

**JOINT LEGISLATIVE
AUDIT AND REVIEW
COMMISSION**

**THE
VIRGINIA
GENERAL
ASSEMBLY**

**CERTIFICATE-OF-NEED
IN VIRGINIA**

*A report in a series focusing on medical
assistance programs in the Commonwealth of Virginia*

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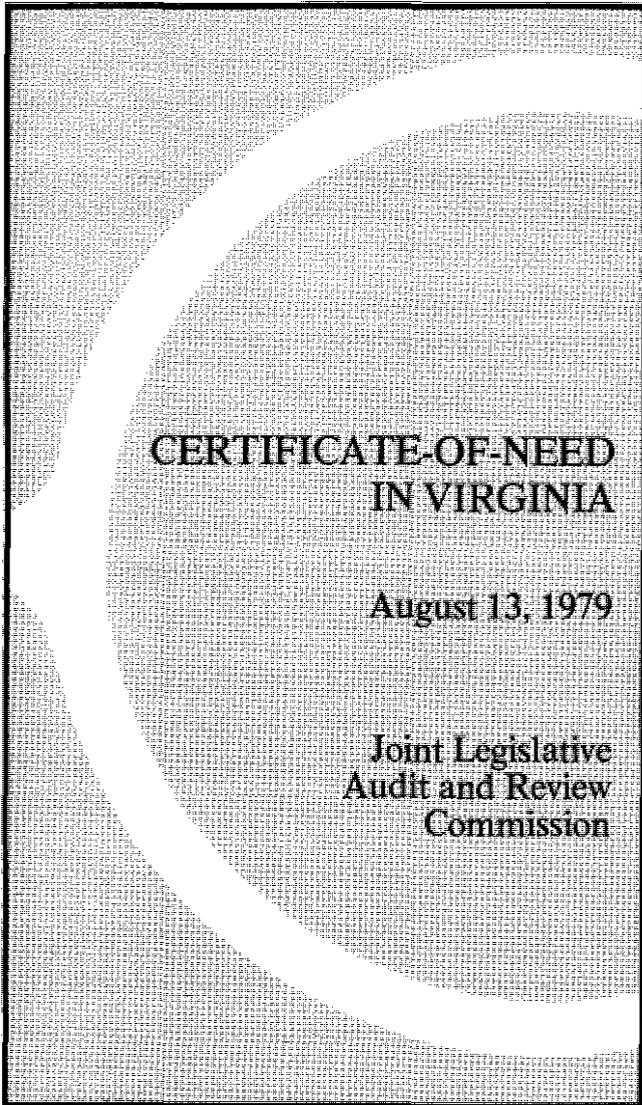
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The 1977 General Assembly charged the Joint Legislative Audit and Review Commission with studying the operation of the State's Certificate-of-Need Law. Key elements of the charge were to determine (1) whether the law served the public interest, and (2) what the probable effect would be if the Commonwealth failed to conform to federal law and regulations.

Through certificate-of-need, the State regulates the development of medical facilities and services. Responsibility for administering the certificate-of-need program rests with the State Department of Health (Bureau of Resources Development).

Under the Certificate-of-Need Law, owners of all non-federal facilities must submit an application to the State and a local health systems agency (HSA) before undertaking: (1) a capital expenditure in excess of \$150,000, (2) an alteration in bed capacity, or (3) a change in service. The final decision to either approve or deny a project rests

with the Commissioner of Health. Through June 1978, the Commissioner acted on 525 applications, worth over \$800 million. Over 90 percent of these applications were approved.

ASSESSING PUBLIC INTEREST AND COST AVOIDANCE

Nonconformance with federal regulations or termination of the certificate-of-need program would have far-reaching consequences. Virginia would lose federal funding for numerous health programs and would likely be faced with a surge of health facility construction. The Commonwealth would be unable to restrain unnecessary facility and service costs.

A JLARC REPORT SUMMARY

Public Interest (pp. 1-6, 100-105)

The Certificate-of-Need Law does serve the public interest and should be retained. Several important reasons lead to this conclusion. First, federal law mandates the State have a certificate-of-need program. If Virginia terminated its program, the State would lose at least \$35 million annually in federal assistance. Second, the marketplace for health care is largely unaffected by the economic forces of supply and demand. Without certificate-of-need, the construction of non-essential medical facilities would go unchecked. Finally, certificate-of-need provides the State its primary device for implementing health plans.

Cost Avoidance (pp. 89-99)

Since July 1973, when the law went into effect, certificate-of-need has resulted in the outright avoidance of \$83.7 million in facility and service costs and many additional millions in costs of operation related to these projects. Despite the avoidance of these costs, however, expenditures for health care continue to climb both nationwide and in the Commonwealth.

The impact of certificate-of-need on health care costs in Virginia cannot be ascertained. No conclusive statement can be made because certificate-of-need, alone, cannot contain costs. Certificate-of-need influences only one portion of total health care costs. An effect on these costs may be offset in areas over which certificate-of-need has no control. For costs to be contained, certificate-of-need should be effectively linked to other health care regulatory mechanisms.

CERTIFICATE-OF-NEED REVIEW PROCESS

The State's certificate-of-need program has two separate mechanisms through which applications may be processed: (1) a 90-day standard review defined in State and federal legislation, and (2) an abbreviated 35-day administrative review procedure developed by the State Department of Health (SDH). The administrative review process is intended to expedite the review of specific types of projects, predominately minor, noncontroversial projects or projects involving an emergency situation.

Two steps in Virginia's standard review process are not federally required—the initial public hearing and the project review conducted by the Facilities Review Committee of the Statewide Health Coordinating Council (SHCC) (See figure). The SHCC is a federally funded, state-level planning body which the General Assembly has elected to incorporate into the certificate-of-need review process. The SHCC has delegated its project review authority to its Facilities Review Subcommittee.

In general, SDH has performed well in developing an orderly procedure for processing project applications. Virginia is one of only seven states which has already received approval for its certificate-of-need program from the U.S. Department of Health, Education and Welfare (HEW). Nonetheless, several areas were found where the certificate-of-need process could be strengthened.

Administrative Review (pp. 19-22)

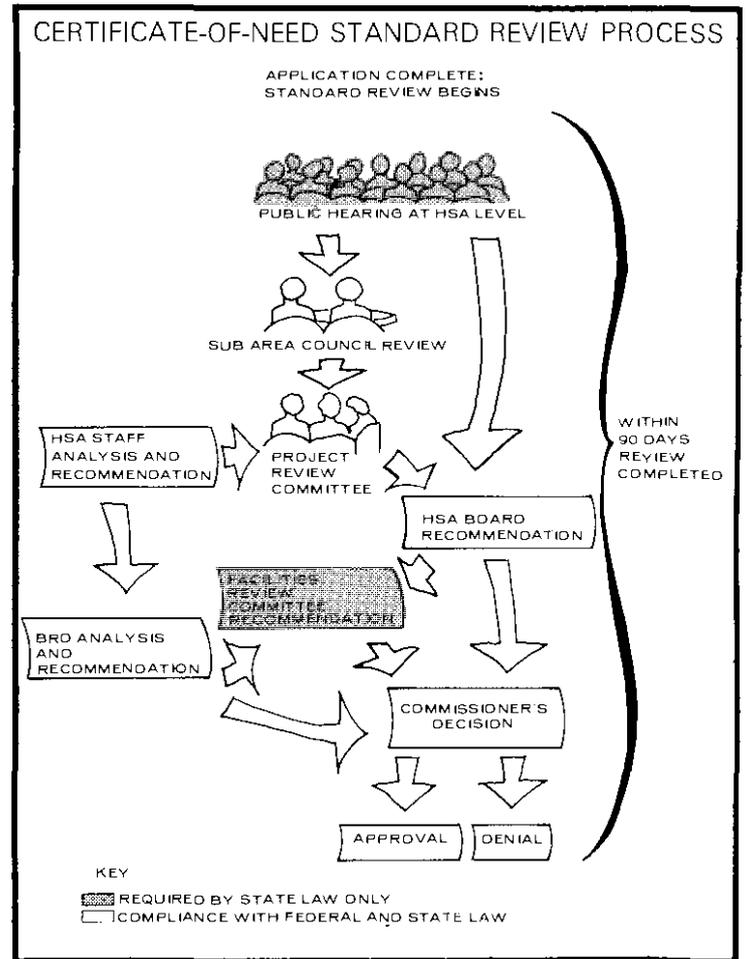
The number of projects undergoing administrative review has steadily increased. In fiscal 1978 more applications were processed through this shortened procedure than through standard review.

However, the administrative review process is not used consistently. Some projects are approved within 35 days while identical projects undergo the full 90-day standard review. In fact, there are instances where projects are reviewed twice, first under the administrative review process, and if denied, again under standard review.

Greater consistency could be achieved if the Certificate-of-Need Law were amended to include the administrative review process.

Facilities Review Committee (pp. 22-24)

The role of the SHCC Facilities Review Committee is outdated and its procedures are in need of change. Under present procedures only the applicant and a representative from the HSA can testify on an application, and only for a period of



ten minutes each. A more flexible hearing schedule needs to be adopted to allow more time for the applicant and the HSA. Other affected parties should be provided the opportunity to address the committee. If more time is allowed, consideration may need to be given to limiting the number of projects reviewed by the committee.

Cases Pending Appeal (pp. 28-35)

The certificate-of-need process involves four levels of appeal. These four levels conform to the requirements of the State's Administrative Process Act. Only the HSA and the applicant have the right to appeal, and only the applicant can appeal to the court.

To date, no project has exhausted all four levels of appeal. However, two projects have been pending at the third level, a hearing by an independent examiner, for over nine months. These delays are in violation of federal and State regulations and may jeopardize the approval Virginia has already received from HEW for the certificate-of-need program.

The General Counsel of the State Corporation Commission, the current independent examiner appointed by the Governor, needs to expedite the pending cases on appeal.

COVERAGE AND NEED DETERMINATION

The Certificate-of-Need Law defines a program that exceeds the present planning and monitoring capabilities of the State. While the Health Department has made considerable progress in narrowing the gap between the law's requirements and the basis for project need determinations, serious problems remain in the areas of coverage, planning, need estimates and monitoring.

Coverage (pp. 39-44)

Virginia has a comprehensive Certificate-of-Need Law. Only a few states exceed the Commonwealth's coverage requirements. Coverage is determined by:

- the types of facilities subject to review; and
- capital expenditures, service development and bed thresholds which, if exceeded, trigger a review.

With the exception of a new threshold for beds, the State's coverage requirements meet or exceed those required under federal regulations.

The State has had a stringent provision governing changes in bed capacity. An amendment to this provision by the 1979 General Assembly, however, may weaken the authority of the Department of Health to regulate changes in bed composition. If so, Virginia may no longer be in conformance with federal regulations. Because the department estimates bed needs by specific types of beds, it is important that all changes in bed composition be reviewed under certificate-of-need.

Health Planning (pp. 44-49)

Since enactment of certificate-of-need, project reviews have been carried out in the face of constantly changing health planning requirements.

Initially, Virginia's certificate-of-need program relied on two existing health planning mechanisms: the Hill-Burton program and the Comprehensive Health Planning Act. Neither were sufficiently developed to provide an adequate planning base from which certificate-of-need decisions could be made.

Not until December 1978, was the first medical facilities plan under the new federal health planning law (P.L. 93-641) adopted. While a vast improvement over previous plans, the new medical facilities plan still contains serious shortcomings.

The latest plan, for the first time, addresses other types of facilities besides nursing homes, hospitals and outpatient facilities. However, no estimates of need are made for these other types of facilities, just inventories. Furthermore, wide differences exist between what the 1978 State medical facilities plan addresses and what is included in the HSA regional plans.

As a result of progress made under P.L. 93-641, a framework now exists upon which plans can be steadily improved. The Health Department needs to continue to build upon that framework, to expand the coverage of its medical facilities plan.

Need Estimates (pp. 49-53)

For the most part, estimates of need have only been made for hospital and long term care beds. While recent estimates have been much more refined than those in the past, fundamental problems were found with the accuracy of the data.

To estimate bed need it is necessary to count three types of beds: existing licensed beds; beds approved under certificate-of-need but not yet licensed; and, beds exempt under certificate-of-need and not yet licensed. (The State's Certificate-of-Need Law exempts projects already underway at the time the law was passed.) An accurate inventory of these three types of beds does not exist.

Inconsistencies were found between past certificates granted, current licensed beds and the annual report issued by the Virginia Center for Health Statistics which itemizes beds by hospital and nursing home throughout the State. Several steps need to be taken to obtain accurate bed counts, among them:

- A facility should be licensed for a specific mix of beds, not just for total beds;
- The length of time a project can remain exempt should be limited; and
- The State and HSA facility plans should include an up-to-date bed inventory by facility.

Some of these steps may require legislative authorization.

Monitoring (pp. 54-65)

Monitoring can perform two useful functions. It can provide information for planning. And, second, it can provide a check on projects approved under certificate-of-need and discourage unapproved project activity.

Responsibility for monitoring approved projects was found to be fragmented. Projects are not usually followed to completion, nor is any completion report filed with BRD. The General Assembly may want to make project completion a requirement under licensure.

In addition, some projects were found to have been undertaken without approval. Greater attention needs to be given to detecting unauthorized project activity.

DISTRIBUTION OF BEDS

One of the basic goals of certificate-of-need is to prevent unnecessary duplication of services and facilities. To assess whether this goal was being achieved, JLARC assessed the impact of the certificate-of-need program on the distribution of hospital and nursing home beds.

Hospital Beds (pp. 70-79)

For the most part, certificate-of-need has been successful in curbing the growth of new hospital beds. At the same time, however, certificate-of-need has not substantially reduced the large number of existing surplus hospital beds that are spread throughout the State.

Since the enactment of the Certificate-of-Need Law nearly 2,500 new beds have been added State-wide, most of which were exempt from review. Only 700 of these beds were approved under certificate-of-need. In contrast, about 4,000 existing beds have been either replaced, converted, or renovated.

The current State facilities plan projects a surplus of over 2,100 hospital beds by 1983. The cost of maintaining these unneeded beds may be as high as \$54 million annually. These costs are passed along to third party payers, the State (through medicaid), and eventually the citizen in the form of higher insurance premiums.

The Health Department does not believe it has sufficient authority to deal aggressively with existing beds despite existing statutory language. Until the authority of the Health Department to deal with existing beds is clarified, the original purposes of certificate-of-need cannot be fulfilled.

Nursing Homes Beds (pp. 79-84)

Certificate-of-need has played a prominent role in achieving an orderly distribution of nursing homes throughout the Commonwealth. Since the enactment of certificate-of-need legislation, nearly 8,000 new nursing home beds have been approved. Sixty-one nursing homes have been built, a reflection of the growth of the nursing home industry in recent years.

CONCLUSION

The passage of certificate-of-need legislation marked the beginning of a new role for the Commonwealth in health care regulation. The necessity for that role remains as real today as at the time of the law's enactment. Yet, the purposes of the law as embodied in the statute have not entirely been fulfilled. Aspects of the process need improving, plans need to be made more comprehensive, and estimates of need must be more timely and accurate. Most important, the authority of the Health Department to deal with existing beds must be clarified if the objectives of the law are to be satisfactorily met.

JLARC

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JLARC is an oversight agency of the Virginia General Assembly. Its primary function is to carry out operational and performance evaluations of State agencies and programs.

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Preface

The Joint Legislative Audit and Review Commission has a statutory responsibility to carry out operational and performance reviews of State agencies and programs. In 1977, the General Assembly directed the Commission in Section 32-211.17, Code of Virginia, to review the operation of the Medical Care Facilities Certificate of Public Need Law.

In its statutory mandate, the General Assembly raised four general questions. (1) Does the law serve the public interest? (2) Should the Commonwealth conform to federal law and regulations? (3) To what extent is the Commonwealth free to depart from federal law and regulations? And (4) What are the likely effects of failure to conform to federal law and regulations? Findings, conclusions, recommendations, and options available to the Department of Health and the General Assembly, consistent with the statutory objectives of certificate-of-need, are contained in this staff report.

In view of the current health care market and federal and State regulatory goals, the necessity for the certificate-of-need process is as real today as at the time the law was enacted. First, the health care market does not respond to the same economic forces of supply and demand as most other private industries. Second, under the present health care system, reimbursement of health care expansion is virtually assured through third party payers. Third, without certificate-of-need, health care expansion would be unrestrained, and unneeded expansion could result in equally unneeded health care cost increases. The report, therefore, recommends continuation of the certificate-of-need program but suggests several modifications to make it more efficient and effective.

A copy of the draft report was sent to the Governor on June 27, 1979. On August 13, 1979 the Commission approved transmittal of the report and an Action Agenda consisting of 12 recommendations to the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health. The Action Agenda also included six additional suggestions for legislative consideration which did not receive the full endorsement of Commission members.

An exposure draft was reviewed by the State Department of Health, the Statewide Health Coordinating Council (SHCC), the SHCC Facilities Review Subcommittee, the Secretary of Human Resources, and each of the five Health Systems Agencies. Agency replies are included in the Appendix.

On behalf of the Commission staff, I wish to acknowledge the cooperation and assistance provided by the Department of Health, by the SHCC, and by each of the five Health Systems Agencies visited during the course of the review.



Ray D. Pethtel
Director

August 13, 1979

I. Introduction

The adoption of certificate-of-need legislation by the 1973 General Assembly marked the beginning of a new role for the Commonwealth in health care regulation. The State became the regulator of development for all nonfederal medical facilities. For the first time, owners of such facilities were required to obtain prior State approval before undertaking: (1) a capital expenditure in excess of \$150,000, (2) an alteration in bed capacity, or (3) a change in service.

Through certificate-of-need, it was expected that unnecessary construction of health facilities could be prevented and a more orderly development of medical resources achieved. The ultimate goal of the certificate process was a better distribution of facilities and services, and a lower cost to the health care consumer.

The necessity for certificate-of-need remains as real today as at the time of the law's enactment for several important reasons.

First, federal law mandates the State have a certificate-of-need program. If Virginia terminated its program, the State could lose at least \$35 million annually in federal assistance.

Second, the marketplace for health care is largely unaffected by the economic forces of supply and demand. The potential for non-essential medical facilities being built is high. Since 1973, one significant accomplishment of Virginia's certificate-of-need process has been the outright avoidance of \$83.7 million in facility and service costs and many additional millions in costs of operation related to those projects.

Finally, without certificate-of-need, the State would forfeit its primary device for implementing health plans.

Despite continued necessity, the State's certificate-of-need program has not entirely fulfilled the purposes of the legislation. The program still requires:

- greater administrative consistency;
- a more stable health planning process for determining facility and service needs;
- better defined authority to deal with existing beds;
- a strengthened monitoring system to provide reliable information on the existing supply of beds and to discourage unapproved changes in beds and services;

- an effective strategy for identifying and eliminating surplus hospital beds; and
- enhanced coordination with other health care regulatory functions.

Purpose and Scope

During the 1977 session, the legislature directed JLARC to study the operation of the Certificate-of-Need Law. JLARC's study of certificate-of-need has also been incorporated as part of a larger review of State health care programs being carried out under the pilot study provisions of the 1978 Legislative Program Review and Evaluation Act.

Purpose. The Legislative charge to JLARC contained in Section 32-211.17 of the *Code of Virginia* defines the purpose of this report.

1. Conduct a study of the operation of certificate-of-need to determine whether such law serves the public interest.
2. Determine the extent to which the public interest requires the Commonwealth to conform its policy regarding certificate-of-need to federal law and related regulations.
3. Determine the freedom of action available to the Commonwealth consistent with federal law and related regulations.
4. Determine the probable effect of failure by the Commonwealth to conform to federal law and regulations.

The Legislative Program Review & Evaluation Act, §30-68, *Code of Virginia*, provides that evaluations consider in addition:

that there is a valid public need for the program or agency; that legislative intent is being carried out; that program and agency performance has been in the public interest; that program objectives have been defined; that intended program outcomes are measurable and have been accomplished; that program and agency operations are managed efficiently, economically, and effectively; or such other specific criteria as the Commission or standing committees deem necessary and desirable.

Finally, the Commission is charged by §30-58.1 and §30-70 to report its findings to the Governor, appropriate standing committees, and members of the General Assembly and make recommendations on:

1. Ways in which the agencies may operate more economically and efficiently;
2. Ways in which agencies can provide better services to the State and to the people; and
3. Areas in which functions of State agencies are duplicative, overlapping, or failing to accomplish legislative objectives or for any other reason should be redefined or redistributed.

Because the five health systems agencies in Virginia are federally funded and not subject to State control, the analysis of the certificate-of-need operation focuses on State-level activity involving the State Health Commissioner, Health Department staff, and the Statewide Health Coordinating Council.

Approach. The legislative charge to JLARC has as its principal element determining if certificate-of-need serves the public interest. Based on legislative reports and the certificate-of-need legislation, JLARC felt the public interest (in operational terms) would be served if the certificate process helped:

- provide an orderly administrative procedure for resolving questions of need;
- ensure that only needed medical facilities were constructed; and
- contain rising health care costs by preventing unneeded development.

In order to assess whether the law was serving the public interest, JLARC staff obtained data from a number of sources. Interviews were conducted with hospital and nursing home administrators, State Health Department personnel, health systems agency staff, and other participants involved in the State's certificate-of-need process. JLARC staff also conducted an extensive review of reports and publications pertaining to certificate-of-need.

Statistical data came primarily from JLARC staff data collection efforts. The Department of Health does not keep a central information file on all project reviews. Instead, there are a variety of sources that reflect different types of project information for different time periods.

To provide a consistent data source upon which to base its analysis, JLARC computerized data on all projects approved or denied by the Commissioner from July 1, 1973 to June 30, 1978. This amounted to 525 separate reviews. Detailed information on each proposed project and its progress through the review process was collected and analyzed. Additional data on FY 1978 reviews were collected to permit a more in-depth analysis of activity during this period.

A technical appendix has been prepared to explain more fully the methodology and research techniques.

Organization. The report reviews each phase of the certificate-of-need process administered by the State Department of Health. This chapter provides general background information on the process including legislative history, review procedures, and review activity. Chapter II examines the orderliness of the application review procedures for resolving questions of need. Chapter III discusses various methods employed by the State for determining facility and service needs. Chapters IV and V analyze the impact of certificate-of-need on preventing unneeded development and containing health care costs. Chapter VI presents alternatives the State has regarding its certificate-of-need program. This discussion addresses specifically the desirability of the Commonwealth complying with federal law and the probable effects of noncompliance.

Legislative History

State interest in certificate-of-need regulation began in the early 1970's. The 1971 Special Session of the General Assembly passed Senate Joint Resolution 20 to establish a "Commission to study prepaid health care plans and costs of medical, surgical and hospital services and insurance." One of the recommendations made by that study commission was passage of certificate-of-need legislation. The Virginia Hospital Association and Blue Cross of Virginia endorsed the concept.

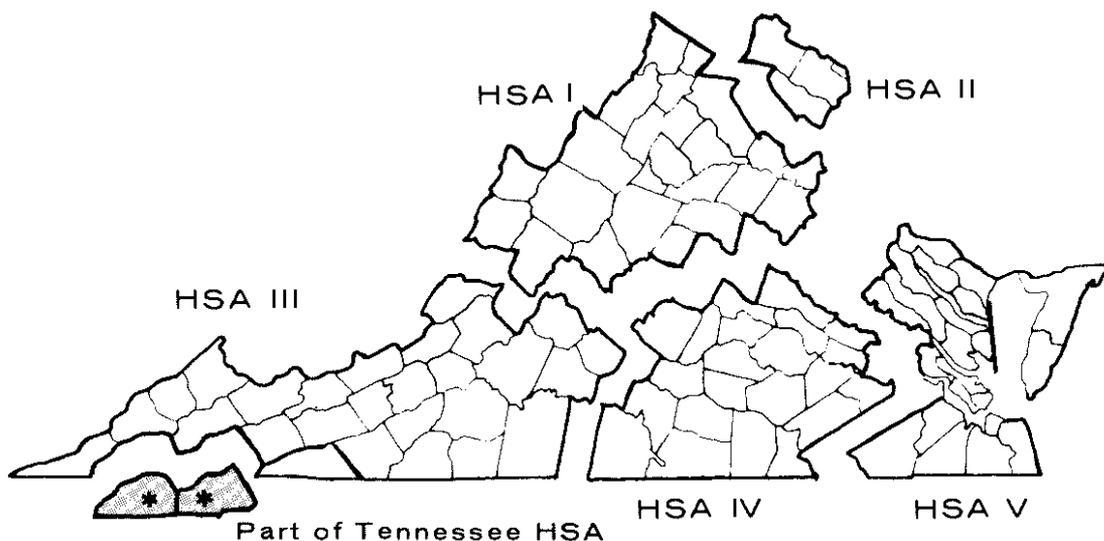
At about this same time concern was also being expressed nationally over the rising costs of medicaid and medicare. Congress amended the Social Security Act in 1972 to tighten controls over these programs. One of the added provisions (Section 1122) permitted the Department of Health, Education, and Welfare (HEW) to deny reimbursements under the medicaid, medicare, and maternal and child health programs, for the portion of any construction costs undertaken without State approval. With the enactment of the State's Medical Care Facilities Certificate of Public Need Law in 1973, Virginia entered into a voluntary agreement with HEW to implement Section 1122.

The National Health Planning and Resources Development Act of 1974, P.L. 93-641, contained provisions which mandated all states to develop a certificate-of-need program by 1980 conforming

to federal guidelines. As a result of this federal requirement, the "1122" agreement became obsolete and was terminated by the State in 1976.

Virginia's original certificate-of-need legislation anticipated most federal requirements. A major change resulting from the act involved the creation of a strengthened regional health planning function. Five health systems agencies (HSAs) were established in the State (Figure 1). Among its duties, an HSA is responsible for reviewing certificate-of-need applications in its area for conformance with regional health plans.

Figure 1
HEALTH SERVICE AREAS IN VIRGINIA



*Washington and Scott County and the City of Bristol, while part of a Tennessee Health Service Area, are subject to Virginia's Certificate-of-Need Law.

Source: JLARC.

Certificate-of-Need Process--A Brief Overview

Except for minor amendments to the law and the development of a shortened, alternative review mechanism by the Department of Health, the State's certificate-of-need process has essentially remained intact since the inception of the program on July 1, 1973. In December 1978, the Department of Health, Education, and Welfare

officially designated Virginia's program as complying with federal guidelines. Virginia is one of only seven states whose program has received full designation.

The Certificate-of-Need Law requires all projects that exceed \$150,000, that change bed capacity, or that represent a change in service to be reviewed. Virginia has two review processes: (1) a standard review defined in State and federal legislation and (2) an abbreviated administrative review developed by the Department of Health in 1975.

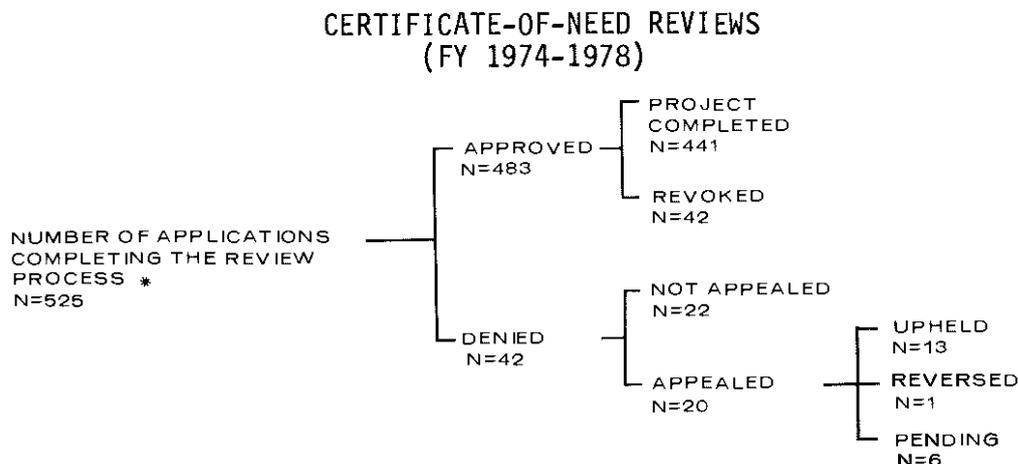
The administrative review process is intended to expedite the review of specific types of projects, predominately minor, noncontroversial projects or projects involving an emergency situation. A project application submitted under administrative review takes a maximum of 35 days to process, compared to 90 days under the standard review procedure.

Project applications undergo several different stages of review beginning at the health systems agency level. The State Health Commissioner has final authority in approving or disapproving a project. The Commissioner's decision may be appealed, however. The appeal process under certificate-of-need involves several stages beginning with an informal reconsideration by the Commissioner and concluding with an independent court review.

Certificate-of-Need Review Activity

Through June 30, 1978 the Commissioner of Health acted on 525 applications. Over 90% of all applications were approved, though some were later revoked (Figure 2). Few decisions have

Figure 2



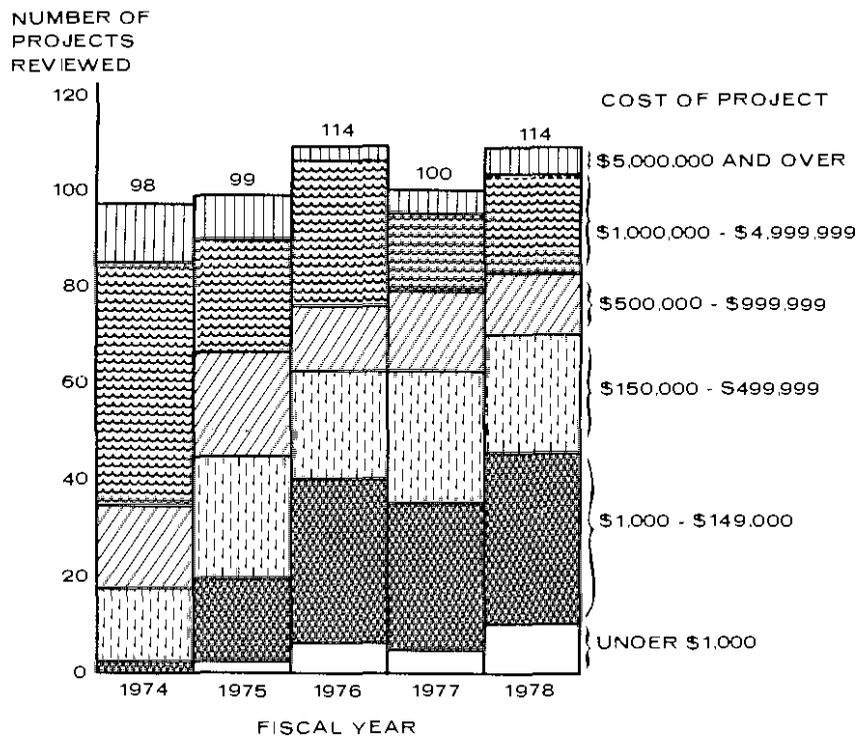
* SOME PROJECTS WERE LATER RE-REVIEWED

Source: JLARC.

been appealed. Only one decision--a denial--was reversed as of June 30, 1978. However, no decision has yet been appealed through all stages of the review process. Six appeals were pending.

The number of applications reviewed by the Commissioner has remained steady. Yearly certificate-of-need decisions range from a low of 98 the first year of the review process, to a high of 114 during FY 1978 (Figure 3). The average number of decisions made each year is 105.

Figure 3
 CERTIFICATE OF NEED
 REVIEW ACTIVITY



Source: JLARC.

Types of Projects Reviewed. Of the 525 applications reviewed by the Commissioner, 233 involved hospitals, 153 involved long term care facilities, and the remainder involved other types of medical facilities such as kidney dialysis centers, mental health centers, and home health agencies. Seven reviews involved a request for an entirely new hospital, 67 applications for new long term care facilities have been reviewed over the five year period, a reflection of the recent growth of the nursing home industry in the State.

The largest application involved a large scale renovation of the Medical College of Virginia in Richmond. A certificate was granted for that project amounting to \$82 million. In contrast, some certificates have been granted for projects involving no capital expenditure at all, but a new service.

Changes in Applications. Over the years, the nature of the applications being reviewed has changed. The average estimated cost of a project fell from a high of \$3 million the first year of the program to an average of \$1.3 million in succeeding years. One reason for this decline is that fewer requests for new facilities are being submitted. In fiscal 1978, only 11% of all applications acted on by the Commissioner represented new facilities, compared to 34% the first year.

A second change in certificate-of-need applications is that in recent years proposals to add beds have declined. In FY 1974, such projects accounted for over 75% of total review activity. From FY 1976 to FY 1978, this figure fell to under 50%.

Finally, the number of applications approved under the administrative review process has steadily increased. In FY 1978, 60% of all applications were processed under administrative review. The next chapter, which deals with the overall organization and administration of the State's certificate-of-need process, examines the effects of this change in greater detail.

II. Certificate-of-Need Review Process

One of the legislatively defined purposes of certificate-of-need is to provide an orderly administrative procedure for resolving questions of facility need. Orderliness implies that the review process is: (1) clearly defined; and, (2) consistently applied to all applicants.

On the whole, the Health Department's development of review procedures has been commendable. JLARC's analysis did find several areas where State action would enhance the orderliness of the review process.

REVIEW PROCEDURES

The certificate-of-need program has two separate mechanisms through which applications may be processed--the standard and administrative reviews. Both processes are administered by the Department of Health and involve several reviewing bodies.

State-Level Administration

The development and administration of the certificate-of-need program is the responsibility of the Health Department's Bureau of Resources Development (BRD). BRD reviews all applications processed through either the standard or administrative review procedures.

BRD is one of three bureaus within the Division of Health Planning and Resources Development. This division also serves as staff to the federally required State health planning body--the Statewide Health Coordinating Council (SHCC). BRD's budget reflects its dual role as both a bureau within the State Department of Health and a participant in federally mandated health planning activities. As seen in Table 1, 75% of the bureau's budget is comprised of federal funds.

Table 1

BUREAU OF RESOURCES DEVELOPMENT BUDGET

	<u>FY 1978</u>	<u>Percent of Total</u>
Federal	\$132,069	75%
State	44,024	25%
Total	<u>\$176,093</u>	<u>100%</u>

Source: Department of Health.

Currently, BRD has eight professional staff, four of whom are assigned full-time to the certificate-of-need program. The remaining staff members perform planning and regulatory functions closely related to this program. BRD's staff commitment to certificate-of-need activities compares favorably with that of surrounding states (Table 2).

Table 2

STAFF COMMITMENT TO CERTIFICATE-OF-NEED
IN VIRGINIA AND SELECTED STATES, FY 1978

<u>State</u>	<u>Number of Reviews</u>	<u>Staff Size</u>	<u>Review/Staff Ratio</u>
Virginia	114	4	28.50
West Virginia	211	4	52.75
Tennessee	132	4	33.00
Maryland	100	4	25.00
South Carolina	53	5	10.60
Kentucky	330	6	55.00

Source: JLARC.

Standard Review Process

The standard review process begins with receipt of an application by the Bureau of Resources Development. BRD then forwards a copy to the health systems agency (HSA) where the proposed project is located. BRD and the HSA must jointly agree that the application is complete before the formal review process is triggered.

A number of steps must be followed by an applicant at both the HSA and State levels before a final decision is rendered by the Health Commissioner (Figure 4). Legally, the Commissioner must act within 90 days of the date the application is accepted for review.

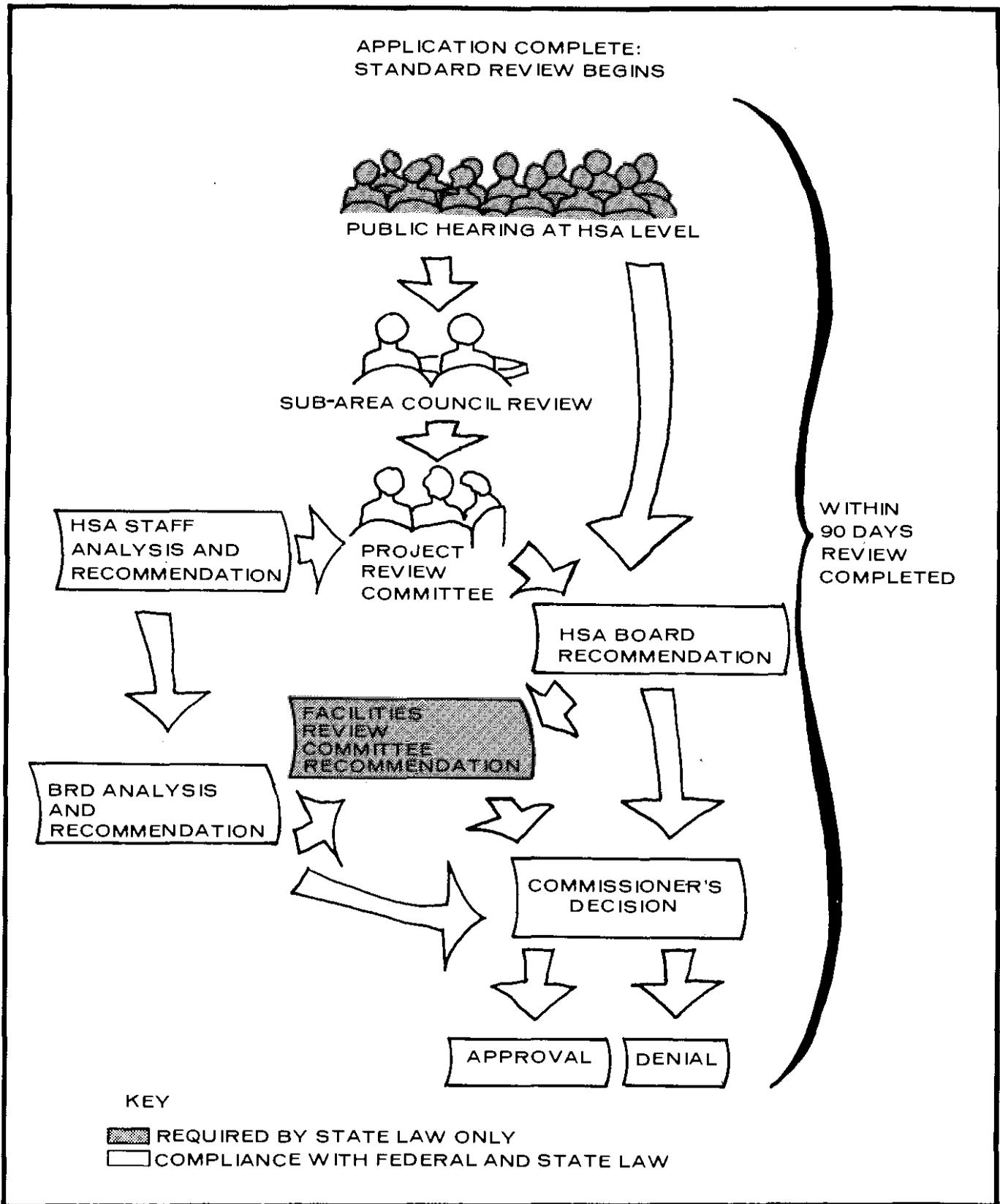
Two steps that go beyond federal requirements have been introduced into the State's standard review process--the initial public hearing and the review of project applications by the Facilities Review Committee of the Statewide Health Coordinating Council. With the exception of these two modifications, Virginia's process conforms strictly to federal regulations.

HSA Level. Although all HSAs generally follow similar review procedures, some differences do exist.

All HSAs are made up of both a staff and a Board. As required by State and federal law, the Board alone makes a final certificate-of-need recommendation to the Commissioner of Health.

Figure 4

CERTIFICATE-OF-NEED STANDARD REVIEW PROCESS



Source: JLARC.

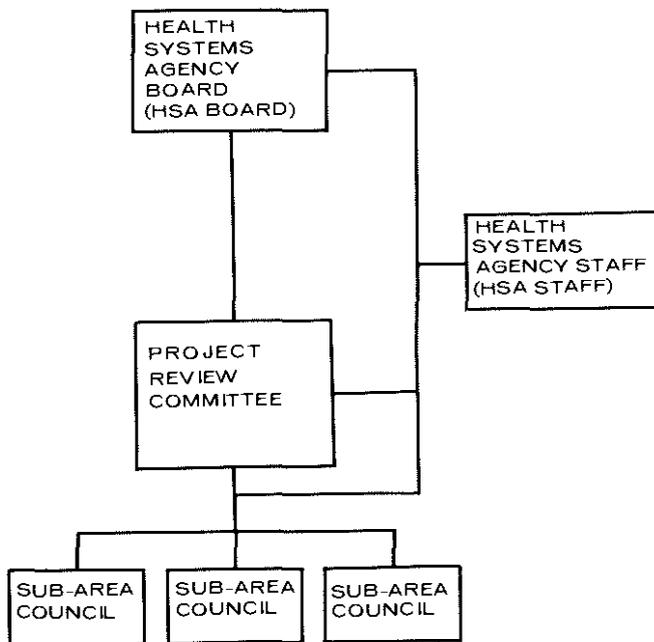
The staff performs analyses of each project and in most HSAs makes recommendations to the Board.

The review process is initiated at the HSA level with a public meeting on each application. Such a meeting is required under the State's Certificate-of-Need Law. Federal law only requires a public hearing if requested by a person directly affected by the project.

After the public hearing, the Board may also receive recommendations on a project from two other bodies--the sub-area council and the project review committee (Figure 5). Neither body, however, is required under federal or State law to perform a project review.

Figure 5

HSA LEVEL PARTICIPANTS
IN CERTIFICATE-OF-NEED PROCESS



Board: Virginia is divided into five health service areas each overseen by an HSA Board. The Boards are federally funded, quasi-public bodies of health care consumers and providers.

Staff: Each HSA has a federally funded professional staff ranging from six to fifteen individuals. Each staff has at least one person responsible for certificate-of-need.

Project Review Committee: Several HSAs have a committee of the full Board review applications for a certificate.

Sub-Area Council: Three HSAs have advisory bodies referred to as sub-area councils.

Source: JLARC.

Three of the five HSAs in Virginia, Northwest (HSA I), Southwest (HSA III), and Central Virginia (HSA IV), use sub-area councils to review certificate-of-need applications. The jurisdiction of a council is generally limited to a particular planning district. In some HSAs the public hearing is held in conjunction with the sub-area council review.

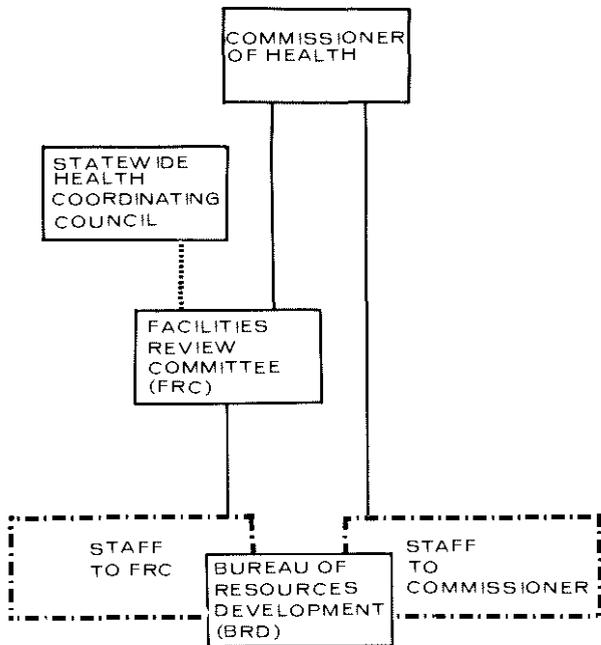
The recommendation of the sub-area council is then forwarded either to a special committee of the Board set up to review certificate-of-need projects, or if none exists, directly to the Board. This committee is called the Project Review Committee. All HSAs but one, Central Virginia (HSA IV), have a Project Review Committee.

The final recommendation of the Board must be forwarded to the Health Commissioner within 60 days of the time an application is accepted for review.

State Level. Under federal law, an application could proceed directly to the Commissioner after HSA review. However, State legislation has injected an additional step into the standard review process--a review by the SHCC, which has delegated its authority to the Facilities Review Committee (Figure 6). Following the HSA review, the Facilities Review Committee holds a public hearing at which the applicant and HSA each testify. An analysis of the project by BRD staff is submitted at this time. The committee, acting on behalf of the SHCC, then formulates a formal recommendation to the Commissioner. The Commissioner then approves or denies the application.

Figure 6

STATE LEVEL PARTICIPANTS
IN THE CERTIFICATE-OF-NEED PROCESS



Commissioner of Health: The Commissioner is the State official responsible for certificate-of-need. He makes all certificate-of-need decisions.

Statewide Health Coordinating Council: This council is a federally funded, quasi-public body of health care consumers and providers.

Facilities Review Committee of SHCC: The Statewide Health Coordinating Council (SHCC) has delegated its certificate-of-need authority to the Facilities Review Committee.

Bureau of Resources Development: Within the State Department of Health, BRD is responsible for certificate-of-need. This bureau administers the program and provides staff assistance to the Commissioner and the Facilities Review Committee of the SHCC.

Source: JLARC.

In making his decision the Commissioner has at least three recommendations to consider: the HSA Board's, the Facilities Review Committee's and BRD's. Before rendering his decision, the Commissioner may also consult with other staff members of the Department of Health. Once the Commissioner has approved or denied an application, his decision is communicated by letter to the applicant and affected HSA.

Administrative Review Process

The administrative review process was devised by the Department of Health in 1975 as a means of expediting the review of minor, noncontroversial projects. Essentially, this review process is designed to provide a shortened alternative for reviewing projects that technically must be covered under the law.

Eligibility. Types of projects eligible for administrative review are those involving small dollar amounts; projects which have no impact on existing beds or services; or projects needed to meet an emergency situation.

The technical eligibility requirements for the utilization of administrative reviews involves projects representing:

- a capital expenditure of a medical care facility in excess of \$150,000 which does not change bed capacity, replace existing beds, or substantially change the services offered by the facility; or,
- a capital expenditure of less than \$150,000 which does change the bed capacity or the services offered by a facility; or,
- a capital expenditure in excess of \$150,000 involving an emergency situation recognized as such by the Commissioner.

Examples of projects which have been approved under administrative review include, a \$2.7 million parking garage at a large hospital, and a new \$5,000 occupational therapy department in a hospital.

Since projects reviewed under the administrative review process tend to be simpler, less detailed information is required from the applicant. In fact, there is no formal application under administrative review but a format of suggested items the applicant should cover in requesting the certificate.

Procedural Differences. A key difference between the standard and administrative reviews is the elimination of the SHCC's Facilities Review Committee from the process. While this committee is notified of each administrative review application, it does not formally act on them.

Another important difference under the administrative review process is that only projects approved by the HSA can be considered by the Commissioner. Should the HSA Board deny the application, no further action is taken. If further consideration is desired, the project must be resubmitted, this time through the standard review process.

The Health Commissioner's decision making authority also takes on a slightly different character under administrative review. Although the Commissioner can approve projects under administrative review, technically he does not deny an application under this process. Rather, he notifies an applicant that the administrative review request was not accepted and a standard review is required. A denial either at the HSA level or by the Commissioner may actually lengthen the review process, since the applicant essentially must begin the process over again. A few projects have been reviewed under the standard review process after having been denied during administrative review.

The administrative review process is optional for the applicant. A project, even if eligible for administrative review, does not have to undergo this shortened review unless the applicant is willing to take the risk of having to resubmit the application in the event it is denied by either the HSA or the Commissioner.

Conclusion

Overall, the State Department of Health has succeeded in establishing an organizational framework and review process for carrying out the provisions of State and federal certificate-of-need legislation. An important accomplishment has been the introduction of the administrative review procedure to expedite the processing of minor, noncontroversial projects.

Still, many of the basic steps involved in the application, review, decision, and appeal phases of the certificate-of-need process require strengthening. The following sections identify some specific weaknesses noted during the JLARC study. Recommendations are presented to correct these deficiencies.

APPLICATION

The preparation and filing of a certificate-of-need application is the most time consuming part of the review process. The amount of time taken in preparing and filing an application is a hidden part of the process. Currently, applicants are not fully informed of this aspect of the review. BRD should provide a better representation of application procedures so that applicants can anticipate the actual cost and time involved in this stage of review.

Cost of Application

It is difficult to ascertain with any certainty the cost of preparing a certificate-of-need application. The Virginia Hospital Association (in response to a JLARC inquiry) cites cost estimates for filing an application ranging from \$385 for the replacement of a single piece of equipment to \$71,925 for a major hospital remodeling and expansion project. The Virginia Medical Society (in response to a similar inquiry) estimates the cost ranges from \$2,000 to \$5,000 for an application for the purchase or rental of a new piece of equipment and from \$30,000 to \$80,000 for an application to construct a new 200 bed hospital.

On the other hand, some hospital administrators contacted at random by JLARC felt the costs to be minimal. As one administrator stated, "the information requested on the application form should be readily available as part of a facility's internal planning. Any good administrator should have the information anyway." This view seemed to be shared by administrators of larger facilities. Smaller facilities are less able to absorb the costs of adequate planning.

It appears that the actual cost of applying for a certificate-of-need varies by facility and by type of project. In order for facility administrators to estimate their cost of applying, they must first understand what the application process involves. In this regard, current State procedures can be misleading.

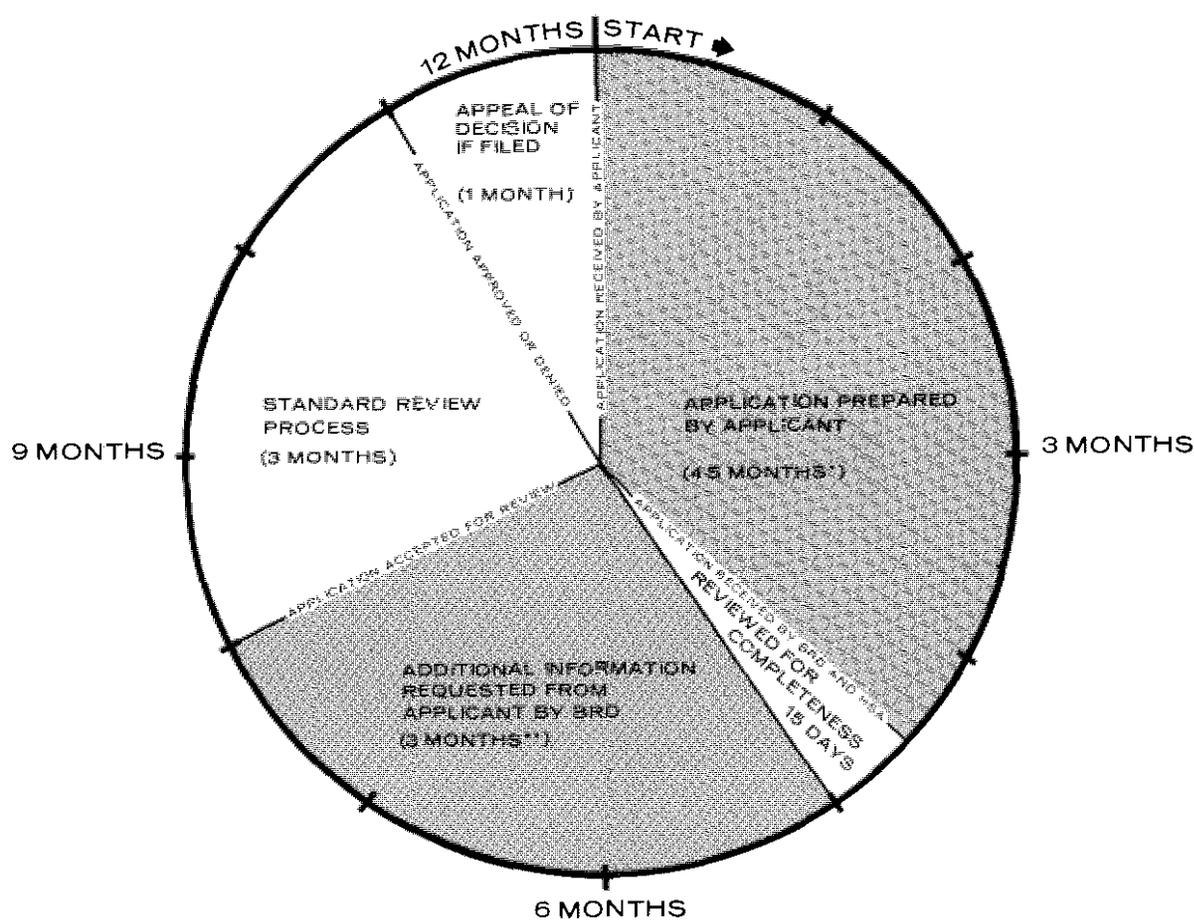
Application Time

In FY 1978, the preparation, filing, and review of an application under standard review procedures took approximately 11 months--eight months longer than the 90 days specified under law. These eight additional months were consumed by the preparation of an application.

State regulations provide the Bureau of Resources Development (BRD) 15 days to evaluate the completeness of an application (commonly referred to as a "completeness review"). At the end of this period, BRD must notify the applicant whether the State and the HSA consider the application complete. If the application is not considered complete, additional information may be requested. This can take an unlimited amount of time since repeated requests can occur. As a result, an applicant may begin the review process with the notion that it will take 90 days, only to later find that considerably more time was needed. The State should take steps to more fully explain the application process, and if possible, shorten the time involved in this stage of certificate-of-need.

Figure 7 illustrates the overall application time for all standard reviews acted on in FY 1978. As can be seen, the process begins with BRD forwarding a copy of an application to a prospective applicant. An average of 4.5 months elapsed between the time an application was sent and the time it was returned by the applicant. During that time the applicant may have consulted with BRD or the HSA regarding information to be incorporated into the application.

Figure 7
 AVERAGE TIME TO COMPLETE STANDARD
 REVIEW PROCESS IN FY 1978



*AVERAGE TIME BASED ON 33 OF 44 APPLICATIONS REVIEWED IN FISCAL 1978
 **AVERAGE TIME BASED ON 43 OF 44 APPLICATIONS REVIEWED IN FISCAL 1978
 ■ PERIOD NOT SPECIFIED IN STATE OR FEDERAL REGULATIONS

Source: JLARC.

If consultation between the applicant and BRD or the HSA occurred, it does not appear to have been effective. Of the 44 standard review applications considered, 39 were deemed incomplete

by BRD and further information was requested. Table 3 summarizes the frequency of such requests. The most frequently requested items of information were:

- data on the deed and property title;
- documentation that all necessary utilities were available for a project; and
- financial data such as audited financial statements, reimbursement contracts, financial feasibility, and methods of financing.

Table 3

FREQUENCY OF REQUESTS FOR ADDITIONAL
INFORMATION FOR STANDARD REVIEWS
(FY 1978)

<u>Number of Requests For Additional Information</u>	<u>Number of Applications Involved</u>
0	4
1	26
2	11
3	2
Unknown	1
Total	44

Source: JLARC.

Providing such information added an average of three months to application preparation. Whether such additional time was due to applicants' inability to provide the information requested or to ambiguities and shortcomings of the application form is not known.

What is known is that requests for additional information have become a normal part of application preparation. The State should inform all applicants of this fact at the time an application is sent by BRD. Without such information, an applicant may seriously misjudge the time and cost involved in preparing an application.

Steps should also be taken to reduce the number of requests for additional information. Such a reduction would require a cooperative effort between BRD and applicants. BRD should attempt to anticipate its data needs for a particular project and communicate those needs to applicants before an application is filed. Particular attention should be given to those items most frequently requested. Applicants, for their part, would find it in their own best interests to consult with BRD and their HSA before filing an application.

PROJECT REVIEW

There are two aspects of the certificate-of-need review process that may require the attention of the General Assembly. Both involve State innovations not mandated by federal law.

The first of these areas involves the use of the administrative review procedure. Action needs to be taken to ensure that this option is utilized consistently by health systems agencies.

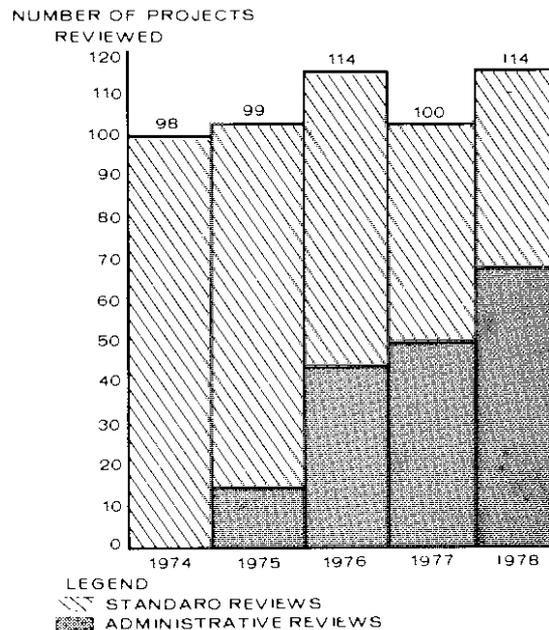
The second point that may need to be addressed is the role of the SHCC's Facilities Review Committee. The original purpose served by this body has become outdated. Its role needs to be redefined and its review procedures structured to reflect this new role.

Use of Administrative Reviews

The use of the administrative review process has risen markedly over the years (Figure 8). More applications are now processed through this shortened procedure than through the standard review process. This does not appear to reflect an inappropriate use of the administrative review process, however.

Figure 8

NUMBER OF STANDARD AND ADMINISTRATIVE REVIEWS (FY 1974-1978)



Source: JLARC.

Table 4 shows the types of projects that have qualified for administrative review. Of the 176 administrative reviews, only one obviously did not meet the technical eligibility requirements for this option.

Table 4

REASONS FOR ADMINISTRATIVE REVIEWS
(FY 1973-1978)

<u>Reason</u> ¹	<u>Number of Cases</u>
Project cost less than \$150,000	104
Project did not change beds or services, but cost more than \$150,000	71
Ineligible*	<u>1</u>
Total	<u>176</u>

*One project converted two existing beds at a cost of \$175,000 and should have undergone standard review.

¹The number of projects considered an emergency is unknown.

Source: JLARC.

Although the administrative review process is used appropriately, it is not applied consistently. Projects that could be considered under administrative review sometimes undergo the full standard review process. In some cases, the applicant chooses to submit the project through the full review process rather than risk having to resubmit the project if denied.

In other cases, however, the HSAs require a project to undergo standard review even though the project would be eligible for administrative review. For example, the Central Virginia HSA has a more stringent set of eligibility criteria than those used by the State.

The Health Department's position (and authority) on the differences among the HSAs is inconsistent with its regulatory role. If an HSA wishes to be stringent in its use of administrative reviews, that is up to the HSA. If an HSA is overly permissive in its use of this alternative, that will be corrected on the State level by the Commissioner sending the applicant back through the standard review process.

While such a position may ordinarily prevent inappropriate use of the administrative review procedure, it does not prevent inconsistent treatment of similar types of applications. The following cases show examples of inconsistencies that have occurred.

Review of Cardiac Rehabilitation Centers

A hospital in the Central Virginia HSA submitted an administrative review application for a cardiac rehabilitation center with an estimated cost of \$54,000. The HSA held a public hearing on the administrative review and recommended to the Commissioner that a standard review should be completed.

At issue was the financial contract between the hospital and the consultant firm which was going to set up the program and train the staff. The applicant received notice from BRD that the administrative review was rejected and received applications for a standard review. The hospital went through the standard review and ultimately received its certificate-of-need.

Nine months elapsed from the submission of the administrative review to the time of decision.

Three other hospitals, two in the Southwest Virginia HSA, and one in the Northwest Virginia HSA, submitted applications for administrative reviews within six months of Central Virginia hospital. The projects were identical in design, cost, and program. A review of Health Department files indicates that no substantive questions were raised regarding a similar contract between the three latter hospitals and another consultant firm.

These three facilities received their certificate-of-need through administrative review within 35 days.

Review of Kidney Dialysis Centers

An eight station renal dialysis center was proposed for a small town in the Eastern Virginia HSA at a cost of \$80,000. The project was approved in January, 1977, under standard review procedures.

Two months later, a new six station renal dialysis center was approved in the Northwest Virginia HSA at a cost of \$35,000. This project was approved under administrative review procedures.

In both of the preceding cases, the added time, expense, and inconvenience might have been avoided if all applicants had been afforded similar treatment. Despite this shortcoming, administrative review serves a useful purpose and should be maintained. The procedure saves time and reduces paperwork for smaller, less complicated projects. Nonetheless, its implementation can be improved.

Greater uniformity in the use of administrative review can be achieved through statute. The Certificate-of-Need Law could be amended to include the administrative review process. Legislation could specify the types of projects eligible for an administrative review. Consideration could also be given to establishing some maximum dollar amount. It is not uncommon for projects costing over \$1 million to be approved under administrative review. A project such as a parking deck can have as much impact on cost reimbursement as a bed renovation.

If the law is amended, eligibility for administrative review should be made the sole responsibility of the Health Department. A requirement similar to the "completeness review" should be added. This would insure that both BRD and the HSA were aware a project was being considered for administrative review. And, the applicant would be officially notified if both bodies did not concur that the project was eligible for the shorter review.

Role of the Facilities Review Committee

The other aspect of the certificate-of-need process that requires attention by the General Assembly is the review function of the SHCC's Facilities Review Committee. The role presently performed by this body has become outdated and needs to be redefined.

The Need for the Facilities Review Committee. The Facilities Review Committee, acting on behalf of the Statewide Health Coordinating Council (SHCC), makes recommendations to the Commissioner on all projects requiring a standard review. The need for this additional review has been the source of considerable debate.

Health Department personnel defend this added review citing the following reasons:

- In the early years of the certificate-of-need program, many areas of the State were not covered by planning bodies that could perform project reviews. Therefore, State-level review by this committee was necessary.
- Even with the advent of health systems agencies, not all HSAs developed project review capability; this necessitated maintaining a State-level review.

In addition, the Health Department maintains that the Facilities Review Committee helps balance the more parochial interests of the HSAs. However, in FY 1978, the Committee agreed with the recommendation of the HSA Boards 90% of the time.

HSA staff and some hospital administrators, on the other hand, see the Facilities Review Committee as:

- time consuming and an additional expense to the applicant; and
- a means of diluting the influence of the HSA recommendation.

Such criticisms are not necessarily related to the need for the committee, but to deficiencies in review procedures.

Review Procedures. Weaknesses were found in the manner in which reviews are conducted by the Facilities Review Committee. The committee generally meets once a month. BRD staff first briefs the committee on all projects to be reviewed. Then, a public meeting is held to hear from the applicant and a representative from the HSA. Each is allowed ten minutes to testify, after which members of the committee may ask questions.

Often the committee reviews a dozen or more applications at a single meeting. While BRD prepares a staff summary on each project, the large volume of material reviewed presents a heavy burden to committee members. Furthermore, the committee has no systematic way of assessing projects.

Change in Role and Procedures. The SHCC and its Facilities Review Committee probably should not be eliminated from the certificate-of-need process. Rather, the committee's role and procedures should be redefined.

The General Assembly could consider adopting criteria to limit the scope of the SHCC's review authority. For example, a project application might be subject to review by the Facilities Review Committee of the SHCC only if:

- (1) requested by certain designated bodies, such as
 - the applicant
 - the Commissioner
 - Virginia Rate Review Commission
 - Blue Cross
 - other third party reimbursers
 - any citizen who previously commented at the HSA level
 - any other interested citizen; or
- (2) over a specified dollar amount.

The development of such criteria would reduce the committee's workload and result in a more meaningful and thorough project review. It should be noted that projects undergoing administrative review would continue to be exempted from committee review. The General Assembly may wish to incorporate this exemption as part of the law. The Facilities Review Committee should also take several steps to improve its review process.

First, a more flexible hearing procedure should be adopted. The ten minute limit on testimony from the applicant and HSA should be subject to change if requested by either party. Ten minutes may not be sufficient time to support or rebut information presented to the committee.

Second, the committee should consider providing other affected parties greater access to the public hearing process. This might include Blue Cross, the Virginia Rate Review Commission, and concerned citizens.

Third, copies of BRD's staff summaries should be made public and sent to the applicant in time to be received at least ten days prior to the meeting. This would enable the applicant to prepare a response to points raised in the BRD analysis.

DECISION

The Commissioner provides a written explanation of his decisions, based on one or more required considerations enumerated in certificate-of-need legislation and regulations. However, this explanation is selective, and often does not address key issues raised during the course of the review. Furthermore, while overall there is a high level of agreement between the Commissioner's decision and the recommendation received from various reviewing bodies, the cases in which there is disagreement tend to involve large, controversial projects.

While the Commissioner need not agree with the recommendations received, to achieve an orderly process his decisions should be consistent over time. During interviews with the Commissioner he expressed an acute awareness of the need for consistency with prior rulings. However, without a well-documented written record of his decisions, the Commissioner and potential applicants have no guide for knowing the precedents being set for future decisions.

Overall Agreement of Recommendations

During FY 1978 there was a high level of agreement between the Commissioner's decision and the recommendations received from the various reviewing bodies (Figure 9). Overall agreement was reached nine times out of ten. Where disagreement did occur, HSA and BRD staff were more likely to recommend denial for a project

Figure 9

EXTENT OF AGREEMENT BETWEEN
REVIEWING BODY'S RECOMMENDATION AND COMMISSIONER'S DECISION¹
(Cost in thousands)
HSA STAFF

	COMMISSIONER APPROVED	COMMISSIONER DENIED	
PROJECTS	13	1	STAFF APPROVED
	3	6	STAFF DENIED
BEDS	735	40	STAFF APPROVED
	461	605	STAFF DENIED
COST	\$25,690	\$4,721	STAFF APPROVED
	\$48,279	\$25,698	STAFF DENIED

HSA BOARD

	COMMISSIONER APPROVED	COMMISSIONER DENIED	
PROJECTS	28	4	BOARD APPROVED
	2	6	BOARD DENIED
BEDS	1580	179	BOARD APPROVED
	67	726	BOARD DENIED
COST	\$95,565	\$24,198	BOARD APPROVED
	\$5,975	\$32,420	BOARD DENIED

STATE BRD STAFF

	COMMISSIONER APPROVED	COMMISSIONER DENIED	
PROJECTS	27	4	STAFF APPROVED
	4	6	STAFF DENIED
BEDS	1133	490	STAFF APPROVED
	490	805	STAFF DENIED
COST	\$50,070		STAFF APPROVED
	\$51,451	\$42,303	STAFF DENIED

STATE FRC/SHCC

	COMMISSIONER APPROVED	COMMISSIONER DENIED	
PROJECTS	32	2	FRC/SHCC APPROVED
	1	7	FRC/SHCC DENIED
BEDS	1427	49	FRC/SHCC APPROVED
	136	856	FRC/SHCC DENIED
COST	\$95,254	\$4,721	FRC/SHCC APPROVED
	\$2,100	\$39,125	FRC/SHCC DENIED

☐ AGREEMENT ■ DISAGREEMENT

¹Based on projects undergoing standard review in FY 1978.

Source: JLARC.

that the Commissioner approved; the HSA Board and the SHCC's Facilities Review Committee were more inclined to approve projects that were ultimately denied. In other words, staff are more likely to recommend a project be denied than the Boards.

Despite the fact that there were relatively few projects where disagreement occurred, these cases usually involved large projects. For example, BRD staff and the Commissioner disagreed on only five reviews in FY 1978. However, these five projects had an average estimated cost of \$10.5 million. By comparison, the average cost of the 87 projects approved by BRD and the Commissioner was only \$829,494.

Need to Clarify Decisions

Current SDH regulations list 14 considerations in making certificate-of-need decisions. These considerations are based on similar requirements listed in State and federal law. Two are based solely on the State's Certificate-of-Need Law (Figure 10).

The 14 considerations are so broadly stated that several could be used as justification to approve or deny the same project. In order to assure consistency in the review process, the Commissioner's decisions should not conflict with earlier rulings. However, the written explanation provided by the Commissioner is selective, making it difficult sometimes to ascertain fully the basis for his decision. This point is illustrated in the following case.

Incomplete Explanation of Decision

In Spring 1977, a hospital submitted an application to add 69 medical-surgical beds at a cost of \$7.2 million. Both HSA staff and BRD recommended denial of the project because (1) the proposal exceeded bed need projected in the State medical facilities plan, and (2) population growth projections did not reveal a need beyond the existing capacity of nearby facilities.

The Commissioner approved the project after cost estimates were lowered nearly \$1 million. In supporting his decision, the Commissioner did not mention that the project exceeded State Health Department projections. He did note facility in an area where population is growing rapidly.

The difference between the Commissioner's decision and the staff findings was not addressed. Without a full written explanation there is no record to document how certificate-of-need

Figure 10

REQUIRED CONSIDERATIONS UNDER STATE REGULATIONS

Considerations Also Required Under Federal Regulations:

1. The relationship of the health services to be provided to the applicable health systems plan and annual implementation plan;
2. The relationship of the proposed project to the long-range development plan of the applicant providing or proposing such project;
3. The need that the population served or to be served by such project has for such project;
4. The availability of less costly or more effective alternative methods, existing or proposed, of providing such services;
5. The impact of the proposed project on the cost and charges for providing health services by the applicant and the financial capability to construct and/or maintain the proposed project;
6. The cost and utilization impact of the services proposed to be provided upon the existing health care system, including proposed facilities, of the area;
7. The availability of resources (including, but not limited to health manpower, management personnel, and funds for capital and operating needs) for the provision of the services proposed to be provided and the availability of alternative uses of such resources for the provision of other health services;
8. The relationship, including the organizational relationship, of the proposed project to ancillary or support services;
9. Special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical and other professions schools, multidisciplinary clinics and specialty centers;
10. The special needs and circumstances of health maintenance organizations;
11. The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages;
12. In the case of a construction project, the cost and methods of the proposed construction, including methods of energy provision, and the probable impact of the construction project reviewed on the costs of providing health services by the person proposing such construction project;

Additional Considerations Required Under State Regulations:

13. The consistency of the proposed project with the facilities and services requirements of the current State Medical Facilities Plan; and
14. The relationship of the proposed project to special criteria promulgated and adopted by the Board, as applicable.

might deal with similar proposals in the future. This is a real concern, particularly for proposals that involve beds in already overbedded areas.

Need to Document Decisions

While present SDH administrators have a familiarity with the decisions made in many of the projects reviewed, this knowledge has not been compiled in a usable form. Should new administrators assume responsibility for certificate-of-need, they would have little information readily available to determine how projects currently undergoing review relate to past review activity. As a result, assuring that certificate-of-need decisions are consistent with precedents already set would be seriously impaired. The fact that the Commissioner does not always concur with recommendations received concerning major project proposals highlights the importance of such consistency.

This deficiency in the certificate-of-need program should be addressed. In order to assure consistent decision-making, the Commissioner should support his approval or denial with a written analysis that fully explains his position. Further emphasis might be placed on this aspect of the review process by amending the certificate-of-need legislation to add consistency as another required consideration. This, coupled with more complete written explanations, would still allow exceptions to be made, but not without justification.

APPEAL

The certificate-of-need process involves four levels of appeal, only one of which is federally required.

1. Commissioner's Reconsideration
2. Formal Evidentiary Hearing
3. Formal Independent Hearing
4. Court Review

These four levels have been established to conform with the requirements of the State's Administrative Process Act, which dictates the structure of the appeals mechanism. To date no project has exhausted all four levels of appeal. Two have reached the third stage and have been pending for over six months awaiting a decision from an independent examiner. The remainder are either pending in an earlier stage or are not being appealed further. Through December 1978, only two appeals have resulted in a denial being reversed. (Analysis of appeals was extended through December 1978, 6 months beyond JLARC's data collection period.)

Only the applicant can appeal a decision through all four stages. Whether others should also have this right of appeal has been a source of major controversy. Several changes to the appeals process have been suggested, especially regarding who should have legal standing to appeal. According to the State's courts such changes would have to result from legislative definition and amendment of legal standing.

Use of Appeals

The appeals process is logically developed, but serious time delays have been encountered by applicants in the third stage. State Corporation Commission hearing officers have failed to comply with the requirements contained in certificate-of-need regulations. In fact, two cases have been awaiting a ruling for over six months.

Appeal Activity. Between FY 1974 and FY 1978, 20 of the Commissioner's 37 standard review denials were appealed. As can be seen in Table 5, the number of appeals has risen slightly in recent years; however, the appeals are evenly distributed among the States's HSAs.

Table 5

CERTIFICATE-OF-NEED APPEALS BY HSA AND FISCAL YEAR

Fiscal Year	HSA					Totals
	I	II	III	IV	V	
1974	0	0	2	0	0	2
1975	0	1	0	2	0	3
1976	0	1	1	1	0	3
1977	1	2	0	0	2	5
1978	2	0	1	2	2	7
Totals	3	4	4	5	4	20

Source: JLARC.

Thirteen of these appeals involved nursing homes; six were filed by hospitals; and, an ambulatory surgical unit also submitted an appeal. These 20 appeals represent projects totaling \$86.8 million and involve 1710 beds.

As of December 1978, only two facilities have been successful in reversing by appeal the Commissioner's denial. Both were existing hospitals requesting approval for renovations and bed changes. One project was estimated to cost \$12 million, the other \$4.7 million.

Figure 11 illustrates the four levels of appeal. As of December 1978, the level reached by each of the 20 projects appealed between FY 1974 and FY 1978 is as follows:

- Fourteen projects were appealed to Level I; the denial was upheld and the appeal withdrawn;
- Two projects were appealed to Level I and the Commissioner reversed his denial;
- One project was pending a Level I ruling;
- One project was appealed through Level II; the denial was upheld at both levels and the appeal withdrawn; and
- Two projects were pending a Level III ruling by the State Corporation Commission (SCC) General Counsel.

Independent Hearing. While none of the 20 appellants has exhausted the entire appeals process, most proceed within the time constraints imposed by the regulations. However, the two cases requiring a formal, independent hearing were found to be in serious violation of the time limits prescribed in both federal and SDH regulations. These delays could jeopardize the full designation Virginia has received from HEW for the State's certificate-of-need program.

These two cases involve the Heritage Hall Corporation's request to build a new nursing home facility in King George County; and the Coliseum Park Nursing Home's request to build a new facility in Newport News. The Heritage Hall case was originally denied by the Commissioner of Health in February 1978. The denial was upheld through Levels I and II of appeal. The Coliseum Park case was originally denied by the Commissioner of Health in October 1976. After a mutually agreed upon delay by the applicant and the State to collect additional information, the denial was upheld through Levels I and II of appeal. Up to this point both cases proceeded in an orderly fashion. Any time delays were mutually agreed to by all parties in the cases.

Both applicants then appealed to Level III. The SCC General Counsel was designated by the Governor as the independent examiner in September 1978, to review the Commissioner of Health's decisions in both cases. Since that time, no decision has been rendered in either case. In a December 1978 letter to the SCC, the Health Commissioner wrote:

At the present time, there are two cases at this level of appeal. In one, the application of Coliseum Park Nursing Home, Mr. Rogers has already solicited legal argument from the counsel representing the respective parties and he indicated several months ago that a decision would be forthcoming. Unfortunately, however, no decision has been received in that case.

Figure 11

CERTIFICATE-OF-NEED APPEAL PROCESS

LEVEL I	LEVEL II	LEVEL III	LEVEL IV
<u>Reconsideration of Initial Determination</u>	<u>Formal Evidentiary Hearing</u>	<u>Formal Independent Hearing</u>	<u>Court Review</u>
<ol style="list-style-type: none"> 1. Within 30 days of Commissioner's initial decision, applicant* or HSA** requests an informal, fact-finding consultation conference before the Commissioner. 2. Certificate-of-Need is suspended by SOH. 3. An informal, fact-finding consultation conference within 30 days of receipt of request. 4. Commissioner affirms or vacates initial determination within 30 days following the conference. 	<ol style="list-style-type: none"> 1. Within 30 days following the reconsideration decision, the applicant* or HSA** may request a formal evidentiary hearing before the Commissioner. 2. Certificate-of-Need is suspended by SOH. 3. A formal hearing is held within 30 days of receipt of request. 4. Within 60 days following the formal hearing, Commissioner provides notification of his final determination. 	<ol style="list-style-type: none"> 1. Within 30 days of the formal evidentiary hearing decision, the applicant* or HSA** may request a formal hearing before an independent examiner.*** 2. Certificate-of-Need is suspended by SOH. 3. A formal, independent hearing is scheduled within 30 days of receipt of request. 4. The review of the hearing examiner is limited to: <ol style="list-style-type: none"> (a) whether there was substantial procedural compliance; and (b) whether the Commissioner exceeded his discretion in evaluating the evidence presented. 5. Within 30 days following the formal, independent hearing, the hearing examiner affirms or vacates the decision of the Commissioner. 	<ol style="list-style-type: none"> 1. Within 30 days of final decision of the hearing examiner applicant may obtain a Circuit Court Review. 2. Applicant may appeal the decision of the Circuit Court to the Virginia Supreme Court, following the procedure specified by law.
<p>*Application must have been disapproved by the Commissioner.</p> <p>**Commissioner's decision must have been contrary to the recommendation of the HSA.</p> <p>***The hearing examiner is appointed by the Governor from an agency of State government other than SOH.</p>			

Source: JLARC.

Although members of my staff, the Attorney General's Office, and counsel representing the private parties have attempted to contact Mr. Rogers both by telephone and by letter, no response has been received.

The situation is very embarrassing to myself and my staff, and the private parties are becoming increasingly anxious. While we all recognize that Mr. Rogers and his staff had significant amount of other work to do, these appeals should not be allowed to grow too old. In fact, the rules and regulations of the State Board of Health specify that a decision from the hearing officer is due within thirty days of completion of the hearing record, as compiled by the hearing officer.

The SCC General Counsel agreed to issue a decision in the Coliseum Park case by February 5, 1979. The Heritage Hall case was to be decided shortly thereafter. As of mid-May 1979, no decision had been issued in either case. At the time of this writing, the applicants were considering court action to force the SCC to issue a decision.

The delay experienced in these two cases could be avoided in the future if certificate-of-need hearing officers were selected like other hearing officers. Section 54-1.38 of the *Code of Virginia* (as revised 1979) provides that any agency of the State may request a hearing officer from the Director of the Department of Commerce. Under Section 54-1.36 (as revised 1979), the Director of the Department of Commerce is required to maintain a list of hearing officers approved and prepared by the office of the Executive Secretary of the State Supreme Court.

Discussion with the Department of Commerce indicates that many State agencies routinely select hearing officers from the approved list. In the future, the Department of Health may wish to recommend that the Governor appoint a qualified hearing officer from this list.

Public Reconsideration

Virginia's certificate-of-need appeals process is designed to comply with the State's Administrative Process Act. The requirements of this law are more involved than federally mandated appeals procedures. Of the four levels of appeal, only one (Level III, the Independent Hearing) is required by federal regulations. The remaining three levels were developed by the State to conform to the Administrative Process Act.

Federal procedures call for a public reconsideration in which anyone showing "good cause" has the right to appeal. In Virginia, the determination of "good cause shown" would rest with the Health Department. Should the Health Department rule that an individual seeking reconsideration had not shown "good cause", that individual could appeal this ruling through the State's Administrative Process Act. This would create essentially two processes:

- (1) one to determine if the person had the right to appeal; and
- (2) the appeal itself.

In order to avoid a situation where the Health Department would be involved in lengthy legal proceedings to determine "good cause" (and not the certificate-of-need decision) the State did not incorporate the public reconsideration stage into its appeal process. The Department of Health, Education, and Welfare (HEW) agreed with the State's concern and granted Virginia an exception from this certificate-of-need requirement.

While HEW agreed with the State not to open the appeals process to any person, this limited right of appeal has been the source of much controversy.

Legal Standing

The right to appeal certificate-of-need decisions varies from state to state (Figure 12). Under the Virginia certificate-

Figure 12

COMPARISON OF CERTIFICATE-OF-NEED
RIGHT TO APPEAL AMONG SEVERAL STATES

STATE	PARTIES	PUBLIC RECONSIDERATION	ADMINISTRATIVE REVIEW	JUDICIAL REVIEW
Virginia	Applicant	X	X	X
	HSA	X	X	
	3rd Parties			
South Carolina	Applicant	X	X	X
	HSA	X	X	X
	3rd Parties	X	X	X
Maryland	Applicant	X	X	X
	HSA	X	X	X
	3rd Parties	X	X	X
West Virginia	Applicant	X	X	X
	HSA	X		
	3rd Parties	X		
Kentucky	Applicant	X	X	X
	HSA			
	3rd Parties			
Tennessee	Applicant	X	X	X
	HSA	X	X	
	3rd Parties	X		
Florida	Applicant	X	X	X
	HSA	X	X	X
	3rd Parties	X		

Source: JLARC.

of-need program only the applicant and HSA may appeal a decision. Only the applicant may pursue an appeal to court; HSAs cannot. Interested third parties are not granted legal standing. Third parties, such as Blue Cross, hold that the appeals process should be open to them. HSAs maintain that they should also have the right of court appeal. Such changes would require legislative amendment of the Certificate-of-Need Law.

Third Party Right of Appeal. Figure 12 compares Virginia's legal standing under certificate-of-need to that of six other states by dividing the appeals process into three stages:

- public reconsideration, which corresponds to Level I of Virginia's appeal process;
- administrative review, which encompasses appeal Levels II and III in Virginia; and
- judicial review, which is identical to Level IV in this State.

As can be seen from this figure, only Virginia and Kentucky do not permit interested third parties to appeal certificate-of-need decisions at the public reconsideration stage.

While Virginia is more restrictive than other states regarding legal standing, the certificate-of-need appeals process is not inconsistent with the appeals processes of other State regulatory agencies. The Administrative Process Act mandates that "aggrieved or interested parties" may ask for reconsideration and appeal State agency decisions. However, there is no single, uniform definition of "aggrieved or interested parties." Who can appeal varies from agency to agency.

Section 32-211.8 of the State's certificate-of-need legislation clearly limits the right of appeal to applicants denied by the Commissioner and to HSAs if the Commissioner did not follow their recommendation. This, then, is the definition of "aggrieved or interested parties" for certificate-of-need.

Recent litigation brought by Blue Cross of Virginia sought to gain legal standing to appeal one of the Commissioner's certificate-of-need decisions. The Virginia Circuit Court of Henrico County held that Blue Cross could not obtain legal standing under the Administrative Process Act. The court ruled that under the Certificate-of-Need Law the General Assembly's intent was that appeals be limited to only those parties the General Assembly designates. Blue Cross appealed this decision to the State Supreme Court. The State Supreme Court denied Blue Cross a hearing in the case, leaving the Circuit Court decision standing. As a result of this court case, a change in legal standing would require legislative action.

In determining whether such change is warranted, the legislature might wish to consider three options:

1. Leave legal standing unchanged.
2. Expand the definition of legal standing to include legislatively specified third parties. This option poses the practical problem of who should be included and excluded among the various third parties.

3. Expand the definition of legal standing to include all interested third parties. This is identical to conforming with federal appeal requirements for a public reconsideration.

Broadening the right of appeal has the advantage of making certificate-of-need decisions more open to public scrutiny. No doubt, more projects receiving approvals would be appealed than is the case now. The chief disadvantage is that expanding legal standing would result in more appeals and, hence, more projects would be delayed. If legal standing is expanded, appropriate measures must be taken to protect applicants from frivolous appeals.

HSA Right of Appeal. Presently, HSAs can only appeal a decision through Level III. One of the options the General Assembly may wish to consider is to grant this additional right of appeal to the HSAs. Three of the six states JLARC contacted permit HSAs to appeal to the courts.

JLARC's interviews with HSA staff found many who believed HSAs should have the right of final appeal. Many believed that granting HSAs this right would result in more projects being denied. Many attributed the present high approval rate to the threat of an appeal by the applicant. With the HSAs also granted the same right, any decision involving an approval or denial would be subject to appeal.

It should be noted that HSAs have shown little interest in pursuing the full appeal process now open to them. Only once has an HSA even appealed a certificate-of-need decision through Level I.

FINDINGS AND RECOMMENDATIONS

The Department of Health has performed creditably in establishing a procedure for processing project applications. There are, however, aspects of certificate-of-need procedures that should be strengthened to make the process more orderly and timely. For this to occur, both legislative and administrative action is necessary.

Application Procedures

Application procedures are not fully explained. As a result, applicants have been faced with unexpected time delays in processing applications. These time delays were found to be a hidden part of the certificate-of-need process. Several months are often required before an application is finally accepted for review.

Staff Recommendation. The Bureau of Resources Development (BRD) should inform applicants of the application time inherent in requests. Improved coordination is needed between BRD, the HSAs, and the applicant during the pre-consultation phase. In particular, certain items of information that are repeatedly requested by BRD should be communicated to applicants prior to an application being submitted. Every effort should be made by BRD and HSAs to reduce the number of requests for additional information. To help minimize the additional requests, BRD should consider developing model applications for different types of typical projects.

Administrative Review Process

The administrative review process created by the Department of Health to expedite the processing of less controversial projects was found to be inconsistently applied. Despite this shortcoming, the administrative review process serves a useful function and should be maintained.

Staff Recommendation. To ensure uniformity of use, the General Assembly might consider amending the Certificate-of-Need Law to include the administrative review procedure. Such an amendment should define the projects eligible for an administrative review. Furthermore, BRD should be assigned sole responsibility for determining the eligibility of projects for this type of review.

Facilities Review Committee

The review conducted by the Facilities Review Committee of the Statewide Health Coordinating Council is required by State but not federal law. But, the role of this reviewing body has become outdated and requires redefinition. In addition, the committee needs to modify its project review procedures.

Staff Recommendation. The General Assembly could limit the reviewing authority of the SHCC and its Facilities Review Committee. The committee's role could be changed so that the only projects reviewed would be those requested by legislatively designated parties. The Health Commissioner, applicant, Blue Cross, and the Virginia Rate Review Commission are parties the General Assembly may want to consider eligible for requesting a project review by the committee.

Modifications in committee review procedures are also needed. Three changes should be made: (1) the applicant and HSA should be granted, on request, additional time to testify; (2) other affected parties should also be allowed, on request, to testify; and (3) the committee should request BRD to prepare a checklist of questions and concerns.

Commissioner Decisions

Overall, the Commissioner agrees with most of the recommendations he receives. Nevertheless, disagreement has occurred, particularly on large, controversial projects. It is important, therefore, that the Commissioner's decisions be consistent and carefully documented.

Staff Recommendation (1). The Commissioner should provide a written analysis that fully explains his decision. Such an explanation should explicitly incorporate:

- the project's conformance or non-conformance with the required considerations as defined and specified;
- the project's conformance or non-conformance with standards of need developed in the State's regulations or as part of the health plans of the State and health systems agencies;
- reasons why exceptions to standards or required considerations are warranted in any particular case;
- points of disagreement between the Commissioner's decision and the health system agency recommendation, as well as reasons supporting the Commissioner's decision; and
- aspects of the applicant's proposal that support approval or denial.

In addition, the General Assembly may wish to consider adding consistency as another "required consideration" in the Certificate-of-Need Law.

Staff Recommendation (2). The Health Department should develop and maintain necessary documentation to identify precedents on similar projects. The Commissioner should direct BRD to prepare a written record which reflects the precedents set by the Commissioner's decisions. This written record should be made available to any one upon written request.

Appeal

The certificate-of-need appeals process was established to conform with the State's Administrative Process Act. As yet, no project has been subjected to all four levels of appeal. Two projects have been at the third level of appeal for over six months, but no decision has yet been rendered by the independent hearing officer. The lengthy time delay is contrary to certificate-of-need State and federal regulations.

In Virginia, only the applicant and HSA may appeal a decision. Only the applicant can appeal to court. Other interested third parties are not granted legal standing.

Staff Recommendation (1). The State Corporation Commission needs to expedite pending cases of appeal. In the future, the Department of Health may wish to recommend to the Governor that an independent hearing officer be appointed from the list of such officers maintained by the Department of Commerce. Such action could expedite third level appeals.

In addition, to insure such delays are avoided in the future, the General Assembly may wish to make the time limitations a part of the State's Certificate-of-Need Law rather than leave them as regulations as they are now.

Staff Recommendation (2). The General Assembly has several options related to the definition of legal standing: (1) the present definition could be left unchanged; (2) other legislatively specified third parties could be granted the right of appeal; and (3) all interested parties could be granted the right of appeal. There are a number advantages and disadvantages associated with each option. Whether or not the appeals process should be broadened, however, is a policy and political question that can only be resolved by the General Assembly. If action is taken to broaden legal standing, steps should be taken to protect the applicant from irresponsible appeals.

It should be noted that some of the advantages of broadening the appeals process might be accomplished if the role of the SHCC's Facilities Review Committee is changed as outlined before. By limiting the committee's review to only projects requested by parties specified in legislation (like Blue Cross or the applicant) a new "pre-appeal" role will have been created. This process would offer a public forum to interested third parties not now available.

III. Need Determination

The purpose of certificate-of-need is to insure that only those medical facilities which are needed will be constructed. Such determinations of need are to be based primarily upon regional and State health plans. The ultimate goal of these plans is to improve health care accessibility and restrain costs.

The State's certificate-of-need legislation defines a program that exceeds the State's present planning and monitoring capabilities. Health plans do not include need estimates for all facilities and services covered by certificate-of-need. And the certificate-of-need program lacks accurate and timely information on the existing bed supply and the status of approved projects. As a result, the justification for certain projects has been at times poorly defined and inconsistent.

The Health Department has made considerable progress in narrowing the gap between the law's requirements and the basis for project need determinations. This progress should be encouraged and specific actions taken to further close that gap.

COVERAGE

Virginia has a comprehensive certificate-of-need law. Few states exceed the Commonwealth's coverage requirements. This broad coverage is the result of the State's definition of:

- the types of facilities subject to review;
and
- capital expenditure, service development,
and bed thresholds which, if exceeded,
require review.

Because of this broad coverage, certificate-of-need reviews encompass a wide range of project activity. However, recent changes in the bed capacity threshold may provide facility owners greater latitude in changing the existing composition of beds without certificate-of-need approval. Such action would greatly weaken health planning efforts.

Types of Facilities Covered

Virginia's Certificate-of-Need Law covers not only the two major types of medical facilities, hospitals and nursing homes, but a host of other types of facilities as well. Many of the other types of facilities covered offer specialized types of services that

are often available in hospitals or nursing homes. For instance, kidney dialysis units are covered whether offered in a hospital setting or in a separately owned facility. By including other specialized types of facilities more uniform coverage is assured.

The State covers all the types of facilities required under federal law and several others as well (Table 6). In fact, in 1976 only three states (Alabama, Hawaii and Iowa) had more extensive coverage than the Commonwealth.

Table 6

COMPARISON OF STATE AND FEDERAL CERTIFICATE-OF-NEED COVERAGE

Facilities Covered Under Virginia Certificate-of-Need Law

<u>Required by Federal Law</u>	<u>Additional Virginia Coverage</u>
<ul style="list-style-type: none"> -Hospitals -Psychiatric Hospitals -Tuberculosis Hospitals -Skilled Nursing Facilities -Intermediate Care Facilities -Kidney Dialysis Units -Ambulatory Surgical Units -Health Maintenance Organizations <p>Plus,</p> <ul style="list-style-type: none"> -Any of the following services: <ul style="list-style-type: none"> .rehabilitative .alcohol or drug abuse .mental health -Facilities receiving third party reimbursements under medicaid, medicare or maternal and child health 	<ul style="list-style-type: none"> -Home Health Agencies -Physician's Offices* -Public Health Centers -Outpatient Facilities -Mental Retardation Facilities -Independent Laboratories -Specialized centers or clinics using equipment not usually associated with primary health care (like kidney dialysis) <p>Plus,</p> <ul style="list-style-type: none"> -Facilities receiving third party reimbursements

*Physician's offices are required to receive a certificate only for equipment purchases exceeding \$200,000; or, as added by the 1979 session of the General Assembly, \$50,000 if for radiation therapy or computerized tomography (CT) scanner.

Source: State and federal law and regulations.

By exceeding federal coverage standards, Virginia did not add appreciably to overall program activity. As can be seen in Table 7, over 75% of all projects reviewed involved hospitals or nursing homes. Only 69 applications were submitted by facilities falling under additional coverage. These 69 projects had a total estimated cost of \$55 million.

Table 7

CERTIFICATE-OF-NEED REVIEWS BY TYPE OF FACILITY
(FY 1974-1978)

<u>Type of Facility</u>	<u>Fiscal Year</u>					<u>Total</u>
	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	
Hospitals*	37	33	45	59	59	233 (44.4%)
Long-Term Care Facilities	43	31	29	21	29	153 (29.1%)
Combination Hospitals/ Long-Term Care Facilities	3	5	5	0	5	18 (3.4%)
Other Federally Covered Facilities	5	2	17	12	16	52 (10.0%)
Other Facilities Falling Under State Coverage	10	28	18	8	5	69 (13.1%)
Total	98	99	114	100	114	525 (100.0%)

*Includes the State's teaching hospitals.

Source: JLARC.

Review Thresholds

With the exception of the regulation on bed capacity, federal and State review thresholds are essentially the same. Virginia has had a more stringent legislative provision governing changes in bed capacity. But a recent amendment to this provision may weaken the State's authority to regulate changes in bed composition. As a result, Virginia may no longer be in conformance with federal regulations.

Facilities covered by certificate-of-need are required to obtain a certificate if they exceed one (or more) of several review thresholds. These thresholds cover: (1) capital expenditures; (2)

bed changes; and (3) the addition of new services. Table 8 compares State and federal review thresholds.

Table 8

STATE AND FEDERAL REVIEW THRESHOLDS COMPARED

<u>Federal Thresholds</u>	<u>State Thresholds</u>
<p>Capital Expenditures</p> <ul style="list-style-type: none"> -construction, development, or establishment of a new health care facility involving capital expenditures in excess of \$150,000, including expenditures for pre-development activities; -any arrangements or commitments for financing 	<p>Capital Expenditures</p> <ul style="list-style-type: none"> -constructing, undertaking, or commencing a medical care facility project, involving a capital expenditure in excess of \$150,000; -acquiring any unit of equipment costing in excess of \$200,000, for use outside of a medical facility
<p>Bed Changes</p> <ul style="list-style-type: none"> -bed changes which increase, redistribute, or relocate beds by more than 10 beds or 10% (whichever is less) over a two year period 	<p>Bed Changes</p> <ul style="list-style-type: none"> -a change (increase)* in bed capacity of a medical facility involving a capital expenditure in any amount
<p>Service Development</p> <ul style="list-style-type: none"> -any new health services 	<p>Service Development</p> <ul style="list-style-type: none"> -change (adding)* a new health service

*Changes made during 1979 Session of General Assembly are shown in parentheses.

Sources: State and federal regulations; public notice defining scope of coverage published by BRD.

As can be seen from this table, State and federal thresholds differ most concerning bed changes. The federal government permits minimal bed shifts to occur without review.

With over 20,000 hospital beds in the State, roughly 1,000 new beds could be added every two years (109 hospitals times 10 beds) if the federal bed threshold was applied in Virginia. The State's definition has been more stringent, however, and would prevent this from occurring. According to the Department of Health, any change in beds would be covered.

Prior to 1979, Section 32-211.5(7) of the Certificate-of-Need Law read "*changes the bed capacity of the facility.*" The Health Department interpreted this legislative provision to mean

any increase, redistribution, or relocation of beds. The Health Department issued a public notice explaining this interpretation as well as all other certificate-of-need coverage requirements.

During the 1979 session of the General Assembly the threshold for beds was amended to read "*increases the bed capacity of the facility*". It appears that the latest definition may be less restrictive than the previous provision. For example, it is now unclear whether the current definition applies to a shift in bed composition that does not involve an increase in bed capacity, a capital expenditure in excess of \$150,000, or the addition of a new service. Past certificate-of-need requests can be used to illustrate the types of projects that may no longer be covered.

Case #1

A hospital requested a reduction of 16 intermediate care beds--7 beds were to be deleted and 9 converted to medical/surgical beds. There was no capital expenditure involved.

The number of existing medical/surgical beds was increased from 57 to 66, but the total bed capacity of the hospital was reduced from 185 to 178.

Although capacity was decreased, medical/surgical capability was increased.

Case #2

A hospital requested a conversion of 30 intermediate care beds to medical/surgical beds. As a part of this request, the hospital deleted 30 existing medical/surgical beds and converted another 11 to other bed uses. The conversion resulted in increases to several existing bed types--4 obstetric, 5 pediatric, and 2 intensive care.

The overall capacity of the hospital was reduced from 97 to 67 beds. The request did not involve a capital expenditure.

Again, the hospital changed its service orientation without increasing beds.

Once the amended State law goes into effect in October 1979, such changes in bed composition may be able to take place without certificate-of-need approval. If so, Virginia may no

longer be in conformance with federal regulations. However, the Department of Health still contends that its original interpretation of a bed change is valid.

Projects Reviewed

The result of these coverage requirements is a certificate-of-need program that encompasses a wide range of health care activity. Tables 9 and 10 summarize Virginia's certificate-of-need reviews between FY 1974 and FY 1978.

As can be seen in Table 9, most projects (71.2%) involve changes to existing facilities, usually hospitals. Table 10 illustrates what the projects involved. Changes in beds and equipment purchases were the two most frequent types of projects reviewed.

Table 9

INTENDED PURPOSE OF PROJECTS REVIEWED UNDER
CERTIFICATE-OF-NEED BY TYPE OF FACILITY
FY 1974 - 1978

Purpose of Project	Hospitals	Long-Term Care Facilities (LTCF)	Combination Hospital/LTCF	Additional Federal Coverage	Additional State Coverage	Totals
Creation of a New Facility	7	67	1	13	19	107 (20.4%)
Relocation of an Existing Facility	11	7	2	6	18	44 (8.4%)
Change to an Existing Facility	215	79	15	33	32	374 (71.2%)
Totals	233	153	18	52	69	525 (100.0%)

Source: JLARC.

HEALTH PLANNING

The health planning mechanism has not been adequate for carrying out the comprehensive requirements of the law. While major federal and State health planning initiatives have occurred recently, planning still falls short of what is needed to effectively guide certificate-of-need decisions.

Table 10

PROJECT ITEMS REVIEWED UNDER CERTIFICATE-OF-NEED
BY TYPE OF FACILITY, FY 1974 - 1978

Type of Project	Hospitals	Long-Term Care Facilities (LTCF)	Combination Hospital/LTCF	Additional Federal Coverage	Additional State Coverage	Totals
Change in Beds	76	143	18	17	4	258 (49.1%)
Equipment Purchase Not Involving Beds	99	0	0	31	42	172 (32.8%)
Service Addition not Involving Beds or Equipment	14	0	0	3	12	29 (5.5%)
Other Activity*	44	10	0	1	11	66 (12.6%)
Totals	233	153	18	52	69	525 (100.0%)

*E.g., facility renovations, land purchases, parking lot construction, and other non-medically related capital expenditure activity.

Source: JLARC.

Major improvements are needed in the following areas:

- The process used to develop regional and State medical facilities plans needs to be regularized. During the past six years health planning agencies and certificate-of-need applicants have had to deal with a confusing array of planning regulations and guidelines.
- Regional and State health plans must be more comprehensive in their coverage. Many types of projects required to be reviewed under certificate-of-need are not addressed in HSA and State medical facilities plans.
- More systematic approaches need to be developed to accurately assess the supply and demand for facilities and services. Existing approaches are applied inconsistently and carelessly by health planning agencies.

Stable Base for Planning

The evolution of certificate-of-need is closely interwoven with health planning. Planning is an essential component of need determination. At the same time, certificate-of-need is used to implement the priorities established through planning. Together the two attempt to deal with health needs and costs through a better distribution of medical facilities. According to the 1978 State Medical Facilities Plan:

These plans, which project future health needs on the basis of utilization of existing and planned facilities, and future trends in the size, composition and growth of the population, represent the basis upon which need is to be established.

Since the enactment of certificate-of-need legislation, project reviews have been carried out in the face of constantly changing health planning requirements. Only within the last two years has the Department of Health made significant progress toward building a stable planning base for guiding certificate-of-need decisions.

Hill-Burton Planning. At the time the Certificate-of-Need Law was adopted, two principal health planning mechanisms were available: the Hill-Burton program and the Comprehensive Health Planning Act. Neither was sufficiently developed to provide an adequate planning base from which certificate-of-need decisions could be confidently made.

The Hill-Burton program was passed by Congress following World War II to provide construction funds for alleviating a shortage of hospital beds. The program called for an annual plan to be issued by each state for use in allocating federal funds to areas identified as most in need. The plan contained need projections for hospital and nursing home beds and out-patient facilities.

Virginia's certificate-of-need program initially relied on Hill-Burton plans, with project applications being reviewed locally in those areas covered by an existing health planning agency. Final approval remained with the State Health Commissioner.

Nevertheless, for the first seventeen months following the initiation of the certificate-of-need program, an adequate facilities plan to guide project decisions was not publicly available. The State delayed publication of the fiscal 1973 Hill-Burton plan to update it for use under certificate-of-need. A revised plan was not issued, however, until December 4, 1974, almost a year and a half after certificate-of-need went into effect. This revised plan remained in effect until March, 1977, when the 1976 Interim Medical Facilities Plan was adopted.

The 1976 plan was essentially another update of the Hill-Burton plan. It reinventoried existing hospital and nursing home beds and re-estimated bed need. It did not deal with any of the substantive issues related to comprehensive health care facility planning. Nevertheless, this interim plan served as the principal decision-making guide for BRD until 1978.

Contributing to the deficiencies in the Hill-Burton planning process was the lack of meaningful planning at the local and state levels. In 1966 Congress passed the Comprehensive Health Planning Act. The act established both state and local planning agencies. Unfortunately, the planning process created under the act suffered from two basic flaws. First, local planning agencies were optional and not mandatory. Second, no plan implementation authority was given to either the local agencies or the state umbrella agency. In Virginia, most of the State's population was covered by one of eight local comprehensive health planning agencies. But, only two of these agencies developed plans, neither of which was implemented.

In 1972, in an attempt to tighten controls over medicaid and medicare costs, Congress enacted Section 1122 of the Social Security Act. Section 1122 provided federal funds to Virginia's local planning agencies to conduct project reviews. The U.S. Department of Health, Education and Welfare (HEW) was authorized to deny reimbursements under certain medical assistance programs for the portion of costs attributable to construction undertaken without State approval. With the enactment of the National Health Planning and Resources Development Act, Virginia ended its participation in Section 1122 planning activities.

P.L. 93-641. In late 1974, recognizing the shortcomings in existing health planning efforts, Congress passed the National Health Planning and Resources Development Act (P.L. 93-641). The new act created regional health systems agencies (HSAs) to replace the voluntary planning organizations established under the Comprehensive Health Planning Act.

The passage of P.L. 93-641 brought about significant progress in health plan development. By 1978, each of Virginia's five health systems agencies had prepared a plan. These regional plans were to be followed by two plans to be issued at the State level: a health plan; and a medical facilities plan.

The State health plan covers the entire health care system, including such items as manpower and services. The medical facilities plan, on the other hand, is intended only to examine and estimate the need for the number of beds, facilities and equipment. Under federal law, responsibility for the two plans is split. The State health plan is the responsibility of the Statewide Health Coordinating Council. The other plan, the State medical facilities plan, is (in Virginia) the responsibility of the State Health Department (Bureau of Resources Development). The latter plan is the plan used for certificate-of-need. While issued separately

both plans must nonetheless be compatible. Both have only recently been issued: the State Medical Facilities Plan in December, 1978; the State Health Plan in early 1979.

Planning efforts within the State, have progressed far since the time certificate-of-need legislation was enacted. As a result of this progress, a framework now exists upon which plans can be steadily improved. The Health Department needs to continue to build upon that framework, to extend its medical facilities plan to the other types of facilities and services required under certificate-of-need, and to eliminate the inaccuracies and inconsistencies in existing plans.

Plan Coverage

The coverage requirements of the Certificate-of-Need Law are broad. But none of the regional and State plans cover the full range of facilities and services required to be reviewed under certificate-of-need legislation. Not until the 1978 medical facilities plan were other types of facilities besides nursing homes, hospitals and outpatient facilities addressed. However, no estimates of need are made for these other types of facilities, just inventories. Wide differences exist between what the 1978 facilities plan addresses and what is included in the HSA regional plans.

The HSAs, while not inventorying as many different types of facilities and services as the State, have gone further in developing standards and criteria for project reviews. The standards and criteria set forth specific guidelines for use in evaluating need. For instance, one criterion cited to demonstrate the need for additional pediatric beds might be that driving time from one location to facilities with existing beds exceeds 30 minutes. Table 11 highlights the type of projects covered by the State and the HSA plans for which standards or need estimates have been made.

The State originally intended to issue more standards than it did. The initial draft of the 1978 facilities plan released for public comment in mid-1978 contained criteria for obstetric services, neonatal intensive care units, computerized tomographic scanners, and renal dialysis facilities.

In public meetings these criteria met with considerable opposition from health professionals. As a result, the criteria were eliminated from the 1978 plan. Instead, task forces involving health professionals were formed to develop more acceptable criteria. Once developed, these new criteria are to be adopted as additional State regulations rather than incorporated into the medical facilities plan.

The importance of these criteria cannot be underestimated. They provide the basis upon which project need is to be evaluated. Not only do standards insure that more consistent decisions will be made, they enable prospective applicants to know in advance the

Table 11

EXTENT TO WHICH STANDARDS OR
ESTIMATES OF NEED HAVE BEEN DEVELOPED

Selected Types of Projects Required to be Reviewed Under Certificate-of-Need	1978 Regional Health Systems Plans					1978 State Medical Facil- ities Plan
	HSA I	HSA II	HSA III	HSA IV	HSA V	
<u>Hospital Beds</u>	X	X	X	X	X	X
<u>Nursing Home Beds</u>	X	X	X	X	X	X
<u>Specialized Beds</u>						
Psychiatric Beds		X	X	X	X	X
Alcoholism Beds		X	X			
Neonatal Beds		X			X	
<u>Selected Equipment</u>						
CT Scanners	X	X	X	X	X	
Ultrasound	X	X	X	X		
Linear Accelerator		X	X	X		
Renal Dialysis	X	X	X	X	X	
<u>Selected Services</u>						
Cardiac Catheterization	X	X		X		
Home Health	X	X	X	X	X	
Out-patient		X	X		X	

X = need addressed in plan

Source: 1978 HSA Health Systems Plan and 1978 State Medical Facilities Plan.

criteria upon which projects will be judged. These criteria are also important because they provide a basis upon which the State can scrutinize the adoption of new, unproven medical technology. A recent report of the U.S. General Accounting Office assessing P.L. 93-641, found the need for project review standards and criteria paramount.

The Bureau of Resources Development should issue guidelines to cover all services and facilities included in the Certificate-of-Need Law. These guidelines should be included in the next revision of the State facilities plan.

Need Estimates

Accurate and timely planning data are prerequisites to effective certificate-of-need decision making. Nevertheless, data used to develop need estimates are often inconsistent and poorly

reported. For the most part, estimates of need have only been made for hospital and long term care beds. In the past, these estimates have been crudely done and have not taken into account the many complexities involved in estimating the need for health care services. Recent estimates have been much more refined. However, while methodologies have improved, problems still remain.

Methods of Estimating Need. There are a variety of ways of estimating need. No single approach is considered best. Regardless of what approach is used, two factors must be taken into account: supply and demand. Estimating demand is by far the more difficult of the two. Measuring supply should merely entail counting beds, physicians, x-ray machines or whatever service is being estimated.

Measuring demand is more complicated and entails measuring either the current use of existing resources or, harder yet, unmet demand. The latter involves some objective estimation of the health status of the population to be served regardless of the level of the utilization of available resources.

The traditional approach to estimating need has been to measure the utilization of existing resources. This is the approach taken by the HSAs and the State in estimating additional bed needs.

The methods used by the HSAs and the State to estimate future bed needs are based on the formula developed for use nationwide in Hill-Burton Plans (Figure 13). This method applies current levels of utilization to future population estimates. A desired level of occupancy is then set to convert the projected levels of utilization to future bed needs.

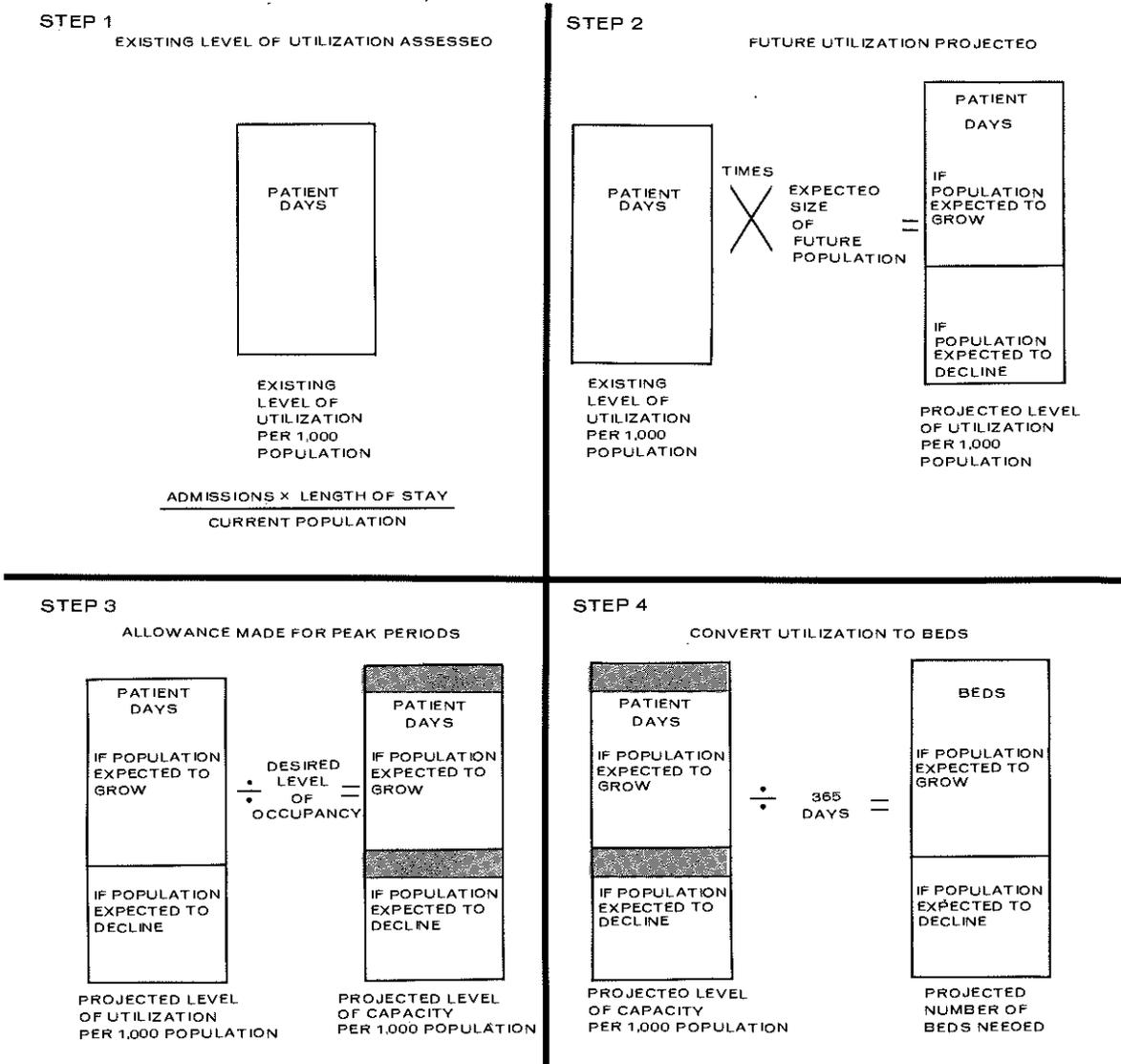
Underlying this approach are two basic assumptions. First of all, it is assumed that current levels of utilization are appropriate. This implies that: (1) the right types of patients are being served; and (2) they are receiving appropriate levels of care. The second assumption is that current levels of utilization will not change in the future.

Both assumptions are easily questioned. Breakthroughs in medical technology, changes in medical practices, and increased use of ambulatory surgical centers are all examples of factors that could change existing levels of bed utilization. All are difficult to take into account in projecting need. Assessing unmet demand is particularly difficult since it is hard to determine who is being underserved and by how much.

The State and HSAs have attempted to address some of the problems inherent in the two assumptions. Estimates are sometimes adjusted to reflect the impact of factors affecting utilization. In addition, to take into account unmet demand, the State, in conjunction with the HSAs, has commissioned a household survey of a random sample of Virginia residents to assess health status more directly. Data from this survey will alleviate the problem of basing estimates

Figure 13

HILL-BURTON METHOD FOR PROJECTING BED NEED



Source: JLARC.

of need solely on utilization. The survey will measure more directly the health needs of the State's population both those being met as well as those unmet. Results from this survey are expected to be available this year for use in future health plans.

Estimates of Hospital Bed Needs. No objective estimate of future hospital bed need was done until 1976. The 1976 interim plan, and the 1973-1974 Hill-Burton revision, used the same Hill-Burton methodology to calculate future need. However, many of the need estimates for individual planning districts contained in the 1973-1974 revision had been adjusted upward to match what already existed. As a result, the estimates were not really estimates at all, but justifications for what already existed.

The estimates in both plans are for total hospital beds and not for specific types of beds (i.e., general medical/surgical, pediatric, obstetric, intensive care). A more refined methodology is used in the 1978 facilities plan. The new formula is still based on current utilization, desired occupancy, and projected population. However, projections are made for specific types of beds, not just for total hospital beds.

The formula also incorporates adjustments to take into account:

- the number of additional patients served from neighboring localities;
- trends in utilization, not just the past year, as under the Hill-Burton method;
- differences in average length of stay by locality; and
- separate estimates of peak demand based on type of service, etc.

While the HSAs adopt the same basic approach as the State, none of the HSA formulas take all these factors into account. The State's formula is more refined, building on the approaches developed in earlier HSA plans. Given the complexities involved in estimating the need for hospital beds, it is not surprising that different approaches would be used. What is surprising is that basic differences exist in what exactly is being estimated.

Table 12 summarizes types of hospital beds for which need is estimated by HSAs and the State. As can be seen from the table, there are fundamental differences in the types of beds for which estimates of need are made. The State develops one estimate for medical/surgical beds and intensive care beds combined. HSA II (Northern Virginia) combines pediatric and medical/surgical beds. HSA V (Eastern Virginia) calculates a single independent estimate of hospital beds in total, with no separate estimates for services except in the case of obstetrics. Such differences make it difficult to make consistent certificate-of-need decisions at the State level.

Estimates of Nursing Home Bed Needs. The method for projecting future long term care bed need, like that for hospital beds, has evolved during the time certificate-of-need legislation has been in effect. The two earlier plans relied on a simple ratio method rather than the Hill-Burton approach. Each planning district was classified as Standard Metropolitan Statistical Area (SMSA), urban, or rural and future need estimated at 50, 40, or 30 beds, respectively, per 1000 population 65 and over. A ratio method was used since a shortage of long term care beds existed at the time. Utilization levels, while high, did not reflect a large amount of unmet need believed to exist.

Table 12

TYPES OF HOSPITAL BEDS FOR WHICH NEED IS ESTIMATED

	1978 Regional Health Systems Plans					1978 State Medical Facil- ities Plan
	HSA I	HSA II	HSA III	HSA IV	HSA V	
Total Hospital Beds ¹		Sum ²	Sum	Sum	X	Sum
Obstetric	X	X	X	X	X	X
Pediatric	X	} X	X	X		X
Medical/Surgical Intensive Care	X		X	X	X	

¹Exclusive of any psychiatric beds.

²Sum = The sum of the estimates for the individual services.

Source: JLARC.

The methodology to project future nursing home beds was modified in 1977. A new plan was issued to reflect the changes. The State Department of Health had apparently recognized the need to develop a more refined means for determining future need. An approach using the original Hill-Burton methodology was adopted but with projected utilization rates instead of current ones. The revised formula was developed by a private firm under contract to the State. Using the traditional formula with a range of projected utilization rates, minimum and maximum estimates of future need were determined.

The results were somewhat different than those from the ratio method, especially in SMSAs where future need turned out to be less than anticipated on the basis of the old ratio method.

The Department of Health requested that the HSAs select an appropriate use rate for each planning district. However, not until the 1978 plan was developed had each done so.

Unlike hospitals, no attempt has ever been made to develop separate estimates for different types of nursing home beds--namely intermediate versus skilled.

Conclusion

Changes in health planning requirements and projection methods have left their mark on the certificate-of-need decision making process. As a result of these changes, plans have not been

used consistently in making certificate-of-need decisions (Figure 14). Before plans can serve as a useful guide, both to the Commissioner and to potential applicants, the health planning process must achieve greater stability.

A higher priority must be given to making need estimates more accurate. This can be accomplished to a large extent by improving the accuracy of the State's count of existing beds. JLARC found serious deficiencies in the State's inventory of beds. As Figure 14 shows, without an accurate inventory, estimates of future bed needs will be in doubt.

MONITORING

Monitoring can perform two useful functions. First, it can provide information on existing beds for planning purposes. Second, it can provide a check on approved certificate-of-need projects and discourage unapproved project activity. In this regard, major shortcomings were found in the State's ability to track the existing supply of beds and monitor approved and unapproved project activity.

An essential part of planning is an inventory of existing beds. A review of various agency data sources revealed that an accurate and up-to-date tally of beds does not exist. JLARC found numerous instances where hospital reported bed data conflicted with licensure reports and health facilities plans.

Monitoring certificate-of-need project activity is fragmented and incomplete. The Bureau of Resources and Development is not systematically informed of project completion. No formal mechanism exists to monitor unapproved project activity. Several projects have been undertaken without prior certificate-of-need approval.

Most owners of private facilities voluntarily comply with certificate-of-need because it is in their own interest to do so. Having a certificate virtually guarantees a franchise to that facility for whatever service the project involves. Furthermore, given the high rate of approval under the program, facility owners know they are likely to receive approval.

Supply Estimates

Agency reports, surveys, and plans do not always agree on the existing supply of beds in the Commonwealth. Fundamental differences were found between the number of beds cited in health facilities plans, the number approved under certificate-of-need, and the number licensed.

Figure 14

CASE STUDY:

IMPACT OF CHANGING PLANS, NEED ESTIMATES, AND BED COUNTS

A proposal to build a 120-bed nursing home in Norfolk was denied by the Health Commissioner in late 1974. The project was inconsistent with the bed projections and recommended geographical distribution contained in the State's unpublished Hill-Burton plan.

Within the next six months, HSA V eliminated two exempt nursing home facilities (252 beds) from its bed count, and revised its need projections for the area. Both facilities were planned before the enactment of the Certificate-of-Need Law and, therefore, exempt from the standard review process. However, neither facility had shown sufficient progress toward project completion. Based on the revised bed projections, a 100 bed nursing home was approved by the HSA for the Norfolk area. The Health Commissioner also approved the project, but the State did not revise its projections to meet those of HSA V.

In late 1975, after learning that another application was being submitted for a new 60 bed nursing home, the owner of the original Norfolk proposal reactivated his application. Neither project was pursued when it became apparent that any new beds would exceed the revised estimates of need for HSA V.

In September 1976, the State published its Interim Medical Facilities Plan, with revised bed needs for each planning district. The beds of the two exempt facilities excluded by HSA V still remained part of the plan. Nonetheless, the plan showed a need for 109 additional nursing home beds by 1980. The interim plan was officially adopted in March, 1977.

In November 1976, during the six months in which the interim plan was published but not formally adopted, a nursing home developer proposed the addition of 120 beds to each of two nursing homes, one located in Virginia Beach, the other in Chesapeake. Bed needs under the official Hill-Burton plan would not permit the approval of either project. However, the State opted to use the new bed projections included in the interim plan despite the fact the plan was not yet officially adopted. These later projections would permit the approval of only one of the two projects. The developer chose to seek approval for the Virginia Beach facility, which was ultimately approved.

The applicant of the 1974 Norfolk nursing home proposal was opposed to both of these projects. He reasoned that his request should have received first consideration once additional bed need was projected for the area. However, Health Department officials replied that this applicant did not have an active proposal before the department for consideration. The applicant was given 60 days to submit an application. But he failed to do so.

After the interim plan was formally adopted in March 1977, the developer of the Virginia Beach facility resubmitted his Chesapeake application. This time the application was approved. Another applicant received approval to build a 120 bed nursing home. This latter proposal was to serve a special religious population with unique needs and would have a service area which extended outside of PD 20.

Approval of these two applications was based on a revision to the 1977 interim plan. The applicants felt that the State should disregard the two exempt facilities previously deleted from projections by HSA V. The State concurred and both proposals were subsequently approved, based on revised needs projections. Nevertheless, the 252 exempt beds are still counted in the 1978 State facilities plan.

Source: JLARC.

The Bureau of Resources Development (BRD) relies upon annual licensing reports for a count of the number of licensed beds at each facility. This, coupled with the number of beds approved under the certificate-of-need program but not yet licensed, plus any exempt from the law, should result in the total number of beds in existence or under construction. However, this is not always the case. What is licensed and what is approved does not always agree with what is shown in the plans or with what actually exists.

Nor does agreement always exist over what is exempt. Three projects that are not likely to be completed are known to be exempt from certificate-of-need review. Doubt exists as to whether the beds involved in these projects should be counted.

Counting Beds. Every hospital and nursing home in the Commonwealth is licensed once a year by the Bureau of Medical and Nursing Facilities Services (BMNFS) of the State Department of Health. A license is issued to a facility for the total number of beds. No differentiation is made on the license in the number of medical/surgical, obstetric or pediatric beds, or, in the case of nursing homes, in skilled or intermediate care beds.

To obtain the composition of beds at a given facility, BRD and the HSAs must turn to an annual survey of hospitals and nursing homes conducted by the Virginia Center for Health Statistics (VCHS). This survey is mailed out yearly along with the annual licensure application to each hospital and nursing home in the Commonwealth. Results from the survey are aggregated and published in the *Annual Survey of Virginia Hospitals and Nursing Homes*. This publication forms the basis on which the State and the various HSAs rely for the inventory of bed needs in their plans. Unfortunately, the results reported from the survey do not always agree with the licensing reports issued annually by BMNFS. Nor, in fact, do the results from the annual survey and the licensing reports always agree with certificates that have been approved. Such differences represent a fundamental problem in the State's ability to accurately estimate need.

Planning District 7. Bed counts reported for hospitals in Planning District 7 (located in HSA I, Northwest Virginia) are illustrative of the types of inconsistencies found between various data sources. It should be noted that data inconsistencies identified here were not unique to this planning district but were found for facilities located throughout the Commonwealth.

Winchester Memorial, the largest hospital in the district, was licensed for 24 fewer beds than what was counted in the 1978 State and HSA plans. Despite this reduction of 24 licensed beds, no change was reflected for this facility in the VCHS annual survey between 1976 and 1977. As a result, BRD and HSA I (Northwest Virginia), using the 1977 annual survey as the basis for their plans, counted Winchester Memorial as having a total of 439 beds instead of the 415 beds for which they were actually licensed (Table 13).

Table 13

WINCHESTER MEMORIAL: DIFFERENCES BETWEEN
LICENSURE REPORT AND PLANS

<u>Total</u>	<u>Licensed As of January 1, 1978</u>	<u>Counted in 1978 State and HSA Plans²</u>	<u>Difference*</u>
Total Hospital ¹	415	439	+24
Medical/Surgical	313	336	+23
Obstetric	33	34	+ 1
Pediatric	42	42	--
Intensive Care	27	27	--

*(Plus (+) indicates 1978 State Medical Facilities Plan shows *more* beds than what may exist.)

¹Excludes 30 psychiatric beds not included in totals.

²As reported in 1977 Annual Survey of Hospital and Nursing Homes.

Sources: January 1, 1978 Licensure Report of Virginia Hospitals, 1978 State Medical Facilities Plan and 1978 Health Systems Plan for HSA I.

Similar inconsistencies were found for another hospital in the planning district. Warren Memorial received a certificate-of-need in November 1975, to build 40 new long term care beds and to renovate 36 existing medical/surgical beds and 8 intensive care beds. A total of 12 beds were to be eliminated--4 obstetric beds and 8 pediatric beds. Nonetheless, differences were found between what was approved under certificate-of-need and 1978 plans (Table 14).

Table 14

WARREN MEMORIAL: DIFFERENCES BETWEEN
CERTIFICATE-OF-NEED AND PLANS

	<u>Certificate-of-Need Approved Changes</u>	<u>Expected Bed Total</u>	<u>Counted in 1978¹ State/HSA Plans¹</u>	<u>Difference*</u>
Total Hospital	-12	111	111	--
Medical/Surgical	36(Replacement)	85	79	-6
Obstetric	- 4	6	9	+3
Pediatric	- 8	12	16	+4
Intensive Care	8(Replacement)	8	7	-1
Long Term Care	40(new beds)	40	Under Construction	

*(Plus (+) indicates that 1978 State Medical Facilities Plan shows *more* beds than may exist.)

¹Agrees with what was licensed January 1, 1977.

Sources: January 1, 1978 Licensure Report of Virginia Hospitals, 1978 State Medical Facilities Plan and 1978 State Health Systems Plan for HSA I.

The remaining two hospitals in this planning district also were found to have differences not reflected in the 1978 plans. Shenandoah Memorial received certificate-of-need approval for two projects. One request, approved in August, 1976, involved the creation of 6 intensive care beds--4 to be converted from existing medical/surgical beds and 2 to be added. The additional 2 beds, however, were never counted in the 1978 plans.

The second approval granted Shenandoah Memorial was in February 1977, for 2 new long-term care beds. However, these beds had already been recorded in the 1976 VCHS survey and counted in the 1976 interim facilities plan. That is, the hospital added the long-term care beds before receiving certificate-of-need approval.

The last remaining facility in Planning District 7 is Page Memorial. In 1977, BMNFS granted 2 provisional obstetric beds to add to 2 existing obstetric beds. These additional beds were to be converted from 2 existing medical/surgical beds. The change in beds was not reflected in the State facilities plan.

Impact on Need Estimates. While separately these bed differences do not seem significant, together they can amount to a considerable number. Table 15 summarizes the aggregate differences found for the four hospitals in Planning District #7. As seen in the table, the differences could significantly change the pattern in the case of medical/surgical beds.

Table 15

PLANNING DISTRICT 7: IMPACT OF DIFFERENCES ON ESTIMATED BED NEEDS

	1978 State Facilities Plan		Other Sources				
	Total Existing Beds	Total Surplus Beds Projected for 1983	Differences Found Between State Plan and Existing Beds	Shenandoah	Winchester	Page	Warren
Medical/Surgical ¹	579	18	+2	+23	-2	-7	
Obstetric	57	21	0	+1	+2	+3	
Pediatric	65	23	0	0	0	+4	

(Plus (+) indicates that 1978 State Medical Facilities Plan shows *more* beds than may exist.)

¹Includes intensive care

Source: JLARC.

Inaccurate estimates of need resulting from unreliable bed counts represent a serious weakness in the health planning process. Inaccurate estimates cast doubt on the validity of project decisions.

While other factors beside need estimates play an important role in approving or denying projects, bed projections are the most objective criteria the State can use.

The Department of Health needs to place a higher priority on monitoring and reporting of existing beds. Specifically, BRD needs to reconcile differences between the VCHS annual survey, licensure reports and certificates granted, and make its findings a part of the medical facilities plan. Furthermore, an application involving beds should not be accepted for review unless the existing beds shown concur with the most recent licensure report.

The HSAs should adopt BRD's inventory as official State counts of the number of existing beds. If an HSA should disagree with the State over how many beds exist in its area, this disagreement should be made part of its regional plan.

Some HSAs also fail to take into account approved beds not yet licensed. For instance, HSA III (Southwest Virginia) failed to include in its projection for hospital beds, 61 beds being built for a new hospital in Buchanan County. All HSAs should include beds approved under certificate-of-need as part of their need estimates.

The types of discrepancies uncovered regarding beds is actually part of a much larger problem JLARC found in the certificate-of-need program. Serious shortcomings were found in the State's ability to monitor the types of projects required to be reviewed under certificate-of-need legislation.

Monitoring Approved Projects

Responsibility for monitoring projects approved under certificate-of-need is fragmented by the type of facility involved, the nature of the project, and the stage of completion. The result is that many gaps exist in the State's ability to follow a project from approval through to completion.

Current Procedure. BRD only monitors approved projects until the applicant is either financially or legally obligated to complete the project. In the case of construction projects, financing must have been secured and detailed architectural plans completed. Often a contract will have been awarded. In the case of equipment purchases, a purchase order must have been placed or a lease agreement signed. If the project simply involves the addition of a new service, there are no formal reporting requirements.

The applicant has one year from the date the certificate is issued to reach this stage. If, after the first twelve months, the applicant has not succeeded in reaching this point, six month progress reports must be submitted and an extension sought, first from the Health Commissioner, and then, if still not underway, from

the Board of Health. The Commissioner may grant the first extension for up to one additional year. If, at the end of this second year the project is still not underway, the applicant must, under law, seek further extensions from the Board of Health.

Section 32-211.1 of the *Code of Virginia* permits extensions to be granted after the first two years only at the discretion of the Board of Health and only if the applicant is making "substantial and continuing progress towards completion. . .". To receive a further extension the applicant must present documentation to show that any delays in the development of the project were beyond the owner's control, that substantial delays may not be attributable to the owner, and that the owner can assure a reasonable timetable for completion. It is then up to the Board of Health to grant an extension.

Once a project is underway, the responsibility for monitoring either passes to others outside BRD or is no longer followed. The law does not call for BRD to follow a project through to completion. And, BRD is not systematically notified of project completion.

Projects approved under certificate-of-need are only followed to completion if licensed by either the Departments of Health, or Mental Health and Mental Retardation. Even then, such monitoring depends on how relevant the project is to the licensing requirements of these two departments. If, for instance, the project involves the construction of a new nursing home, the Bureau of Medical and Nursing Facilities Services, which licenses all nursing homes in the State, will closely follow the project from start to finish, including a detailed review of the architectural plans. If, on the other hand, the project involves the installation of an expensive piece of x-ray equipment, the same bureau may or may not check the relevance of the installation to what was approved under certificate-of-need.

In neither case is BRD notified by the licensing bureau or by the applicant when the project is complete. JLARC's contact with facilities revealed that most hospital and nursing home administrators assumed licensure inspectors were reporting completions to BRD. This is generally not the case and indicates a shortcoming in the certificate-of-need process.

While no requirement exists under the law for BRD to follow projects until they are completed, the State needs to know the final status of what has been completed and when in order to evaluate other projects that may be proposed. As was seen earlier, not all projects are completed exactly as approved. Some facilities, such as Warren Memorial in Planning District 7, received approval for a bed related project which was not reflected in the final bed composition reported for that facility. These kinds of reporting differences are enough to alter the State's estimate of need and may impact on a future certificate-of-need application.

Improving Coordination. The respective bureaus responsible for licensure in the Departments of Health, and Mental Health and Mental Retardation should specifically check the status of projects approved under certificate-of-need for those facilities that they license, or in the case of the Department of Health, any that are certified for medicaid. When, upon inspection, a project is found completed, final notification should be made to BRD and the original applicant. By including the applicant, the possibility of misunderstandings over questionable project alterations would be eliminated. Examples of such alterations follow.

Case #1

JLARC found some instances where facilities built less than what was approved. This left doubt as to whether to count what was unfinished in future needs estimates. An example of this occurred in HSA V (Eastern Virginia). A new hospital was approved in a rural part of this HSA for 114 beds. However, for economic reasons only 76 beds were built. For planning purposes, the status of the 38 unbuilt beds remains unclear.

Case #2

Another example involves a facility owner who changed the clientele to be served by an approved project. A certificate-of-need was granted in HSA II (Northern Virginia) to build a psychiatric facility. The facility was approved on the basis that 60 of the 90 beds to be built would serve adolescents. Once completed, however, the owner chose to serve adults, an entirely different service population.

Once a certificate is issued, the project should conform with the approved application. Conformance with certificate-of-need conditions could be ensured through the project completion report and licensing function.

Monitoring Unapproved Projects

Currently no formal mechanism exists to detect project activities that have taken place without prior approval under certificate-of-need. As a result, some projects have been undertaken without the Health Commissioner's approval. These projects include: (1) changes in beds, (2) retroactive approvals, and (3) renovations to State facilities.

Current Procedure and Bed Changes. BRD relies upon licensure reports and medicaid audits to detect unauthorized project activity. However, neither the Bureau of Medical and Nursing Facilities Services (BMNFS) nor those responsible for cost settlements under medicaid look in detail for changes that may have been made without prior approval.

BMNFS only notes such a change if it was in violation of licensing standards. Projects, if unapproved under certificate-of-need, would not necessarily be reported unless the project was also in violation of licensing requirements.

The medicaid program is not equipped to pinpoint capital expenditures in excess of \$150,000 unless the expenditure all happened to occur within one year and if no other capital expenditures were made that year. The reason is that medicaid cost reports are not sufficiently detailed to link expenditures for projects approved under certificate-of-need to other types of capital expenditures (e.g. minor room renovations and repairs).

Costs of approved projects are shown separately on the cost report from the total of all capital expenditures in another section. The total figure only reflects expenditures for projects *completed* in the year being reported. The costs reported for certificate-of-need projects, on the other hand, reflect any expenditure for that project made during the period--whether completed or not. Without knowing whether the costs being reported for approved projects are final and included in the total figure, the State cannot effectively monitor the expenditures of either approved or unapproved projects.

The State's medicaid program should alter the cost reporting form so these costs can be separately identified. If necessary, the medicaid program could require facilities to file a separate cost report for any certificate-of-need project upon its completion. This report would reflect what expenditures have been included in the totals on the medicaid cost report filed for that period.

BRD also needs to make better use of the annual survey of hospitals and nursing homes conducted by the Center for Health Statistics. The survey contains detailed information on the types of beds, services, and equipment at each facility. A comparison of the bed composition of hospitals reported from the 1976 and 1977 surveys revealed numerous changes which should have been detected by BRD, but were not. Table 16 highlights these changes. Many of these changes are similar to the types described earlier for hospitals in Planning District 7.

Retroactive Approvals. Several projects have been retroactively approved by the Health Commissioner. That is, the Commissioner granted a certificate-of-need to a project that was already underway or completed. In the course of its review, JLARC identified five instances where this occurred:

Table 16

UNEXPLAINED (UNAPPROVED) CHANGES IN BED
TYPES FROM 1976 TO 1977

Hospital	Type of Bed Changed					Net Changes
	Medical/ Surgical	Intensive Care	Pediatric	Obstetric	Other	
A	-51		+15		+36	0
B	+ 3	+16	- 2			+17
C	- 3	+12				+ 9
D	- 8	+ 6		- 4		- 6
E	+ 2	+ 6	- 8			0
F	- 7	+ 7				0
G	- 1			+ 6		+ 5
H	- 6		+ 6 ^a			0
I	- 6		+ 1		+ 5 ^b	0
J	- 6	+ 4			+ 2	0
K	- 4	+ 4				0
L	- 4	+ 2		+ 2		0
M	- 3				+ 3	0
N	- 2	+ 2				0
O	- 2			+ 2		0
P	+ 2			- 2		0
	<u>-96</u>	<u>+59</u>	<u>+12</u>	<u>+ 4</u>	<u>+46</u>	<u>+25</u>

A plus (+) indicates an increase on the number of beds reported between 1976 to 1977; a minus (-) a decrease.

^arepresented a new service as well

^bincludes one psychiatric bed

Sources: 1976 and 1977 Annual Survey of Hospitals and Nursing Homes. Virginia Center for Health Statistics.

- A hospital purchased a parking lot for \$400,000 to replace a lot previously sold.
- A nursing home converted 13 short term beds to fully licensed intermediate case beds.
- A hospital added two long term care beds.
- A kidney dialysis center relocated its facility and purchased six additional kidney dialysis machines.
- A major hospital leased a laboratory computer system for \$284,535 for five years.

Unauthorized project activities can significantly alter the character of a facility and the services it offers. The results of such unapproved changes can be unnecessary duplication of services, increased health costs to the consumer, and conflicts with health plans. Therefore, it is important that the Department of Health develop appropriate mechanisms to monitor unauthorized project activity.

Unapproved MHMR Projects. During the course of the review JLARC found that 15 projects were undertaken by the Department of Mental Health and Mental Retardation (MHMR) without approval. These projects were appropriated nearly \$6 million during the 1974-76 and 1976-78 biennia.

MHMR claims that these unapproved projects were the result of confusion over whether State-owned facilities were covered by certificate-of-need legislation.

Four projects were submitted by MHMR during 1976 and 1977 for certificate-of-need review. All four were approved. One of these projects, the creation of a new mental health institute in Danville, cost over \$3.8 million, while the other three involved changes in bed mix at no cost.

The State's Certificate-of-Need Law specifically mentions coverage of mental hospitals, mental retardation facilities, and other institutions which are either "owned or operated for profit or nonprofit and which are either owned or operated privately or by a local governmental unit". However, coverage of State-owned or operated facilities is never explicitly addressed.

P.L. 93-641 requires all health care facilities to undergo certificate-of-need review. The law specifies that facilities receiving reimbursement under the Social Security Act for maternal and child care, medicare, or medicaid are to be covered. MHMR's facilities have received large sums of money as reimbursement under medicaid and medicare especially for the treatment of its geriatric patients. Clearly, MHMR's 15 projects fall under the category of those medical facilities covered under the federal definition.

Prior to 1977, the State's law did not address this aspect of the federal definition. In 1977, after funds for MHMR's 15 projects had been appropriated, an amendment to the State's Certificate-of-Need Law brought Virginia's definition of medical care facilities more explicitly in conformance with the federal definition. The amendment broadened the types of facilities covered to include those . . . "which [are] the recipient of reimbursements from third party insurance programs or prepaid medical service plans." This would include any facilities, such as the State's mental institutions and mental retardation facilities, which receive medicaid or medicare funds. However, confusion still remains as to whether State medical facilities which do not receive reimbursements from third party insurance programs are covered.

Recently MHMR has sought clarification from the Health Department as to whether or not a certificate is required. Clarification came in the form of a memorandum dated December 20, 1978 from the assistant attorney general assigned to MHMR to health department officials. The memorandum stated that MHMR projects are definitely required to undergo certificate-of-need review under federal law. As a result of the memorandum, MHMR and Department of Health officials met and agreed that all of MHMR's projects undertaken after February 1, 1979 will be subject to certificate-of-need review.

Sanctions

The State has a variety of sanctions it can impose for projects built that are not in conformance with certificate-of-need. Projects that have been approved but are subsequently altered without written approval from the Commissioner may have their certificate revoked. In such a case, the applicant may, if desired, have the project reviewed again.

In the case of projects that have not received prior approval, the State has four possible sanctions it may invoke. The Department of Health may go to court and enjoin the project as specified in Section 32.211.12 of the *Code of Virginia*. Or, the State may impose a fine of not less than \$50 nor more than \$1,000 as provided under the certificate-of-need law. As further sanction the State could impose a fine of \$10,000 a day for violating State regulations as provided under the Administrative Process Act.

Under federal law, the State can also withhold medicaid reimbursement from the facility for that portion of its costs attributable to the unapproved project. The same sanction can be applied federally, not only to medicaid but to medicare reimbursements as well. In Virginia, Blue Cross of Virginia has voluntarily adopted the same policy. In some states, such as New York, Blue Cross is required to withhold this payment by law.

To date, no monetary sanctions have been applied. Only one injunction has been issued, a test case involving a large purchase of equipment by a physician's office. The five retroactive projects cited earlier were all approved without sanctions.

FINDINGS AND RECOMMENDATIONS

Certificate-of-need decisions must be objective and based on sound plans and information. The planning and monitoring activities of the State have not kept pace with implementation of the Certificate-of-Need Law. Many project decisions have been made without the benefit of credible plans, need estimates, and bed counts. As a result, determinations of need have been at times ill-defined or suspect.

In order to improve need determination, the State should clearly define the bed capacity threshold, further refine the health planning process, and develop systematic monitoring practices.

Bed Threshold

The 1979 General Assembly redefined the review threshold regulating changes in bed capacity. The current definition seems to be less restrictive than the previous provision because it does not cover changes in the composition of existing beds. If so, the State's certificate-of-need process may no longer be in conformance with federal regulations. Nonetheless officials of the Department of Health do not concur with this observation. As yet, no written interpretation of the 1979 amendment has been prepared by the department.

Legislation directs the Department of Health to develop a health facilities plan. As a part of this plan, the department estimates bed needs by specific types of beds. Therefore, it is important that changes in bed composition be reviewed under certificate-of-need.

Staff Recommendation. The department should carefully review the revised bed capacity threshold contained in Section 32.1-93(3) of the *Code of Virginia* (Title 32, 1979 Revision) and request a written interpretation of its application from the Attorney General. If the interpretation concludes that the new threshold hampers the State's ability to regulate changes in bed composition, the department should request the General Assembly to amend the law to cover such changes.

Plan Development

The State and HSAs have made substantial progress in the development of a health planning framework. However, expansion and refinement of medical facilities plans should be encouraged. Particular attention needs to be given to making plans more uniform, comprehensive, accurate, and current.

Staff Recommendation (1). JLARC found numerous inconsistencies in approaches taken by the State and HSAs to prepare plans, inventory existing facilities, and project future needs. Such variations present a confusing basis upon which certificate-of-need decisions must be made. The State Health Commissioner, with the assistance of the Statewide Health Coordinating Council, should form a committee to explore and recommend ways to bring about greater uniformity between HSA and State health planning methods.

Staff Recommendation (2). Estimates of need are not done for many types of facilities and services. In the absence of standards and criteria, the State may not be able to adequately evaluate an applicant's project proposal. The Bureau of Resources

Development should develop standards and estimates of need for facilities and services not currently included in the 1978 State medical facilities plan.

Staff Recommendation (3). Numerous data errors were found in past and current State facilities plans. Planning data must be accurately represented if planning bodies are to make objective decisions on certificate-of-need applications. The Bureau of Resources and Development should verify need projections and eliminate inaccuracies and inconsistencies contained in the 1978 medical and facilities plan.

Staff Recommendation (4). There is no formal, systematic method for updating plans. Anywhere from eight months to a year can elapse between the time a plan is prepared and the time it is officially adopted.

The Bureau of Resources Development should develop a formal mechanism for publicly updating information between issuance of the State medical facilities plans. Such a mechanism is necessary to incorporate changes which occur between plan preparation and adoption, and during the time the plan is in effect. Bed counts by facility need to be continually updated.

Monitoring

A major gap in the State's certificate-of-need program is the lack of a formal project monitoring function. Weaknesses were found in the way the Health Department tracks the existing supply of beds and approved and unapproved project activity.

Staff Recommendation (1). Significant differences were observed between the number of beds licensed, the number cited in health plans, and the number approved under certificate-of-need. To help eliminate such inconsistencies, BRD should reconcile differences between these data sources and compile an accurate and up-to-date Statewide inventory of beds by type and by facility. The Bureau's findings should be reflected in the next revision of the State facilities plan. Applications involving beds should not be accepted for review unless the existing beds shown concur with the BRD inventory and licensure reports. The General Assembly may also want to consider placing a limit on the length of time an incomplete project can remain exempt.

Each HSA should adopt the BRD inventory as the official State count of existing beds. If an HSA should disagree with the State over how many beds exist in its area, this should be made part of its regional plan.

Staff Recommendation (2). To assist in monitoring changes in bed composition, the State Department of Health should issue certificates by type of bed. Moreover, the Bureau of Medical and Nursing Facilities Services should begin licensing facilities

not simply for a total number of beds but for a specific mix of beds. Provision for this may have to be made by the General Assembly in Section 32.1-127(D) of the *Code of Virginia* (Title 32, 1979 Revision).

Staff Recommendation (3). Responsibility for monitoring projects approved under certificate-of-need is fragmented among a number of different Department of Health bureaus and State agencies.

As a first step, the Bureau of Medical and Nursing Facilities Services and the Department of Mental Health and Mental Retardation should begin monitoring all approved certificate-of-need activity and report the completion of all projects to BRD and the applicant.

BRD should be responsible for inspecting facilities like Health Maintenance Organizations and Public Health Centers, which are covered under Virginia Certificate-of-Need Law but are not licensed by either the Departments of Health or Mental Health and Mental Retardation.

In order to formalize the monitoring activity and discourage unauthorized changes to approved projects, the General Assembly may want to consider making project completion a requirement under licensure. The Virginia Medical Society has pointed out to JLARC that such a requirement exists in the Maryland certificate-of-need law. The Maryland law requires applicants to show evidence of conformance to all certificate-of-need conditions prior to "first use of the service or facility." Such evidence is submitted prior to the issuance of a "license to operate."

Staff Recommendation (4). The large number of unexplained changes in hospital beds and the occurrence of retroactive project approvals signal a need to pay greater attention to detecting unauthorized project activity. Two steps should be taken to guard against unapproved activity.

First, closer scrutiny of medicaid cost reports is required. The medicaid program should modify the cost reporting form so capital expenditures can be more closely followed. In addition, facilities could be required to file a separate cost report on a completed certificate-of-need project.

Second, the General Assembly may need to determine if all State-owned facilities, whether receiving third-party reimbursements or not, are required to undergo certificate-of-need review. Clarification may also be needed in the capital outlay process as to whether a proposed project should receive a certificate-of-need before it receives an appropriation, or if it is more appropriate to grant an appropriation on the condition that the project receives a certificate before construction begins. The latter approach was used by the 1978 General Assembly to transfer beds from Blue Ridge Sanatorium to the University of Virginia Hospital.

IV. Distribution of Beds

Two separate but interrelated objectives of certificate-of-need are:

- to ensure an adequate distribution of health care services; and
- to prevent unnecessary duplication of services and facilities.

The duplication of services and its impact on costs were of serious concern at the time certificate-of-need was passed. In 1972, a Virginia legislative study commission had concluded that by preventing unnecessary duplication, certificate-of-need could be a key factor in stemming the tide of rising health care costs.

To assess whether these objectives of certificate-of-need were being satisfactorily met, JLARC examined the impact of the certificate-of-need program on the distribution of hospital and nursing home beds. Bed-related projects comprised 78 percent of the total estimated cost of all projects reviewed under the process since July 1973.

On the one hand, certificate-of-need has been effective in curbing the growth of new hospital beds in most sections of the State. But the law has not been effective in eliminating unneeded existing beds. All Health Service Areas (HSAs) have an excess supply of hospital beds and occupancy rates continue to decline. Unnecessary beds will have to be eliminated if the purposes set forth in the State's certificate-of-need legislation are to be effectively carried out.

Stronger public actions will be needed over time to reduce existing hospital beds that are uneconomical to maintain. Otherwise, the cost of supporting surplus beds will continue to be passed along to third party payors, to the State through the medicaid program, and eventually to the public in the form of higher insurance premiums.

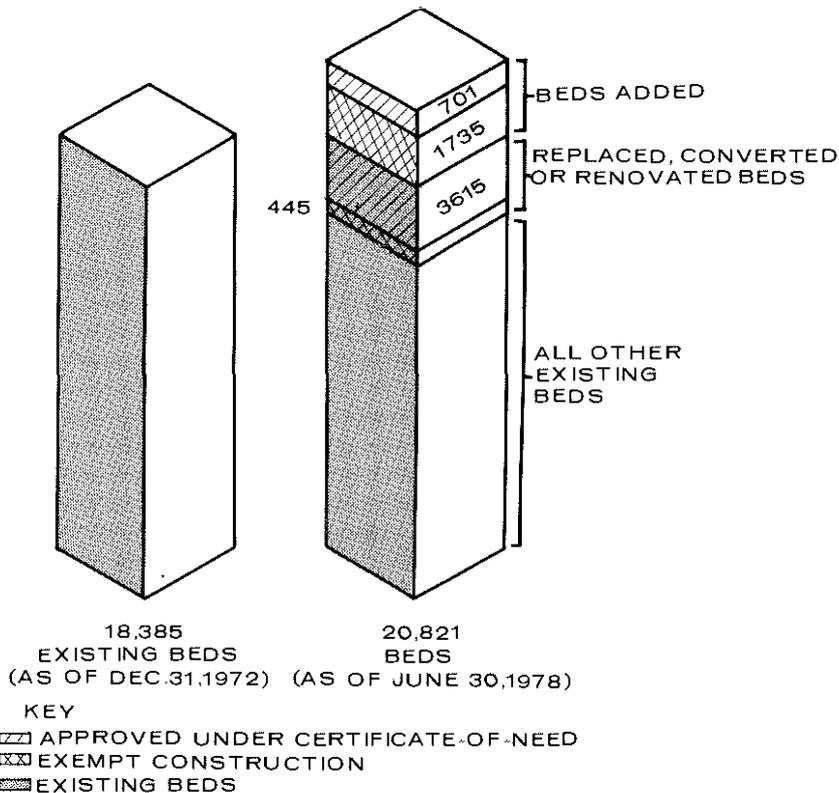
For the most part, nursing home beds have been in short supply since the enactment of certificate-of-need legislation. Therefore, the response to the need for nursing home beds has been to provide Virginians with the greatest possible access to this type of long term care. Similar to hospital beds, however, the supply of nursing home facilities in metropolitan areas is beginning to outstrip demand.

HOSPITAL BEDS

There were 18,385 hospital beds when certificate-of-need legislation was passed.* In June 1978, the total supply of beds had increased to 20,821 (Figure 15).

Figure 15

HOSPITAL BED CONSTRUCTION (FY 1974 - 1978)



Source: 1973-74 Virginia Plan for Construction and Modernization of Medical Facilities (SDH), JLARC.

Although nearly 2,500 new beds have been added, most of these beds were exempt from review--over 1,700. These were projects initiated on or before December 31, 1972, that satisfied certain exemption conditions specified in Section 32-211.15 of the Certificate-of-Need Law.

The addition of new hospital beds represents only a portion of overall construction activity. Approximately 4,000 existing beds have been either replaced, converted, or renovated.

*Figures throughout this discussion include only short-term acute care beds and exclude psychiatric beds.

The State's reluctance or inability to deal aggressively with existing beds has contributed to overbedding problems in large urban centers.

Impact of Planning on Hospital Beds

It appears that State facilities plans have been used to guide project decisions on additional beds, but not on existing beds. Table 17 shows the number of beds proposed and approved during the periods different plans were in effect. For the purposes of this analysis, planning activities were divided into three distinct phases:

- Phase I: No officially adopted plan for guiding certificate-of-need decisions (July 1, 1973 - December 4, 1974)
- Phase II: 1973-74 Hill Burton Plan (December 5, 1974 - February 28, 1977)
- Phase III: Interim Medical Facilities Plan (March 1, 1977 - June 30, 1978)

Table 17

PROPOSED AND APPROVED HOSPITAL BED CONSTRUCTION (July 1, 1973 thru June 30, 1978)

	PHASE I		PHASE II		PHASE III	
	Proposed	Approved	Proposed	Approved	Proposed	Approved
Additional Beds	825	613	468	58	236	30
Replaced, Converted, or Renovated Existing Beds	1736	1825*	689	871*	1050	919

*Modifications may result in more existing beds being approved than originally proposed.

Source: JLARC.

Half of all beds approved under certificate-of-need were approved during Phase I, the first 17 months the law was in effect. Ninety percent of all additional beds were approved during this period.

After the first plan went into effect, most of the beds approved represented replacements, conversions, or renovations to beds that already existed. Almost all proposals to replace or renovate beds were approved by the State.

If facilities plans are to be effective guides for approving or disapproving existings beds, greater emphasis will have to be placed on identifying which beds are not needed, especially in overbedded urban areas of the Commonwealth. Effective alternatives will have to be presented in the State facilities plan to deal with existing beds that are no longer needed.

Impact on Distribution

Virginia residents have reasonable access to hospital services, but excess bed capacity is a cause for serious concern. A number of beds approved under certificate-of-need have been built in areas of the State considered most overbedded. If surplus beds are to be reduced, ways will have to be found to eliminate some existing beds.

Surplus Beds. According to the 1978 State facilities plan, Virginia will have 2,100 surplus beds by 1983 (Table 18). The

Table 18

SURPLUS HOSPITAL BEDS BY HSA

	<u>Existing Beds Licensed or Under Construction</u>	<u>Number of Sur- plus Beds 1983</u>
HSA I (Northwest)	2,805	171
HSA II (Northern)	2,898	463
HSA III (Southwest)	5,420	305
HSA IV (Central)	4,694	618
HSA V (Eastern)	<u>4,720</u>	<u>545</u>
	20,537 ²	2,102

¹January 1, 1978

²Differs from total shown in Figure 14. See Appendix 1 for explanation.

Source: 1978 State Medical Facilities Plan, Table 5 (SDH).

exact number of beds now surplus is unknown. Over three-quarters of the surplus beds will be concentrated in the most urbanized sections of the State, Northern Virginia (HSA II), Richmond (HSA IV), and Tidewater (HSA V). These are the same areas generally acknowledged to be overbedded at the time certificate-of-need was being considered. The Richmond area in particular was singled out as having an

excessive number of beds. The legislative study commission which originally recommended passage of certificate-of-need cited Richmond as one of their rationales "...where the highest ratio of hospital beds in relation to population in the nation will exist upon completion of new hospital facilities now contemplated or currently under construction."¹

The impact of these surplus beds is most apparent in declining hospital occupancy rates in all HSAs (Table 19).

Table 19

HOSPITAL OCCUPANCY RATES*

	<u>1975</u>	<u>1976</u>	<u>1977</u>
<u>Statewide</u>	<u>74%</u>	<u>73%</u>	<u>72%</u>
HSA I (Northwest)	75%	73%	72%
HSA II (Northern)	72%	69%	67%
HSA III (Southwest)	77%	76%	74%
HSA IV (Central)	75%	73%	71%
HSA V (Eastern)	76%	74%	73%

*Based on licensed bed capacity

Source: Annual Survey of Virginia Hospitals and Nursing Homes, for 1975, 1976, 1977; Virginia Center for Health Statistics, SDH.

Occupancy levels have decreased over the last three years not only as a result of additional beds being built, but also as a result of other factors. Reduced length of stays, more ambulatory surgery, and the creation of Health Maintenance Organizations are all examples of current forces believed to be contributing to the lower utilization of existing hospital beds.

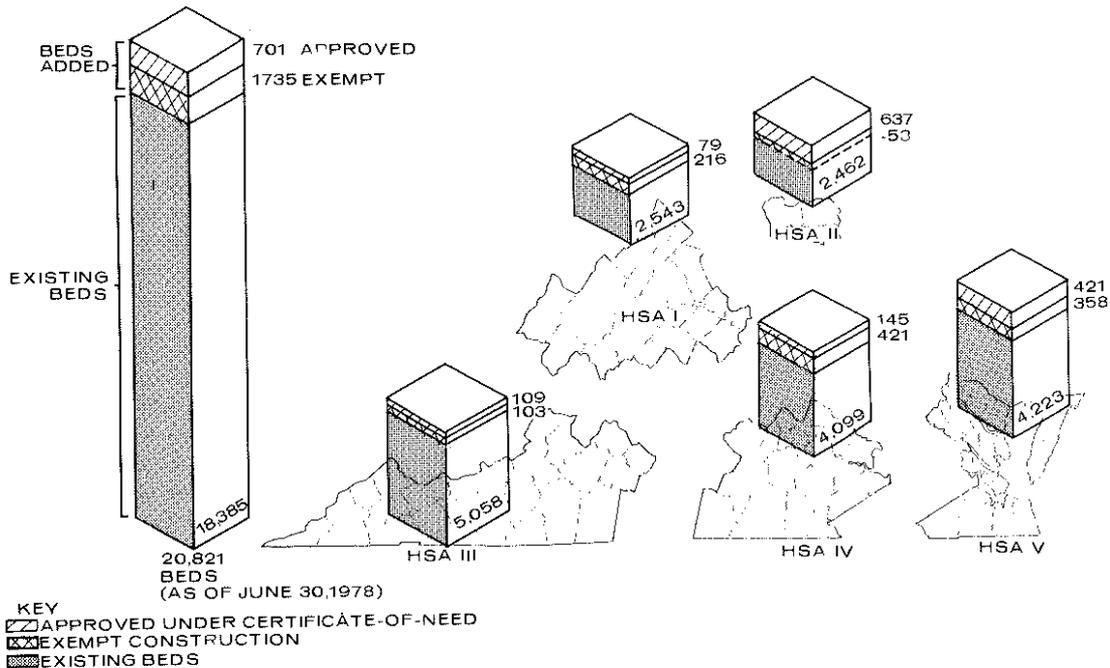
New Beds in Surplus Areas. Nearly 2000 beds have been added in the three HSAs most overbedded, HSA II (Northern Virginia), HSA IV (Central Virginia), and HSA V (Eastern) (Figure 16).

A number of these new beds were exempt from review, however. This was particularly true in Northern Virginia, where all 637 beds were the result of exempt projects. It is probable that facility owners in Northern Virginia, anticipating the enactment of a certificate-of-need regulatory process, expedited the

¹Senate Document No. 14, 1972. Commission to Study Prepaid Health Care Plans and Costs of Medical, Surgical and Hospital Services and Insurance, page 5.

Figure 16

HOSPITAL BEDS ADDED SINCE CERTIFICATE-OF-NEED
STATEWIDE AND BY HSA



*Though approved under certificate-of-need, 142 beds added in HSA IV were later declared exempt by court order.

Source: JLARC.

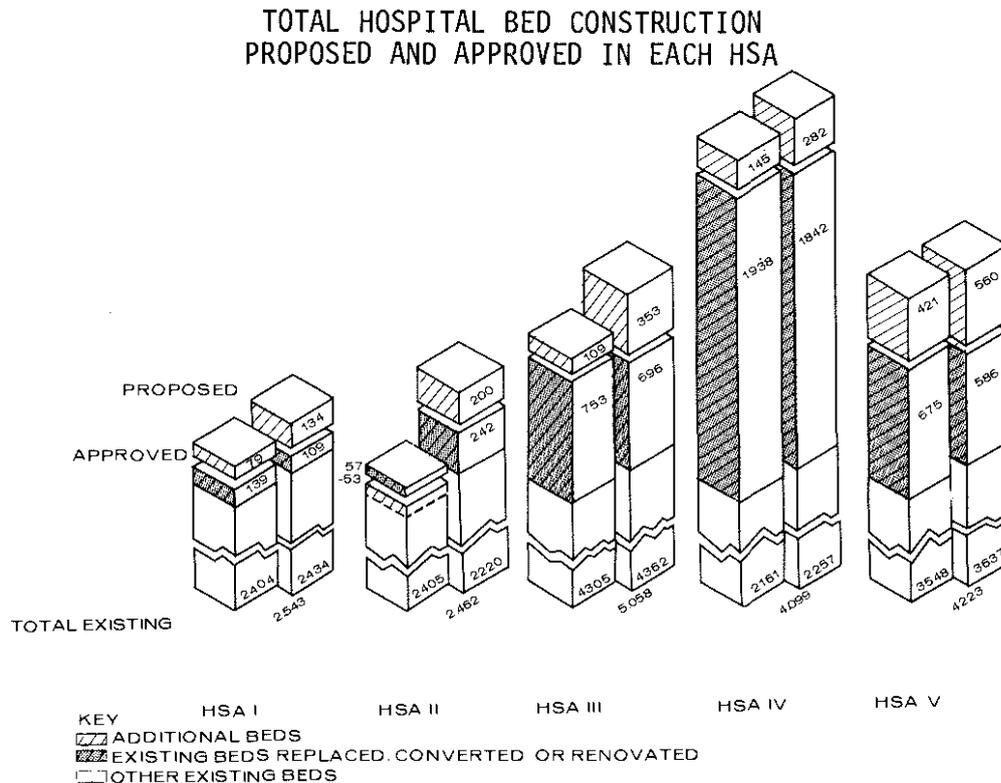
planning and development of hospital projects to qualify for exemption under the law. As a result, Northern Virginia has the lowest occupancy rate in the State and a projected surplus of 463 hospital beds. In fact, 5 of the 12 hospitals in HSA II reported average occupancy rates below 60% during 1977.

In HSA IV, only 145 of the 566 additional beds built were required to undergo certificate-of-need review. All but 31 of these 145 beds were located in the City of Richmond.

In HSA V, over 700 beds were added to what already existed. While 358 of these were the result of projects exempt from review, the others, over 400 beds, were approved under certificate-of-need. Of these, 167 beds were the result of two new hospitals being built in rural parts of this health service area. Nonetheless, 200 of the remaining beds were approved in Planning District 20, the area considered most overbedded within HSA V.

Project Denials. Even more beds would have been added if all the beds proposed had been approved (Figure 17). In fact, a number of proposed beds were eliminated as a result of certificate-of-need reviews. Some projects involving beds were denied. Others were modified during the process. That is, the number of proposed new beds were either reduced, or substituted with the renovation, replacement, or conversion of existing beds.

Figure 17



Source: JLARC.

Few approvals for additional beds were granted after the first State facilities plan was issued in December 1974. Furthermore, when approvals were granted they tended to be projects outside larger metropolitan areas. In the few instances when additional beds were approved for a facility in an urban area, these additional beds were often offset by voluntary reductions from other facilities in the area or by reductions in other projects being reviewed. As a result, a net Statewide gain of only 88 beds occurred after the first plan was issued.

After the second plan was issued in February 1977, only HSA V (Eastern Virginia) experienced an increase in beds through certificate-of-need approvals. This increase of 69 beds was the result of an approval granted to a facility to occupy a shelled-in floor built under a previously granted certificate. The series of illustrations in Figure 18 show certificate-of-need activity in each HSA for the three planning periods.

Figure 18

BEDS PROPOSED AND APPROVED UNDER
 CERTIFICATE-OF-NEED BY HSA AND BY PLANNING
 PHASE (INCLUDING BEDS REVIEWED MORE THAN ONCE)

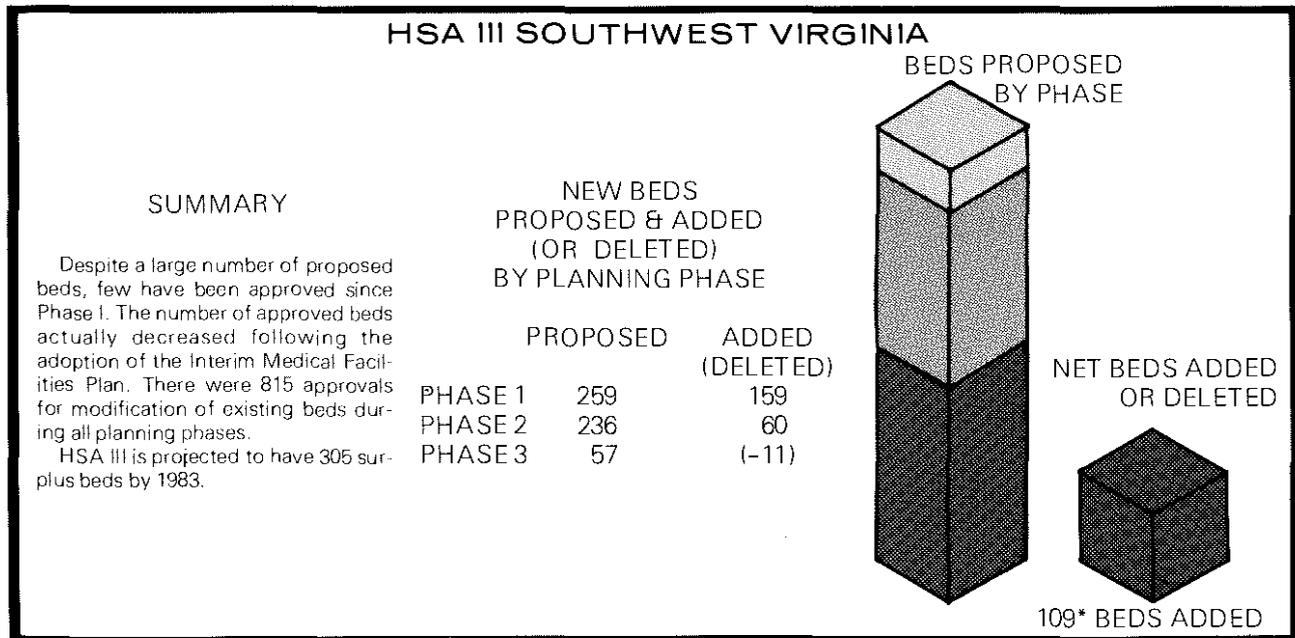
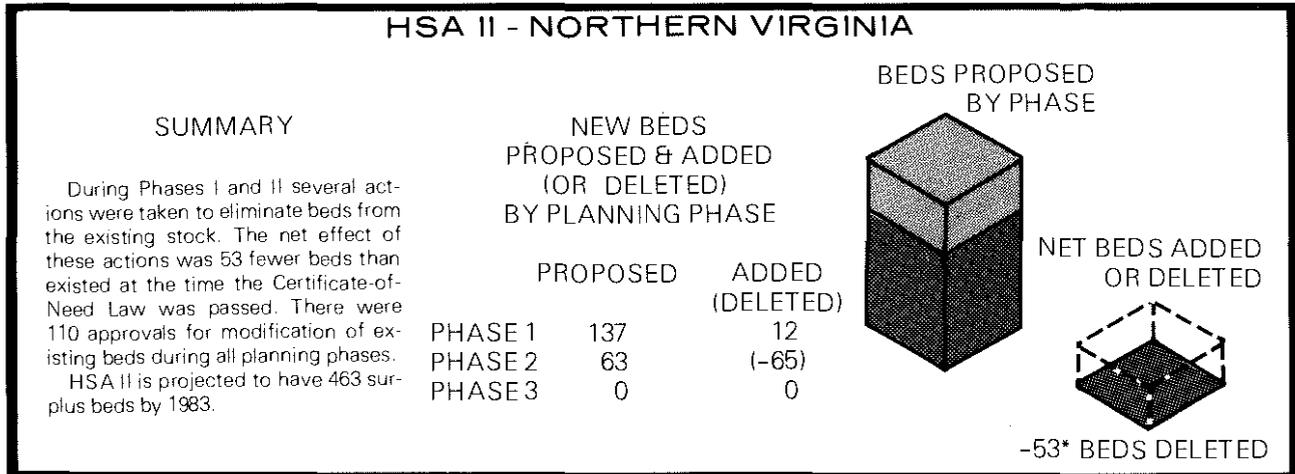
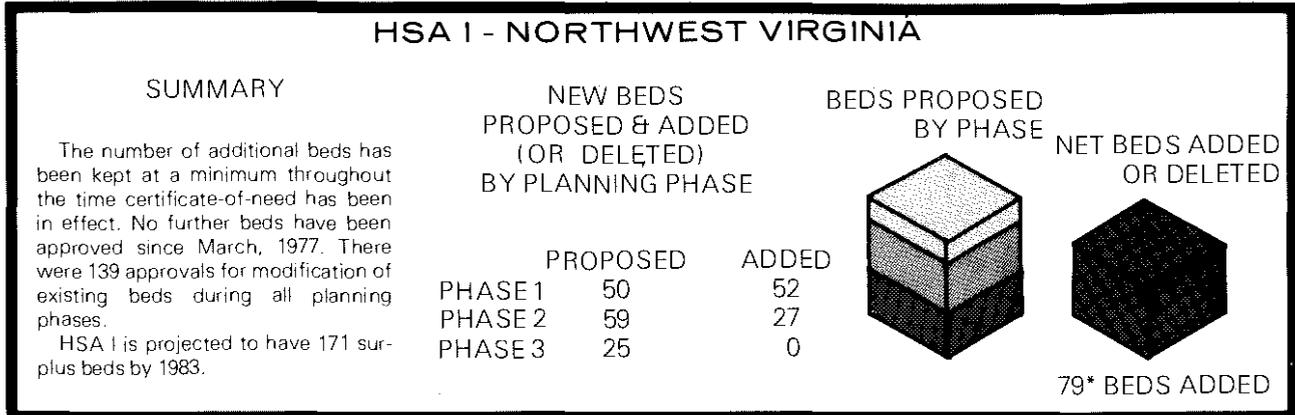
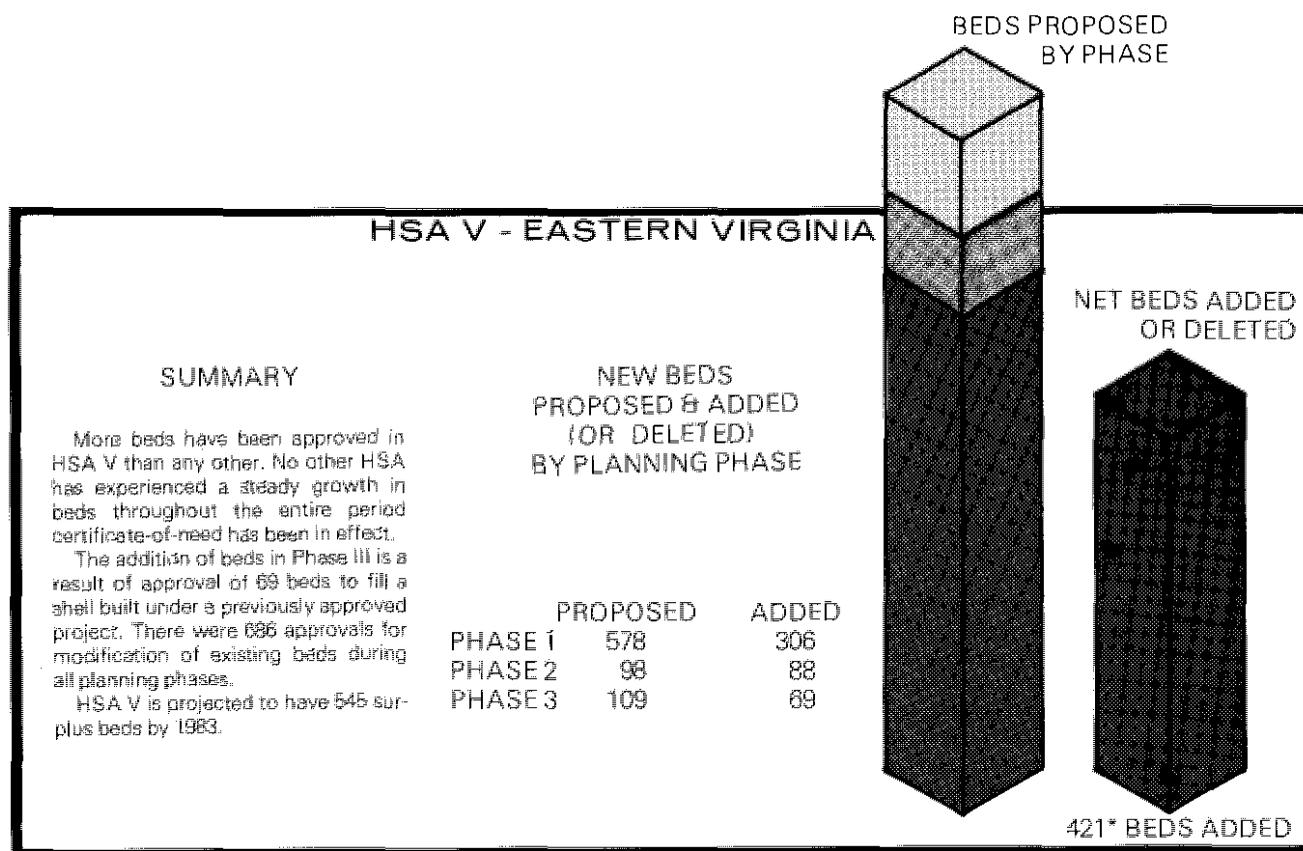
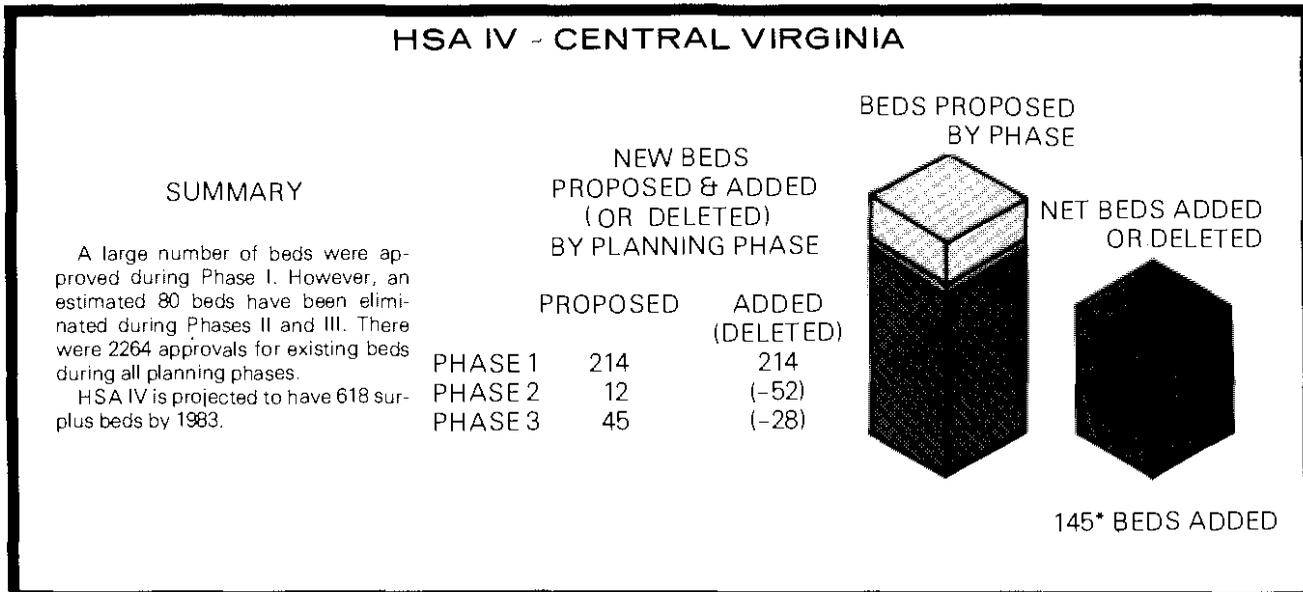


Figure 18 (Cont.)



- PHASE I NO PLAN
JULY 1, 1973-DEC.4, 1974
 - ▨ PHASE II 1973-74 HILL BURTON PLAN
DEC.5,1974-FEB.28,1977
 - ▩ PHASE III INTERM MEDICAL FACILITIES PLAN
MARCH 1,1977-JUNE 30,1978
- * EXCLUDES BEDS RE-REVIEWED

Since the release of the Hill-Burton plan in 1974, the certificate-of-need process seems to have been effective in restraining the growth of new hospital beds. In spite of this effort, surplus beds and declining hospital occupancy rates persist in each HSA. This problem has been aggravated by a high rate of approval for the renovation, replacement and conversion of existing beds.

Impact on Existing Beds

One of the stated purposes of the Certificate-of-Need Law is to resolve "questions concerning the necessity of construction or modification of medical care facilities" (Section 32-211.4). Modifications to facilities include bed replacements, conversions, and renovations. Nevertheless, the certificate-of-need process has not been able to deal effectively with applications involving modifications to the existing stock of beds. With the exception of HSA II (Northern Virginia), the number of beds in the existing stock has not been reduced.

The Department of Health contends that existing hospitals cannot be required to eliminate beds or be prevented from relocating. For this reason, requests involving the renovation, conversion, or replacement of beds are usually approved, even in overbedded areas. The following case studies illustrate actions taken by the department in response to requests for replacement beds:

Replacement of Substandard Facility

A hospital in HSA V operating at less than a 50% occupancy rate submitted an application for the complete renovation and relocation of the facility. The application was necessitated by a determination of the Bureau of Medical and Nursing Facilities Services that the facility was not operating in compliance with applicable health and safety codes. The hospital was directed to remedy the problem or cease operating.

In its review of the application, the Eastern Virginia Health Systems Agency staff reported an excess of 643 beds in the area, which contributed millions to the cost of health care in the region.

The Health Department's legal counsel advised the Commissioner that denial of the project and the subsequent closure of the facility as a result of the certificate-of-need process would constitute improper seizure of property.

The Commissioner denied the hospital's first application because the site chosen for relocation was near an existing satellite facility of another hospital. The hospital's second application requesting relocation to a different site was approved on the basis that the site change would provide a better distribution of the area's existing beds. Nonetheless, the approved site was within a few miles of another large existing hospital.

Merger Prevented Due to Conflicting Interests

Failure to promote a merger between two hospitals in a small rural community resulted in the approval of separate applications for the rebuilding of each facility. The Health Department favored a merger of the two hospitals, one operated by a community board and the other by a religious order. The Department hoped to eliminate a duplication of services between six hospitals in the same general vicinity. However, the merger was opposed by both hospitals on the grounds that a religious and public hospital would be incompatible in delivery of services, particularly in the areas of abortion and family planning. Thus, the Commissioner granted approval of the two applications separately.

The approval of these applications represents a major shortcoming in the State's ability to use certificate-of-need to alleviate bed surpluses. Existing hospitals operating with low occupancy rates and marginal services are assured of perpetuation, even in overbedded communities.

The certificate-of-need process is hampered by the Department of Health's interpretation of the law. A court ruling has not been pursued on the opinion rendered by the department's attorney. However, the department's informal reading of the law has far-reaching implications for carrying out the intent of the Certificate-of-Need Law with respect to facility modifications involving beds. The intent of the law should be clarified through a court test or legislative action.

NURSING HOME BEDS

In contrast to hospitals, nursing homes have been in short supply throughout the State. Only until very recently has

the projected demand for long term care beds been met in sections of the Commonwealth. In fact, the supply of nursing home beds may be beginning to surpass demand in metropolitan areas. Nonetheless, a notable achievement of certificate-of-need has been the orderly distribution of a large number of new nursing homes throughout the Commonwealth.

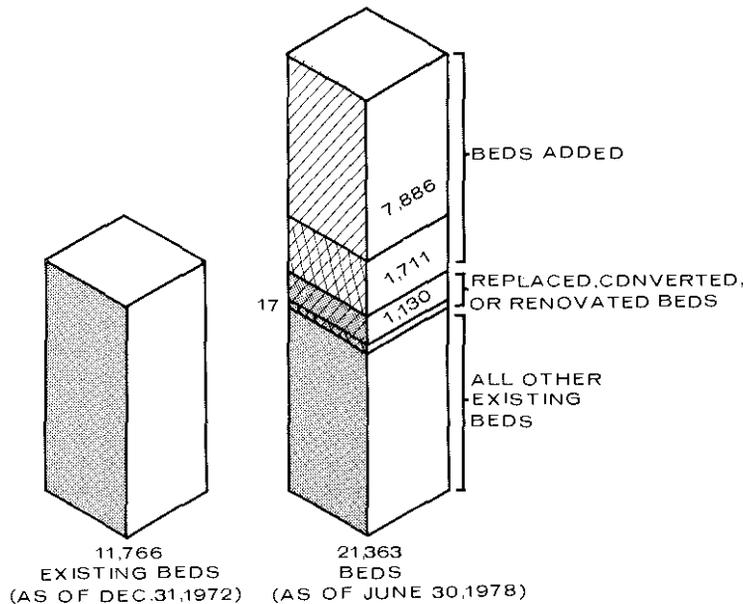
Construction of Nursing Home Beds

The total number of nursing home beds has nearly doubled since enactment of Certificate-of-Need Law. Most of these beds were built as a result of projects approved under certificate-of-need. Unlike hospitals, few beds were added as the result of projects exempt from review.

Most of the beds approved were new beds. Renovations and replacements of existing beds constituted only a small fraction of of all nursing home bed construction (Figure 19). Sixty-one homes

Figure 19

NURSING HOME BED CONSTRUCTION
UNDER CERTIFICATE-OF-NEED
(FY 1974-1978)



KEY
 [diagonal lines] APPROVED UNDER CERTIFICATE-OF-NEED
 [cross-hatch] EXEMPT CONSTRUCTION
 [solid grey] EXISTING BEDS

Source: 1973-74 Virginia Plan for Construction and Modernization of Medical Facilities (SDH); JLARC.

have been approved under certificate-of-need, a reflection of the growth of the nursing home industry in the Commonwealth since the law went into effect.

Impact of State Facilities Plans. Similar to the analysis for hospitals, planning phases for nursing homes were also identified. The phases identified were:

- Phase I: No officially adopted plan for guiding certificate-of-need decisions (July 1, 1973 - December 4, 1974)
- Phase II: 1973-74 Hill Burton Plan (December 5, 1974 - February 28, 1977)
- Phase III: Interim Medical Facilities Plan (March 1, 1977 - March 16, 1978)
- Phase IV: Part I, State Medical Facilities Plan (March 17, 1978 - June 30, 1978)

When compared to the hospital planning periods, nursing homes have one additional phase. This additional phase reflects the adoption of Part I of the State Medical Facilities Plan in March 1978. This plan covered nursing homes, but not hospitals. The period for this plan only extends three months, to June 30, 1978, the cut-off date JLARC used for its data collection.

Table 20 shows the number of long term care beds proposed and approved during the periods when different plans were in effect.

Table 20

PROPOSED AND APPROVED LONG TERM CARE BED CONSTRUCTION
(JULY 1, 1973 THRU JUNE 30, 1978)

	PHASE I		PHASE II		PHASE III		PHASE IV	
	Proposed	Approved	Proposed	Approved	Proposed	Approved	Proposed	Approved
Additional Beds	4,417	3,600	4,490	3,196	1,847	1,047	292	43
Replaced, Converted, or Renovated Existing Beds	165	141	400	456	234	401	123	132

Source: JLARC.

As in the case of hospital bed construction, much of what was approved occurred in the first 17 months the law was in effect, the period in which no plan was officially adopted. However, even

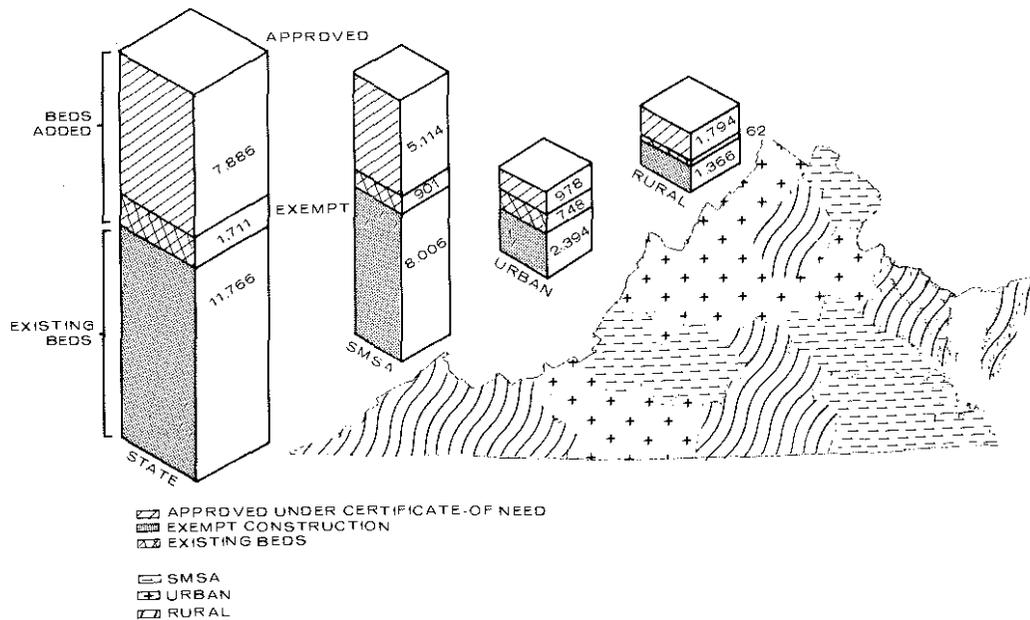
after the first plan was implemented, nursing home projects continued to be approved at a high rate, whereas approvals of additional hospital beds began to sharply decline.

Urban and Rural Differences

The greatest need for additional nursing home beds was originally in the metropolitan areas, the areas with the largest number of nursing home beds already in existence. Fewer were thought to be needed in the smaller urban or rural areas of the State. As a result, most of the beds approved were located in metropolitan areas (Figure 20).

Figure 20

NURSING HOME BEDS ADDED SINCE CERTIFICATE-OF-NEED STATEWIDE AND BY GEOGRAPHIC AREA

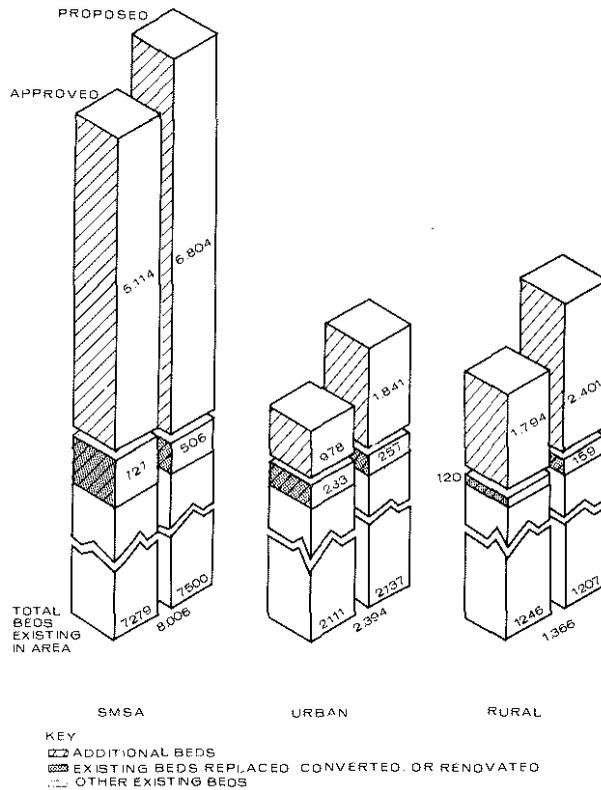


Source: JLARC.

Figure 21 shows the total number of beds proposed and then approved in the rural, urban, and metropolitan areas of the State. As can be seen, a substantial proportion of beds requested in smaller urban areas and rural areas were denied. Many of these denials involved multiple applications to add long term care beds in the same vicinity. In order to promote competition, such applications

Figure 21

PROPOSED AND APPROVED LONG TERM CARE BED CONSTRUCTION BY GEOGRAPHIC AREA OF THE STATE



Source: JLARC.

can be reviewed concurrently under State and federal regulations. Usually one application of the several submitted will satisfy a limited number of beds needed in a particular area.

Statewide, over 60% of the nursing home beds denied were part of proposed projects concurrently reviewed. In contrast, virtually no hospital beds were similarly reviewed. The following example illustrates the circumstances under which many of these proposed beds were denied using a concurrent review.

Concurrent Review of Three Nursing Home Projects

The 1976 Interim Medical Facilities Plan indicated a need for 38 additional long term care beds in an urban planning district of HSA I. Applications were filed for three separate nursing home construction projects.

Two of the projects would have created new facilities of 130 beds each. The other application requested approval for a 67 bed addition to an existing facility. While that project also involved the construction of more beds than were needed, either of the other two proposals would have resulted in even a greater surplus. In addition, the per bed cost for the new facilities would have been significantly higher than for the addition to the existing nursing home (\$13,500 versus \$9,500).

The three applications were concurrently reviewed. The proposals to build new facilities were both denied. The project to add beds to the existing facility was approved.

Current Bed Needs

The 1978 State facilities plan identifies a need for over 1,500 additional beds by 1983, largely in selected rural areas. At the same time, the plan projects the metropolitan areas in Richmond and Tidewater will be overbuilt (Table 21).

Table 21

DISTRIBUTION OF NURSING HOME BEDS BY AREA

	<u>Existing Beds Licensed or Under Construction</u>	<u>Number of Additional (Surplus) Beds Needed by 1983</u>
Metropolitan Areas	13,137	(499)
Urban	3,372	1,002
Rural	3,160	1,239
	<u>19,669</u>	<u>1,742</u>

Source: 1978 Medical Facilities Plan, Table 6 (SDH); JLARC.

This places certificate-of-need in the same position with nursing homes as it does with hospitals, namely, reducing excess bed capacity. The problem is less critical, however. Nursing homes do not have to be as close to those being served as hospitals.

FINDINGS AND RECOMMENDATIONS

The accomplishments of certificate-of-need are mixed. Certificate-of-need has been used with some success to control the

addition and distribution of hospital and nursing home beds. The growth of hospital beds has been slowed to a minimum. Shortages in nursing home beds have been largely eliminated. However, certificate-of-need has failed to substantially reduce the large number of surplus hospital beds statewide.

The current State facilities plan projects over 2,100 surplus hospital beds by 1983. The cost of maintaining these unneeded beds may be as high as \$54 million annually. If the provisions of certificate-of-need legislation are to be effectively carried out, ways will have to be found to eliminate existing beds that are not needed. Some steps can be taken by the State Department of Health. Others, however, will require legislative action.

Department of Health

The State Department of Health has attempted to address the problem of surplus beds in at least three ways: encouraging mergers; promoting the conversion of hospital beds to long term care beds; and forcing one for one compromises in overbedded areas. In the latter approach, no additional bed is approved unless another bed somewhere in the same general area is eliminated. These steps, however, have not reduced the supply of surplus beds.

Nearly all project applications involving the renovation, replacement, or conversion of existing beds in overbedded areas have been approved. The reluctance of the Commissioner to deny these types of facility modifications is based on doubts the department has sufficient legal authority to eliminate beds or close a facility.

Often the renovation or replacement of beds in a hospital facility is undertaken to meet licensure requirements. If denied a certificate, such a facility may be faced with two alternatives--avoid using the beds or lose its license. Ultimately the facility might be forced to close.

Section 32-211.4 of the Certificate-of-Need Law includes two expressions of legislative purpose regarding modifications in facilities.

- The General Assembly finds that unnecessary construction or modification of medical care facilities increases the cost of care and threatens the financial ability of the public to obtain necessary health, surgical, and medical services (emphasis added).
- The purpose of this chapter is . . . to provide an orderly administrative procedure for resolving questions concerning the necessity of construction or modification of medical care facilities (emphasis added).

The General Assembly stated that certificate-of-need was to be used to resolve questions concerning the need for facility modifications. Such resolution might include denial of unnecessary modifications to existing beds, particularly in overbedded areas. Nevertheless, the Certificate-of-Need Law may not provide the Commissioner with sufficient authority to carry out this charge.

The Commissioner, in a written response to the JLARC report on Inpatient Care in Virginia, stated that "Under State Law, there is no authorization for the State Health Department to force reduction in hospital beds". In addition, the Commissioner has been advised by the Health Department's legal counsel that denial of applications involving the replacement or renovation of beds could constitute improper seizure of property. This informal opinion has not been tested in court.

Staff Recommendation (1). The authority of the Health Department to deal with existing beds and thereby eliminate unnecessary and surplus beds needs to be clearly established by court test or by legislation.

Legislative Options

The issue of surplus hospital beds has been the subject of much discussion and debate at the State and national level. There is considerable agreement that surplus beds result in increased health costs. Little agreement exists on how to eliminate surplus beds. Several states have already enacted legislation to begin addressing certain aspects of the surplus bed problem, including specific identification of surplus beds and adoption of prospective reimbursement methods.

If the General Assembly wishes to deal with surplus beds, Virginia may have to initiate similar actions. Among several options available to the State are: (1) preparation of plans which identify unnecessary hospital beds or facilities, and (2) examination of the full range of actions that can be taken by the Commonwealth to eliminate excess bed capacity.

Option (1). The General Assembly could direct the Department of Health to identify specific beds at each facility for elimination and include its findings in the State medical facilities plan. Currently, this question is being addressed indirectly on an application by application basis. What is needed, however, is a comprehensive needs assessment of all existing beds in the Commonwealth. This was the intention of the federally mandated appropriateness review process. But current federal guidelines will not require appropriateness review to be done for each facility as was envisioned by Congress.

As a first step, the Bureau of Resources Development should develop criteria for identifying which facilities, or even parts of facilities, are good candidates for (1) merger,

(2) conversion to a lower level of care such as from an acute care hospital bed to a long term care nursing home bed, (3) conversion to swing beds, and (4) elimination. Once criteria have been developed, the State should assess the need for certain bed types by hospital. The results of this assessment should be incorporated in the State facilities plan. Then, applicants would know ahead of time what the State's planning position is regarding their facility.

The legislature in the State of Michigan has taken similar action. That State recently enacted an excess capacity statute. The statute is far reaching in that it places a moratorium on all certificate-of-need decisions involving hospital construction. The moratorium is to last for 14 months until the HSAs have developed plans to assess the need for existing facilities. The law addresses many of the complex issues that may be associated with closing a facility, such as the repaying of bonds, the status of pension benefits, and the reassignment of hospital privileges to physicians.

If excess beds are to be reduced it may be necessary for the General Assembly to consider placing some sort of temporary halt on certain hospital bed construction (except emergency proposals) until the new plan can be put into effect. Without such a limitation there may be a surge of proposals to renovate and replace beds before the plan takes effect.

Option (2). There are clearly a number of alternatives available to the Commonwealth to reduce excess capacity. Such alternatives include adopting a prospective reimbursement method, linking reimbursement to an acceptable occupancy rate, de-licensing of beds, and compensating facility owners for losses. Each of these alternatives is laden with a number of complex economic, legal, and political issues that require careful legislative study and analysis.

Because of the high cost associated with maintaining excess bed capacity, the General Assembly may wish to familiarize itself with various methods of eliminating surplus hospital beds and their relationship to certificate-of-need. This can be accomplished by introducing a resolution requesting that The Commission to Study the Containment of Health Care Costs examine the following areas:

- identification of various methods to reduce unnecessary hospital beds including:
 - swing bed use
 - prospective reimbursement
 - linking reimbursement to occupancy
 - de-licensing
 - medicaid decertification
 - compensation to facility owners.
- determination of the potential impact of such methods on State government and facility owners, including:

- existing contractual obligations
- taking of private property
- Hill-Burton hospital obligations
- State appropriations.

Such a study will provide the General Assembly and the Department of Health with the policy rationale necessary to deal effectively with the 2,100 surplus hospital beds projected over the next four years.

V. Cost Containment and Health Regulation

By preventing unnecessary duplication of health care resources, certificate-of-need assists in containing rising health care costs. While certificate-of-need can affect the distribution of beds and services, this will not necessarily lead to cost containment.

Certificate-of-need is primarily a device for implementing health plans and secondarily a means of containing health care costs. Overly emphasizing certificate-of-need as a cost containment mechanism results in unrealistic expectations for the program and its role in overall health care regulation.

It is necessary to place certificate-of-need in perspective by understanding what it can and cannot do regarding cost containment. Certificate-of-need can avoid the incurrence of certain costs that may have resulted had the program not existed. However, by itself, certificate-of-need cannot contain the overall rise in health care costs.

Certificate-of-need is but one part of a much larger health regulatory approach. To be a meaningful part of cost containment it must be viewed in this larger context and explicitly linked to other, on-going efforts aimed at health care cost containment.

Cost Containment

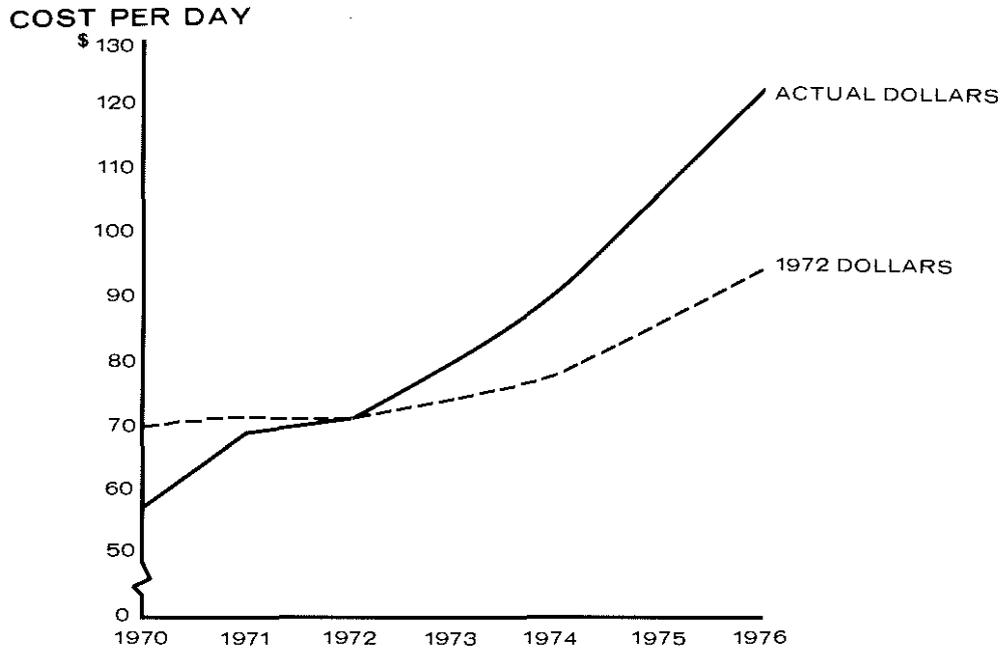
Certificate-of-need has not kept health care costs from continuing to rise. Both nationally and in Virginia, health costs have continued to climb. The cost per patient day for Virginia hospitals nearly doubled between the time certificate-of-need legislation passed and 1976 (Figure 22). The cost of nursing home beds has also continued to increase, though at a slower pace (Figure 23).

Despite these trends a conclusive statement concerning the effect certificate-of-need has had on costs cannot be made at this time. There are several reasons why a definitive statement on certificate-of-need and health care cost containment would be premature:

- the full effect of capital costs avoided may take several years to be felt;
- it is possible that health care costs would have increased more rapidly without certificate-of-need; no one knows what would have happened if this program did not exist;

Figure 22

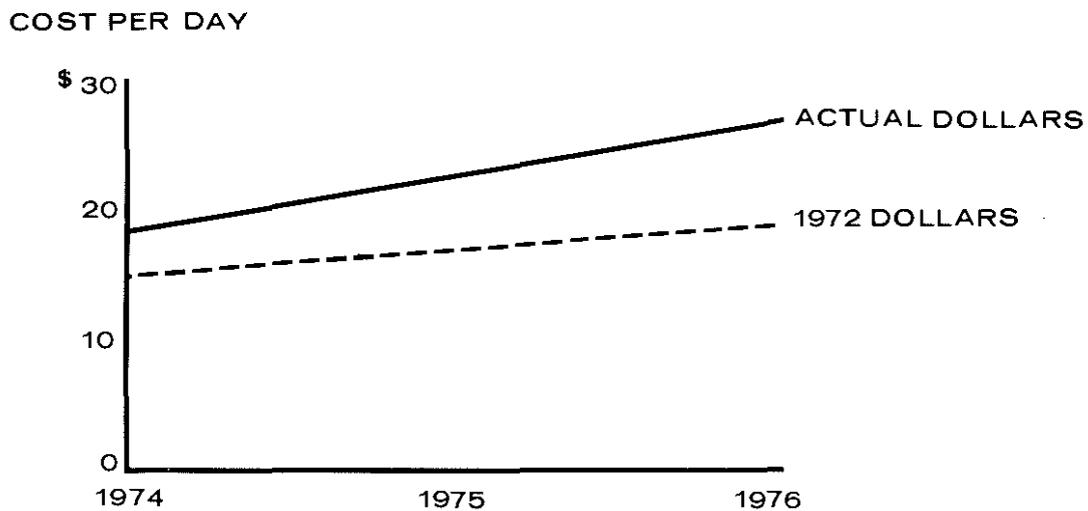
AVERAGE COST PER DAY FOR SHORT TERM
NON-FEDERAL HOSPITALS IN VIRGINIA
(1970-1976)



Source: Virginia State Health Plan, Vol. 1 (Draft) 1978-1983.

Figure 23

AVERAGE COST PER DAY FOR
NURSING HOME CARE IN VIRGINIA
(1974-1976)



Source: Virginia State Health Plan, Vol. 2 (Draft) 1978-1983.

- The lifting of President Nixon's wage and price controls in late 1972 resulted in a spate of health care development that clouds attempts to estimate the effect of certificate-of-need costs.

However, the most important reason why the impact of certificate-of-need activity on rising health costs cannot be ascertained is because this program, by itself, cannot contain costs. Certificate-of-need influences only one portion of total health care costs. Any effect on these costs may be offset by increases over which certificate-of-need has no control.

The following figure summarizes what can and cannot be expected of certificate-of-need in the area of cost containment.

Figure 24

CERTIFICATE-OF-NEED AND COST CONTAINMENT

<u>What Certificate-of-Need Can Do</u>	<u>What Certificate-of-Need Cannot Do</u>
<p>Certificate-of-need can avoid certain capital expenditures associated with projects that are:</p> <ul style="list-style-type: none"> -denied -revoked -scaled down -discouraged <p>as a result of certificate-of-need.</p> <p>Over the long run certificate-of-need can bring about a better distribution of health resources that indirectly will reduce cost</p>	<p>Certificate-of-need cannot contain costs because:</p> <ul style="list-style-type: none"> -rising health care rates are affected by non-capital expenses such as labor costs, over which certificate-of-need has no control. -inappropriate utilization of facilities and services (even those approved under certificate-of-need) increase health care costs in ways certificate-of-need cannot affect. -existing maldistributions of facilities and services that may escalate costs cannot be influenced by certificate-of-need. Certificate-of-need must wait for changes to be proposed to the existing system before acting.

Source: JLARC.

Costs Avoided

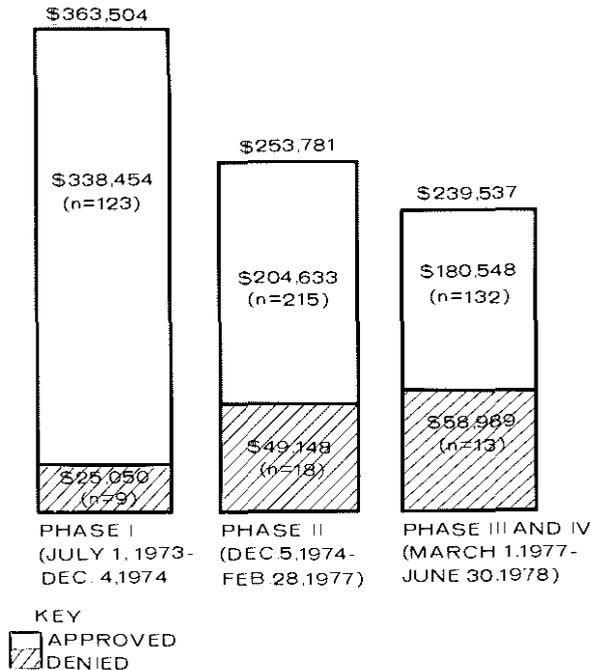
Certificate-of-need can avoid costs. That is, it can cause the reduction or prevention of a capital expenditure that otherwise might have been incurred had certificate-of-need not existed. There are several ways in which such cost avoidance can occur.

Project Denials. An important way in which the certificate-of-need process affects costs is by approving or denying applications. From the inception of the program on July 1, 1973 to June 30, 1978 the Commissioner of Health approved 483 projects. Forty-two applications were denied.

When a comparison of the total approvals and denials is made over time, it is apparent that the number of dollars involved in denied projects has steadily increased. Only \$25 million was denied in the first seventeen months, when no plan was in effect. In contrast, over \$300 million in projects was approved. Between March 1977 when the interim plan took effect and June 30, 1978, only half this amount was approved while the amount of money involving denials nearly doubled (Figure 25).

Figure 25

TOTAL ESTIMATED COSTS APPROVED AND DENIED BY COMMISSIONER OVER TIME
(Costs in thousands)



Source: JLARC.

While a comparison of approvals and denials provides a useful overview of certificate-of-need activity, this can also be very misleading. Not all approved projects remain approved. Some are later revoked. Similarly, not all denied projects remain denied. Some are appealed and the decision reversed. Others are later resubmitted and approved.

Another reason why simply discussing approved or denied projects can be misleading is because cost avoidance involves more than just denied projects. It can involve reductions as well.

Total Costs Avoided. Figure 26 summarizes certificate-of-need activity from the beginning of the program through June 30, 1978. As can be seen, there are many exceptions to the certificate-of-need process that are not reflected in simple totals of approved or denied applications.

Figure 26 divides review activity into three stages:

- original review, involving all activity up to the Commissioner's decision;
- post-review activity, consisting of denied applications that were appealed;
- second reviews, encompassing the 17 proposals that were submitted for review a second time.

Each of these three stages represents a separate opportunity when capital costs may be avoided.

Costs may be avoided one of two ways: either directly through denial of a project or indirectly through modification of a project.

Between FY 1974 and FY 1978, \$83.7 million in capital costs were avoided that otherwise might have been incurred. Of the costs avoided, \$72 million were the direct result of denials. Another \$12 million were avoided through modifications. Not all these costs were avoided at the same point in the process, however.

Original Review. A total of \$46 million in costs were avoided as the direct result of the initial review. A total of \$12 million of these costs were the result of alterations to what was first proposed. Forty projects underwent such a change. Such modifications are no longer permissible, however. Alterations to applications after the HSA review are now required by federal law to be resubmitted.

In addition to the costs avoided as the result of modifications, \$34 million in capital costs were avoided as the result of denials. These costs were not associated with all 42 of the projects denied, however. Twenty-six projects that were denied

were either appealed or later resubmitted and approved. As a result, the costs associated with all of these projects were not necessarily avoided. What costs were avoided in association with these projects occurred after the original review.

Post-Review Activity. Eleven of the denied projects which were appealed remained denied. A total of \$37.5 million in costs were avoided as the result of these denials being upheld. Only one denial was overturned as a result of the appeal process, a renovation of a hospital costing \$12.8 million. All the other projects either were still in the appeal process as of June 30, 1978, or were simply resubmitted for another review. All of the projects resubmitted for a second review were subsequently approved. Table 22 summarizes the capital costs avoided under certificate-of-need.

Table 22

CAPITAL COSTS AVOIDED UNDER
CERTIFICATE-OF-NEED
(FY 1974 to FY 1978)

Projects Modified During Review	\$11.9 million
Denied Projects Not Later Reconsidered	\$34.1 million
Denied Projects Upheld on Appeal	<u>\$37.7 million</u>
Total	\$83.7 million

Source: JLARC.

Another \$48 million in capital costs were never incurred, because several projects that had originally been approved were revoked. These projects experienced serious delays that prevented the project from being completed. For instance, one project encountered so many delays in construction that costs exceeded the owner's financing arrangements. The costs associated with many of these projects would have been avoided regardless of whether or not the project had been subject to certificate-of-need. Nine projects which were revoked were able to overcome their problems and resubmit their application for another review. All of these projects were approved.

It should be stressed that this is an estimate. JLARC was unable to verify a factor sometimes cited as part of certificate-of-need's effect on costs, the discouragement factor. The requirement of obtaining a certificate is felt to discourage capital activity or service development even before an application is submitted. Such an effect cannot be quantified at this time. Among hospital administrators contacted, some cited this as a concern. Most did not see it as substantial.

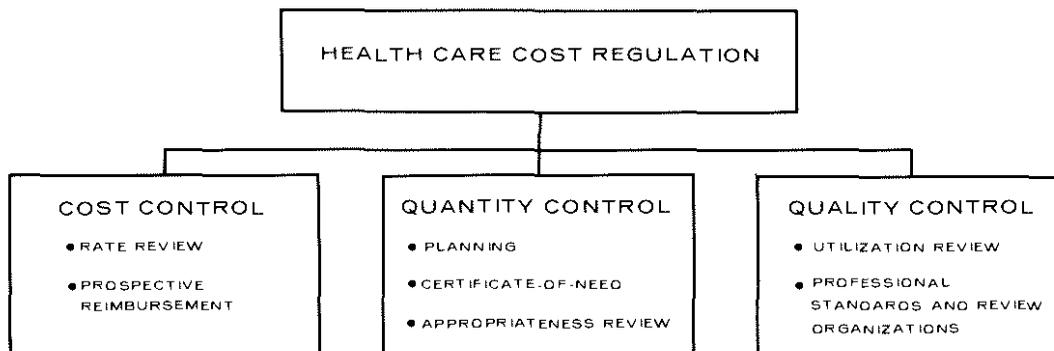
Despite this limitation, this estimate remains the best assessment of certificate-of-need's overall cost avoidance in Virginia.

Certificate-of-Need and Health Regulation

For health costs to be effectively contained other regulatory mechanisms must be in place. A meaningful cost containment effort requires that certificate-of-need and other health regulatory activities be closely related. As Figure 27 illustrates, present efforts in health care cost regulation go well beyond certificate-of-need.

Figure 27

OVERVIEW OF HEALTH CARE COST REGULATION



Source: JLARC.

Many aspects of rising costs not affected by certificate-of-need are the responsibility of some portion of the health regulatory effort outlined here. Figure 28 illustrates this point by indicating which participant in this total health regulatory effort can address aspects of cost over which certificate-of-need has no control.

If this overall regulatory approach to health care is to be meaningful, the various regulatory efforts involved need to work together.

Figure 28

HEALTH REGULATORY EFFORTS RELATED TO THE ASPECTS
OF COST NOT ADDRESSED BY CERTIFICATE-OF-NEED

<u>What Certificate-of-Need Cannot Do</u>	<u>What Other Health Regulatory Efforts Can Do</u>
<p>Certificate-of-need cannot contain costs because:</p> <ul style="list-style-type: none">-existing maldistributions of facilities and services that may escalate costs cannot be influenced by certificate-of-need. Certificate-of-need must await for changes to be proposed to the existing system before acting.-rising health care costs are effected by non-capital expenses such as labor costs, over which certificate-of-need has no control.-inappropriate utilization of facilities and services (even those approved under certificate-of-need) increase health care costs in ways certificate-of-need cannot affect.	<ul style="list-style-type: none">- <i>Appropriateness Review</i> is intended to be a means of influencing the base of facilities and services currently offered. Its exact form is not known at this time because it is still being developed and has not been implemented. However, its role can be seen as analogous to certificate-of-need, except that appropriateness review will consider the need for existing services, not proposed changes to that base.- <i>Rate Review</i> can consider the full range of costs, capital and non-capital, that are associated with health care.-ensuring appropriate utilization and quality of care is the province of <i>Utilization Review Committees</i> and their successor, <i>Professional Standards and Review Organizations</i>.

Source: JLARC.

FINDINGS AND RECOMMENDATIONS

As a cost containment device, certificate-of-need is limited. Even if certificate-of-need could prevent all unnecessary duplication of health care resources, this, by itself, would not contain rising health costs. While some costs can be avoided, there are aspects of health care cost over which certificate-of-

need has no control. As primarily a device for implementing health planning decisions, certificate-of-need should be viewed as but one part of a total health regulatory effort.

To be a meaningful part of that effort, certificate-of-need should be formally related to overall health regulation. This might be accomplished in the following ways:

- Rate Review. The 1978 session of the General Assembly created a Hospital Rate Review Commission to monitor hospital expenditures. It is important that costs permitted by the Commission are compatible with the State facilities plan and decisions made under certificate-of-need.

For instance, one of the costs permissible under rate review is an increase in rates in anticipation of a future purchase. If large enough, or if involving a new service, such a purchase would eventually have to be granted under certificate-of-need. Unless tied to certificate-of-need, rate increases might be permitted under rate review for purchases later denied under certificate-of-need.

To prevent this from happening, approval of such anticipated purchases may have to be brought under certificate-of-need as a type of predevelopment cost. This and other linkages associated with the long term plans of facilities available only to the Hospital Rate Review Commission could be made part of the certificate-of-need process.

- Professional Standards and Review Organizations (PSRO). These are federally required peer review organizations created to ensure quality of care and the appropriate utilization of health resources. Quality is not an explicit factor in certificate-of-need decisions, a complaint voiced to JLARC by many health providers in the course of this review. To incorporate quality considerations more explicitly into the certificate-of-need review process, applications submitted for review could be forwarded to the appropriate regional PSRO for comment.

- Appropriateness Review. Appropriateness Review, another review mechanism mandated under P.L. 93-641, is analagous to certificate-of-need except that its focus is on the need for what already exists, not on what else may be proposed. For appropriateness review to be effective, the standards for judging need should be the same as those used under certificate-of-need.

Linkages such as those suggested here could greatly enhance certificate-of-need and overall health regulation.

The General Assembly could direct the Commissioner of Health and the Statewide Health Coordinating Council to initiate a study that would consider the relationship of the various health regulatory efforts in the State and recommend appropriate steps to integrate those efforts. If undertaken, the study should specifically address any needed legislative changes required to strengthen the relationship of these separate regulatory efforts.

VI. Alternatives

Legislation specifically directs JLARC to examine the probable effect of not conforming with federal certificate-of-need regulations. The concerns identified thus far--inconsistent review procedures, gaps in planning and monitoring, and limitations of certificate-of-need as a cost containment measure--would appear to leave the State two options:

- (1) abolish certificate-of-need; or
- (2) seek to improve the present certificate-of-need program by addressing the major problems affecting its performance.

Abolishing certificate-of-need, however, appears to have far-reaching consequences, not in terms of federal sanctions, but in terms of the effect it could have on the health care market in the Commonwealth.

ABOLISH CERTIFICATE-OF-NEED

The most direct solution to the problems discussed in this report would be to simply do away with certificate-of-need. However, this would be a rash action resulting in consequences far worse than those problems presently facing certificate-of-need.

Federal Sanctions

The first consequence of such an action would be federal financial sanctions for failure to comply with federally mandated certificate-of-need requirements.

These sanctions would be levied in two stages. The immediate effect would be the loss of all federal funds for the State Health Planning and Development Agency. In Virginia, this agency is the Division of Health Planning and Resources Development in the Department of Health. Federal funds represent 75% of the division's budget or \$340,000 in FY 1979. These funds would be withheld.

The long term federal financial sanctions go well beyond one division in the Health Department. If, by 1980, a certificate-of-need program meeting the federal standards has not been established, the State would lose federal funding for numerous health and health-related activities. For FY 1976, total monies involved in such sanctions was equal to \$27 million. Table 23 summarizes the source and size of these funds. For FY 1978 the amount is estimated to be closer to \$35 million.

Table 23

FEDERAL FINANCIAL SANCTION FOR NONCOMPLIANCE
WITH CERTIFICATE-OF-NEED, FY 1976

<u>Source of Funds</u>	<u>Amount</u>
Public Health Service Act*	\$18,671,000
Community Mental Health Centers Act	3,526,000
Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act and, the Drug Abuse Office and Treat- ment Act of 1972	4,713,000
Miscellaneous	<u>95,000</u>
Total	\$27,005,000

*Included under this Act are monies for such programs as Family Planning, Migrant Labor and Rural Health Initiations. For a description of these three programs see the JLARC report - Medical Assistance Programs in Virginia: An Overview

Source: Federal Outlays in Virginia, FY 1976, compiled by HEW, PHS, BHRDP.

Uncontrolled Development

Other states such as Missouri, which has no certificate-of-need law, and North Carolina, which abolished its law then recently reinstated it, represent examples of what Virginia might experience if its Certificate-of-Need Law were abolished.

The case of Missouri is unique in that this state has neither an 1122 agreement nor certificate-of-need legislation. The state had an 1122 agreement from July 1973 until June 1976. Since then, the only controls to cover capital expenditures have been: (1) a voluntary Cost Effectiveness Council, made-up of representatives from the State Medical Society and Hospital Association, and (2) the Blue Cross plans. In Missouri, Blue Cross will not reimburse any of its hospitals which do not receive an HSA approval of their capital project. This, however, is being challenged in the courts.

In North Carolina, a certificate-of-need law was enacted but was later declared unconstitutional by the state's Supreme Court. A three judge federal court upheld the constitutionality of the law as did the United States Supreme Court. The North Carolina legislature reenacted the law effective January 1, 1979.

If certificate-of-need were abolished in Virginia it is probable the State would also experience significant litigation. Without certificate-of-need, a spate of health facility construction and changes would likely be attempted. Such activity would be based on the assumption that the State, either on its own or at federal insistence, would eventually reinstate a certificate-of-need program. Therefore, new construction or contemplated changes would be best commenced before such a control is reintroduced. Such a consequence is, of course, speculative. But Virginia's experience thus far indicates that having a certificate-of-need law has limited what would have been a much larger rise in hospital bed construction.

In Virginia, the growth in beds has been 13.2% from the time certificate-of-need was passed until June 30, 1978. However, most of the hospital beds added in Virginia were exempt from review. The growth of beds as the direct result of certificate-of-need approvals was only 3.8%. Without certificate-of-need, the growth could have reached 17.8% if all the beds that were exempt and the beds proposed for certificate-of-need had been built.

Furthermore, the bulk of the hospital beds added under Virginia's Certificate-of-Need Law were approved soon after the law went into effect and before the first plan was issued. After the first plan was issued only 88 additional beds were approved, or a growth of .5% over what existed at the time the law was passed.

The real justification for keeping certificate-of-need, however, should not be the loss of federal funds or the unbridled growth of beds and services. The chief concern should be the economic factors unique to the health care industry that foster unwarranted expansion of facilities.

The Health Care Market

In most market situations, unnecessary expenditures are discouraged by the normal economic forces of supply and demand. But, basic economic principles are not operative in the health care market. Health professionals, not consumers, largely determine the amount of health care that is demanded; health insurance insulates consumers from the true cost of the health care received; and, present reimbursement practices permit the creation and perpetuation of an oversupply of health care resources.

Certificate-of-need is a regulatory response to this situation. The program regulates supply by requiring that medical facilities obtain prior governmental approval before adding beds, instituting services, or making capital expenditures in excess of pre-defined limits. Such approval is to be based on a determination that a proposed undertaking is needed. Need determination, then, substitutes for demand as a control on the supply of health care resources.

This phenomenon, which gave rise to certificate-of-need initially, is as real today as when certificate-of-need was passed. To abolish certificate-of-need would be to ignore the realities of the present health care market. If certificate-of-need is to be terminated, the conditions that resulted in the program's passage must first be considered.

Abolishing certificate-of-need might have undesired consequences, but it should not be concluded that certificate-of-need is an absolute necessity. In theory, the health market could be altered to approximate a competitive situation in which consumer demand would play an active role. The specific alterations suggested to achieve this end are many and varied. Which of these would actually work is unknown. The important point to be made here is that if such changes occurred to enhance the power of consumer demand, certificate-of-need would not only be unnecessary, it would be contradictory.

In practice, such basic alterations to the health care market do not appear imminent. Exploring what the State could do to bring about such changes was considered beyond the scope of this study. However, the State should be aware that alternatives to regulatory efforts such as certificate-of-need are being considered.

Currently, on the federal level, the appropriate role of regulation is being debated. The Department of Health, Education and Welfare favors an increased regulatory approach. The Justice Department's Anti-Trust Division is seeking to encourage more traditional competitive forces to regulate health care and its costs. As a payor, provider and regulator within the health care system, it would be in the State's interest to keep abreast of such developments.

IMPROVE CERTIFICATE-OF-NEED

Given federal requirements for certificate-of-need and the present functioning of the health care market, continued State involvement with certificate-of-need is warranted. Recognizing the shortcomings of this regulatory program, the most viable alternative for the State to pursue would be to seek to improve the program's operation so as to better achieve its intended purpose.

This JLARC report has identified a series of actions the State should take to improve the operation of certification-of-need. These recommendations are summarized below.

Review Process

To ensure that the certificate-of-need review process is orderly, the State should:

- provide a full explanation of the application process and work with applicants to reduce the number of requests for additional information;
- ensure uniformity in the utilization of administrative reviews by consulting with the HSA over the proper use of this alternative and by placing the Department of Health in a position of greater accountability for the consistent employment of this review procedure;
- redefine the role and procedures of the Facilities Review Committee of the Statewide Health Coordinating Council;
- require the Commissioner to provide a detailed explanation of his decisions, that addresses all points of disagreement between his ruling and the recommendations he received;
- expedite cases of appeal by appointing independent hearing officers from the list maintained by the Department of Commerce.

Need Determinations

The gap between the requirements of the Certificate-of-Need Law and the planning, projecting, and monitoring capabilities of the State is a serious impediment to certificate-of-need's ability to determine the need for a project. In order to close that gap the State should:

- organize a committee to explore and recommend ways to bring about greater uniformity in health planning methods;
- develop standards and estimates of need for facilities and services not included in the existing State facilities plan;
- verify need projections and bed counts, and eliminate inaccuracies and inconsistencies contained in the 1978 State facilities plan;
- develop a formal mechanism for updating planning information, especially between issuance of plans;
- formalize the project monitoring activity by making project completion a requirement under licensure; and

- up-grade the monitoring and data capabilities necessary for certificate-of-need by integrating and more fully utilizing existing data resources in the Department of Health.

Distribution

The certificate-of-need progress has successfully curbed the growth of new beds. But, the process has not been effective in dealing with the existing stock of beds. As a result, HSA regions have an excess supply of hospital beds, and occupancy rates are declining. In order to carry out the full intent of the Certificate-of-Need Law the following actions may have to be taken:

- clarify the authority of the State Department of Health to eliminate unnecessary beds through the certificate-of-need process.
- identify unnecessary hospital beds in the State facilities plan.
- prepare a comprehensive study on the alternatives available to the State to eliminate excess hospital capacity.

Cost Containment

Certificate-of-need by itself will not contain health care costs. However, this program does play a part in overall health regulation and cost containment efforts. In order to ensure its effective operation, certificate-of-need should be explicitly related to other health regulatory efforts. Ways in which certificate-of-need can be linked to rate review, Professional Standards and Review Organizations, as well as other aspects of health regulation should be studied by the Department of Health. The findings and recommendations of such a study should be presented to the General Assembly for its consideration.

Appendices

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Agency Response

JLARC policy provides that each State agency involved in a program review be given the opportunity to comment on an exposure draft. This process is one part of an extensive data validation process.

Appropriate corrections resulting from the written comments have been made in the final report. It should be noted that page references in the responses relate to the draft report and do not necessarily correspond to page numbers in the final report.

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APPENDIX 1

EXPLANATORY NOTE TO CHAPTER IV BED DISTRIBUTION

The figures shown in Chapter IV reflect two basic counts:

- 1) net beds added
- 2) existing beds reviewed.

Net beds added reflects the net increase resulting from all certificate-of-need reviews involving beds. For example, a project deleting ten medical/surgical beds and adding 20 new obstetric beds would represent ten additional beds.

This net figure was calculated for each project, for each facility ever reviewed under certificate-of-need from July 1, 1973 to June 30, 1978. The figure is cumulative and represents the net result of all projects across all facilities. Thus, if ten beds were added at one facility and ten deleted at another, there would be no net increase in beds. However, if 15 beds were added to one facility and ten deleted at another, there would be a net increase of five beds overall.

Figures for the existing beds reviewed reflect the net result of all changes involving existing beds. This could be bed renovations, conversions, or even deletions or replacements involving new beds as long as the new beds did not increase the number of beds overall. Thus, the conversion of ten medical/surgical beds to intensive care beds would represent a change to ten existing beds. The deletion of ten medical/surgical beds and the addition of ten new intensive care beds would represent a change involving ten existing beds but with no net beds added. Had the project involved a deletion of ten medical/surgical beds and the addition of 12 new intensive care beds, ten existing beds still would have been involved in a change, but two beds would represent a net addition.

Reviews Not Counted

Figures presented in this chapter do not coincide with what was reviewed in two types of cases. First, projects that were approved but later revoked and never resubmitted are not counted in the analysis except in one figure (Figure 18).

Second, projects reviewed more than once are only counted as of the last review. Earlier reviews are only reflected in Figure 18.

Figure 18 shows the number of projects reviewed in different time periods in each HSA. For the purposes of that figure alone everything reviewed is shown, even projects later revoked and never

built and projects reviewed more than once. The figure does reference the resulting beds added with these two types of projects eliminated.

Discrepancies with Licensure

JLARC's totals do not always coincide with totals reported in plans based on licensure reports. This can be accounted for in a number of ways. (1) The time periods differ slightly. JLARC's data extend through June 30, 1978. Licensure is based on January 1, 1978. (2) Beds can be deleted, facilities can go out of business and not be reviewed and yet be dropped from licensure. (3) What is approved under certificate-of-need may not strictly agree with what is built. For these reasons, and the related problems noted in monitoring in Chapter III, totals may differ somewhat from totals shown in the State's latest medical facilities plan.

TECHNICAL APPENDIX

JLARC policy and sound research practice require a technical explanation of research methodology. A technical appendix was prepared for this report and was part of the exposure draft. The technical appendix is available on request from JLARC, 910 Capitol Street, Richmond, Virginia 23219.

The technical appendix includes a detailed explanation of the methods and research employed in the development of this study. The following areas are covered:

1. Data on All Projects Approved or Denied. Much of the statistics for this report was derived from data JLARC collected on every project approved or denied by the Commissioner from July 1, 1973 to June 30, 1978. Outlined are the types of data collected, the sources for the information, and the steps taken to verify what was recorded. A copy of the instrument used to record the data is included.
2. Survey of Facilities Reviewed Under Certificate-of-Need. JLARC surveyed a random sample of 30 hospitals and nursing homes that had at least one application approved or denied. The administrators of the facilities selected were either contacted by phone or in some cases visited in person. Details of the survey and a copy of the questionnaire used are provided.
3. Survey of Facilities Seeking Application but Never Completing a Review. To determine if certificate-of-need discouraged projects, JLARC surveyed 18 facilities that had never completed the review process. The questions used in the phone interview are provided.
4. Analysis of Facilities with no Certificate-of-Need Activity. The medicaid cost reports of a selected number of facilities which had never applied for or even requested a certificate-of-need was scrutinized to see if any capital expenditure had been made which might have required approval. The selection of these facilities is described.



COMMONWEALTH of VIRGINIA

*Department of Health
Richmond, Va. 23219*

JAMES B. KENLEY, M.D.
COMMISSIONER

June 5, 1979

*Mr. Ray D. Pethtel, Director
Joint Legislative Audit and Review Commission
Suite 200
823 East Main Street
Richmond, Virginia 23219*

Dear Mr. Pethtel:

This letter and its attachment represent the State Health Department's response to the draft report of the Commission entitled "Certificate-of-Need in Virginia."

In the attached discussion and listing of comments, the order of the draft report is maintained. I hope that you will carefully consider these concerns and issues.

Sincerely,


*James B. Kenley, M.D.
State Health Commissioner*

Attachments

Comments on Study of Certificate of Need in Virginia

(JLARC Exposure Draft)

by Virginia Department of Health

Chapter 1

The Legislative Charge under which this study was conducted has been fulfilled. Each of the specific tasks assigned to JLARC has been accomplished; some have been exceeded.

Our interpretation of the report in response to the tasks outlined in the legislative mandate is as follows:

Task 1: "Conduct a study of the operation of Certificate of Need to determine whether such law serves the public interest."

Comment: The conclusion of the report is: the Virginia Certificate of Public Need Law does indeed serve the public interest.

Task 2: "Determine the extent to which the public interest requires the Commonwealth to conform its policy regarding Certificate of Need to federal law and related regulations."

Comment: The conclusion of the report is: the Virginia Certificate of Public Need Law is required to conform to federal law and related regulations in order to allow the Commonwealth's continued participation in several federal financial assistance programs directed toward improving the nation's health.

Task 3: "Determine the freedom of action available to the Commonwealth consistent with federal law and related regulations."

Comment: The conclusion of the report is: the Commonwealth has the freedom of action to develop a Certificate of Need Program to extend beyond federal minimal requirements and that this has been done in several areas in a reasonable manner.

Task 4: "Determine the probable effect of failure by the Commonwealth to conform to federal law and regulations."

Comment: The conclusion of the report is: the probable effect of failure by the Commonwealth to conform the Certificate of Public Need Program to federal law and regulations would be significant in terms of loss of some federal financial assistance to State health services and research projects and in controlling health facility development.

The Approach - The approach taken by the JLARC Staff in conducting the study has been reviewed by the Department of Health and determined to be appropriate. Since a portion of the process of reviewing Certificate of Need applications is conducted by private non-private non-governmental agencies (health systems agencies), it is appropriate to focus the study upon state level reviews and actions which are responsive to and accountable to the legislature.

Legislative History - The Department feels it is important that the reader of this report be cognizant of the fact that the Virginia Certificate of Public Need Law was passed without accompanying appropriations and that until the Governor entered into agreement with the Secretary of HEW for implementation of Section 1122 of the Social Security Act no additional funds were available to the Department of Health for conducting Certificate of Public Need reviews. As a result, only one person was able to devote full time to the activities in the Certificate of Need Program during its first year of operation. Despite this handicap, Virginia is one of only seven states where the Certificate of Need Program has been determined to be in full compliance with federal requirements.

Administrative Review Process - The Department of Health takes exception to the phrase "small non-controversial projects or projects involving an emergency situation" as a description of the administrative review process because this phrase does not adequately depict the type of project which can be given administrative review. The regulations developed by the Board of Health state the purpose of the administrative review process to be "to permit appropriate consideration and response to those projects which would create minimal impact

upon the scope, quality or cost for health services provided by health facilities or to permit required responsiveness in meeting emergency situations."

Certificate of Need Activity - The State Health Department has reviewed and agrees with the summary of Certificate of Need activities as presented in the report.

Chapter 2

Chapter 1 indicated that the Commonwealth has one of only seven (7) federally approved Certificate of Need Programs. The Department takes exception to the comparison made with surrounding states in Chapter 2 and believes that JLARC Staff should be requested to compare the Virginia Certificate of Need staff and resources to those other states with federally approved Certificate of Need Programs in order to achieve an adequate comparison of the Virginia program resources. It is our opinion that Virginia is doing more with less resources than any other state with an approved Certificate of Need Program.

The Statewide Health Coordinating Council - The report indicates the Statewide Health Coordinating Council (SHCC) delegated its review responsibilities in Certificate of Need to the Facilities Review Committee. The Department takes exception to the use of the term "delegated responsibilities" and submits that SHCC retains responsibility but has delegated the "authority" to one of its standing committees. This has been done in order that a committee of manageable size can become deeply involved in this activity while other committees of the SHCC engage in fulfillment of other SHCC activities.

The Application - The Department questions whether the report adequately informs its readers about what an application entails. It suggests that the

Department should "provide a better representation of application procedures so that applicants can anticipate the actual cost and time involved in this stage of review." The report does not, however, explain that most major projects by medical care facilities involve a great deal of time in planning and review by respective boards of directors, etc., prior to being undertaken, whether or not a Certificate of Need Program exists. The cost of completing a Certificate of Need application is not necessarily burdensome upon any medical care facility project applicant. Data and information requested in the application would generally be required to be available prior to the undertaking of any medical care facility project.

In presenting a summary of the cost of making application - The JLARC

Staff cites interviews with representatives of the Virginia Hospital Association and the Medical Society of Virginia who have only second-hand information for providing estimates of the cost of applying. Since hospital administrators contacted at random who have been through the process and can provide first-hand information relative to the cost of applying indicate "the information requested on the application should be readily available as part of a facility's internal planning," the Department submits that the order of presentation relative to the cost of application may lead one to false conclusions.

Application Timing - The chart presented in the report which assesses the time lapse from which an application is begun to be prepared until the time of decision is misleading. According to the JLARC chart, the average cost of projects which were reviewed in developing the chart was 1.3 million dollars. The chart indicates approximately 11 months were taken to complete the application and review process on these projects. The chart does not reveal the amount of time in preparation of a project which would have occurred without a Certificate of Need application process. Certain data, information and other activities

associated with development of any project would have to be undertaken by any applicant. Because the Certificate of Need application requires certain data and information to be completed prior to a review, these requirements do not necessarily cause delays in projects. The Department of Health does not have control over the time it takes an applicant to file or complete an application. The Department does control the time in which an application is under review and does adhere to the requirements of the law during the time it has an application. Each application is considered on its own merit and requests for additional information are often required to fully explain information provided in the original application. The Department submits that it is practically impossible to develop a single application form which would be project specific, because of the multitude of variations in projects for similar services, without being unreasonable to all applicants. It should be noted that the application forms themselves were developed with input from planners and representatives of various segments of the health care industry. Additionally, the application forms were subjected to the same public hearing and comment processes as the rules and regulations governing the Certificate of Need Program.

Role of the SHCC - Facilities and Services Review Committee - The continued role of the SHCC in evaluating Certificate of Need applications probably should be reevaluated; however, the report does not provide an adequate description of the role the SHCC currently fulfills. The SHCC is the only organization other than the staff which reviews local recommendations coming to the Commissioner. In this respect, they have the role of balancing local and state-wide interests. This is an important and often critical contribution to the review system as it provides a State-wide overview in decision-making. This role should not be discarded without further study.

In conducting reviews, the Facilities and Services Review Committee, in a public meeting, reviews staff summaries of applications, the HSA recommendations and oral presentations, and oral presentations from the applicant. Ten minutes for oral presentation are accorded to the applicant and the HSA in consecutive order to present whatever they desire and subsequently the committee engages both parties in a question and answer dialogue prior to voting a recommendation to the Commissioner. The applicant and HSA each are provided copies of the state staff reports prior to the meeting (reports are mailed to each at the time they are mailed to the committee).

Decisions - *The Department submits that all of the decisions made on Certificate of Need applications are public and are routinely made available to applicants and to appropriate HSAs. The criteria upon which the decisions are made are set forth in the rules and regulations governing the program and the law. It should be emphasized that it is incumbent upon the applicant to demonstrate public need. In all cases, the decisions of the Commissioner attempt to address any differences which may exist between his decision and the rationale for the official recommendations that he receives (HSA and SHCC).*

Appeals - *The Department believes that the appeal process for certificate of need decisions is appropriately designed, however, the third level of administrative appeal has proven to be unresponsive to the need for timely decisions. Federal regulations require that appeals of certificate of need decisions be heard by an agency of state government other than the State Health Planning and Development Agency (State Health Department) as appointed by the Governor. The State Corporation Commission is experienced in handling such administrative appeals and can, without conflict or bias, make the necessary appeal determinations required. The delay in rendering decisions in matters under appeal is not tolerable. It would be appropriate to fix a deadline in law in which time such appeal decisions must be rendered.*

The legislature has considered the process for certificate of need appeal in past sessions and fixed the process in law. The Department of Health is supportive of retaining the present process with the imposition of some deadline to insure a timely process. We do not believe a necessity exists at this time to open the process to more parties unless restrictive and explicit constraints could be imposed to eliminate frivolous use of the appeal process to delay approved projects.

Recommendations on Application Procedures

Recommendation: "The Bureau of Resources Development (BRD) should inform applicants of the application time inherent in requests. Improved coordination is needed between BRD, the HSAs, and the applicant during the pre-consultation phase. In particular, certain items of information that are repeatedly requested by BRD should be communicated to applicants prior to an application being submitted. Every effort should be made by BRD and HSAs to reduce the number of requests for additional information."

Comment: The Department does attempt to hold requests for additional information to only what is required and necessary to make a decision on a project. Based upon the figures in the chart on page 25, out of the 44 application files reviewed, 30 of the applications were completed as submitted or after one request for additional information. In many instances applicants for various projects have not thought through the projects for which they apply. In such cases, the presence of the Certificate of Need Law forces the applicant to conduct appropriate planning of the project in order to complete the application. In other words, applicants enter the process in varying stages of readiness and for those who are less prepared to undertake a project the process of completing an application will naturally take longer.

Administrative Review Process

Recommendation: "To ensure uniformity of use, the General Assembly might consider amending the Certificate-of-Need Law to include the administrative review procedure. Such an amendment should define the projects eligible for an administrative review. Furthermore, BRD should be assigned sole responsibility for determining the eligibility of projects for this type of review."

Comment: The Department of Health has no objection to this recommendation, should it be the desire of the legislature to so amend the law; however, it is possible for this to be accomplished through amended regulations and this matter will be considered in the next revision of the regulations. The Department recognizes a need to bring more uniformity to the process of determining eligibility of projects for administrative review.

Facilities Review Committee

Recommendation: "The General Assembly could limit the reviewing authority of the Facilities Review Committee. The Committee's role could be changed so that the only projects reviewed would be those requested by legislatively designated parties. The Health Commissioner, HSA Board, applicant, Blue Cross and the Virginia Rate Review Commission are parties the General Assembly may want to consider eligible for requesting a project review by the Committee."

Modifications in Committee review procedures are also needed. Three changes should be made: (1) the applicant and HSA should be granted, on request, additional time to testify; (2) other affected parties should also be allowed, on request, to testify; and (3) the Committee should request BRD to prepare a checklist of questions and concerns."

Comment: The Department can recognize some merit in this recommendation; however, it should be recognized that the Facilities and Services Review Committee does serve a significant function in the review process in that its statewide overview does tend to moderate potential parochial interests. Consideration will be given to providing additional time to applicants and others for presenting matters to this Committee of the Statewide Health Coordinating Council.

Commissioner's Decision

Recommendation: "The Commissioner should provide a written analysis that fully explains his decision. Such an explanation should explicitly incorporate

mention of:

- the project's conformance or non-conformance with the required considerations as defined;
- the project's conformance or non-conformance with standards of need developed in the State's regulations or as part of the health plans of the State and health systems agencies;
- reasons why exceptions to standards or required considerations are warranted in any particular case;
- points of disagreement between the Commissioner's decision and the health systems agency recommendation as well as reasons supporting the Commissioner's decision; and
- aspects of the applicant's proposal that support approval or denial.

In addition, the General Assembly may wish to consider adding consistency as another "required consideration" in the Certificate-of-Need Law."

Comment: The Department position relative to this recommendation is that the Commissioner's decisions and rationale are shared with the applicant and appropriate HSA in every case. In such decisions, which are written, he attempts to identify and explain any differences between his decision and the recommendations he receives. He often responds separately to other interested parties concerned about decisions which have been made. Any decision made by the Commissioner is a part of the public record and subject to the provisions of the Freedom of Information Act. Additionally, any decision is subject to appeal by the applicant or HSA.

Recommendation: "The Health Department should develop and maintain necessary documentation to identify precedents on similar projects. The Commissioner should direct BRD to prepare a written record which reflects the precedents set by the Commissioner's decisions. This written record should be made available to any one upon written request."

Comment: It is the position of the Department of Health, given the fact that applications are considered on their own merits and the singular circumstances that make up the environment in which they are proposed, that such decisions which have been made under certificate of need are consistent one with the other.

Appeal

Recommendation: "The State Corporation Commission needs to expedite pending cases of appeal. In the future, the Department of Health may wish to recommend

to the Governor that an independent hearing officer be appointed from the list of such officers maintained by the Department of Commerce. Such action could expedite third level appeals."

Recommendation: "The General Assembly has several options related to the definition of legal standing: (1) the present definition could be left unchanged; (2) other legislatively specified third parties could be granted the right of appeal."

Comment: It is the position of the Department of Health that the present appeal systems should remain unchanged with the exception that a time should be set in law for the independent hearing examiner to render a decision following the completion of the hearing record. The State Corporation Commission is the most appropriate and capable agency to serve in the role of hearing examiner.

Chapter III

Need Determination

Recommendation: "The Department should carefully review the revised bed capacity threshold contained in Section 32-.1-93(3) of the Code of Virginia (Title 32, 1979 Revision) and request a written interpretation of its application from the Attorney General. If the interpretation concludes that the new threshold hampers the State's ability to regulate changes in bed composition, the department should request the General Assembly to amend the law to cover such changes."

Comment: There are many difficulties in the current ability to count numbers of beds by types of service in facilities. This is a difficulty created by lack of staff time to devote to such counting. The Department has devoted considerable time and effort over the life of the Certificate of Need program in making point-in-time accurate bed counts. Bed mixes are continually changing and keeping tabulations of such changes can be a full-time job for an individual. The Department is confident in the accuracy of each count of beds it publishes ; however, by the time a count is published it is out of date. We will continue to work to establish a continual up-to-date count of beds by service and facility.

The most recent amendments to the Virginia Certificate of Need Law do not limit the ability of the program in reviewing changes in the service mix of beds within a medical care facility. The Department is not interested in requiring

review under certificate of need for reductions in bed capacity in facilities. However, it would certainly be interested in determining the need for increasing beds in any category of service. The Department intends to issue revised regulations which will interpret and clarify the program's coverage with respect to increasing the bed capacity of a given service unit within any facility. These clarifying regulations will ensure continued conformance with federal requirements should there be any question.

Recommendation: "The State Health Commissioner, with the assistance of the Statewide Health Coordinating Council, should form a committee to explore and recommend ways to bring about greater uniformity between HSA and State health planning methods."

Comment: The Department of Health, SHCC and HSAs have, since July, 1976, continuously sought to bring about greater uniformity in the planning process. We have found that such uniformity is a gradual process because of the multiplicity of methodologies in some cases and the fact that no acceptable methodologies exist in other important aspects of health service delivery. We believe recently published plans will demonstrate that this recommendation is being achieved, however, to expect such to be accomplished overnight is unrealistic.

Recommendation: "The Bureau of Resources Development should develop standards and estimates of need for facilities and services not currently included in the 1978 State Medical Facilities Plan."

Recommendation: "The Bureau of Resources Development should develop a formal mechanism for publicly updating information between issuance of plans. Such a mechanism is necessary to incorporate changes which occur between plan preparation and adoption, and during the time a plan is in effect. Bed counts by facility need to be continually updated."

Recommendation: "To help eliminate such inconsistencies, BRD should reconcile differences between these data sources and compile an accurate and up-to-date Statewide inventory of beds by type and by facility. The Bureau's findings should be reflected in the next revision of the State facilities plan. Applications involving beds should not be accepted for review unless the existing beds shown concur with the BRD inventory and licensure reports. Each HSA should adopt the BRD inventory as the official State count of existing beds. If an HSA should disagree with the State over how many beds exist in its area, this should be made part of its regional plan."

Recommendation: "The Bureau of Medical and Nursing Facilities Services should begin licensing facilities not simply for total number of beds but for a specific mix of beds."

Recommendation: "The Bureau of Medical and Nursing Facilities Services and the Department of Mental Health and Mental Retardation should begin monitoring all approved certificate-of-need activity and report the completion of all projects to BRD and the applicant. BRD should be responsible for inspecting facilities like Health Maintenance Organizations and Public Health Centers which are covered under Virginia certificate-of-need law but are not licensed by either the Departments of Health or Mental Health and Mental Retardation. The General Assembly may want to consider making project completion a requirement under licensure."

Recommendation: "First, closer scrutiny of medicaid cost reports is required. The medicaid program could require facilities to file a separate cost report on a completed certificate-of-need project. Second, the General Assembly may need to clarify if all State-owned facilities, whether receiving third-party reimbursements or not, are required to undergo certificate-of-need review. Clarification may also be needed in the capital outlay process as to whether a proposed project should receive a certificate-of-need before it receives an appropriation or, if it is more appropriate to grant an appropriation on the condition that the project receives a certificate before construction begins. The latter approach was used by the 1978 General Assembly to transfer beds from Blue Ridge Sanatorium to the University of Virginia Hospital."

Comment: *There are many different task forces working to develop standards methodologies and estimates of need for the various facilities and services covered under the Virginia Certificate of Need Program. Each plan that has been produced by HSAs, the Department, and the SHCC is more sophisticated than previous plans and it is our belief that as the state of the art of health planning in Virginia continues to improve so will the plans.*

The scope of coverage of the State Medical Facilities Plan is substantial and we are consistently working to ensure its accuracy. One must recognize, however, that uniform definitions of particular health service categories of beds do not exist and as a result, when beds are counted, they may be identified as being in any one of many different categories. It is the Department's position that we are in a better position to accurately count beds than any other organization and that given the problems that exist throughout the health care system, our count of beds is the most accurate one available. We do, however, recognize

that problems exist in our count and we are constantly striving to improve our ability to keep tabs on changes. We soon hope to initiate licensure of beds by type of service which will provide greater consistency in our inventorying ability. This change in the way in which facilities are licensed will standardize the count and make continuous monitoring of facility development activity routine. Additionally, the Department of Mental Health and Mental Retardation is presently making a detailed count of all of its beds by type of service in order that accurate counts and monitoring may take place in its facilities.

The Department of Health was unaware of the projects identified by JLARC staff that have been developed by MH/MR. However, in discussions with the Department of Mental Health/Mental Retardation, it appears that some of the projects identified by JLARC staff would not have required certificates. It will take some time to make final determinations on the exact status of such projects, but jointly between the two departments, it will be worked out. State-owned medical care facilities are covered by the Virginia Certificate of Need law, as is required by federal regulations. Several legal opinions have been made on this subject including one from the Attorney General.

Chapter IV

Recommendation: "The authority of the Health Department to eliminate unnecessary beds needs to be clearly established by court test or by legislation."

Comment: The Department interprets the Certificate of Need law to cover primarily the development of new facilities and services. We do not believe the legislative intent at any time has been to focus the law upon eliminating existing surpluses of beds that undoubtedly do exist in many areas of the Commonwealth. As a result, we have not used the law to eliminate surpluses but we have taken such surpluses into account when making Certificate of Need determinations for projects proposed in oversupplied areas. Likewise we have not used certificate of need in conjunction with the licensure program we administer to close excess beds.

Licensure evaluations are used to a great extent in determining the "need" for modernization of facilities. The facility licensure program focus is to ensure the patient's health, welfare and safety when he is in a facility and to maintain facilities in a manner which meet current state and federal standards for construction and operation. Because construction and operation standards are constantly being upgraded, as time passes, facilities older than 15-20 years generally find themselves with substantial compliance problems which involve major renovation projects. The Department's position is that it is incumbent upon the owners and board of directors of these facilities to develop reasonable proposals for keeping the facilities modern, that is, in conformance with current standards. Our concern when viewing one of these projects under certificate of need is not whether the existing facility is needed but whether the renovation proposed is reasonable. Does the project correct noted deficiencies or are the deficiencies being used as a means of unnecessary expansion? It is technically possible for the Department to use the certificate of need program in conjunction with the licensure program to close facilities in medical services areas where excess beds exist. Through licensure we could determine that a facility is in need of modernization and through certificate of need we could refuse to approve the modernization project, which would eventually lead to closure of the facility for failure to meet licensure requirements. We have never done this. We do not believe the legislature intended such use of certificate of need. Additionally, advice from our legal counsel indicates such action would involve some very complex issues, such as, confiscation of private property without compensation, how to terminate staff and employee privileges and positions, and liquidation of outstanding indebtedness. To engage in issues of this nature would require very specific legislation to indicate the circumstances under which a facility would be required to close and remuneration to the owners, if any, and how such closure

would be accomplished.

Nevertheless, the economic implications of excess beds (capacity) do exist and each year the cost of supporting of excess beds continues to rise. The JLARC staff has incorporated our estimates of oversupply and we feel confident that these estimates are indicative of the true picture. Readers should understand however, that there is no single precise scientific method of determining excess beds. If it is the desire of the legislature to deal with the issue of eliminating excess or surplus beds, the Department of Health stands ready to assist with whatever knowledge and experience we can bring to bear on the subject.

Chapter V

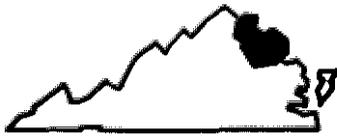
Cost Containment and Health Regulation

Comment: It is the position of the Department of Health that this chapter of the report provides an excellent description of what can be expected of a certificate of need program and what should not be expected of a certificate of need program. We agree that certificate of need is but one component of an integrated regulatory system necessary for the control of health care costs. It is obviously a controversial program because it does require a measure of public accountability for decisions which prior to certificate of need were made by private agencies, organizations and individuals without being subject to public scrutiny. We will continue in the future to make every effort, consistent with our available resources and legislative authority, to link the certificate of need process with other necessary regulatory programs to benefit the citizens of the Commonwealth and maintain a healthy and economically sound health care delivery system. We commend the JLARC staff on the inclusion of this chapter because of the concise insightful perspective of the certificate of need program it provides.

Chapter VI

Alternatives

Comment: This chapter of the report summarizes the recommendations previously made and commented upon by the Department of Health, therefore no further comment is perceived necessary by the Department. We believe this indepth analysis of the Virginia certificate of need program provides rather persuasive evidence that the program is necessary and should not be abolished, while pointing out the many problems that exist and merit the attention of all persons concerned with its effective administration. While we do have some differences of opinion with respect to certain conclusions and recommendations contained in the report, we believe the effort of the study team has been commendable and that the results will enable the Department and the legislature to improve the certificate of need program.



THE
HEALTH SYSTEMS AGENCY
OF NORTHERN VIRGINIA

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July 3, 1979

Ray D. Pethtel, Director
Joint Legislative Audit
and Review Commission
Suite 1100
910 Capitol Street
Richmond, VA 23219

Dear Mr. Pethtel:

The Virginia Association of HSAs (VAHSAs) recently reviewed JLARC's exposure draft of its study of the Virginia Certificate of Public Need law. The Association, which represents the five HSAs located wholly within Virginia, developed several generic comments, outlined below, that we hope you will consider in revising the document prior to final release. Each HSA will comment directly on factual errors and other concerns shortly, if they have not already.

1. We were impressed, generally, with the quality, accuracy, and "fairness" of the report.
2. We felt that, generally, the report is concise and presented clearly.
3. We question strongly the advisability of attempting to make the SHCC Facilities Review Committee (FRC) a forum for "appealing" negative HSA decisions and recommendations. The desire to "open up" the review process by allowing parties other than the applicant and the HSA to appear before the FRC is laudable, but the results of this, without taking several other steps to strengthen the FRC review process, would be to undermine meaningful local planning and to politicize further the FRC review, a step in the review process that already is weak analytically.

We believe the weakness of the JLARC analysis on this question lies in the assumption that the FRC, as a Statewide body, is further removed from the "parochial" interests that influence HSAs and hence can render a more objective evaluation of a proposal. Given this assumption, one would expect that the FRC, better insulated than the HSA against parochial pressures that promote projects "beneficial" (i.e., desired by) to local communities, would be more likely than the HSAs to disapprove CON projects, particularly

marginal projects.

Unfortunately, as the record shows, that is not the case. The FRC regularly recommends approval of projects that have little, if any, merit and that often have been rejected by the HSA. This occurs because of several reasons, but the principal ones include

- a) the logistics of the FRC review process are such that it must perforce be superficial: the FRC is seldom prepared to evaluate an application in depth;
- b) weak (limited number) staff support for the FRC;
- c) the ability of provider interests to focus on the FRC in contrast to the inability of consumer interests to do so: provider interests are paid (salaried) to come to Richmond to present their views, whereas consumers must incur significant expenses to do so. In other words, the Richmond atmosphere is provider dominated; and
- d) the ideological climate of the Committee: not enough care is taken to balance carefully what are truly provider and consumer interests within the SHCC.

This problem will continue unless changes more far reaching than those suggested in the report are made.

The VAHSAs recommends (in order of preference):

- a) that the SHCC FRC be authorized to review only those CON projects that affect more than one health service area;
- b) If this is not done, the FRC should be given adequate staff and review only those projects recommended for approval by the HSA. This is much preferable to reviewing only those disapproved at the local level, given that the CON law is intended to limit unnecessary costs and the assumptions about parochial influences on HSAs and how they encourage HSAs to approve unnecessary projects.

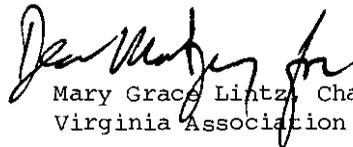
- c) If neither of these suggestions can be implemented, the VAHSA suggests that the FRC review be eliminated entirely. Given the limited SHPDA staff available, and the formidable logistics of the FRC review process, very serious thought should be given to this option. The SHCC has other important responsibilities that will keep it busy full time.
4. We agree that something should be done to "rationalize" the administrative review process. Our preference, and we believe the best and most logical option, is to eliminate administrative reviews as they now exist and go to batch processing (once or twice a year) most applications, with a highly restricted administrative review process available for true emergency situations. The administrative review process would be controlled by the Commissioner's office and invoked only in emergency situations. We take this position because, given the time schedules of all the interested parties, it is very difficult and sometimes impossible to process CON applications under the existing statutory time limits. This is particularly true for administrative reviews; and, as you know, applicants increasingly want nearly all applications handled administratively. Batch processing is needed to permit some element of competition (for needed projects) among potential applicants and to solve the problem of the time delays you noted, but could not explain fully, in processing applications. It should be stressed that this is a realistic option (it is used in several states); any applicant proposing a major capital expenditure knows about it (and should be planning for it) at least six to 12 months in advance. Indeed, Section 234 of P.L. 92-603 requires that hospitals participating in the Medicare program have a three year capital budget.
5. We agree with the point made in several places in the report that SHPDA decisions should show a high degree of consistency, and that the Commissioner should give a detailed explanation of the basis for a decision. We are concerned, however, that in places the report argues for "consistency with past decisions" and in others for "consistency with review criteria." We hope the report will be clarified and will state clearly that the Commissioner's decision should be consistent with established review criteria (improved, more specific and detailed) and plans, not necessarily with past decisions that may have been a mistake (bad decision). We

agree fully that the Commissioner's findings in each case should be set out in writing in detail. This is the only way to develop a good record with which future decisions can be compared for consistency.

6. We believe strongly that the discussion of the delays (usually while additional information is being requested) in processing CON applications is not adequate, and may be misleading. Certainly, your suggestion that SHPDA and HSA staff make a greater effort to help applicants and potential applicants understand the CON review process better should be followed. But we do not believe that poor communications is the underlying cause of the delay. The essential underlying causes are:
 - a) applicants' strong reluctance to supply certain types of information (e.g., contracts, lease agreements, and especially hard economic data);
 - b) the virtual absence of internal planning by health care facilities (hospitals and nursing homes): this means that much of the data requested in the application is not readily available in usable form and applicants try to "get by" without providing it; and
 - c) the slow "turn around" time in the applicant organizations and institutions: provider organizations, agencies, corporations, and institutions are as slow, if not slower, in responding to information requests (requests may go through several bureaucratic layers, including attorneys) as public agencies; the only real difference is that the process is recorded in public agencies and "hidden" in the private agency.

We hope these comments are helpful, and that you will give them careful consideration. As mentioned earlier, individual HSAs will be commenting directly to you on concerns specific to that Agency. If you have questions about these comments, please let me know.

Sincerely,



Mary Grace Lintz, Chairperson
Virginia Association of HSAs

/lgw



THE
HEALTH SYSTEMS AGENCY
OF NORTHERN VIRGINIA

7245 ARLINGTON BOULEVARD/SUITE 300 /FALLS CHURCH, VIRGINIA 22042/PHONE (703)573-3100

July 11, 1979

Ray D. Pethtel, Director
Joint Legislative Audit
and Review Commission
Suite 1100
910 Capitol Street
Richmond, VA 23219

Dear Mr. Pethtel:

We have reviewed carefully JLARC's exposure draft of its study of the Virginia Certificate of Public Need law. This review has led to a number of observations and comments that we hope you will take into consideration as you revise the draft report. These comments are presented below in two groups: 1) comments that deal with technical accuracy and errors, and 2) comments that deal with major generic issues.

Technical Comments

1. We believe the term "with the exception of these two modifications..." should be deleted from line 6, page 15. The two modifications referred to do not make the Virginia law inconsistent with Federal requirements, but some may read the paragraph to suggest that they do.
2. The diagram on page 16 and the language in paragraph three of page 17 should be revised to state clearly that advice from sub-area councils and project review committees does not come after and apart from a public hearing, but often as part of the public hearing process. For example, the Northern Virginia Health Systems Agency Project Review Committee (composed of nine HSA Board members) conducts the public hearing for the HSA. Also, full staff analyses precede and are a basic ingredient of the public hearing.
3. As Ms. Lintz, Chairperson of the Northern Virginia HSA, and I stressed at the June 7 briefing, the HSA of Northern Virginia does not discourage administrative reviews "altogether." Although we believe that efforts are made by applicants to pressure state and local planning officials to use the administrative review process for nearly all projects and, thereby, reduce the time available to gather detailed information and compile full analyses of all basic questions, we do not and have not discouraged administrative reviews, and our record demonstrates this. For example, during the last 15 months, 15 of the 23 (65%) projects reviewed were handled

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under the administrative review process.

4. The discussion on legal standing for appeals (pp. 46-69) should include information on the effect or results of more open appeals processes in other states. For example, if "frivolous appeals" are a potential problem, how do these states discourage them?
5. The data in paragraph 3 of page 56 appear to be incorrect. The data presented suggest that, on average, the 69 projects reviewed under those aspects of the Virginia law that exceed the federal minimum requirements cost about \$900,000. This sounds extraordinarily high. Perhaps the data should be checked.
6. Table 12 on page 74 is incorrect. The Northern Virginia Health Systems Plan does contain estimates of the number of ICU beds needed.
7. Contrary to what is stated in pages 70-72, the HSA of Northern Virginia does not use a bed projection (estimation) formula that assumes that current utilization levels are appropriate. Our analyses predict decreasing utilization based on several factors (e.g., historical demand, decreasing ALOS, and growth of HMOs and ambulatory surgery).

Major Issues Comments

1. We support strongly the recommendations you outline in pages 94-100. All of those findings are basically correct and the suggestions for dealing with them are realistic and appropriate. We are especially pleased with your recommendations for better monitoring of compliance with State laws and regulations and for issuing certificates of need and licenses for specific types of beds.
2. We agree fully that the State Health Department must have clear authority to deal with the supply of existing beds and thereby eliminate unnecessary surplus. In other words, given the substantial surplus of hospital beds in Virginia, the Health Department must have decertification authority. Although we believe personally that the Department already has this authority implicitly in its licensing authority (the authority to license is meaningless unless one has the authority to withdraw or terminate the license), the philosophy of the Department is such that a court test of this question is highly unlikely. Consequently, we favor strongly the legislative option outlined in the report.
3. We agree that something should be done to "rationalize" the administrative review process. Our preference, and we believe the best and most logical option, is to eliminate administrative reviews as they now exist and go to batch processing most applications (once or twice a year), with a highly restricted

administrative review process available for true emergency situations. The administrative review process would be controlled by the Commissioner's office and invoked only in emergency situations. In other words, the SHPDA would determine whether an emergency existed.

We take this position because, given the time schedules of all the interested parties, it is very difficult and often impossible to process CON applications under the existing statutory time limits. This is particularly true for administrative reviews; and, as you know, applicants increasingly want nearly all applications handled administratively. These requests become necessary because even for administrative reviews a public hearing, with at least 9 days published legal notice, must be held in the jurisdiction of the project. We routinely have to request that administrative review applicants extend the time voluntarily. This, of course, places the regulatory agency in a defensive position.

Batch processing is needed to permit some element of competition (for needed projects) among potential applicants and to solve the problem of the time delays in processing applications that you noted, but could not explain fully. It should be stressed that batch processing is a realistic option; it has been used in several states. Any applicant proposing a major capital expenditure knows about it, and should be planning for it at least six to 12 months in advance. Indeed, Section 234 of P.L. 92-603 requires that hospitals participating in the Medicare program have a three year capital budget.

4. We agree with the point made in several places in the report that SHPDA decisions should show a high degree of consistency, and that the Commissioner should give a detailed explanation of the basis for a decision. We are concerned, however, that in places the report argues for "consistency with past decisions" and in others for "consistency with review criteria." (See pages 34, 38 and 39 for example.) We hope the report will be clarified and will state clearly that the Commissioner's decision should be consistent with established review criteria and plans, not necessarily with past decisions that may have been mistakes (bad decisions). We agree fully that the Commissioner's findings in each case should be set out in writing in detail. This is the only way to develop a good record with which future decisions can be compared for consistency. We recognize also that the review criteria specified in law and regulations must be refined further, and stated more clearly and in greater detail.
5. We believe strongly that the discussion of the delays (usually while additional information is being requested) in processing CON applications is not adequate, and may be misleading. Certainly, your suggestion that SHPDA and HSA staff make a greater

effort to help applicants and potential applicants understand the CON review process better should be followed. We will do so; but we do not believe that poor communications are the underlying cause of the delays. The essential underlying causes are:

- a) applicants' strong reluctance to supply certain types of information (e.g., contracts, lease agreements, and especially, hard economic data);
 - b) the virtual absence of internal planning by health care facilities (hospitals and nursing homes). This means that much of the data requested in the application is not readily available in usable form and applicants try to "get by" without providing it; and
 - c) the slow "turn around" time in the applicant organizations and institutions. Provider organizations, agencies, corporations, and institutions are as slow, if not slower, in responding to information requests (requests may go through several bureaucratic layers, including attorneys) as public agencies. The only real difference is that the process is recorded in public agencies and "hidden" in the private agency.
6. We question the advisability of attempting to make the SHCC Facilities Review Committee (FRC) a forum for "appealing" negative HSA decisions and recommendations. The desire to "open up" the review process by allowing parties other than the applicant and the HSA to appear before the FRC is laudable, but the results of this, without taking several other steps to strengthen the FRC review process, would be to undermine meaningful local planning and to politicize further the FRC review, a step in the review process that already is weak analytically.

We believe the weakness of the JLARC analysis on this question lies in the assumption that the FRC, as a statewide body, is further removed from the "parochial" interests that influence HSAs and hence can render a more objective evaluation of a proposal. Given this assumption, one would expect that the FRC, better insulated than the HSA against parochial pressures that promote projects "beneficial" (i.e., desired by) to local communities, would be more likely than the HSAs to disapprove CON projects, particularly marginal projects.

Unfortunately, as the record shows, that is not the case. The FRC regularly recommends approval of projects that have little, if any, merit and that often have been rejected by the HSA. This occurs because of several reasons, but the principal ones include:

- a) the logistics of the FRC review process are such that it must perforce be superficial. The FRC is seldom prepared to evaluate applications in the depth that most HSAs review them;
- b) weak (limited number) staff support for the FRC because SHPDA staff are busy with other matters;
- c) the superior ability of provider interests to focus on the FRC. Provider interests are paid (salaried) to come to Richmond to present their views, whereas consumers must incur significant expenses to do so. In other words, the Richmond atmosphere is provider dominated; and
- d) the ideological climate of the Committee is strongly "pro approval" of nearly all projects except those, such as HMOs, that deviate from the basic structure of the present health care delivery system.. Not enough care is taken to balance carefully what are truly provider and consumer interests within the SHCC.

This problem will continue unless changes more far reaching than those suggested in the report are made.

We recommend (in order of preference):

- a) that the SHCC FRC be authorized to review only those CON projects that affect more than one health service area;
- b) if this is not done, the FRC should be given adequate staff and review only those projects recommended for approval by the HSA. This is preferable to reviewing only those disapproved at the local level, given that the CON law is intended to limit unnecessary costs and the assumptions about parochial influences on HSAs and how they encourage HSAs to approve unnecessary projects. Presumably the FRC would reject those projects that were approved by HSAs for parochial reasons; or
- c) if neither of these suggestions can be implemented, we suggest that the FRC review be eliminated entirely. Given the limited SHPDA staff available, and the formidable logistics of the FRC review process, serious thought should be given to this option. The SHCC has other important responsibilities that will keep it busy full-time.

We hope these comments are helpful, and that you will give them careful consideration. If you have any questions about them, please let me know.

Sincerely,


Dean Montgomery
Executive Director

/cb

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ROBERT W. WENTZ, JR.
President

PAUL M. BOYNTON
Executive Director

June 29, 1979

Mr. Ray D. Pethtel, Director
Joint Legislative Audit & Review
Commission
Suite 1100, 910 Capital Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

Thank you for your letter of June 20, 1979 and the copy of the draft report on Virginia's Certificate of Need Program.

In order to respond by the deadline stated, our staff has conducted a brief review of the document and offer the following comments. I anticipate we will have further comments later. We have followed the report's format and have directed our comments to the recommendations.

Chapter One
Purpose and Scope

It appears that JLARC has appropriately responded to the General Assembly's charge and has carried out the study in a comprehensive manner, addressing all issues requested as well as other important areas.

EVHSA staff feels that the study is a commendable one and should assist in improving an effective law.

Chapter Two
Certificate of Need Review Process Recommendations

1. Application Procedures--Page 50. The assumption that something should occur during the formal process to improve what occurs in the informal process does not follow. What does follow is that applicants are not in a hurry to submit (4.5 months since letter of intent) required information (3 months). The most frequently requested items for additional information (page 25) are items clearly requested in the application form and therefore should have been submitted initially. This shows that applicants are not following instructions.

Given this understanding, EVHSA staff agrees with the recommendation.

2. Administrative Review--Page 51. The JLARC should be aware that the Administrative Review process is optional on the part of the applicant. The fact that a project is eligible does not mean it is required to undergo the abbreviated process or that once submitted it should be approved. The cases given (p. 29 & p. 30) as examples of inconsistency do not show inconsistency of Administrative Review applicability. The first example shows an issue (financial contract) which was considered important by one HSA but not by other HSAs. The other example, renal dialysis facilities, is not a good example since the applicant chose to submit

via the standard process. In fact, the ESRD Network #30 encourages the standard process for all new facilities, regardless of cost.

The important element in this section is recognized by the statement "consideration could also be given to establishing some maximum dollar amount." EVHSA staff is of the opinion that the Administrative Review process could be improved by narrowing its scope of applicability and formalizing the submission process which is suggested in the report.

3. Facilities Review Committee--Page 51. EVHSA staff agree that the original need for state level review (because the old CHP councils did not cover the entire state) is now eliminated. The argument that the Facilities Review Committee (FRC) affords a statewide viewpoint, or may serve to correct "parochial" HSA viewpoints, is not supported by experience. Very few projects have potential statewide or multi-HSA impact, and there is no evidence of which we are aware to suggest that HSA recommendations have been "parochial" or that the FRC has corrected "parochial" positions.

Most importantly, a regional planning perspective is not, by definition, a "parochial" one, and the lack of familiarity with local needs and circumstances by out-of-area FRC members only serves to increase the probability that the FRC will make poor decisions.

EVHSA staff would, however, support a COPN review role for the FRC if it were confined only to projects having potentially a multi-HSA impact.

Finally, the attempt of the JLARC study team to open up the process at the state level is understandable but, we think, ill-advised. There is adequate allowance made within the process itself for public review and comment via the public hearing process at the HSA level. Allowing the FRC meeting to become in part a public hearing rather than a time for presentation and consideration of the applicant's and the HSA's respective positions will contribute to making this step in the process a very chaotic one and will encourage applicants to have as many organizations and individuals speak in behalf of the project as possible. Rather than being a rational and analytical decision-making process, it will become an intimidating process where more weight probably will be given to how many speak pro or con on the project than to the quality of the arguments made pro or con.

If the goal is to improve the overall public accountability of the process at the state level, than those who represent the public interest such as HSAs, the Rate Review Commission, consumer groups, etc., should have the right to appeal at every level after the Commissioner's decision including appealing in court. Presently, only an aggrieved applicant can appeal in court which means appeals only take place in cases of denials by the Commissioner. Nevertheless, the record is clear that some approvals may not be in the best interest of the public, and those who represent those interests should have status in court to appeal.

5. Commissioner's Decisions--Pages 52-53. The EVHSA fully agrees with these two recommendations. However, we trust that the suggestions of "consistency" and "precedent" does not allow repetition of past mistakes.

Contrary to the SHPDA's argument, the letters usually transmitted do not state reasons for inconsistency with the HSA position as required by Federal Law.

6. Appeal--Pages 53-54. EVHSA staff agrees with Recommendation #1.

In regards to Recommendation #2, we would recommend opening the appeals process to those mentioned at Steps I, II, & III, and opening the Step IV, court action, to the HSA.

Until this is done, it can never be accurately stated that COPN decisions are balanced and without bias. As noted above, by providing only for an aggrieved applicant to appeal, the local community has been closed out of the system. There is no counter balance to the threat of suit by the applicant. Presently, the Commissioner's decisions for approval can never be legally upheld or invalidated because there is no way approvals can ever reach the courts. This is patently unfair to the general public which eventually pays for every approval issued by the Commissioner.

The above suggestion would allow equal accessibility to the courts by the officially recognized entity (the HSA) responsible for the planning and development of health resources for a given population. It would be good if Virginia could recognize this now, for the future is highly likely to see such a determination by federal courts.

Centering the responsibility on the HSA for any court action on behalf of the community would eliminate any irresponsible court appeals.

This problem runs deeper than is readily seen. The fact that the HSA Board can make no meaningful objection to the SHPDA action permeates their thoughts and, perhaps, their votes on projects.

Chapter III

Need Determination Recommendations

1. Bed Thresholds--Page 95. Agree.
2. Plan Development--Pages 95-96. Agree with all four recommendations. Suggest #4 be clarified to specify the State Medical Facilities Plan as HSA plans (HSPs) do have a formal updating method. That is, the HSPs are updated annually. In that regard, it should be noted that the inventory on page 74 is based on the 1978 HSP, and consequently is out of date. Our 1979 HSP now covers all of these elements.
3. Monitoring--Page 97. Agree with all four recommendations.

Chapter IV

Distribution of Beds Recommendations

1. Department of Health--Page 123. In Recommendation #1 the words "by court test" should be deleted. It is clearly impossible to establish through the courts the SHPDA position on not dealing with existing beds, since the courts are blocked to all but the applicant who would certainly not object to the policy.

We think it is misleading for legislators who read this to think there really is an option other than legislation.

Otherwise, we agree with this recommendation.

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