Virginia and Certificate of Need Programs

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What are Certificate of Need Programs?

Certificate of Need (CON) programs are state-based regulatory programs that require healthcare facilities to apply for and receive approval from the state prior to large capital expenditures, expansions in capacity or establishing new centers. Each state has specific criteria that healthcare facilities must meet to gain approval and defines which types of equipment purchases, capital expenditures or capacity additions fall under CON regulation. While some states regulate relatively few expenditures, others have broader criteria, although nearly all states with active CON programs regulate long-term care beds.[1] Figure 1 shows the variation in criteria for state CON programs. Currently, 37 states and DC have some variation on a CON program.[1]

Purpose of the CON Programs

States with CON programs contend that the regulatory review enables the state to:

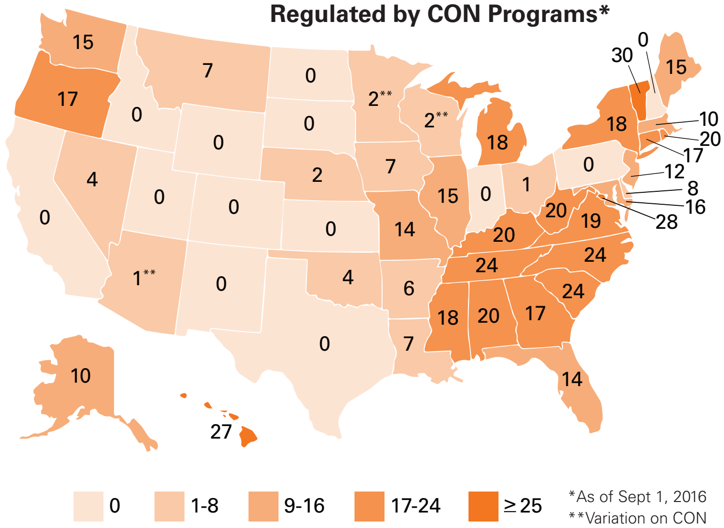
1. Promote adequate geographic access to services, especially in lower income, unprofitable areas;[2]
2. Reduce likelihood that facilities will increase prices to compensate for unused services or excess bed capacity;[1]
3. Maintain viability of facilities that offer both typically profitable and unprofitable services, by restricting market access to facilities that specialize in the profitable services only;[3,4] and
4. Maintain quality by consolidating complex surgical procedures into specific facilities to ensure volume is sufficient to maintain competency.[4,5]

Virginia Certificate of Public Need

The Virginia CON program, referred to as the Certificate of Public Need (COPN), was established in 1973. This was one year prior to the National Health Planning and Resource Development Act of 1974 which required all states to enact such programs to receive federal funding. Although the federal law was repealed in 1986, the Virginia COPN law (§32.1-102, Code of Virginia)[6] has remained largely intact since its inception. While the state legislature voted to deregulate nursing home and inpatient beds in 1989, the deregulation was postponed until 1991 and repealed in 1992, sustaining the program.

The State Medical Facilities Plan (SMFP) defines the criteria the state uses to assess each applicant and is maintained by the Virginia Department of Health Office of Licensure and Certification (VDH OLC). Currently, Virginia's SMFP covers 19 services including diagnostic imaging such as computed tomography (CT) and magnetic resonance imaging (MRI) scanners, inpatient beds, and nursing home facilities. Each type of regulated service is reviewed in batch groups twice a year, with the exception of long-term care expenditure requests, which are reviewed 6 times per year based on a call for applications by VDH OLC.[2]

FIGURE 1: Number of Services Regulated by CON Programs*



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Services Regulated by Virginia

- Diagnostic imaging (eg. CT, MRI, PET)
- Radiation therapy
- Stereotactic radiosurgery services
- Lithotripsy services (eg. open heart surgery, catheterizations)
- General surgery operating rooms and ambulatory surgical centers
- Inpatient beds
- Nursing facility beds
- Organ transplantation services
- Capital expenditures >$18,608,519
- Medical rehabilitation services
- Acute mental health and substance abuse disorder services
- Intermediate care facilities for individuals with intellectual disabilities
- Perinatal and obstetric services
- Neonatal special care service

The Current Debate

Opposition to the COPN program contends that the requirement to undergo state review is anti-competitive and may contribute to an increase in healthcare costs overall. Physician groups and ambulatory surgical centers assert that they could offer care of equal quality for a lower cost than the current regulatory environment permits and additional beds and equipment would bring down the cost of care in neighboring centers.[7] Additional concerns about the COPN program include the fees and time constraints associated with the application process.[8]

Hospitals support maintaining the COPN program, citing the requirement for hospitals to care for all persons regardless of acuity or ability to pay. The Virginia Hospital & Healthcare Association has suggested that removing barriers to entry for other facilities would undermine hospitals' revenue stream, and therefore, their ability to subsidize unprofitable but necessary services, especially in rural areas.[8] Several Virginia chambers of commerce have sided with hospitals suggesting smaller modifications to update the current COPN program.[8] Additional arguments for the program have suggested that charity care overall is increased under COPN, as facilities are encouraged to provide more charity care in order to obtain state approval for their project. However, others have suggested that any increase in charity care under COPN is minimal and does not counter the harm done by restricting competition.[4, 7]

What to watch for

In July of 2016, Virginia House of Delegates Speaker William Howell (R-Stafford) along with Senate of Virginia President Pro-Tempore and Chairman of the Senate Committee on Education and Health, Stephen Newman (R-Bedford) announced the establishment of a "Joint Working Group on Certificate of Public Need." The workgroup was created after 18 COPN-related bills, listed in the Appendix, were introduced but failed to reach the Governor's desk in the 2016 session.[9] The workgroup consists of 5 Republican Delegates, 3 Republican Senators, and 2 Democratic Senators and is tasked with preparing a proposal for the 2017 General Assembly to revise or repeal COPN.[10] Previous efforts to devise a compromise plan included a taskforce formed through the 2015 Appropriation Act and included stakeholders selected by Virginia Secretary of Health and Human Resources Dr. William Hazel.[4] Although the group did publish a final report with recommendations for revision, the proposal was not passed by the General Assembly.[4]

The debate on the repeal or modification of the Virginia COPN program continues to be watched closely by stakeholders and legislators concerned with free markets, healthcare costs and service access. While hospitals argue the necessity of regulations to maintain unprofitable services and access to care, especially in rural areas, physician groups and outpatient surgical centers argue that a more open market will decrease overall cost of care throughout the state.

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[1]CON-Certificate of Need State Laws. National Conference of State Legislatures. http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx. Published August 25, 2016. Accessed August 29, 2016. [2]State Medical Facilities Plan. 12VAC 5-230. Sec 10-1000. Virginia's Legislative Information System. [3]Sartoris, L. Certificate of Need, and Moo Goo Gai Pan. Focus. Virginia Hospital & Healthcare Association; September 2006:1-6. [4]Certificate of Public Need Workgroup – Final Report. 2015. https://www.vdh.virginia.gov/Administration/documents/COPN/Final Report.pdf. [5]Vaughan-Sarrazin MS, Hannan EL, Gormley CJ, et al. Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation. JAMA. 2002;288(15):1859. DOI:10.1001/jama.288.15.1859. [6]Medical Care Facilities Certificate of Public Need. Code of Virginia. §32.1-102. Virginia's Legislative Information System. [7]Koopman C, Stratmann T. Certificate-of-Need Laws: Implications for Virginia. Mercatus Center George Mason University; February 2015. [8]Fain T. Certificate of need reform bills move; heavily lobbied fight rolls on. Daily Press. http://www.dailypress.com/news/dp-nws-ga-copn-hospital-reform-20160204-story.html. Published February 4, 2016. [9]VA Legislation 2016 Regular Session. LegiScan. https://legiscan.com/MD/legislation. Published 2016. Accessed July 14, 2016. [10]House and Senate announce Joint Working Group on Certificate of Public Need Reform. 2016. http://us3.campaign-archive2.com/?u=a8970db37d2569f1a2b65e59d&id=76023031db&e=f238546add.

Bill Number	Description
HB59	Revises definition of medical care facility to exempt specialized centers, ASCs, or physicians clinics that function as outpatient or ambulatory surgery clinic, thereby exempting from COPN requirements.
HB193‡	Beginning with ambulatory and outpatient surgery centers, creates a 2-phase process to sunset COPN requirements for all services except nursing homes, rehabilitation hospitals and beds, organ or tissue transplant services, certain open heart surgery services, and rural medical care facilities.
HB347	Exempts LASIK eye surgery from COPN requirements.
HB348	Exempts certain equipment and services acquired by existing facilities provided quality standards and charity care levels are met.
HB349	Repeals requirements for COPN for medical care facilities other than nursing homes and those located in rural areas.
HB350*	Exempts some behavioral health facilities from COPN review, established expedited review processes for uncontested applications, modifies the definition of "charity care," requires the state to create a website with all relevant COPN documents, and creates a permit process for projects that would no longer be subject to COPN review.
HB463	Exempts relocating medical equipment within 5 miles from COPN.
HB621	Exempts projects related to psychiatric facilities and facilities for individuals with intellectual disabilities.
HB651	Eliminates COPN requirement for additional beds, services, or equipment at certain existing facilities.
HB688	Repeals COPN in total, requires permit process and charity care.
HB689	Exempts diagnostic imaging services from COPN.
HB1083	Renames the State Medical Facilities Plan to the State Health Services Plan, exempts specialized clinics, ASCs, and physician clinics with outpatient surgery, magnetic sources imaging, nuclear medicine, obstetric services and lithotripsy from certain COPN requirements. Establishes an expedited review process, minimizes days permitted for good cause cases and creates a digital filing system.
SB333	Creates 3-phase process to sunset COPN requirements for most medical facility requirements, with the exception of some open heart surgery, nursing home and organ transplantation services.
SB398	Exempts cataract surgery facilities from COPN.
SB561‡	Incorporates SB333, SB398, SB585, SB641, and SB777.
SB585	Authorizes the Commissioner to grant COPN approval to facilities in partnership with organizations providing charitable care for disabled veterans.
SB641	Exempts specialized clinics, ASCs, and physician clinics with outpatient surgery, magnetic sources imaging, nuclear medicine, obstetric services and lithotripsy from certain COPN requirements. Establishes an expedited review process, minimizes days permitted for good cause cases and creates a digital filing system.
SB777	Clarifies that the COPN program should address cost containment, underserved populations, quality of care, access, and support research and training at teaching hospitals. Establishes process to review new technology, enables the Commissioner to provide COPN contingent on facility participation in Medical Assistance programs and charity care.

‡Continued in 2017 session by unanimous vote in Senate Education and Health Committee.
* Bill was passed out of the House and listed as continued in 2017 Senate Finance Committee.
Source: LegiScan VA Regular Session