DESERTCOM Committee
Agenda
April 20, 2026, at 9:00 a.m.
Perimeter Center, Training Room (B&C)
9960 Mayland Drive, Henrico, VA 23233

1. Call to Order and Welcome
2. Roll Call
3. Review of Meeting Minutes
4. Public Comment Period
5. Review and Discussion of Materials
    - Fast Track Project - COPN Expedited Review Process
    - Potential Expedited Review or Preference Criteria for Medical Deserts
6. Next Steps and Wrap Up
7. Meeting Adjournment

Meeting Minutes
SHSP TF – DESERT Committee
April 7, 2026, 1:00 pm
Virtual

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

Staff in Attendance (alphabetical by last name): Ms. Mikayla Ferguson, SHSP TF Planner; Mr. Geoff Garner, Senior Policy Analyst; Ms. Casey Miller, Policy Analyst

Guest Speaker: Rexford Anson-Dwamena of Virginia Department of Health, Office of Health Equity

Ms. Cameron welcomed the committee and called the meeting to order at 1:02 pm.

Ms. Miller called the roll.

Quorum was established.

The meeting minutes were reviewed. Mr. Phillips' name is to be corrected from Philips to Phillips. Mr. Beckner motioned to approve with that correction, Ms. Davis seconded the motion, and the committee approved the minutes.

There was no comment from the public.

Ms. Miller kicked off the discussion with the mapping request from the March 11,2026 committee meeting. Th maps would be shaded by the items included in the bill (20% or more in poverty, distance from a hospital, primary care providers) by county and, if available, any smaller geographic are (ZIP, census, etc.); each on a separate map and then showing areas that meet at least two of the requirements. What we have isn't exactly what the general assembly has outlined.

Mr. Garner explained that in the 2025 General Assembly (GA) session, the task force was tasked with developing an expediated review process for projects that meet two of the three very specific criteria, including population density of 1,500 residents per square mile, at least 1 primary care provider (PCP) per 3,500 residents, and an annual poverty rate of at least 20%. He raised the question if the committee will go back to the GA and advise them that it doesn't fit within the exact parameters, but it is a very good substitution.

Mr. Anson-Dwamena introduced himself. He explained that with the first criteria, poverty data, needs to be determined whether it is one federal poverty level (FPL) or two FPL. These are two different things; one FPL means those who are 100% below the federal poverty level and two FPL means those who are 199 below the federal poverty level. A determination needs to be made whether it is one FPL or two FPL. In either case, he can find data from the census. Public data is easy to get at a census track level. Mr. Anson-Dwamena's office is calling for analysis to be done at the census track level because county level data and census track data are not linear transformation for a given typical example. As example, if the committee looks at the poverty rate at Fairfax County by county level, it is about 6%; however, if you look at it by census track, there are certain pockets that are above 20-25% poverty rate in Fairfax County, one of the richest counties in the state. He is calling for this analysis to be done at census track so his team can look at the target areas.

The second criterion, the PCP, is that his team does not count the number of doctors, they count the number of hours the providers spend with the patients or FTEs. His office uses a methodology to estimate the number of hours providers spend with their patients. They don't map number of doctors, they map number of hours, one FTE equals one full time, or 40 hours. Not every census track will have a provider. A patient might live in a census track area within 15 miles, 30-minute drive from an area but that might not mean a provider is accessible to them. Calculating a PCP should be a function of distance. Within the threshold of 30-minute drive time, is the criteria that has access to medical care. The methodology to do that uses the population as demand, the FTE as supply and the distance as a function to calculate. Using the supply and demand to come up with a score. The higher score has higher accessibility because any provider close to this census track population has more weight than those who are further apart as the first law of geography. His team thinks that the maps should use the population, the FTEs and the distance to determine accessibility of the PCP.

The third criterion is the 15-mile radius. In Fairfax or Alexandria, it can take an hour to drive less than 15 miles due to traffic, traffic lights, speed limits, and population so his team uses travel time, not the distance to calculate. Instead of a 15-minute radius, they need to be more detailed to be able to make sure they are using the correct variables in determining this designation.

The committee and staff thanked Mr. Anson-Dwamena for his explanation and help.

Ms. Cameron asked the committee if they had any concerns deviating from the original language written by the GA in the year one bill and providing a rationale.

Ms. Dulin agreed to go back to the GA to inquire what their preliminary definitions resulted in, ask about their original intent, and advise the new methodology that Mr. Anson-Dwamena has proposed. This is going to drive the ability for everyone to see what communities are meeting those thresholds.

Ms. Cameron agreed with Ms. Dulin and said it would be beneficial to produce a map what the GA had presented and in addition, as an option, produce a map using Mr. Mr. Anson-Dwamena recommendations and talk to the GA.

Mr. Stone agreed. Having both maps draws a good differentiation that's helpful for discussion.

Mr. Beckner concurred. The committee should give both maps, what they asked for and what the committee think will get more at the heart of what they were asking for.

Mr. Phillips concurred. This is not only going to give them what they were asking for but also cause them to open their eyes because when you get down to the census track, and look at some areas of the state, the GA may not have been pondering these specific areas during the first version of this bill, including those rural areas. In the second iteration, the GA didn't mention that. They simply called it medical desert, and this approach gives them more of what they want.

Mr. Garner asked Mr. Anson-Dwamena if he could map out census track areas that have less than one PCP per 3,500 residents.

Mr. Anson-Dwamena advised he has the data to do that.

Mr. Garner asked for clarification from his understanding from previous conversations that Mr. Anson-Dwamena could not. He asked if Mr. Anson-Dwamena could put a dot on the map for every health care provider in the commonwealth.

Mr. Anson-Dwamena advised he has the location of every PCP on the map.

Mr. Garner asked if dots could be put on the map for hospitals and PCP.

Mr. Anson-Dwamena advised absolutely, yes.

Mr. Garner suggested including inpatient hospitals and outpatient surgical hospitals be shown on the map in different colored dots.

Ms. Dulin agreed that inpatient, outpatient, and PCP should all be listed on the map. These three data points are going to be extremely helpful in showing exactly where these resources are located. She asked about zip codes.

Mr. Anson-Dwamena advised they could overlay the zip code on the map by census track if needed.

Mr. Beckner asked if there is a working definition for primary care and primary care provider.

Mr. Anson-Dwamena said that there are seven categories of primary care internal medicine. If a physician assistant works in the same clinic as a doctor, the PA is counted as a quarter, they are weighted.

Ms. Cameron asked to have the definition that Mr. Anson-Dwamena uses for PCP to be included in data requested for the next meeting on April 20th.

Mr. Garner asked the COPN team if it would be beneficial in determining whether an applicant should be subject to normal processing or expedited review processing for COPN if there were maps available that show poverty levels, areas of low population density, and where hospitals and PCPs currently exist.

Ms. Scarborough confirmed that it would be helpful. It depends on the criteria that this committee decides on how helpful the map will be, but it would be a wonderful start to be able to determine where there are pockets that need additional care and services.

Ms. Kagle agreed.

Ms. Honaker said that the COPN team had been talking offline and the way they would envision this is that two of the three criteria that overlap would be easily identified and whoever the appointed person to create these maps would develop periodically, annually, bi-annually, showing the medical desert areas. The applicant would identify their project as potentially a medical desert project upon submission. The COPN team would then know whether to expedite or process as normal.

Mr. Beckner asked Mr. Anson-Dwamena if the map could eventually be interactive, where you could drill down into specific services.

Mr. Anson-Dwamena said that they may need to create a dashboard to achieve that.

Ms. Cameron confirmed with Mr. Anson-Dwamena that the higher the score, the more accessible in the methodology. She advised Mr. Anson-Dwamena that the committee would like to see 200% of the federal poverty level because it would capture the working poor and the indigent care criteria for VCU and UVA is 200% which means if you are less than 200% you get your services offered at a significantly reduced cost.

Mr. Phillips agreed that 200% of the federal poverty level is tied to the charity care condition.

Mr. Anson-Dwamena exited the call.

Ms. Cameron clarified that the request to Mr. Anson-Dwamena will be to map the original criteria laid out by the GA and additionally map the areas of the census track.

Ms. Dulin said this is a good start, but the committee will need to see the results of these maps to decipher whether the census track will show the underserved communities that need expanded access. She said it would be beneficial to have a map with each criterion separately and then one map with the three combined.

The committee and staff discussed the request to Mr. Anson-Dwamena.

The request will include a definition of PCP and the following maps:

- one map inclusive of the original criterion as laid out by the GA
- four maps of the census track with the FPL at 200% and a 30minute drive time range inclusive of the following:
    - first map will be of inpatient hospitals (a dot in one color)
    - second map will be of outpatient surgical hospitals (a dot in a separate color)
    - third map of PCP (a dot in an alternate color not already used)
    - fourth map will show the combined results above (IH, OSH, PCP)

The committee agreed that the drivetime of 15 minutes of a hospital and 30 minutes to primary care services is reasonable; however, the committee will need to make a note these times underrepresent patients living in more urban areas that utilize public transportation.

The committee discussed charity care and walked through the materials provided by VHI. The report includes charity care conditions, and it is not tied to bad debt. The COPN team advised the definitions of charity care changed and it is being changed back to what it was prior.

The committee walked through and discussed the Charity Care materials.

The committee walked through and discussed the COPN Inventory of Equipment & Services materials.

Ms. Cameron requested for the next meeting to provide VHI occupancy bed rate data and the use rate of overall beds and types of beds by region. Additionally, if there is time, a map by planning region, population 65+ to see where the nursing homes are located.

Ms. Miller summarized the materials needed for next time to include, in addition to the maps discussed with Rex, the committee would like to have the PCP defined by Rex and team, the bill relating to charity care, a map with nursing facilities by planning region (this is not for the immediate but may be used for future recommendation). Ms. Miller will send a draft email detailing the request for the maps to the committee for approval and to make any changes prior to sending it to Rex.

The meeting adjourned at 4:05 pm.

Project 8366 - Fast-Track

Department of Health

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 <u>60</u> 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. <u>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.</u>

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.

Reviewable services	Any preference or access type criteria already included or proposed to be included	Potential Expedited Review or Preference Criteria for Medical Desert Areas

2026 SESSION

INTRODUCED

26101247D

HOUSE BILL NO. 606

Offered January 14, 2026

Prefiled January 13, 2026

A BILL to amend and reenact § 32.1-276.5 of the Code of Virginia, relating to medical care facility data reporting; value of charity care.

———————

Patrons—Willett and Clark

———————

Referred to Committee on Health and Human Services

———————

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-276.5 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-276.5. Providers to submit data; civil penalty.

A. Every health care provider shall submit data as required pursuant to regulations of the Board, consistent with the recommendations of the nonprofit organization in its strategic plans submitted and approved pursuant to § 32.1-276.4, and as required by this section. Such data shall include relevant data and information for any parent or subsidiary company of the health care provider that operates in the Commonwealth. Notwithstanding the provisions of Chapter 38 (§ 2.2-3800 et seq.) of Title 2.2, it shall be lawful to provide information in compliance with the provisions of this chapter.

B. In addition, health maintenance organizations shall annually submit to the Commissioner, to make available to consumers who make health benefit enrollment decisions, audited data consistent with the latest version of the Health Employer Data and Information Set (HEDIS), as required by the National Committee for Quality Assurance, or any other quality of care or performance information set as approved by the Board. The Commissioner, at his discretion, may grant a waiver of the HEDIS or other approved quality of care or performance information set upon a determination by the Commissioner that the health maintenance organization has met Board-approved exemption criteria. The Board shall promulgate regulations to implement the provisions of this section.

The Commissioner shall also negotiate and contract with a nonprofit organization authorized under § 32.1-276.4 for compiling, storing, and making available to consumers the data submitted by health maintenance organizations pursuant to this section. The nonprofit organization shall assist the Board in developing a quality of care or performance information set for such health maintenance organizations and shall, at the Commissioner's discretion, periodically review this information set for its effectiveness.

C. Every medical care facility as that term is defined in § 32.1-3 that furnishes, conducts, operates, or offers any reviewable service shall report data on utilization of such service to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data. ~~For purposes of this section, "reviewable service" shall mean inpatient beds, operating rooms, nursing home services, cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging, medical rehabilitation, neonatal special care, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, psychiatric services, organ and tissue transplant services, radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging except for the purpose of nuclear cardiac imaging, and substance abuse treatment.~~

Every medical care facility for which a certificate of public need with conditions imposed pursuant to § 32.1-102.4 is issued shall report to the Commissioner data on charity care, as that term is defined in § 32.1-102.1, provided to satisfy a condition of a certificate of public need, including (i) the total amount of such charity care the facility provided to indigent persons; (ii) the number of patients to whom such charity care was provided; (iii) the specific services delivered to patients that are reported as charity care recipients; and (iv) the portion of the total amount of such charity care provided that each service represents. The value of charity care reported shall be based on ~~the medical care facility's submission of applicable Diagnosis Related Group codes and Current Procedural Terminology codes aligned with methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq~~ *gross patient charges*. Notwithstanding the foregoing, every nursing home as defined in § 32.1-123 for which a certificate of public need with conditions imposed pursuant to § 32.1-102.4 is issued shall report data on utilization and other data in accordance with regulations of the Board.

A medical care facility that fails to report data required by this subsection shall be subject to a civil penalty of up to $100 per day per violation, which shall be collected by the Commissioner and paid into the Literary Fund.

D. Every continuing care retirement community established pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 that includes nursing home beds shall report data on utilization of such nursing home beds to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and

INTRODUCED

HB606

2/3/26 16:00

disseminate such data.

E. Every hospital that receives a disproportionate share hospital adjustment pursuant to § 1886(d)(5)(F) of the Social Security Act shall report, in accordance with regulations of the Board consistent with recommendations of the nonprofit organization in its strategic plan submitted and provided pursuant to § 32.1-276.4, the number of inpatient days attributed to patients eligible for Medicaid but not Medicare Part A and the total amount of the disproportionate share hospital adjustment received.

F. Every hospital shall annually report, in accordance with regulations of the Board consistent with recommendations of the nonprofit organization in its strategic plan submitted and provided pursuant to § 32.1-276.4, data and information regarding (i) the amount of charity care, discounted care, or other financial assistance provided by the hospital under its financial assistance policy pursuant to § 32.1-137.09 and (ii) the amount of uncollected bad debt, including any uncollected bad debt from payment plans entered into in accordance with subsection C of § 32.1-137.09.

G. The Board shall evaluate biennially the impact and effectiveness of such data collection.