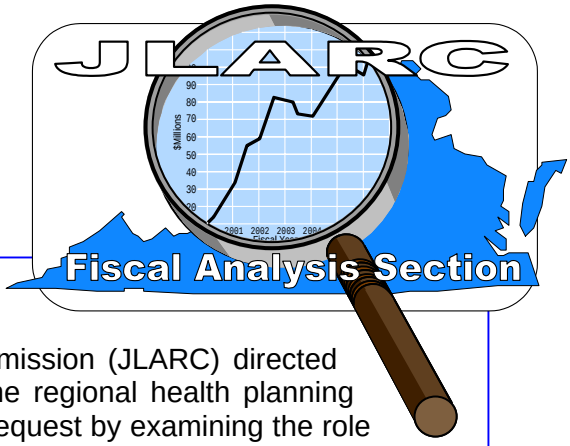
Special Report: State Spending on Regional Health Planning Agencies



Summary

The Joint Legislative Audit and Review Commission (JLARC) directed staff to undertake a review of State spending for the regional health planning agencies. This special report responds to JLARC's request by examining the role of the health planning agencies (HPAs) in Virginia's certificate of public need (COPN) program. The report provides background on the COPN program, discusses the duties performed by the HPAs, identifies areas of duplication in the COPN application review process, and presents alternatives to the current system for achieving greater efficiency. By utilizing a collaborative review process between the Virginia Department of Health and the regional HPAs, the State could achieve savings of approximately $76,000

Since 1973, Virginia has required the State Health Commissioner to certify that a public need exists for the introduction of a new medical facility or the expansion or replacement of an existing medical facility. With the inception of the COPN program, the State created five regional health planning agencies to assist the commissioner in making determinations of need. These agencies are non-profit corporations governed by volunteer boards composed of consumers, providers, local government officials, and members of the business and academic communities from their respective regions. In FY 2002, the HPAs received slightly more than $1 million in State general funds and special funds from COPN application fees. However, State funding of the HPAs is anticipated to drop to $826,000 in FY 2004.

This review shows that duplication of services exists in the COPN program, as both the HPAs and Virginia Department of Health staff independently review the merits of applications using the same criteria and data sources. However, some of this duplication may be beneficial to the process, as it provides for a system of checks and balances, inclusion of local perspectives within a statewide model, and a broad base of information for the commissioner before issuing a decision. These benefits of the current dual-review process are important considering the implications that COPN decisions may have on the healthcare and economy of Virginia. In FY 2002, for example, the commissioner approved 96 projects with a total value of $629 million and denied seven projects with proposed expenditures of $45 million.

Four policy options are presented in this report for achieving possible efficiencies in the COPN program. These options include: (1) maintain the status quo, (2) eliminate the HPAs, (3) establish a collaborative review process, and (4) reduce the level of application review by Virginia Department of Health staff. Of the four options, establishing a collaborative review process appears to best meet the goals of maintaining a thorough, unbiased analysis of public need while reducing duplication of services and cost to the State. JLARC staff estimate that time savings of between 25 to 40 percent may be achieved through use of the collaborative review model.

July 2003

Joint Legislative Audit and Review Commission of the Virginia General Assembly
A Special Report in a Series on Issues Related to JLARC's State Spending Study Mandate

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BACKGROUND

Following the *Review of State Spending* report to the Joint Legislative Audit and Review Commission (JLARC) in June 2002, the Commission directed staff to undertake a series of follow-up reviews focused on specific areas of possible savings in State spending. One area of study approved by the Commission was an examination of the regional health planning agencies (HPAs) in the certificate of public need (COPN) process. This special report addresses State expenditures for regional HPAs and expenditures for the overall administration of the certificate of public need program. The report does not, however, address the necessity of the certificate of public need program.

This report provides a brief background on the COPN process used to plan for and provide healthcare facilities and services, and on the main agencies involved in the COPN process – the regional HPAs and the Virginia Department of Health (VDH). The report discusses possible areas of duplication between the agencies and presents several options for possible savings in the process. In addition to the status quo, the options presented in this report are: an elimination of the regional HPAs, a limited supervisory role for VDH, and a collaborative analysis of COPN applications by both agencies.

In undertaking this review, JLARC staff conducted a series of interviews, analyzed three years of COPN application data, and collected revenue and expenditure data on the HPAs and the VDH Division of Certificate of Public Need. Interviews were conducted with staff from VDH and all five of the HPAs. Relevant stakeholders in the COPN process were also interviewed, including staff from the Virginia Healthcare Association, the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, and selected healthcare providers. In addition, officials from several other states were interviewed regarding COPN procedures in their states.

OVERVIEW OF REGIONAL HEALTH PLANNING AGENCIES AND THE CERTIFICATE OF PUBLIC NEED PROGRAM

Since 1973, Virginia has regulated the provision of new or expanded healthcare facilities through the certificate of public need program. This program is designed to control healthcare costs and ensure that healthcare providers invest only in those services that are necessary to meet the public need. In addition, the COPN program helps ensure that providers invest in medically underserved areas and promote access to quality healthcare for indigent populations in all regions of the State. The COPN program requires healthcare providers to submit an application demonstrating the need for the facility or service, and the Commissioner of Health is responsible for certifying that a need for the facility or service truly exists.

Within the COPN program, Virginia has designated five regional health planning agencies (HPAs) to assist the commissioner in determining whether a need

exists for a proposed medical facility or service. For each COPN application, the commissioner is required to consider the recommendation of the HPA for the region in which the facility or service is proposed. Federal law mandated the creation of regional health planning entities, but this law was repealed in 1986. Virginia, however, chose to continue utilizing and funding the HPAs. The five HPAs combined receive approximately $1 million per year in State general funds and COPN application fee revenues, and they employ a total of ten full-time staff plus several part-time staff positions.

History of the Certificate of Public Need Program in Virginia

In 1973, one year prior to the enactment of a federal law requiring state certificate of public need programs, the Virginia General Assembly enacted its COPN law (§32.1-102, *Code of Virginia*). Designed to ensure that healthcare needs across the Commonwealth were met and to curtail the development of duplicative services, the Virginia COPN law's stated objectives were: (1) promoting comprehensive health planning to meet the needs of the public; (2) promoting the highest quality of care at the lowest possible cost; (3) avoiding unnecessary duplication of medical care facilities; and (4) providing an orderly procedure for resolving questions concerning the need to construct or modify medical facilities.

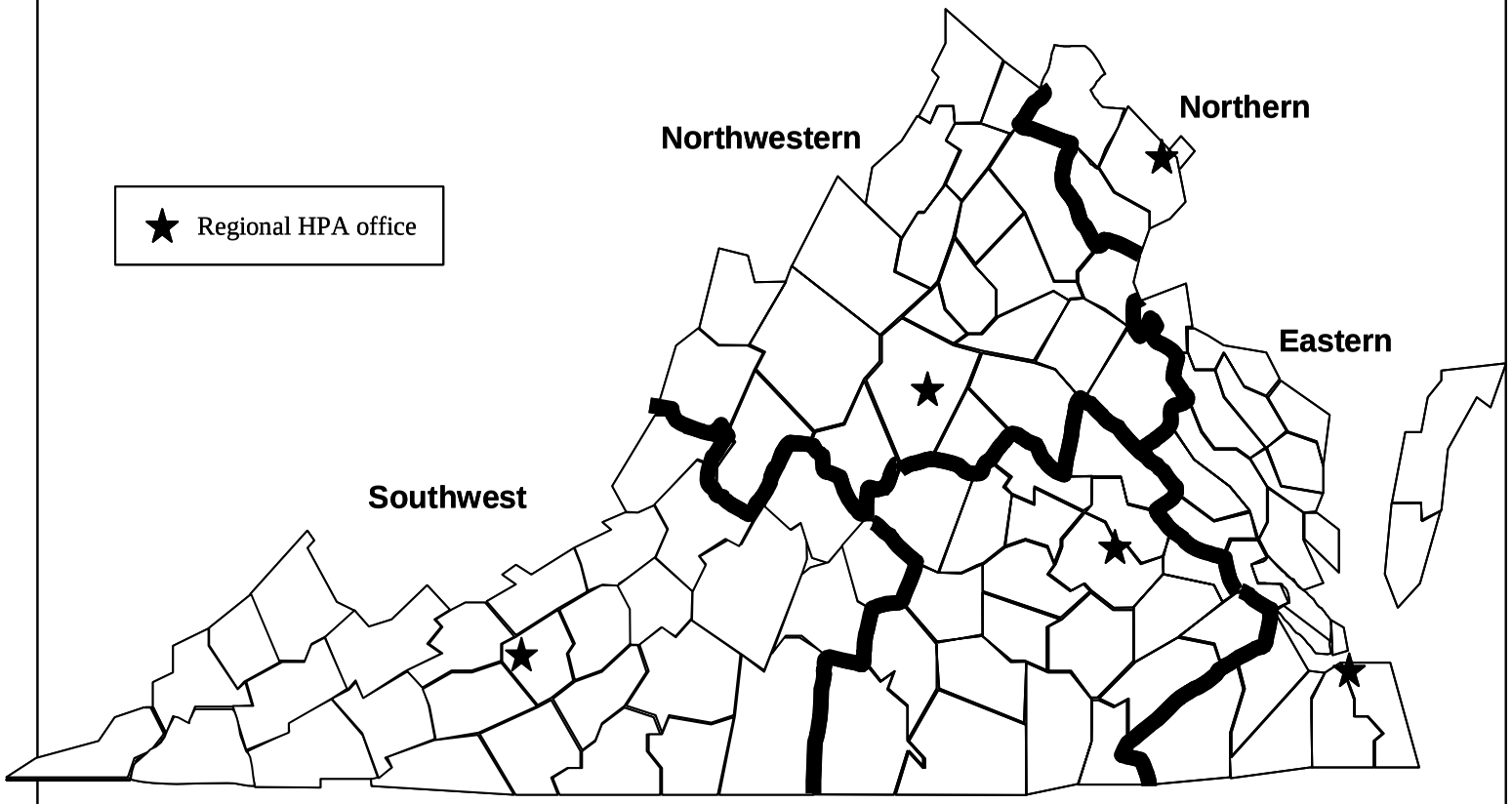
The COPN legislation also sanctioned regional health planning agencies "for the purpose of representing the interest of health planning regions and performing health planning activities at the regional level." Currently, there are five HPAs that serve their respective health planning regions (Figure 1). The planning region boundaries are contiguous with the planning district commission boundaries. Except for the Northern Virginia HPA, the planning regions contain multiple planning districts. Boards consisting of healthcare consumers and providers, local government representatives, and members from the business and academic communities govern each of the HPAs. Full-time professional health planners staff each of the HPA boards.

In addition to the HPAs, a Statewide Health Coordinating Council (SHCC) was created by the 1973 COPN legislation, which was then replaced by the Virginia Health Planning Board (VHPB) in 1989. This board was created to serve as the analytical and technical resource to the Secretary of Health and Human Resources in matters requiring health analysis and planning. However, the VHPB ceased functioning at some point after its origination. Consequently, the 2002 General Assembly repealed the language creating the VHPB and transferred its health planning duties to the State Board of Health.

In 1986, Congress repealed the federal COPN requirements. Virginia, in turn, amended its COPN law in 1989 to provide for the 1991 sunsetting of the COPN process on medical facilities. While there was a period of formal deregulation of many medical services from mid-1989 to mid-1992, Virginia re-regulated in July 1992 in response to perceived excesses during the preceding years. Consequently, the State COPN program is still in place within Virginia. However, without federal

Figure 1

Virginia Health Planning Regions



Source: Virginia Department of Health.

funding, the HPA budgets were reduced significantly, which caused a subsequent reduction in HPA staff

In 1996, following an eight-year moratorium on new nursing home beds, the COPN program was amended to require the Virginia Department of Health to issue a request for applications (RFA) when a determination was made that a need existed for additional nursing home beds in a particular area. The RFA process is similar to the request for proposals (RFP) process required by Virginia's Administrative Process Act. Nursing home providers respond to an RFA and compete for the certificate. Thus, nursing homes are now treated differently from other medical facilities, in that the State determines the need prior to the submission of applications by providers. Additionally, facilities operated by the federal government are currently exempt from the COPN process.

In 2000, the General Assembly directed the Joint Commission on Health Care to examine the costs of phasing out the Virginia COPN program (SB 337). The commission presented its findings in 2001 (Senate Document No. 0A, 2001). After receiving the report, the General Assembly decided not to deregulate the COPN program, as deregulation would have adverse effects on the adequate funding of Medicaid providers, indigent care, and medical education at teaching hospitals. The report estimated the price of deregulation to be $158 million.

During the 2002 General Assembly session, a bill (HB 293) was introduced to abolish the HPAs. Based on interviews with several healthcare providers and advocacy groups, this bill resulted primarily from perceived problems with the Eastern Virginia HPA. Certain providers had become dissatisfied with the Eastern Virginia HPA staff and its board. Apparently, there had been very little turnover of board members since its inception in the 1970s, and the public hearings were being held without any board members in attendance. According to several individuals, the board was simply "rubber-stamping" the recommendations of the executive director, which brought into question the usefulness of the HPA as a mechanism for providing local input to the COPN process.

Although HB 293 failed to gain passage, a change was made to the *Code* in 2002 to partially address the problems. Whereas the original *Code* language gave the HPAs the ability to establish limitations on the number of terms that board members may serve, the language now requires that board members be appointed for no more than two consecutive four-year terms. Also, the language now requires the HPA to submit board membership reports to the State Board of Health to ensure that the HPAs are appointing board members in accordance with Virginia law.

The *Code of Virginia* language pertaining to the COPN program has always required that the HPA board members or a sub-committee of the board hold public hearings. Therefore, the Eastern Virginia HPA was not in compliance with Virginia law when it held public hearings without board member attendance. Following the attempt to abolish the HPAs in 2002, the Eastern Virginia HPA has begun to hold public hearings with board members in attendance, and turnover of the board members is now in accordance with the current statute.

Certificate of Public Need Application Review Process

The COPN program in Virginia requires healthcare providers to obtain a certificate from the State Health Commissioner prior to opening or expanding a medical care facility. The *Code of Virginia* (§31.1-102.1 *et seq*.) specifies the types of medical facilities covered by the COPN program, the criteria that must be considered in determining public need, and the application review procedures that must be adhered to by the applicants, the Virginia Department of Health, and the regional HPAs. The statutory process is summarized within this section, and examples of COPN applications are provided.

Certain Medical Facilities Require Certification. The *Code of Virginia* specifies the types of medical facilities for which certification is required by the State Health Commissioner. Hospitals, nursing homes, sanitariums, mental hospitals, mental retardation facilities, and rehabilitation hospitals (including those intended for the treatment of alcoholics and drug addicts) all require a certificate of public need prior to their initiation, expansion, or replacement. In addition to the facilities listed, specialized centers or portions of physicians' offices developed for the provision of certain medical procedures must also gain certification. These services include outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), and several other specialty services. Facilities operated by the Department of Mental Health, Mental Retardation, and Substance Abuse Services are exempt from the COPN regulations.

COPN Applications. The Virginia Department of Health and the regional health planning agencies reviewed 282 COPN applications over the three-year period between 2000 and 2002. The most common type of application during the period was for diagnostic imaging equipment, which accounted for 38 percent of all COPN applications. The Eastern Virginia HPA reviewed the most applications of any region (26 percent), while the Central Virginia HPA reviewed the fewest (13 percent). Table 1 lists the number of applications reviewed by type and region

In FY 2002, the commissioner approved 96 medical facility projects with capital expenditures of $629,138,592. Eleven projects involving general hospitals, obstetrical services, and neonatal special care services accounted for 46 percent ($288 million) of the total capital expenditures of all approved projects. The commissioner also approved 21 projects with expenditures of nearly $250 million for additional surgery centers. Six nursing home projects were approved with expenditures of $21 million. Several examples of recent COPN applications are provided below.

> *The Virginia Commonwealth University Health System Authority submitted an application to add four operating rooms to its hospital facility. The application was reviewed by the Central Virginia HPA and the VDH. Both the HPA and VDH recommended approval of the application, and the commissioner approved the operating rooms in February 2002.*
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Table 1

COPN Applications by Type and Region 2000-2002

Facility Type	Planning Region: Central	Eastern	Northern	North-western	South-west	Total
General hospitals, obstetrical services, neonatal special care services	6	10	13	9	8	46
Open heart surgery, cardiac cath., ambulatory surgery centers, operating room additions, transplant services,	7	18	9	5	10	49
Psychiatric facilities, substance abuse treatment, mental retardation facilities	3	8	5	4	2	22
Diagnostic imaging	14	29	23	28	14	108
Medical rehabilitation	2	0	1	0	1	4
Gamma knife surgery, lithotripsy, radiation therapy	2	5	8	5	6	26
Nursing home beds, capital expenditures	3	4	2	5	13	27
Total	37	74	61	56	54	282

Source: Virginia Department of Health, Division of Certificate of Public Need.

Inova Health System submitted an application to add 73 beds and three operating rooms to its Inova Fair Oaks Hospital in Fairfax County. The Northern Virginia HPA recommended approval of the operating rooms and recommended approval of the beds if there were offsetting bed for bed reductions elsewhere, but VDH recommended denial. After an informal fact finding conference was held, the commissioner denied the application in February 2002.

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Alliance Imaging, Inc. submitted an application to introduce a mobile positron emission tomographic (PET) scanning service in southwestern Virginia. The Southwest HPA recommended ap-

proval of the project, but VDH recommended denial. An informal fact finding conference was held, and the commissioner approved the project in May 2002.

Twenty Criteria for Determining Public Need. Before issuing a decision regarding the need for a medical facility project, the commissioner must consider 20 criteria listed in the *Code of Virginia* (§32.1-102.3). The first criterion listed is the recommendation and reasoning of the appropriate regional HPA. The remaining 19 criteria are fairly broad and often subjective. Appendix A lists the 20 criteria. Among these criteria, the commissioner must consider:

- the relationship of the project to the applicable health plans of the State Board of Health and the HPA;
- the need of the population for the project, including, but not limited to, the needs of rural populations in areas having distinct barriers to access to care;
- the extent to which the project will be accessible to all residents in the area;
- less costly or more efficient alternate methods of reasonably meeting identified health service needs;
- the immediate and long-term financial feasibility of the project;
- the relationship of the project to the clinical needs of health professional training programs;
- the special needs and circumstances of health maintenance organizations;
- the special needs and circumstances for the projects which are designed to meet a national need;
- the costs and benefits of the proposed construction;
- the efficiency and appropriateness of the use of existing services and facilities in the area similar to the proposed projects.

The *Code* also mandates that any decision on the issuance of a certificate must be consistent with the State Medical Facilities Plan (SMFP). The SMFP is a planning document, approved by the State Board of Health, that includes methodologies and formulas for projecting the need for additional medical facility beds and services. The methodologies and formulas in the SMFP provide specific guidance for assessing existing and projected need. The SMFP is the primary document used by the Virginia Department of Health and the HPAs for determining public need for additional services.

The *Code* provides the commissioner with some discretion in determining if the SMFP is not applicable to a particular locality's needs, or if the SMFP is outdated. The document is updated periodically, and was last updated in 2002. Because localities may often have special needs, the SMFP will not always be applicable to every project. This is a source for many of the discrepancies in the recommendations to the commissioner from the HPAs and VDH staff. According to staff at VDH and the HPAs, the VDH is more likely to adhere strictly to the SMFP, while the HPAs are more likely to base their recommendations on perceived special needs of the region. If the commissioner determines the SMFP, or a portion thereof, is not applicable to a particular application, the SMFP is declared outdated and is subsequently revised.

COPN Application Review Cycle. The *Code of Virginia* specifies the procedures in the application review cycle from an applicant's notice of intent to apply through the commissioner's decision and possible court appeal. Decisions on applications must be issued within 190 days of the start of the review cycle. The application review process is described below and illustrated in Figure 2.

Except for new nursing home beds, for which providers may only apply on the issuance of a request for applications (RFA) by the State, the provider starts the COPN review process by notifying the commissioner and the appropriate HPA of its intent to apply for a certificate. Application forms are then sent to the potential service provider, and the completed application is submitted to both VDH and the HPA. Each entity then reviews the application for completeness. If the application is deemed to be complete and the appropriate fee is paid, review of the merits of the application begins.

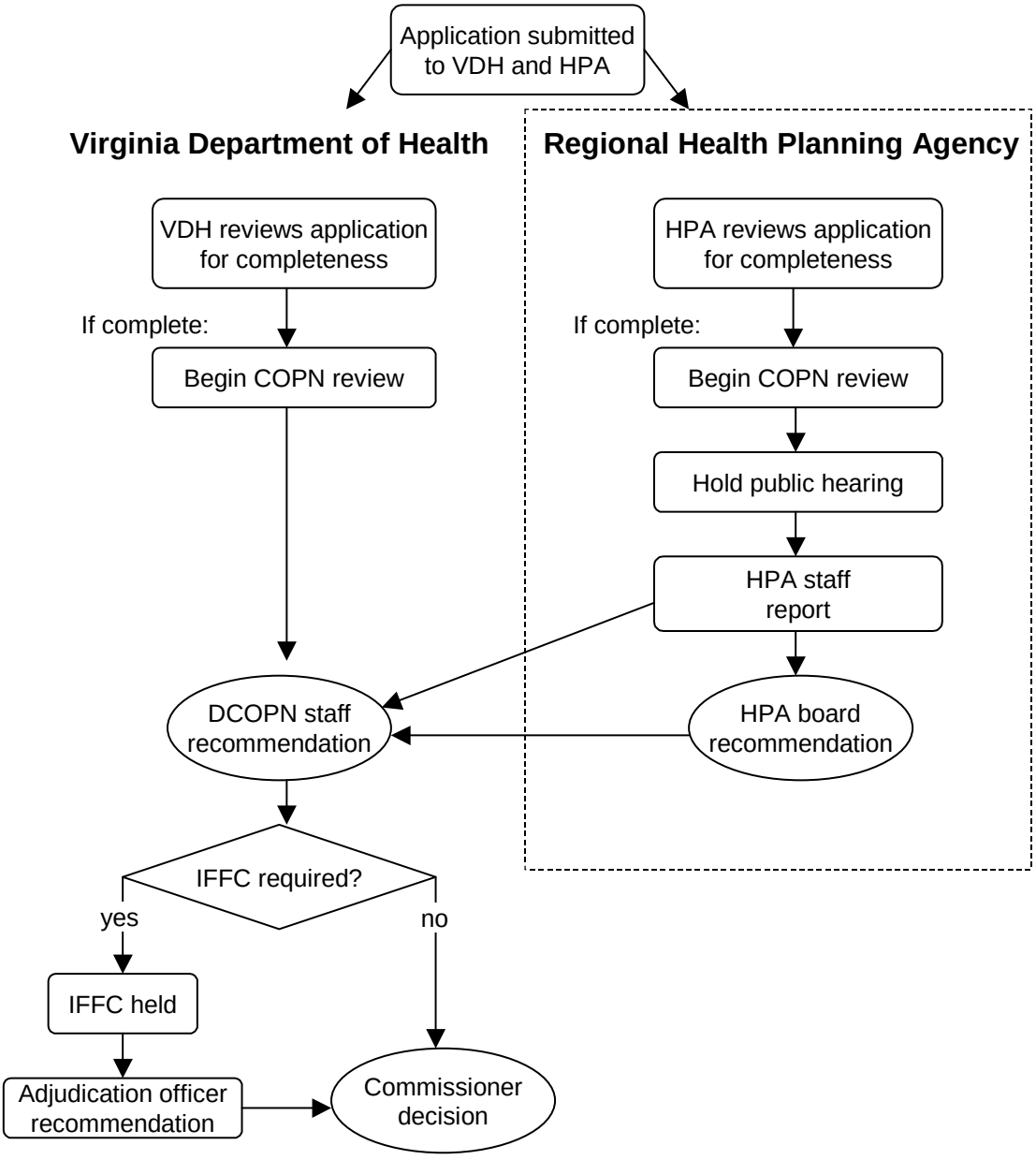
The Division of Certificate of Public Need (DCOPN) within VDH and the regional HPA staff conduct independent and simultaneous reviews of the completed application. Each entity performs its review based on the project's consistency with the SMFP and determines the need for the project based on each of the 20 criteria. (The HPA considers only 19 criteria, as the first criterion is the HPA recommendation.) However, while the DCOPN relies primarily on the written record for its review, the HPA also conducts a public hearing. The public hearing provides the applicant and other members of the public an opportunity to argue for or against the merits of the proposed facility or service. A subcommittee of the HPA board conducts the public hearing.

After the public hearing, HPA staff complete their report and submit their findings to the full HPA board. The board then issues a recommendation for approval or denial of the project within 60 days of the beginning of the review cycle, and this recommendation along with the HPA staff report are sent to the DCOPN for consideration. The DCOPN must then submit its own recommendation, along with the HPA recommendation, to the commissioner within 70 days of the beginning of the review cycle.

If the two recommendations disagree, the case automatically proceeds to an informal fact finding conference (IFFC), which is an administrative appeal procedure conducted by an adjudication officer. The case may also proceed to an IFFC if

Figure 2

Certificate of Public Need Process



Source: VDH, *Annual Report on the Status of Virginia's Medical Care Facilities Certificate of Public Need Program*, 10/1/2002.

both entities recommend denial, the applicant rejects a proposed condition, a competing request is recommended by either agency for denial, or if any person "seeking to be made a party to the case for good cause" protests the recommendation. The adjudication officer, who is a full-time VDH employee, reviews the reports of the DCOPN and the HPA, and hears testimony from the applicant or other party showing good cause. In FY 2002, the adjudication officer conducted 44 IFFCs for disputed applications. Upon completion of the IFFC, the adjudication officer submits his own recommendation to the commissioner, who in turn issues a decision to approve or deny the certificate.

Finally, the applicant or other party showing good cause may appeal the commissioner's decision to the circuit court. Therefore, applicants are entitled to both an administrative appeal and a judicial appeal, if necessary.

Health Planning Agency Operations and Finances

The regional HPAs are non-profit corporations that were created to assist the State Health Commissioner in determining public need for medical facilities and in performing other health planning activities. To accomplish this, the HPAs have volunteer boards and a few professional staff to advise the boards. The HPA staff members conducted 282 COPN application reviews over the past three years. The HPAs are funded primarily through State funds, but also receive some local and other revenues. Revenues in FY 2002 totaled nearly $1.5 million, while expenditures of the HPAs totaled nearly $1.3 million.

Health Planning Agency Responsibilities. While the primary responsibility of the HPAs is to issue recommendations on COPN applications, the *Code of Virginia* specifies several additional duties. These additional duties include:

- conducting data collection, research, and analyses as required by the State Board of Health;
- preparing reports and studies in consultation and cooperation with the Board;
- reviewing and commenting on the components of the State Health Plan;
- conducting needs assessments as appropriate and serving as a technical resource to the Board;
- identifying gaps in services, inappropriate use of services or resources, and assessing accessibility of critical services;
- conducting such other functions as directed by their regional health boards.

The extent of these additional duties varies by planning region. While most of the HPAs spend the majority of their time on COPN application reviews, staff at the Northern Virginia HPA state that they spend most of their time on data collection and analysis outside of the COPN application review process. All of the HPAs

participate in conducting community needs assessments and in collecting data for the State's Nursing Home Patient Origin Survey. One responsibility, reviewing and commenting on the State Health Plan, is no longer relevant as the State Health Plan has not been in effect since 1988.

Health Planning Agency Composition. Large volunteer boards and small professional staffs characterize the current composition of the HPAs. The *Code* specifies membership on the regional boards to include "consumers, providers, a director of a local health department, a director of a local department of social services or welfare, a director of a community services board, a director of an area agency on aging, and representatives of healthcare insurers, local governments, the business community and the academic community." A majority of the board members must be consumers, and thus the minimum number of board members is 19. The maximum number of members is set at 30. Three of the HPA boards have 30 members, while one has the minimum of 19 members.

The HPAs have very small professional staffs, with the average number of full-time positions at the HPAs being two. Each HPA is staffed by an executive director, who is a professional health planner and responsible for all daily operations of the agencies. The Northern, Eastern, and Central Virginia HPAs each employ an additional full-time health planner, while the Northwestern and Southwest Virginia HPAs rely on part-time employees or contractors to assist the executive director.

Health Planning Agency COPN Application Reviews. The primary responsibility of the HPAs is to conduct reviews of COPN applications, hold public hearings, and submit recommendations to the State Health Commissioner. According to data provided by the DCOPN, the HPAs conducted 282 reviews over the past three years. The HPAs recommended approval of 257 applications, some with conditions, and recommended denial of the remaining 25 applications. In comparison, the DCOPN recommended approval for 222 of the applications. The HPAs and DCOPN agreed on the recommendation 83 percent of the time, with the Northwest Virginia HPA having the highest agreement rate at 96 percent and the Central Virginia HPA having the lowest agreement rate at 65 percent. Table 2 shows the number of reviews conducted by each agency from 2000 to 2002 and the breakdown by recommendation.

Health Planning Agency Finances. In FY 2002, the HPAs received revenues of $1.47 million and had expenditures of $1.26 million. The majority (78 percent) of the revenue derived from State funding. About 74 percent of expenditures were for personnel.

The regional HPAs receive funding from the State, several localities, and consulting and data services. Table 3 shows the revenues from each source in FY 2002. The HPAs have two sources of State funding: general funds and special funds. General fund revenues are appropriated each year to the HPAs, and special fund revenues are derived from unused COPN fee revenues from the previous year. Applicants are charged a fee of one percent of the estimated capital expenditure for the project, with a $1,000 minimum fee and a $20,000 maximum fee. The DCOPN is

Table 2

COPN Application Recommendations by Regional HPA 2000-2002

HPA	# Approved	# Denied	Total	% Agreement with DCOPN
Central	32	5	37	65%
Eastern	61	13	74	84%
Northern	55	6	61	84%
Northwestern	56	0	56	96%
Southwest	53	1	54	81%
Total	257	25	282	83%

Source: JLARC staff of analysis of DCOPN data.

funded entirely by COPN fee revenues, and any unused amounts are transferred to the HPAs the following year. In FY 2002, the HPAs received $651,951 in general fund appropriations and $491,939 in excess COPN fee revenues. General fund appropriations were reduced to $403,687 in FY 2003 and $333,072 in FY 2004. Special fund revenues to the HPAs totaled $627,808 in FY 2003, but they are expected to be significantly lower in FY 2004 due to lower fee revenues and appropriation act language that transfers a minimum of $125,000 in application fee revenue to the general fund.

Table 3

Health Planning Agency Revenues (FY 2002)

HPA	State General Funds	State Special Funds	Local Government Funds	Other Funds	Total
Central	$ 130,054	$ 82,894	$ 28,963	$ 25,602	$ 267,513
Eastern	137,554	117,593	0	3,554	258,701
Northern	135,873	133,376	150,382	85,111	504,742
Northwestern	108,819	69,399	2,755	16,687	197,660
Southwest	139,651	88,677	0	9,662	237,990
Total	$ 651,951	$ 491,939	$ 182,100	$ 140,616	$1,466,606

Source: JLARC staff survey of health planning agencies.

Local governments may elect to provide funding to their regional HPA. However, only the Northern Virginia HPA receives a significant amount of funding from local governments. As total revenues are expected to decline in FY 2004, the HPAs may try to procure more funding from localities in their respective regions.

Of the $1.26 million in FY 2002 expenditures, 74 percent was spent on staff at the HPAs. The remainder was spent on board meetings (including public hearings), facilities and equipment, and other expenditures. The average salary and benefits of the executive directors was $89,153, and ranged from a low of approximately $63,000 to a high of approximately $112,000. Table 4 lists the expenditures by general category for the HPAs in FY 2002.

The HPAs have also accumulated cash reserves over a number of years. These reserves are maintained to enable the HPAs to continue normal operations when funding is unstable and to fulfill any contractual obligations, such as leases, in the event of closure. As of July 1, 2002, net cash reserves (excluding contractual obligations) at the HPAs totaled $618,675. All five HPAs noted that they will have to draw on these reserves in order to maintain functionality at current funding levels.

SOME DUPLICATION EXISTS IN THE COPN PROCESS

Virginia's certificate of public need (COPN) law (§32.1-102, *Code of Virginia*) requires that both the Division of Certificate of Public Need (DCOPN) within the Virginia Department of Health (VDH) and the Regional Health Planning Agencies (HPAs) review applications for certificates of public need and make recommendations to the commissioner. Because of the dual requirement, portions of the

Table 4

Health Planning Agency Expenditures (FY 2002)

HPA	Personnel	Facilities and Equipment	Board Meetings (including public hearings)	Other	Total
Central	$ 190,828	$ 10,669	$ 36,067	$ 15,229	$ 252,793
Eastern	216,324	13,817	13,525	17,018	260,684
Northern	317,288	26,068	42,863	22,888	409,107
Northwestern	101,527	11,841	18,663	13,777	145,808
Southwest	103,973	21,408	64,219	2,749	192,349
Total	$ 929,940	$ 83,803	$ 175,337	$ 71,661	$1,260,741

Source: JLARC staff survey of health planning agencies.

codified process are duplicative. Some of this duplication may be beneficial, however, as it provides checks and balances within a complicated system and facilitates the inclusion of all available perspectives in the analysis. Additionally, the HPAs perform certain activities beyond those currently performed by the DCOPN.

Duplication Is Inherent in Codified Process

Section 32.1-102 of the *Code of Virginia* requires that the DCOPN and the HPA conduct independent and simultaneous reviews of COPN applications. Reviews are made based on 20 codified criteria. Current procedure dictates that both the DCOPN and the HPA evaluate 19 of the 20 criteria (one criterion is the recommendation of the HPA, and thus only considered by the DCOPN). The HPA submits its report and recommendation to the DCOPN, and both final reports are tendered to the commissioner. Prescribed situations require an adjudication officer at an informal fact finding conference (IFFC) to also consider the applications.

This legislated dual review contains some inherent duplication. Review of all criteria by the DCOPN and the HPA means that both agencies evaluate the merits of the application based on numerous criteria, including applicability to the State Medical Facilities Plan (SMFP), the demographics of the locality in question, the current availability of services in the region, the availability of resources for the project, and the costs and benefits of the proposed construction. Analysis of the 20 criteria requires both DCOPN and the HPA to complete data collection and analysis. Each agency utilizes similar methods to quantify need and assess access to services, and both agencies procure the majority of their data from the same sources.

Although the reviews are done simultaneously, there is currently little collaboration between the agencies. Prior to 2000, the agencies were directed to conduct collaborative reviews. In 2000, however, the commissioner was concerned about the appearance of DCOPN staff not performing their own analysis and thus issued a directive ending collaboration with the HPAs. While this directive is no longer in place, there remains only minimal cooperation between the agencies.

An additional layer of potentially duplicative review takes place through the IFFC. When the recommendations from the HPA and the DCOPN disagree, or when either entity recommends denial, the case proceeds to an IFFC in which an adjudication officer, employed by the VDH, considers the application. The adjudication officer then makes a recommendation to the commissioner based on review of the HPA and DCOPN reports and the testimony of the applicants and other parties. Including the public hearing and the HPA board meeting, applicants therefore have three opportunities to present their case in a public forum.

Some Duplication May Be Beneficial

JLARC staff interviews with HPA and VDH officials, Virginia health advocacy groups, and other state certificate of need directors suggest that some of the duplication within the COPN process may be beneficial. Dual review facilitates checks and balances in the process as it provides multiple opportunities to uncover

problems with applications and determinations of need. Additionally, the different focuses of the two agencies inherent in their missions allows for the application of statewide consistency while enabling localities to demonstrate why the State model may not work under all circumstances. Finally, dual review provides the commissioner with a broad base of information from which to make final decisions.

Checks and Balances May Reduce Error. Because of the complicated nature of many of the COPN applications, a duplicative process may provide greater opportunity to uncover problems or discrepancies. Virginia's COPN process includes both subjective and objective analysis, which can result in both information and numerical bias. One advocacy group interviewed by JLARC staff stated that the process, which calls for similar reviews by both VDH and the HPA, helps reduce the potential for such bias by counterbalancing the weaknesses of one agency with the strengths of the other. Duplication may diminish the likelihood that need will be miscalculated or important information will be excluded or misinterpreted throughout the review. Among other things, this may also reduce the chance that the commissioner's decision will be overturned if the case goes to appeal.

Dual Review Enables Inclusion of State and Local Perspectives. The DCOPN and HPAs maintain slightly different focuses within the COPN review process. DCOPN's primary focus is to ensure that the regulations are applied consistently statewide. The HPAs, however, focus primarily on the needs within their respective health planning regions. Several individuals interviewed by JLARC staff described this as an objective/subjective review; the State process demands objectivity, while the HPA's are afforded more flexibility and subjectivity during their reviews.

The different focuses may strengthen the COPN review process in two ways. First, it provides an opportunity for the localities to demonstrate why the State model may not work in unique cases. One VDH official interviewed by JLARC staff stated that the HPAs bring up unique and sometimes compelling issues that would probably not be considered by VDH staff. According to the director of another state certificate of need program, while state agencies are very good at consistently applying a set of criteria to everyone, they do not always understand the local healthcare climate, making their decisions susceptible to debate. He stated, "the local perspective represents the left hand of the COPN process, where the State represents the right hand."

The different focuses provided by the DCOPN and the HPAs also help ensure that each of the 20 review criteria is addressed completely. One VDH official, for example, stated that the second criteria, which addresses consistency with the State Medical Facilities Plan, is usually better addressed by DCOPN staff, while the fourth criteria, which deals with community needs of specific populations, is better addressed by the HPAs. Allowing the two agencies to maintain different concentrations preserves the integrity of all 20 criteria, which increases the probability that the information on which the final decision is based will be correct.

Dual Review Provides More Information for the Commissioner. Several entities interviewed by JLARC staff stated that because of the complicated na-

ture of the cases and the implications of every decision, more information and analysis provided to the commissioner results in better decisions. The COPN review process currently in place provides the commissioner with two opinions (in some cases, because of the IFFC, three opinions) regarding the potential implications and outcomes of a decision. Two independent reports enable the commissioner to consider a broad base of information on each application and to make a decision based on all available objective facts and subjective realities. Additionally, as noted in the commissioner's 2002 report to the Governor, the COPN process has broad financial and health planning implications. In FY 2002,

> The State Health Commissioner authorized 96 projects with a total expenditure of $629,138,592 and denied 7 projects with proposed expenditures of $45,370,371.

A broader base of information enables the commissioner to better consider the sweeping implications of each decision on the healthcare and economy of Virginia.

Portions of the COPN Review Process Are Not Duplicative

Figure 1, located within the discussion of the certificate of public need application review process, illustrates that some portions of the COPN review process are not duplicative. There are three components that are primarily conducted by the HPAs and only minimally by the DCOPN. These include public hearings, provider site visits, and provider consultation. Because of the unique nature of the HPAs, the regional entities may be better suited to perform these activities. Additionally, because HPAs are not State entities, they may be better able to work with providers to promote regional health planning.

Within the current COPN review structure, the public hearing process, which provides a forum for local citizens and officials to express their opinions about any COPN application, is conducted only by the HPAs. No public hearing equivalent is conducted by the DCOPN. Rather, the DCOPN relies primarily on letters from citizens and officials to gauge public support. Additionally, there is no public comment portion of the IFFC.

Similarly, according to current practice, the HPAs conduct the majority of provider site visits. While the DCOPN may occasionally visit a COPN applicant during its review, they primarily rely on the HPA in the appropriate region for this portion of the analysis. Given the geographic location of the HPA offices, site visits are more easily accomplished by the regional entities. Also, HPA staff are more likely to be familiar with the operations of providers in their region.

A third aspect of the COPN review that is chiefly conducted by the HPAs is provider consultation. Each of the five HPA directors encourages potential applicants to meet with staff prior to submitting an application. This provides the HPA with an opportunity to discuss the strengths and weaknesses with an applicant and, in come cases, discourage unnecessary or frivolous applications. In some instances, a provider will request an opportunity to consult with DCOPN staff prior to submit-

ting an application. However, several providers interviewed by JLARC staff stated that the ease of meeting with HPAs in their local area, coupled with the HPA's knowledge of local issues, facilitates a smoother consultation process. Some examples of HPA consultation with providers are listed below.

> *An applicant filed a letter of intent to apply for a certificate to establish a CT scanning facility. Upon receiving the letter, HPA staff contacted the provider and explained that three CT scanners already existed within several miles of the proposed facility. Furthermore, these existing facilities had only marginal utilization rates. After being informed of the financial risk and the probability of the application being denied, the provider chose not to submit an application.*
>
> *****
>
> *HPA staff negotiated with an applicant to relocate a proposed cancer treatment facility from one county to a neighboring county, after showing the applicant that the need was significantly greater in the neighboring county. Without this negotiation, an additional cancer treatment center would likely have been added in the neighboring county, thus increasing the level of unused capacity in the health care system.*
>
> *****
>
> *The largest medical care provider in one planning region developed plans to build an additional hospital with capital expenditures exceeding $100 million. Given concerns that this new facility would jeopardize the financial viability of several community hospitals in the area, a citizen task force was formed to examine the consequences of the new facility. The regional HPA staff supplied data and analyses to the task force and the provider. After demonstrating the negative effects of the new facility on the region's health care system, the provider withdrew its plans for the facility.*

Finally, HPAs are non-profit corporations that receive State funding and have board membership that includes local public officials and private citizens. As such, they act as brokers between the public and private sectors. This unique relationship may enable them to work with providers to promote health planning in ways that may be beyond a State agency's capability.

OPTIONS FOR REDUCING STATE SPENDING IN THE CERTIFICATE OF PUBLIC NEED REVIEW PROCESS

JLARC staff have identified four options for reducing State spending in the certificate of public need review process. Each option has certain advantages and disadvantages, and each option is associated with a cost to the State. The four options include: (1) maintaining the status quo, (2) eliminating the regional health planning agencies, (3) establishing a collaborative review process between the HPAs

and the DCOPN, and (4) minimizing the role of the Division of Certificate of Public Need at the Virginia Department of Health in the application review process.

Option I: Maintain Status Quo

The first option available to the State is to maintain the COPN review process as it currently exists. This process, as discussed earlier, includes two independent reviews for each COPN application. Both the regional HPA and the DCOPN evaluate COPN applications based on the 20 codified criteria and present independent reports to the commissioner. If either party recommends denial, the case is automatically referred to an adjudication officer who conducts an informal fact finding conference (IFFC). The commissioner then makes the final decision based on all three recommendations. Over at least the last three years, the commissioner's decision has always agreed with the adjudication officer's decision.

Advantages Associated with Option I. There are several advantages to maintaining the status quo in the COPN process. These advantages, discussed previously, include a system of checks and balances in the review process, inclusion of both local input and State oversight to ensure consistency, and provision of a broad base of information to the commissioner. In addition, the status quo option would require no change to the *Code of Virginia* or disruption of service.

Disadvantages Associated with Option I. The primary disadvantage of maintaining the status quo is the duplication of services in the COPN review process. This duplication likely results in higher costs to the State in administering the COPN program. More resources are required for each agency to conduct application reviews independently. Also, an IFFC is needed more often under the current process, as the conference is necessary whenever the agencies disagree on an application.

Another disadvantage of maintaining the status quo is that it may not be practical. As noted earlier, State funding of the HPAs has steadily decreased over the last few years. At current levels, it will be difficult for the HPAs to continue operating by the year 2005. Maintaining the status quo will significantly reduce the ability of the HPAs to execute their role in the COPN review process unless funding is restored to a level comparable to funding in FY 2002.

Option II: Eliminate HPA Participation in the COPN Review Process

A second option available to the State is to eliminate HPA participation in the COPN review process. This option would require a change in the *Code of Virginia*. While potentially reducing duplication and cost, eliminating the HPAs would also result in a loss of local input, a significant reduction in local health planning activities, a decrease in provider buy-in to the COPN review process, and a decrease in the amount of relevant information provided to the commissioner.

Change in the* Code of Virginia *Would be Required. Because current law requires that the commissioner consider the recommendation of the HPA when evaluating a COPN application, execution of this option would require a change in

the *Code*. It should be noted that the HPAs are non-profit entities and not agencies of the State. However, eliminating State funding and amending the Code to strike language relating to the HPAs would effectively remove the HPAs from the COPN review process and the State governance structure.

Advantages Associated with Option II. There are two principle advantages associated with eliminating the HPAs from the COPN review process. First, it would achieve a reduction in duplication of services. Second, by eliminating general fund payments to the HPAs and reverting excess COPN application fee revenue to the general fund, the State could achieve savings of approximately $453,000 in FY 2004.

As described earlier, current procedure dictates that the DCOPN and the HPAs conduct dual reviews of each COPN application. Removal of the HPAs from the process would eliminate this duplication in the review process. This option may not save any review time, because the current dual review occurs simultaneously. However, submission of only one recommendation to the commissioner will likely reduce the number of IFFCs that must be conducted, as a portion of the current IFFCs are held because of opposing recommendations from the HPAs and the DCOPN. This reduction in IFFCs could result in some savings and could reduce costs to healthcare providers, who often must pay attorneys to represent them at the IFFC.

This option could also save the State money. An analysis conducted by the Department of Planning and Budget (DPB), in response to House Bill 293 of the 2002 General Assembly session, estimated that elimination of the five HPAs would require VDH to add at least six positions to assume additional COPN activities (primarily conducting public hearings). DPB estimated the cost of these positions to be approximately $56,250 per position for salaries and benefits. DPB also estimated that the agency would expend approximately $5,000 per position in non-personnel services such as equipment, communications, supplies, and travel costs. Thus, DPB and VDH estimated that elimination of the HPAs would require an estimated $367,500 increase in annual DCOPN expenditures. Given the 2.25 percent salary increase beginning in December 2003, elimination of the HPAs would require approximately $372,859 in additional expenditures in FY 2004.

The additional personnel and non-personnel costs would be offset, however, by the elimination of HPA funding. Table 5 lists general fund and excess COPN funds received by the HPAs in FY 2002 and FY 2003, and the estimated funds to be received in FY 2004. The HPAs received slightly more than $1 million in fiscal years 2002 and 2003, but are expected to only receive approximately $826,000 in FY 2004. State expenditures on the HPAs will be lower in FY 2004 because the general fund appropriation was reduced to $333,072, COPN fee revenue is expected to be approximately 80 percent of the fee revenue collected in the previous year, and the General Assembly mandated that a minimum of $125,000 in excess fee revenue will be reverted to the general fund each year. Therefore, elimination of the HPAs would save approximately $453,000 in combined general fund and excess COPN fee revenue in FY 2004.

Table 5

HPA State Revenues (FY 2002 - FY 2004)

Fiscal Year	General Fund	Excess COPN Application Fees	Total
2002	$ 651,951	$ 481,939	$1,133,890
2003	403,687	627,808	1,031,495
2004	333,072	492,617*	825,689*

* Estimate

Source: JLARC staff analysis of FY 2003 -04 Appropriations Act and VDH data.

Disadvantages Associated with Option II. While likely reducing duplication and cost, eliminating the HPAs from the COPN review process has four principal weaknesses. First, it would result in a significant loss of local input in the COPN process. Second, it would reduce the extent of local and regional health planning conducted. Third, it may diminish provider participation in the COPN review process. Finally, it would eliminate a valuable source of information for the commissioner.

Within the current COPN process, the regional HPAs are the primary catalyst for local input. They conduct the public hearings, perform site visits, and often are engaged in provider consultation. Several parties interviewed by JLARC staff noted that it is the HPAs that understand the local perspective. One provider stated that "the State staff is not intimately familiar with all the regions of the State ... The HPAs are in the position to understand the different problems and challenges of each area." Another provider representative commented,

> Just like all politics is local, all healthcare is local. The local understanding of the HPAs means that the discussion of need and appropriateness is less theoretical, even down to issues such as travel time.

While it appears that the VDH currently assumes only a minor role in health planning beyond the COPN review process, the HPAs are currently engaged in health planning within their regions of the State. The director of one other state's certificate of need process stated,

> Good HPAs get involved in the study of local issues. They have more flexibility in conducting research projects and statistical analysis than the State ever does. They are able to act more quickly.

In Virginia, the HPAs currently administer the Nursing Home Patient Origin survey on behalf of the State. Also, the Virginia HPAs play an instrumental role in promot-

ing and planning for the provision of charity care within their regions. With the assistance of hospitals, local health departments, and non-profit groups, the HPAs conduct a periodic community needs assessment survey. This survey highlights several areas of concern in the regions, including access and quality of healthcare, community health, and the percentage of households without health insurance.

A third disadvantage to eliminating HPA participation in the COPN review process is that it may reduce provider participation. Because of the geographic locations of the HPAs, they are in a better position than State staff to consult with and visit local healthcare providers. Because turnover at the HPAs has historically been lower than at the DCOPN, HPA employees have a greater opportunity to develop and cultivate relationships with local providers. For example, when there existed a need for radiation therapy on the Eastern Shore, the regional HPA staff were able to meet with providers and eventually got Sentara Health System and the Eastern Virginia Medical School involved in the project to offer the service in a medically underserved area.

Another aspect of provider participation that might be lost if the HPAs were eliminated is the participation on the HPA boards. The volunteer nature of the HPA boards facilitates community and provider involvement. With the exception of the Eastern Virginia HPA, which has previously had problems with a lack of turnover on its board and inattentive or absent board members, the HPA boards have provided a forum for assessing regional needs and cultivating relationships with the local providers. The problems with the Eastern Virginia HPA board have been partially addressed by the 2002 General Assembly, which required that board members serve no more than two consecutive four-year terms.

Finally, exclusion of the HPAs would eliminate a valuable source of information for the commissioner. One VDH official stated,

> HPAs provide a helpful perspective in that they champion local perspectives of need. They bring up unique and sometimes compelling issues that would probably be overlooked by VDH staff.

Another individual interviewed by JLARC staff stated that it would be problematic to have no HPA recommendation. "If there is only one recommendation, the commissioner is almost bound by the staff decision." Data provided by the DCOPN suggests that the commissioner and IFFC find the HPA participation helpful. As illustrated in Table 6, while the HPA and the DCOPN agree in approximately 83 percent of cases, when there is disagreement, the IFFC and commissioner decision follows the HPA recommendation approximately 71 percent of the time.

Option III: Establish Collaborative Review Process

A third option available to reduce the cost of the COPN review is to establish a collaborative review process. Such a process would involve one agency taking

Table 6

Summary of HPA and DCOPN Recommendations (2000 – 2002)

	Number	Percent
Total COPN application reviews	282	100%
HPA and DCOPN agree	235	83
HPA and DCOPN disagree	47	17
When agencies disagree:		
Commissioner follows HPA recommendation	30	71
Commissioner follows DCOPN recommendation	12	29
Commissioner decision is pending	5	

Source: Virginia Department of Health, Division of Certificate of Public Need.

the lead on certain issues, while the other agency would focus primarily on other issues. The two agencies would then confer and consult when formulating their recommendations. While a collaborative review process is currently used infrequently, it has been utilized in the past to a greater extent. From 1997 to 2000, the HPAs and the DCOPN were directed to conduct collaborative reviews of COPN applications. In 2000, however, the commissioner issued a directive that the DCOPN was no longer to collaborate with the HPAs. This directive is no longer in effect, but DCOPN has continued the practice of primarily reviewing applications independently.

A collaborative review process has both advantages and disadvantages. The advantages include more comprehensive analysis, fewer disagreements resulting in fewer IFFCs, and reduced time necessary to conduct an analysis. Additionally, because the process can still result in different recommendations, some checks and balances of the current process are preserved. Disadvantages associated with collaborative review may include difficulty in establishing and administering the process and a potential reduction in checks and balances. Moreover, increased cooperation could limit the independence of the recommendations.

Advantages Associated with Option III. Both DCOPN and HPA staff stated that collaboration works very well in many cases. If utilized appropriately, it can produce more comprehensive reviews, reduce disagreements, conserve time, and retain many of the benefits of independent reviews.

Collaboration may result in more comprehensive reviews. One HPA executive director reported that collaboration results in better reports - reports that are "more comprehensive, with greater analytical precision and detail." Collaboration allows each agency to concentrate on certain aspects of the report and enables spe-

cialization. Specialization, in turn, may result in a greater, more focused knowledge of the issues and a more complete analysis.

Collaborative review should also result in fewer conflicting recommendations. One HPA director stated that,

> A by-product of the cooperative reviews is that there are fewer disagreements between regional and state findings and recommendations, which in turn results in fewer projects requiring IFFC hearings at the State level.

During the collaborative review, issues are resolved as both agencies, as well as the applicants, work together to understand the needs of the public from both a State and local perspective. This reduction in conflicting opinions reduces the number of IFFCs, thus saving the State and the applicants time and money and reducing the workload of both the HPAs and the DCOPN.

Collaborative analysis may also reduce the amount of staff time necessary to complete a review. These reductions may be possible at both the State and HPA level. However, because many of the activities are conducted only by the HPAs (including scheduling and holding public hearings, meeting with the HPA boards, and conducting community needs assessments), and because the HPA staffs are already very small, greater savings in time and cost may be achieved at the State level.

DCOPN and HPA staff reported to JLARC that collaborative reviews could save between 25 and 40 percent of the time spent on COPN application reviews. In FY 2004, the DCOPN will have approximately four full-time-equivalent analysts dedicated to application reviews. The average salary and benefits of an analyst at DCOPN is approximately $55,700. Using the conservative estimate of 25 percent savings, greater use of collaborative reviews could potentially eliminate the need for one analyst and reduce DCOPN costs in FY 2004 by approximately $55,700. Actual savings may be higher because of non-personnel related expenditures. Additionally, collaborative reviews should reduce the need for contractors and part-time analysts at the HPAs. The HPAs spent approximately $20,500 for these personnel services in FY 2002. Therefore, total savings from implementing this option are estimated to be $76,200 (Table 7).

Because collaborative reviews do not necessarily result in one recommendation, this option continues to provide the commissioner with a broad base of information. Collaborative reviews, while limiting the extent of analysis necessary by either agency, could still require both agencies to consider all of the codified criteria. For example, the HPA and the DCOPN could split the review such that the HPA would focus its analysis on regional issues, including the public hearing and local need, and the DCOPN would focus on the appropriateness of the application with relation to the State Medical Facilities Plan. Both agencies would share their analyses with each other. The HPA would come to its recommendation based on its own analysis and the analysis provided by the DCOPN, and submit its recommendation to the DCOPN. The DCOPN would then have the option to either agree or disagree. If the

Table 7

Potential Savings Associated with a Collaborative Review Process (FY 2004)

Agency	Cost Savings	Staff Reduction
DCOPN	$55,700	1 FTE
Health Planning Agencies	$20,500	Contractor staff
Total	*$76,200*	

Source: JLARC staff analysis of DCOPN and HPA personnel expenditures.

DCOPN agrees with the HPA recommendation, it could submit a short memo endorsing or amplifying the regional agency report. If it disagrees, the DCOPN would be free to submit an independent report or a memo explaining areas of disagreement.

Disadvantages Associated with Option III. While there are several advantages associated with this option, there are also disadvantages associated with collaborative review. First, collaborative review may be difficult to institute and administer. Second, it would reduce the extent of checks and balances in the current system. Finally, it could reduce the independence of the agencies in the review process.

Establishing a process of collaborative review may be complicated. It would require effort to determine which criteria are best suited to each agency. Additionally, it would require that the HPAs and the DCOPN maintain a basic level of trust in the work of the other agency. One individual stated, "the success of this cooperative process is highly dependent on the support of the review analyst's immediate supervisor and those to whom the supervisor reports." Successful collaboration would require that all parties involved support the process and commit themselves to its success.

Collaborative review may also result in some reduction in checks and balances within the system. If the agencies rely solely on the data analysis provided by the other agency and do not check the work they are provided, there may be an increase in reportable error. Expending minimal time to confirm results, however, may eliminate this disadvantage.

Finally, a collaborative review by the DCOPN and the HPA may result in a loss of independence in agency recommendations. External parties may be concerned that their particular needs are not adequately addressed by one agency or another, and that the review is biased. If the collaborative review is constructed appropriately, however, and the agencies retain their independent focuses, final recommendations could maintain independence.

Option IV: Minimize DCOPN Role in Review Process

A fourth option available to reduce State spending in the COPN review process is to reduce DCOPN's role in the application review. Instead of conducting an independent review of the 20 criteria, DCOPN could act in a supervisory role by reviewing the HPA report prior to submitting it for commissioner review but conducting no original analysis. Limiting the role of the DCOPN would result in decreased duplication by eliminating one of the dual-review tracks and may result in reduced costs to the State. Such elimination, however, may also result in a diminished focus on statewide consistency and would require the commissioner to rely heavily on the HPA analysis.

Advantages Associated with Option IV. Redefining the role of the DCOPN in the review process may have several benefits. Minimizing DCOPN's role may diminish any duplication in the current process and reduce costs associated with the review. Similar to eliminating the HPAs from the review process, reducing the role of DCOPN would result in the elimination of one of the dual-review tracks and be accompanied by similar reductions in the required number of IFFCs. Similarly, reducing the role of the DCOPN from analysis to supervision may reduce State expenditures on COPN reviews. In FY 2004, the DCOPN will dedicate approximately four FTE staff for application reviews. This option would reduce personnel needs by reducing the time necessary to evaluate the HPA report. If DCOPN were to limit its role to supervision of the COPN review process and rely on the HPAs for original analysis of the applications, it is reasonable to assume savings of at least 50 percent at the division. Fifty percent savings would equate to the elimination of two analysts at a savings of $111,400.

Disadvantages Associated with Option IV. The disadvantages of reducing the role of DCOPN are similar to those of eliminating the HPAs in Option II, as one of the dual-track reviews would be eliminated. One weakness of this option is that statewide consistency in application reviews and recommendations would be reduced. Another weakness of this option is that the commissioner would lose a valuable source of information and need to rely heavily on the HPA analysis when issuing decisions.

Consistency across the health planning regions would likely be reduced, as the State's ability to ensure consistent interpretation of the State Medical Facilities Plan would be compromised. Although the HPAs meet periodically as a group to discuss various issues of statewide interest, the HPAs are primarily focused on health issues within their respective regions. Without conducting its own original analysis of the applications, it would be very difficult for the DCOPN to adequately review all applications for consistency with the State Medial Facilities Plan before submitting the recommendation to the commissioner.

Redefining the role of the DCOPN would force the commissioner to rely more heavily on the HPA analysis, reducing the amount of information available to him in making decisions. Similar to removing the HPAs from the COPN process, reducing the role of DCOPN to that of supervision would also remove a valuable source of information. One individual stated that if there is only one recommenda-

tion, the commissioner "may not be provided with the whole story." A substantial burden could be placed on the commissioner to adequately identify any error in the analysis and come to an informed decision. The commissioner may, however, be able to draw on the IFFC for some of this information, but only if the applicant or a third party appealed the recommendation.

CONCLUSION

Each of the options for improving the certificate of public need process and reducing the amount of money required to fund the program has certain advantages and disadvantages, as listed in Table 8. If the goal of the State were to save the most amount of money in the COPN process, then eliminating the regional HPAs (Option II) would accomplish this goal. However, COPN application data show that the HPAs provide valuable analysis for the commissioner, as the commissioner agreed with the HPA recommendation in a majority of cases in which the HPA recommendation opposed the recommendation of VDH staff. In addition, a majority of healthcare advocacy groups and providers interviewed by JLARC staff indicated that the HPAs provide a valuable service to the State, as did several certificate of need administrators from other states.

If the State wishes to maintain an effective, unbiased COPN review process while reducing duplication of services, then establishing a collaborative review process (Option III) may be the most desirable alternative. The collaborative review option may be expected to produce savings of approximately 25 percent in the review process while maintaining many of the advantages of the current process. The primary disadvantages of the collaborative review process include a possible reduction in checks and balances, a possible difficulty in implementation and administration, and a possible loss of independence in agency recommendations. However, these disadvantages can be mostly avoided or corrected if the process is implemented and administered adequately. Using minimal effort to check the other agency's analysis would enable the system of checks and balances to be preserved, and continuing the ability to submit separate recommendations to the commissioner would retain agency independence. Also, the disadvantages should be outweighed by increased efficiency resulting from the reduction in duplication of reviews.

Finally, implementing a collaborative review process may enable the regional HPAs to continue operations for the foreseeable future despite the recent reductions in State allocations to these entities. State HPA allocations will decrease by approximately 20 percent from FY 2003 to FY 2004. Several of the HPA directors informed JLARC staff that they may not be able to continue operations, given projected funding levels, beyond 2004 without additional revenue sources. If a 25 percent level of savings could be achieved through collaboration, the HPAs should be able to continue operations. However, savings resulting from the more efficient review process may need to be transferred back to the HPAs in order for them to continue.

Table 8

Options for Reducing State Spending in the Certificate of Public Need Review Process

Option	Advantages	Disadvantages	Potential Savings
I. Maintain Status Quo	• Maintain system of checks and balances • Maintain statewide and local perspectives • Maintain broad base of information	• Impractical to continue at projected funding level • Duplicative Review Process	$0
II. Eliminate HPAs	• Reduce Duplication • Reduce Cost	• Lose local input • Reduce local health planning • Reduce provider buy-in • Less information for commissioner	$452,800
III. Establish Collaborative Review Process	• Reduce Duplication and Streamline Process • More comprehensive review • Reduce number of IFFCs required • Reduce Cost	• May reduce checks and balances inherent in current system • May be difficult to implement • Loss of recommendation independence	$76,200
IV. Minimize DCOPN Role in Review Process	• Reduce Duplication • Reduce Cost	• Reduce statewide consistency • Less information for commissioner	$111,400

Recommendation (1). **The General Assembly may wish to continue the role of regional health planning agencies in the certificate of public need program.**

Recommendation (2). **The Virginia Department of Health and the regional health planning agencies should collaborate on certificate of public need application reviews.**

JLARC Staff for this Special Report:

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Appendix A

20 Criteria for Determining Public Need

Code of Virginia §32.1-102.3(B) Certificate required; criteria for determining need

B. In determining whether a public need for a project has been demonstrated, the Commissioner shall consider:

1. The recommendation and the reasons therefore of the appropriate health planning agency.

2. The relationship of the project to the applicable health plans of the Board and the health planning agency.

3. The relationship of the project to the long-range development plan, if any, of the persons applying for a certificate.

4. The need that the population served or to be served by the project has for the project, including, but not limited to, the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access care.

5. The extent to which the project will be accessible to all residents of the area proposed to be served.

6. The area, population, topography, highway facilities and availability of the services to be provided by the project in the particular part of the health service area in which the project is proposed, in particular, the distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access care.

7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.

8. The immediate and long-term financial feasibility of the project.

9. The relationship of the project to the existing health care system of the area in which the project is proposed; however, for projects proposed in rural areas, the relationship of the project to the existing health care services in the specific rural locality shall be considered.

10. The availability of resources for the project.

11. The organizational relationship of the project to necessary ancillary and support services.

12. The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.

13. The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health service area in which the project is to be located.

14. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the Commissioner may grant a certificate for a project if the Commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organization or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost-effective manner.

15. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

16. In the case of a construction project, the costs and benefits of the proposed construction.

17. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

18. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and costs effectiveness.

19. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed, including, in the case of rural localities, any distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

20. The need and the availability in the health service area for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

COMMONWEALTH of VIRGINIA

Department of Health

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June 6, 2003

Mr. Philip Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you for giving us the opportunity to review and comment on the Commission draft of the Joint Legislative Audit and Review Commission's (JLARC) special report titled *State Spending on Regional Health Planning Agencies* (Report). The certificate of public need (COPN) program is very complex and elicits strong feelings from opponents and proponents alike and a comprehensive review of it is no simple task. I appreciate your meeting with us and your consideration of our recommendations, including the numerous changes you made to the Report. In particular, the increased savings estimates associated with elimination of the Health Planning Agencies (HPAs) from the COPN process (Option II), from $250,000 to $453,000, now reflects the actual savings potential of that option for fiscal year 2004. In addition, we appreciate the removal of the prior recommendation that collaborative reviews of COPN applications be mandated through legislation.

The Virginia Department of Health (VDH) agrees, in principle, with the two recommendations contained in the Report, specifically that there is a continuing role for the HPAs in the COPN process and that the VDH and the HPAs should collaborate more on reviews of COPN requests. However, we continue to believe that the magnitude of the savings presented is overstated and cannot be realized in practice. While the reduction in the estimated savings attributed to the practice of collaborative review of COPN requests (Option III) from $161,000 to $76,000 is more reasonable, and also included projected savings from the HPAs, we continue to believe that this estimate is excessive.

I would like to briefly discuss the concept of collaborative reviews, and their utilization in the COPN program. Most COPN requests are complex enough that a firm idea of the resulting recommendation is not developed, by either the HPA or the DCOPN, until well into the review, after a number of the 20 statutorily required considerations have been

analyzed. It is at that point that the differences in opinion between the HPA and the DCOPN occur. The analysis that leads to these conflicting opinions does not then translate well into opposing recommendations in separate reports. Changing direction from a collaborative review on a complex request will actually increase the workload, as elements of the report developed by the collaborative partner must be recreated. This difficulty would be compounded, as this redirection will occur in the later days of a review cycle, limiting the time available for the analytical work, with the potential of not meeting the legislatively mandated timeframes for completion.

Reports that do lend themselves well to collaborative review are those that are rather routine and for which the appropriate recommendation is very clear and obvious from the first reading of the request. By their very nature the reports and recommendations for these types of requests are not very work intensive. The economy of time realized in these collaborative reviews is important but rather minor. It is certainly not sufficient to expect to be able to reduce the number of staff or realize any significant cost savings. It is very important to note that the HPAs and the DCOPN do produce collaborative reports now, although not as many as they did prior to 2000. The comparatively low volume of collaborative reviews is easily remedied with a simple change in internal practice.

Collaboration is often interpreted as "do it my way" by one party or the other. There is a statement on page 23 of the Report that says there are fewer conflicting recommendations when reviews are done collaboratively. This is true only because of the types of requests appropriate to collaborative review. If opposing viewpoints enhance the COPN program, as the Report suggests, then the reviewing agencies need the flexibility to develop differing recommendations, or differing reasons supporting the same recommendation, in those cases where that seems appropriate. An expectation that all reviews would be completed as a collaborative process will remove, or at least hamper, that flexibility. Without that flexibility there can be no disagreement, and without the option of disagreement there is no need for dual, concurrent review by two separate agencies.

Our greatest concern with the Report lies with the cost savings estimate presented as part of Option III. VDH believes that the dollar amount reported as the potential savings that may be realized under Option III continues to be overstated, and that this overstatement could result in inappropriate public policy and budgetary decisions, while also diminishing DCOPN effectiveness. The savings factor applicable to DCOPN utilizing a collaborative review process with the HPAs might be in the 25% to 40% range as stated on page 23 of the Report. However, it must be realized that refers to 25% to 40% of the *time* required for *each* COPN application reviewed collaboratively, not an across the board savings to the entire Division. If half of all reviews were done collaboratively (which VDH believes to be an exceedingly optimistic figure) and each collaborative review resulted in the maximum estimated 40% savings in review time there would be a 20% overall time savings to the DCOPN, or only about one half of a FTE position (approximately $20,000). The Report's conclusion that VDH can eliminate the need for one of its COPN analysts (for a $56,000 savings) appears to be based on the assumption that all of the applications reviewed by that analyst could be reviewed collaboratively

with the HPAs. We believe that this assumption is invalid, for the reasons previously stated.

As you know, the DCOPN is funded entirely from special State funds generated from application fees collected for COPN requests. Any fees not expended to operate DCOPN remaining at the end of the fiscal year, less a small retention, are mandated to be distributed to the HPAs. Consequently, the only savings that could be realized by the Commonwealth result from a reduction in payments from the general fund and/or from being able to retain excess COPN fees. However, the HPAs are the only agencies in the COPN program that receive general fund disbursements and the Appropriation Act requires that excess COPN fees be distributed to the HPAs. A reduction in the number of staff in DCOPN, even if that were possible from the minor time savings that may be realized from more widespread use of the collaborative review, would not produce real savings to the Commonwealth. It would however, increase the amount of excess fees to be distributed to the HPAs and create an illusion that the Commonwealth is spending less.

There is more to the COPN program than basic review of COPN project requests, significant change and extension requests. As indicated in the Report, the HPAs are engaged in data gathering and analysis and consultations outside the immediate review process. They participate in local health planning issues and conduct community needs assessments. The DCOPN also has functions beyond the immediate review process. The DCOPN staff is responsible for monitoring compliance with conditions placed on certificates and is also involved in the gathering and analysis of data, and issuing annual Requests for Applications for nursing homes. DCOPN provides consultation regarding the operation of the program and guidance to current and potential applicants. All of these services are valuable and necessary for the smooth operation of the program.

Concurrent with the HPAs' obtaining more robust funding via Appropriations Act language earmarking DCOPN's prior year application fee balances to them, DCOPN has significantly reduced its staffing. This is despite the average annual number of COPN requests increasing by about 50% during the same time period. In FY 1996 the DCOPN had 12.5 FTE positions assigned, with 3.5 of them devoted as analysts to COPN project review, and the division reviewed approximately 65 COPN requests. In FY 2003 DCOPN has 5.5 FTEs, 2.5 of which are analysts devoted to project review, with another half FTE engaged in review. Approximately 96 requests are expected to be reviewed in FY 2003. In recognition of increasing COPN requests due to legislation (HB 1621), the 2003 General Assembly authorized another analyst position for the DCOPN, however, the total Division staffing will still be only 60% of the FY 1996 level.

In FY 2003 the DCOPN personnel costs, salary, wages and benefits, were approximately $55,000 per FTE. On the other hand, information contained in the Report reflected the HPA average cost per FTE was approximately $94,000. While it is reported that the HPAs have reduced their staff in the past, so too has the DCOPN. The DCOPN has reduced staff when appropriate and has contained personnel and operating costs. It would be reasonable that the HPAs look for internal efficiencies in their own personnel

costs and operating expenses, as all state agencies have been required to do. Along these lines, I would call attention to page 13, Table 4 of the Report and the wide variation in expenditures for Board Meetings (including public hearings) of $18,633 to $64,219.

A common theme throughout the Report is that having both the HPAs and the DCOPN involved in the review of COPN requests provides balance and enhances the quality of the recommendations presented to the Commissioner. The Report places value on the expression of two, sometimes divergent, views on an application. Moreover, the Report expresses concern that at the current level of funding from the State, the HPAs will be unable to continue to operate. However, the same consideration should be given to the DCOPN. I am concerned that a report titled *State Spending on Regional Health Planning Agencies* is focused on reducing State spending for the DCOPN and that reductions will diminish the timeliness and quality of the support that I, as the Commissioner, currently receive from my staff.

Collaborative review of COPN requests is a workable enhancement to the COPN process and should be encouraged and utilized more than it is currently. I will immediately direct the DCOPN staff to conduct collaborative reviews with the HPAs when conditions allow, when such collaboration is likely to result in savings, and to the extent that such collaboration does not conflict with each of the agencies' ability to serve their purposes and missions. It still must be realized by all parties that increased utilization of collaborative review will not result in substantial cost savings for the Commonwealth. While a good idea, collaborative review is not the panacea it is presented to be and to suggest that it will result in substantial costs savings may mislead the General Assembly in formulating appropriate public policy, and budgetary decisions, on this issue.

Thank you again for the courtesies extended by you and your staff during the study, the opportunity to comment on the exposure draft, and your consideration of our previous comments.

Sincerely,

Robert B. Stroube, M.D., M.P.H.
State Health Commissioner