle, after the submitted application has been deemed complete. No application for expedited review shall be reviewed until the application form has been received by the department and the appropriate regional health planning agency, has been deemed complete, and the application fee has been paid to the department. The expedited review period shall begin on the first day of the applicable review cycle within which an application is determined to be complete, in accordance with scheduled batch review cycles described in 12VAC5-220-285. If the application is not determined to be complete for the applicable batch cycle within five calendar days from the date of submission, the application may be refiled in the next applicable batch cycle.

12VAC5-220-300. Participation by other persons.

Any person directly affected by the review of a project under the expedited review process may submit written opinions, data and other information to the appropriate regional health planning agency and to the commissioner prior to their final action. Any member of the public may request a public hearing for an expedited application.

12VAC5-220-310. Action on application.

A. Decisions to approve any project under the expedited review process shall be rendered by the commissioner within 45 90 days of the start of the relevant batch review cycle. The commissioner may approve and issue a certificate for any project which is determined to meet the criteria for expedited review set forth in 12VAC5-220-280.

B. If the commissioner determines that a project does not meet the criteria for an expedited review set forth in 12VAC5-220-280, the applicant will be notified in writing of such determination within 45 90 days of the receipt of such request. In such cases, the department will forward the appropriate forms to the project applicant for use in filing an application for review of a project in the appropriate review cycle in accordance with Part V of this chapter.

C. Any project which does not qualify for an expedited review in accordance with 12VAC5-220-280, as determined by the commissioner, shall be exempted from the requirements of 12VAC5-220-180 A and B when such project is filed for consideration in accordance with Part V of this chapter.

Recommendations

from the Medical Desert Committee

to the State Health Services Plan Task Force

Definitions:

"**Support Team**" means person(s) who provide non-medical support to patients (i.e., caregiver)

"**Medical desert**" means an area with unique geographic, socioeconomic, cultural, transportation and other barriers to access to healthcare. A medical desert may be geographically identified by meeting at least two of the following criteria: (i) does not have a hospital or health care provider (a) within a 30-mile radius where the population density is estimated to be less than 1,500 residents per square mile or (b) within a 15-mile radius where the population density is estimated to be more than 1,500 residents per square mile; (ii) has less than one primary care physician per 3,500 residents; or (iii) has an annual poverty rate of at least 20 percent, according to the latest data provided by the U.S. Census Bureau.

Expedited review:

If a COPN applicant demonstrates that the proposed facility or service would serve the population in a medical desert, the application shall be processed using the expedited review process set forth in sections 285 through 310 of this chapter.

- *Note: These regulatory sections for expedited review of psych beds are currently under review at OSHHR. Should these sections for any reason fail to be promulgated prior to the drafting of the SHSP, then the medical desert expedited review regulations will need to contain the full procedural language rather than incorporating by reference.*

Preference language:

In making a determination on a COPN application for a facility or service which would serve the population in a medical desert, the Commissioner shall consider the following if documentation thereof is submitted by the applicant :

1) whether the proposed facility or service would facilitate access to primary or specialty care to persons who live in a medical desert and
2) the long-term impact the proposed facility or service may have on the economic development of the community to be served, considering factors including creation of jobs both directly and indirectly and demands upon housing, schools, retail and infrastructure.

Continuum of services:

The following continuum of care language should be included in the regulations for the following services:

- General Hospitals
- Neonatal Care
- Open Heart, Transplants, and Cardiac Catheterization
- Outpatient Surgical Hospitals and OR Additions
- Substance Abuse Treatment, ICF/IIDs, and Medical Rehabilitation Beds
- Radiation Therapy Services

  To ensure the appropriate levels of patient care, providers must show evidence of providing or the commitment to provide a continuum of ambulatory services aligned to the patient population. The continuum may be accomplished through formal relationships with community-based providers.

COPN resources:

There is a significant shortage of resources needed to monitor and track charity care obligations and COPN conditions. Additional resources should be identified, and the General Assembly in conjuncture or partnership with the State Health Commissioner should provide the staffing necessary to support effective oversight of charity care, COPN preferences, and other COPN-related conditions and requirements.