STATE HEALTH SERVICES PLAN TASK FORCE

Friday, August 28, 2026, 9:00 AM to 12:00 PM
Virginia Department of Health Office of Licensure and Certification
Perimeter Center
Board Room 1
9960 Mayland Drive, Henrico, VA 23233

Meeting Agenda

1. **Welcome and Call to Order**
   - *Ms. Karen Cameron, Chair*
2. **Approval of June 12, 2026 Meeting Minutes**
3. **Public Comment Period**
4. **Review of Statutory Obligations and Next Steps**
   - *Mr. Geoff Garner*
5. **Subcommittee Reports**
   - *i. Neonatal Committee (NEONATCom)*
     - *Dr. Kathy Baker, Chair*
   - *ii. Medical Desert (DESERTCom)*
     - *Ms. Karen Cameron, Chair*
6. **Schedule the Next Meeting**
7. **Adjournment**

State Health Services Plan Task Force

June 12, 2026

Time 9:00 a.m.

Virtual meeting (via Teams)

Task Force Members in Attendance (alphabetical by last name:

Ms. Jeannie Adams; Dr. Kathy Baker; Mr. Jim Beckner; Mr. Erik Bodin; Ms. Karen Cameron (Chair); Ms. Carrie Davis; Mr. Michael Desjadon; Ms. Tracy Douglas; Mr. Paul Dreyer; Ms. Amanda Dulin; Mr. Paul Hedrick; Mr. Deepak Madala; Mr. Dean Montgomery; Mr. Tom Orsini; Mr. Rufus Phillips; Mr. Neil Rolfes

Absent Committee Members: Dr. Keith Berger; Mr. Thomas Eppes; Mr. Marcus Stone ; Dr. Marilyn West

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

Ms. Cameron called the meeting to order at 9:04 am.

Ms. Miller called the roll; quorum was established.

Ms. Cameron called for review of the meeting minutes from February 27, 2026.

Ms. Adams referred to page 31, under the Nursing Home Summary, "data" should be corrected to "date". Ms. Miller corrected the error. Ms. Adams motioned to approve the minutes, Ms. Davis seconded the motion, and the committee unanimously approved with the noted amendment.

Ms. Cameron opened the meeting for public comment; there were none.

Ms. Cameron turned the meeting over to the chair, Dr. Baker, to walk through the redlined recommendations of Open Heart, Transplant Surgery Committee & Cardiac Catheterization (OHTC).

Dr. Baker advised that she would walk through the red line, point out the areas that were already presented during the update from the February SHSP TF meeting, and spend more

time on areas that the committee asked for clarification than on areas that were considered more favorable.

Dr. Baker started with open heart; this was reviewed at the last meeting and was found favorable by the committee. The OHTC aligned all definitions with VHI.

Expansion of service, the OHTC recommends that they align with the way data is reported to VHI so that there is a consistent standard that is can be easily reported and validated by all parties.

Dr. Baker stated that the committee agreed to use the VHI version, which clarifies 1,600 hours of service hours per cardiac operating room per year for the most recent year cardiac surgery operating rooms have been reported by VHI. She invited the rest of the OHTC committee to opine.

Mr. Dreyer gave a high-level overview of the rationale behind the recommendation to utilize APRDRGs; calling out additional practices that occur in cardiac operating rooms that don't fit into the parameters which open heart surgery is narrowly defined. He explained under establishing new service, the need to meet the volume for the definitions of APRDRGs is required and for expansion, if utilizing the CVR fully as defined as 1600 hours of service, you should be able to expand.

Ms. Dulin expressed appreciation for OHTC Committee.

Ms. Cameron paused for comment. Dr. Baker proceeded with Organ Transplantation. She shared the committee's recommendation Under Sub-section B, the proposed language to read, "Applicants shall demonstrate that they will achieve and maintain one-year survival rates equal to or higher to the most recent Tier III performance of the Scientific Registry of Transplant Recipients".

Dr. Baker moved into the Cardiac Catheterization Services section of the standards and advised the committee clarified alignment with the VHI definitions for standardization. Since the last review, there has been an increase in free standing resulting in questions from the full committee at the last SHSP TF meeting. She addressed the concerns with having two separate sections, the alignment of criteria between non-emergent and freestanding, and ensuring access would not be limited in underserved areas. She explained the recommendation to create one section, called non emergent catheterization (only offering non emergent catheterization), applicable to any program that is within a facility with a free-standing cardiac cath. It will still adhere to all of the same criteria. In bullet 2, the committee proposed adhering to a written plan in patient- selection criteria.

Bullet 7, was rewritten into a new section B, to include preferences given to programs which provided PCI 24 hours a day, seven days a week.

Ms. Dulin and Mr. Dreyer thanked Dr. Baker for the great summary and advised they are there to support any questions from the Task Force.

Ms. Cameron asked Ms. Miller to carry out a roll-call vote. With no objections, the committee approved the recommendations.

Ms. Cameron thanked the subcommittee for all their efforts and called on Ms. Dulin to walk through the proposed recommendation from the General Hospital Committee.

Ms. Dulin thanked the committee, VDH, and DCOPN. She began to speak to the many discussions this committee had relating to pediatric beds. The committee looked at the current bed standard of 80% for medical surge and observed that the pediatric units were not getting close to those occupancy standards. There should always be a pediatric bed every time there should ever be a need. She proposed recommended change for pediatric medical surge beds and pediatric beds to be considered at a 65% occupancy standard. She explained that this will free up providers to have a lower utilization, making sure that those units always have the necessary beds available.

The committee added a new subsection C for obstetric care beds, which they recommended as a 70% occupancy standard. The changes appear to have been simple; however, there were several in-depth conversations to come to these decisions.

Dr. Baker appreciated the recommendations and shared her support. Ms. Dulin thanked her for her support.

Ms. Dulin called for the removal of the previous subsection C, Capital Expenditure, as these have been repealed.

Mr. Madal called for a correction on the top of page 18, in the first paragraph, to include "less than" before "70% of obstetric beds" to maintain consistency. Ms. Miller will make the correction.

Ms. Dulin moved into Long-term acute care hospitals (LTACH). She thanked Mr. Dreyer with his help in driving much of this revision. The committee looked at how LTACHs are plating a role in the continuum. There was less of a need to change the standard and more of a need to make the language clear and consistent so that it is easier to identify the need for LTACH beds.

Mr. Dreyer shared that to be established as an LTACH, they must be certified by the Centers for Medicare and Medicaid Services (CMS) and adhere to their requirements. The committee did not want to duplicate the requirements; they wanted to rewrite the standard so that it was clearer.

Ms. Cameron thanked the committee for the fantastic job and opened the floor to a vote on the proposed recommendations.

Ms. Miller called the roll toward the vote; without objections the task force unanimously accepted the recommendations.

Ms. Cameron asked for a progress report on the open committees.

Dr. Baker shared a high-level overview with the progression of the Neonatal committee (NEONATCOM) which she chairs. She shared the deep dive into the directional approach, incorporating guidance as written in the American Academy of Pediatrics (AAP), COPN guidelines, and the work done by other states. She updated the taskforce on a productive information session, which the committee hosted including an expert panel of neonatologist and hospital administrators from INNOVA, Carillion, and UVA.

Ms. Cameron thanked the committee for their hard work and the update.

Ms. Cameron then proceeded with an update on the Medical Desert Committee (DESERTCOM) which she chairs. She shared one of the tasks to nail down a definition for medical deserts, explaining the two years ago the general assembly had a one very specific definition and a second definition was included in a bill from last year's session. The bill from last year supersedes the one from the year prior. She explained the need for an expedited was very apparent in the purpose of last year's bill. She shared that the general assembly may not have seen the regulatory work that went into psychiatric beds by the taskforce. She advised the committee has done some substantial work in the general language that exists right now. Certificates of need can be conditioned to provide a certain level of free or reduced-price care through charity care or primary care. The committee has been discussing whether they could use the preference to try to help to make sure that many services identified are regulated by COPN. She provided examples that point out that it would not make sense to put rehab facilities in every underserved area in the state because the population is not large enough to support that. Additionally, services that are being regulated by COPN can reach out and complement either pre or post care transportation services as well as other services to make accessibility easier in medical desert areas. The committee also discussed preferences given to those who provide complementary telehealth services to persons in medical deserts. She ensured that the

committee would change the terminology, medical deserts, but for the time being, it will be used when referring to these designated underserved areas. She also shared discussions among the committee to include preferences given to providers who have demonstrated specific health literacy improvement efforts and actionable plans to provide access to primary and specialty care and facilitate persons living in medical deserts.

Mr. Garner added that an ongoing obstacle in defining medical deserts has always been the inability to show where they are on a map. Mr. Garner acknowledged the huge undertaking in ascertaining exactly where these areas are. Rex Anson Dwamena, who's one of the epidemiologists in the department's Office of HealthEquity, has been invaluable to this committee in developing maps with the criteria defined by the General Assembly. Rex has been patient while working with the committees. Mr. Garner is confident in the revised of maps that will be made available when the committee reconvenes on June 26th

Ms. Cameron responded that is what the committee is hoping for. She advised the committee will be recommending overall preference language to bring additional insight into applicants.

Mr. Philips noted that the rural health transformation funding could certainly help bolster the ability of incumbent COPN holders to meet and provide what is described these preferences.

Ms. Cameron asked if Mr. Garner could briefly go over what has already been recommended and what's in regulation, additionally what will be packaged to the General Assembly from the taskforce's recommendations.

Mr. Garner advised the primary task from General Assembly was to develop an expedited review process. There are two pieces; the ability to show where the medical deserts are and defining the expedited review process. The taskforce has already developed an expedited review process for PSYCHBEDS. Mr. Garner referenced the chart on page 27, the 90-day review cycle. He continued to explain that there are four different cycles and as long as the applicant provides all the required documentation and has a complete application by the due date for review cycle, their application will be reviewed and processed in accordance with a certain timeline.

Ms. Cameron reminded the committee that they added the language on page 28, under 12VAC5-220-300, that any member of the public may request a public hearing for an expedited application. She stated that was not part of the review process. By splitting this into four batches, it is now more structured. She advised the committee also added psyche beds and certain capital expenditure projects.

Ms. Cameron asked if these were going to go into regulation.

Mr. Garner advised that these are in current regulations.

The committee engaged in conversation relating to regulation examples.

Ms. Cameron asked about the timeline relating to the last two committee's proposed recommendations (which are currently still in progress) and the package to be delivered to the General Assembly.

Mr. Garner advised there are two pieces that need to be watched simultaneously. All of the recommendations made by the subcommittees will need to be merged into the State Health Service Plan which will replace the State Medical Facilities Plan. The two will need to be reviewed to ensure nothing was missed or replicated. The second piece is the medical desert timeline of October first, as set by the General Assembly, is met.

The Commissioner must report back to the Senate Committee by October 1st and the regulations for medical deserts must be implemented by January 1st of 2027. The next hard and fast due date prescribed by the General Assembly is the January 1st deadline for regulation promulgated.

Ms. Cameron asked to continue with the previous committee's recommendations.

Mr. Garner advised it would be valuable for the committees and their chairs to review what was produced on their own.

Ms. Adams opined that the committee could review offline before the next task force meeting.

Mr. Bodine agreed.

Mr. Garner advised that Ms. Miller has handed over the committee to Ms. Fergueson.

The next task force meeting will be in person at the Perimeter Center, Friday, August 28, 2026.

Ms. Cameron asked for a motion to adjourn at 10:21 am. Mr. Phillips motioned; Ms. Dulin and Mr. Bodine seconded the motion.

Neonatal Special Care Services Committee (NEONATCOM)

12VAC5-230-940. Travel time.

A. ~~Intermediate~~ Level II neonatal special care services should be located within 30 minutes driving time one way.

under normal conditions of hospitals providing general level newborn services using mapping software as determined by the commissioner.

B. ~~Specialty~~ Level II and ~~subspecialty~~ level III neonatal special care services should be located within 90 minutes driving time

one way under normal conditions of hospitals providing general or ~~intermediate~~ level II newborn services using

mapping software as determined by the commissioner.

12VAC5-230-950. Need for new service.

No new level of neonatal service shall be offered by a hospital unless that hospital has first obtained a COPN granting approval to provide each such level of service.

12VAC5-230-960. Level II ~~Intermediate level~~ newborn services.

~~A. Existing intermediate level newborn services as designated in 12VAC5-410-443 should achieve 85% average annual occupancy before new intermediate level newborn services can be added to the health planning region.~~ An application for level II newborn services shall demonstrate capability for compliance with all applicable regulations pertaining to licensure of level II newborn services and consistency with the current level II newborn services standards published by the American Academy of Pediatrics.

B. ~~Intermediate~~ Level II newborn services as designated in 12VAC5-410-443 should contain a minimum of six bassinets.

C. No more than four bassinets for ~~intermediate~~ level II newborn services as designated in 12VAC5-410-443 per 1,000 live births should be established in each health planning region.

12VAC5-230-970. ~~Specialty~~ Level III newborn services.

~~A. Existing specialty level newborn services as designated in 12VAC5-410-443 should achieve 85% average annual occupancy before new specialty level newborn services can be added to the health planning region.~~ An application for level III newborn services shall demonstrate capability for compliance with all applicable regulations pertaining to licensure of level III newborn services and consistency with the current level III newborn services standards published by the American Academy of Pediatrics.

B. ~~Specialty~~ Level III newborn services as designated in 12VAC5-410-443 should contain a minimum of 18 bassinets.

C. No more than four bassinets for ~~specialty~~ level III newborn services as designated in 2VAC5-410-443 per 1,000 live births should be established in each health planning region.

D. Proposals to establish ~~specialty~~ level III services as designated in 12VAC5-410-443 shall demonstrate that service volumes of existing ~~specialty~~ level III newborn service providers located within the travel time listed in 12VAC5-230-940 will not be significantly reduced.

12VAC5-230-980. ~~Subspecialty~~ Level IV newborn services.

A. ~~A Existing subspecialty level newborn services as designated in 12VAC5-410-443 should achieve 85% average annual occupancy before new subspecialty level newborn services can be added to the health planning region.~~ An application for level IV newborn services shall demonstrate capability for compliance with all applicable regulations pertaining to licensure of level IV newborn services and consistency with the current level IV newborn services standards published by the American Academy of Pediatrics.

B. ~~Subspecialty~~ Level IV newborn services as designated in 12VAC5-410-443 should contain a minimum of 18 bassinets.

C. No more than four bassinets for ~~subspecialty~~ level IV newborn services as designated in 12VAC5-410-443 per 1,000 live births should be established in each health planning region.

D. Proposals to establish ~~subspecialty~~ level IV newborn services as designated in 12VAC5-410-443 shall demonstrate that service volumes of existing ~~subspecialty~~ level IV newborn providers located within the travel time listed in 12VAC5-230-940 will not be significantly reduced.

12VAC5-230-990. Neonatal services.

The application shall identify the service area and the levels of service of all the hospitals to be served by the proposed service.

12VAC5-230-1000. Staffing.

All levels of neonatal special care services should be under the direction or supervision of one or more qualified physicians as described in 12VAC5-410-443, and staffing shall be consistent with the current staffing standards as set forth by the American Academy of Pediatrics.

Redlined Version

Medical Desert Committee (DESERTCOM)

Definitions:

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

"Limited access area", also referred to as "medical desert", means an area with unique geographic socioeconomic, cultural, transportation, and other barriers to access to healthcare.

Preference language:

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

whether the proposed facility or service would facilitate access to primary or specialty care to persons who live in a limited access area The following continuum of care language should be included in the regulations for the following services:

> The Commissioner shall give preference to COPN applicants who have demonstrated or have actionable plans to provide and/or facilitate access to primary and specialty care to persons who live in a limited access area. To ensure the appropriate levels of patient care, providers of (service inserted here) must show evidence of providing or the commitment to provide a continuum of ambulatory services, aligned to their service patient population. The continuum may be accomplished through formal relationships with community-based providers.
>
> Services:
>
> - 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

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, including enforcement.

State Health Services Plan Task Force

August 28, 2026

Prepared by: Geoff Garner, Senior Policy Analyst, OLC

VDH VIRGINIA DEPARTMENT OF HEALTH

Legislative and Regulatory Requirements

- Certificate of Public Need (COPN): § 32.1-102.1 et seq.
- State Medical Facilities Plan (SMFP): 12VAC5-230
- State Health Services Plan (SHSP): § 32.1-102.2:1
  - Task Force to advise Board re:
    - Periodic revisions to SHSP
    - Specific objective standards of review
    - Types of projects which are generally uncontested
    - Projects which should receive expedited review
    - Improvements to COPN process

Task Force Powers and Duties

1. Develop by November 1, 2022 recommendations for SHSP including:
    i. Specific formulas for projecting need for medical care facilities and services subject to the requirement to obtain a COPN
    ii. Current statistical information on availability of medical care facilities and services
    iii. Objective criteria and standards for review
    iv. Methodologies for integrating goals and metrics
2. Engage private consultants or contract with private organization for professional and technical assistance and advice
3. Review SHSP annually and develop recommendations for revisions every two years

Regulations recommended by the Task Force and adopted by the Board of Health are APA-exempt, requiring only a Notice of Intended Regulatory Action and one public hearing.

Statutory Goals

- Meeting the health care needs of the indigent and uninsured citizens of the Commonwealth;
- Protecting the public health and safety of the citizens of the Commonwealth;
- Promoting the teaching missions of academic medical centers and private teaching hospitals; and
- Ensuring the availability of essential health care services in the Commonwealth and are aligned with the goals and metrics of the Commonwealth's State Health Improvement Plan

Legislation Impacting Task Force

2024 Session

- **(Chapter 423; SB277; Hashmi) directed the SHSP-TF to develop recommendations on expedited review of projects that are generally non-contested and that present limited health planning impacts, specifically including:**
  - **(a) increases in inpatient psychiatric beds,**
  - **(b) relocation of inpatient psychiatric beds,**
  - **(c) introduction of psychiatric services into an existing medical care facility, and**
  - **(d) conversion of beds in an existing medical care facility to psychiatric inpatient beds.**

Legislation Impacting Task Force

- 2025 Session
  - SB1064 (Hashmi): expedited review for relocation, conversion, and addition of psychiatric beds
    - Fast track regulatory action has been approved by Governor. Next step is publication by registrar for public comment period.
  - HB2119 (Walker) / SB1203 (Head): medical deserts
    - Required Task Force to develop expedited review process
    - Bill articulated objective, metrical criteria for determining medical deserts
- 2026 Session - HB1337 (Clark) / SB239 (Head): medical deserts
  - Required Task Force to develop 1) recommendations for designating areas with identifiable needs as defined using vague and subjective criteria ("unique…barriers to access to health care") and 2) criteria for determining when expedited review should apply to projects in such areas
  - Commissioner to report TF's recommendations to Senate Ed & Health by 10/1/26
    - BOH meets 9/17/26

Next Steps And Timeline

- Final committees reporting-out today
  - Neonatal Care
  - Medical Deserts
- Drafting of the SHSP
- Final review of draft SHSP before submission to Board of Health
  - Target: SHSP-TF meeting in December
- SHSP-TF will then transition into "review mode": *review SHSP annually and develop recommendations for revisions every two years*