Agency Response to the Department of Planning and Budget's Economic Impact Analysis (EIA) on 12 VAC 5-230 *et seq.*

Generally, VDH takes strong exception to several statements made and conclusions drawn in the EIA regarding the proposed amendments to the State Medical Facilities Plan (SMFP), specifically, those questioning the continuing existence of the COPN program and its economic benefits. As the executive agency tasked with administering this statutorily authorized program, VDH will continue its commitment to administering it according to the law. Any questions regarding the economic viability of this program is solely within the purview of the General Assembly to determine. Notwithstanding the merits of the COPN program, VDH takes exception to the following disparities in the EIA related directly to Virginia's COPN program and the SMFP:

1. The changes in the proposed SMFP that result in more restrictive standards are limited to very narrow aspects of a COPN project review and are, in a practical sense, *not* more restrictive as stated. The relatively few more restrictive criteria are more than offset by the large number of less restrictive changes. With the exception of the transplant volume and survivability criteria, which were strengthened along nationally accepted standards based on sound empirical evidence suggesting such changes result in healthier outcomes, the *overall* effect of the changes is *a less restrictive regulatory environment*.

2. The SMFP is one of twenty criteria used to assess COPN applications. To suggest that the SMFP "has a significant impact on approval/denial decisions" in relation to COPN decisions is misleading. While § 32.1-102.3 of the Code states that decisions regarding the issuance of a certificate "shall be consistent with the most recent applicable provision of the SMFP," each of the 20 criterion is measured on its own merit. Therefore, decisions to grant a certificate are *based on the entirety of the application*.

3. The statement: "The 1988 General Assembly introduced the conditioning process into the COPN process and at the same time created the Indigent Health Care Trust Fund (IHCT) to more evenly distribute the uncompensated care burden," again, is misleading. While the goal is to "more evenly distribute the uncompensated care burden," the COPN conditioning process and the IHCT are uniquely different programs. The purpose of the IHCTF, established in 1989, is to compensate those hospitals that provide the majority of the uncompensated care through their emergency room services and admissions. Only hospitals and the Commonwealth contribute to the IHCTF. Disbursements are pro-rated to the hospitals providing the charity care. The COPN conditioning process, established in 1991, grants a COPN based on an applicant's agreement to: (i) provide a level of care at a reduced rate to indigents, accept patients requiring specialized care, and (iii) beginning in 1998, "facilitate the development and operation of primary medical care services in designated medically underserved areas of the applicant's planning district." Such conditions can be placed on all applicants, is not limited just to hospitals as is the IHCTF.

4. Reducing the bed capacity from 20% to 10% of the number of non-nursing home beds was directed at continuing care retirement communities or CCRCs, *not* "existing acute care facilities" as stated in the EIA. CCRCs are contractual retirement communities that provide

residential, health care and support services. By law, CCRCs are prohibited from participating in Medicaid. Therefore, the establishment of nursing beds in CCRCs is treated differently from traditional nursing facilities, which accept patients from the community. CCRCs are allowed to accept patients from the community for the first three years of operation. Such "open" admissions allow CCRCs to admit private paying patients who may otherwise be admitted to Medicaid certified nursing facilities. Private-paying patients generate revenue for Medicaid participating facilities that helps traditional nursing facilities offset the cost of caring for Medicaid patient admissions.

In summary, VDH and the State Health Commissioner are committed to continuing its efforts in administering the COPN program effectively, as Virginia law authorizes and requires. As long as Virginia law requires the existence and administration of the COPN program, it will be carried out in accordance with law. The agency's mission requires nothing less. The General Assembly has revisited the COPN statute several times in recent years. Indeed, much public discussion regarding the difficult issues of the very existence and merits of the COPN program has occurred in recent years – of which DPB may not be fully cognizant. VDH has been an active participant in these discussions. Until such time as the General Assembly, in its wisdom, elects to revise the COPN law comprehensively, perhaps by carrying through substantially on a plan of deregulation, any analysis exploring the general merits and efficacy of the COPN program seems beyond the proper scope of an EIA on the amendments currently proposed by the State Board of Health.