COPN CLAIMS: Setting the Record Straight

MYTH

Virginia's COPN law is a vital component of state health care policy that helps hospitals and other providers balance their mission to provide high quality, affordable health care to all patients regardless of their ability to pay and meet other community and social needs in an increasingly challenging policy environment.

FACT

According To A Review Of 2012-2013 Financial Reports, 88% Of Virginia's Non-Profit Hospitals Turned "The Nonprofit Equivalent Of A Profit" Despite Uncompensated Care Responsibilities. "Charity care and other uncompensated costs haven't prevented Virginia's nonprofit hospitals from taking in revenue far in excess of their expenses, with 88 percent turning the nonprofit equivalent of a profit. A Watchdog.org review of 2012-13 financial reports from 25 nonprofit members of the Virginia Hospital & Healthcare Association found that the nonprofits averaged $30 million more in revenue than expenses."

(Jason Hart, "Virginia Nonprofit Hospitals Doing Well Without Medicaid Expansion," Franklin Center for Government & Public Integrity, 3/3/16)

- "On average, uncompensated care costs amounted to 11 percent of the nonprofit VHHA members' total expenses in 2012-13, the most recent year for which complete figures are available."

  (Jason Hart, "Virginia Nonprofit Hospitals Doing Well Without Medicaid Expansion," Franklin Center for Government & Public Integrity, 3/3/16)

- "Hospitals' uncompensated care costs include charity care provided to the poor free of charge, unreimbursed Medicaid costs incurred because the program underpays for the services Medicaid enrollees receive, and bad debt from billed patients who fail to pay."

  (Jason Hart, "Virginia Nonprofit Hospitals Doing Well Without Medicaid Expansion," Franklin Center for Government & Public Integrity, 3/3/16)

Charity Care Provided By Virginia Nonprofit Hospitals Averaged Only 4.2 Percent Of Total Expenses. "For non-profit Virginia hospitals, charity care averaged 4.2 percent of total expenses, unreimbursed Medicaid averaged 2.7 percent of total expenses, and bad debt averaged 4.1 percent."

(Jason Hart, "Virginia Nonprofit Hospitals Doing Well Without Medicaid Expansion," Franklin Center for Government & Public Integrity, 3/3/16)

- At a time when nonprofit hospitals are seeking handouts from the state, they are signing lucrative sponsorship deals with professional sports teams and university sports programs.
  - » April 2011: Inova was named the official jersey sponsor for the Washington Mystics.

    (Kathy Orton, "New Look, Sponsor For Mystics," The Washington Post, 4/8/11)

- October 2012: Bon Secours was named the main sponsor of the Washington Redskins' Richmond, VA training camp facility.

  (Robert Zullo, "Redskins Plan Gets Celarer," Richmond Times Dispatch, 10/23/12)

- December 2014: VCU Medical Center was the named the "exclusive medical sponsor" of the 2015 UCI Road World Championship.

  (Marianne Aiello, "VCU Medical Center Shifts Gears, Adds Race Sponsorship," HealthLeaders Media, 12/17/14)

- August 2015: Carilion Clinic will pay $5 million over 10 years for the naming rights to Virginia Tech's basketball courts.

  (Mark Berman, "Tech's Cassell Court Gets A Name," The Roanoke Times, 8/6/15)

- August 2016: Inova signed a 10-year deal to rename Redskins Park the Inova Sports Performance Center at Redskins Park along with a package of media sponsorships.

  (Dan Steinberg, "Redskins, Inova Reach Naming Rights Deal For Redskins Park," The Washington Post, 7/24/16)

- Virginia's COPN law does little to ensure indigent care needs are being met .
- COPN protects monopolies not charity care:
  - Of the 1,133 Certificates of Public Need issued since 1999, only half (52%) included charity care requirements.
  - Of the 593 Certificates of Public Need issued contingent on providing charity care, the average amount required was 2.9%.

    (1730.215 divided by 593, as of 10/16) http://www.vdh.virginia.gov/licensure-and-certification/the-certificate-of-public-need-program/
- CMS data shows that there are almost 2 ambulatory surgical centers per 100,000 people in states without a CON program compared to approximately 1.5 ambulatory surgical centers in states with a CON program.

  (Stephen Weiss JCHC presentation Sept 28 2015)
- **Mercatus Center: "Contrary To The Intended Goal Of Protecting Access, The Presence Of A Con Program In A State Is Correlated With Both Fewer Community Hospitals Per Capita And Fewer Ascs Per Capita Across An Entire State And Specifically Within Its Rural Areas."**

  (Thomas Sratman and Christopher Koopman, "Entry Regulation And Rural Health Care: Certificate-Of-Need Laws, Ambulatory Surgical Centers And Community Hospitals," Mercatus Center, 2/2016)
  - Mercatus Center: "We estimate that, when controlling for demographics and year-specific effects, the presence of a CON program is associated with 30 percent fewer total hospitals per 100,000 state population and 30 percent fewer rural hospitals per 100,000 rural population. Moreover, we find 14 percent fewer total ASCs per 100,000 state population and 13 percent fewer rural ASCs per 100,000 rural population. These findings suggest that CON programs do not protect access in rural healthcare markets."

    (Thomas Sratman and Christopher Koopman, "Entry Regulation And Rural Health Care: Certificate-Of-Need Laws, Ambulatory Surgical Centers And Community Hospitals," Mercatus Center, 2/2016)

Piecemeal deregulation of select services or repeal would upend this balance and threaten access to care, the provision of essential health services and the financial viability of many Virginia health care providers.

- **Of the 80 rural hospitals that have closed since August 2017, 59 have been in states with CON laws on the books.**

  (Ayla Ellison, "State-by-state breakdown of 80 rural hospital closures," Becker's Hospital Review, 8/15/17)

- The Federal Trade Commission and U.S. Department of Justice said CON programs "tend to sweep broadly, limiting competition for a wide variety of health care services" and are less effective at funding indigent care.

  ("Joint Statement Of The Federal Trade Commission And The Antitrust Division Of The U.S. Department Of Justice To The Virginia Certificate Of Public Need Work Group," Federal Trade Commission and U.S. Department Of Justice, 10/26/15)

- The FTC said "competition is the most reliable and effective mechanism for controlling healthcare costs while preserving quality of care, including in rural areas facing economic challenges."

  ("Federal Trade Commission Staff Submission To The Southwest Virginia Health Authority And Virginia Department Of Health Regarding Cooperative Agreement Application Of Mountain States Health Alliance And Wellmont Health System," Federal Trade Commission, 9/30/16)

- Virginia's COPN law jeopardizes the availability of essential health services by blocking private investment to expand health care facilities and purchase new equipment.

  - » $1,362,466,203: Value of COPN Requests Denied 1999-2016
  - » $44,576,735: Value of COPN Requests Denied in 2015

- Hospital systems like Inova and Centra are profitable and have billions of dollars in investments.

  - » At the end of 2015, Inova Health System Foundation had investments totaling $3.89 billion.

    ("Inova Health System Foundation Bond Issue Official Statement," Industrial Development Authority Of Fairfax County, Virginia, 4/25/16)

  - » Centra reported a profit of $38 million in fiscal year 2016.

    (Virginia Health Information, Fiscal Year 1/1/2016 – 12/31/16)

COPN exists to control overall health care costs, ensure access to care for indigent and uninsured, promote quality of care, ensure the availability of essential health services and meet other community needs.

A Comprehensive State-To-State Comparison Indicates COPN Laws Do Little To Control Costs. The Virginia Joint Commission on Health Care studied the changes to per capita health expenditures from 1991 through 2009 and found that while the trend in health care expenditures was increasing at about the same rate across the country, per capita costs for personal health expenditures were higher in states with CON laws.

(Virginia Joint Commission On Health Care, A Review Of Certain Health-Care System Characteristics In States With And Without Certificate Of Need, Prepared By Stephen Weiss, 9/9/15)

A Recent Mercatus Study Found That Certificate-Of-Need Laws Do Not Raise The Quality Of Care At Hospitals And May Even Lead To More Readmissions And Complications. "Using a broad dataset, the study finds no evidence that CON laws improve hospital quality. In fact, there are more deaths and serious postsurgery complications in hospitals in states with CON laws. …There is no scholarly consensus that CON laws improve hospital quality."

(Thomas Stratmann and David Wille, "Certificate-Of-Need Laws And Hospital Quality," Mercatus Center At George Mason University, 9/27/16)

- **CON Laws Do Not Raise The Quality Of Care:** "There is no evidence that the quality of care at hospitals in states with CON regulations is better than the quality of care in non-CON states."

  (Thomas Stratmann and David Wille, "Certificate-Of-Need Laws And Hospital Quality," Mercatus Center At George Mason University, 9/27/16)

- **CON Laws Lower The Quality Of Medical Services:** "Hospitals in CON states perform worse than those in non-CON states on eight of the nine indicators in the study. For four of these indicators, the difference in performance is statistically significant. The only indicator for which CON states did better than non-CON states is postsurgery development of pulmonary embolism, by about four cases per 1,000 patient discharges."

  (Thomas Stratmann and David Wille, "Certificate-Of-Need Laws And Hospital Quality," Mercatus Center At George Mason University, 9/27/16)

- **CON Laws Are Associated With Higher Death Rates:** "The average 30-day mortality rate for patients with pneu-monia, heart failure, and heart attack who were discharged from hospitals in CON states was 2.5 – 5 percent higher than that of their non-CON-state counterparts. The largest difference is in deaths following a serious postsurgery complica-tion, with an average of six more deaths per 1,000 patient discharges in CON states."

  (Thomas Stratmann and David Wille, "Certificate-Of-Need Laws And Hospital Quality," Mercatus Center At George Mason University, 9/27/16)

An Analysis Of COPN Data From The Virginia Department Of Health Shows Virginia's COPN Law Does Little To Ensure Access To Care For Indigent And Uninsured. Only half of the certificates of public need that have been granted since 1999 came with a charity care contingency and of the certificates contingent on charity care the average amount required was only 2.9%.

(Analysis Of COPN Monthly Report, Virginia Department Of Health, Conducted October 2016)

Further, COPN Denial Statistics Indicate Virginia's COPN Law Jeopardizes The Availability Of Essential Health Services By Blocking Private Investment To Expand Health Care Facilities And Purchase New Equipment.

- $1,362,466,203: Value of COPN Requests Denied 1999-2016
- $44,576,735: Value of COPN Requests Denied in 2015

  (Analysis Of COPN Reports, Virginia Department Of Health, Conducted October 2016)

COPN does not regulate those services typically used by consumers - such as primary care - but instead focuses on more complex, specialized services.

- Originally established in 1973, the Virginia COPN was amended in 1999 to remove equipment purchases and replacement from the regulatory scheme. Deregulation of hospital and ambulatory surgical centers was repealed by the legislature in 1992.

  ("Report Of The Special Joint Subcommittee Studying Certificate Of Public Need – Senate Document No. 6," Commonwealth Of Virginia, 2001)

- McGuire Woods Consulting's Tyler Bishop: The State Medical Facility Plan regulations for neonatal intensive care services have not been "substantially updated in 20 years."

  (Virginia Depart-ment Of Health, www.vdh.virginia.gov, Accessed 10/12/16)

On average, over 80% of COPN applications are approved.

- Virginia's COPN law regulates: Any facility licensed as a hospital, nursing homes, intermediate care facilities and Facilities for individuals with intellectual disability. These are NOT health care facilities exclusively for complex, specialized services.
- A Northern Virginia physician spent $175,000 in legal and other fees to acquire an MRI machine for his office in 2003. The same physician also challenged the constitutionality of Virginia's COPN program claiming it prohibited him from expanding his practice in Virginia and was designed to protect established healthcare providers.

  (Lisa Schencker, "Federal Appeals Court Upholds Virginia's Certificate-Of-Need Law," Modern Healthcare, 1/22/16)
- The process is more contentious than the approval rate may indicate because many systems know their applications will be opposed so they never apply or do not finish their process. If you counted those, the "approval" rate would be much lower.
- Current COPN laws make the application and approval process extraordinarily difficult and costly to navigate.
- According to the Virginia Department of Health log: Only 51% of all COPN applications submitted finished the process and were ultimately approved and granted a certificate of need.
- Of the 2285 COPN applications started, 1152 certificate numbers are provided, 206 applications are listed as denied, 4 applications were found to not require a certificate of public need and the remaining 931 never completed the process. (accessed 12.20.17)

  http://www.vdh.virginia.gov/licensure-and-certification/the-certificate-of-public-need-program/

Other states rely on policy levers - such as indigent care funds, robust public hospital systems, broader Medicaid eligibility, and Medicaid expansion - to maintain balance in their health care systems.

- States without CON programs, including Arizona, California, Colorado, Minnesota, New Mexico, Pennsylvania and Texas all have state programs to provide indigent care.

  (Commonwealth Of Virginia, dls.virginia.gov Accessed 10/18/16)

Hospitals treat all patients regardless of their ability to pay 24/7/365

Higher percentage of Medicare and Medicaid patients (74% at rural hospitals, 60% at urban)

Hospitals provided nearly $600 million in charity care (2014), a 57% increase since 2001

COPN helps address market inequities and helps address below-cost reimbursements for Medicare and Medicaid patients by offsetting those losses with payments from commercially insured patients.

- Virginia received $95,210,561 in disproportionate share hospital (DSH) allotments in FY 2016.

  (The Henry J. Kaiser Family Foundation, kff.org, Accessed 12/20/17)

- In FY 2015, Virginia received $94,925,784 in federal DSH allotments.

  (The Henry J. Kaiser Family Foundation, kff.org, Accessed 12/20/17)

- Legislation passed by the Virginia House of Delegates protects Medicare and Medicaid funding for rural hospitals by reaffirming the authority of the Health Commissioner to designate rural hospitals, develop a rural health plan and applying for additional Medicare and Medicaid funding.

  (Virginia General Assembly, lis.virginia.gov, Accessed 10/18/16)

- While Virginia hospitals reported $1.43 billion in community benefits in FY 2015, only $584.9 million – or 40.9 percent – was for "financial assistance."

  ("Caring For Our Communities: 2017 Annual Report On Community Benefit," Virginia Hospital & Healthcare Association,)

- The remaining 59.1 percent went towards Medicaid shortfall, subsidized health services, means-tested government programs and "community programs and services."

  ("Caring For Our Communities: 2017 Annual Report On Community Benefit," Virginia Hospital & Healthcare Association)

- FTC: "competition is the most reliable and effective mechanism for controlling healthcare costs while preserving quality of care, including in rural areas facing economic challenges."

  ("Federal Trade Commission Staff Submission To The Southwest Virginia Health Authority And Virginia Department Of Health Regarding Cooperative Agreement Application Of Mountain States Health Alliance And Wellmont Health System," Federal Trade Commission, 9/30/16)

- FTC: "competition is no less important in rural and economically-stressed communities than it is in urban and more prosperous ones."

  ("Federal Trade Commission Staff Submission To The Southwest Virginia Health Authority And Virginia Department Of Health Regarding Cooperative Agreement Application Of Mountain States Health Alliance And Wellmont Health System," Federal Trade Commission, 9/30/16)

- A study conducted by the Lewin Group found "no evidence" safety-net hospitals "are financially stronger in CON than other states."

  ("An Evaluation Of Illinois' Certificate Of Need Program," The Lewin Group, 9/15/07)

- The study noted other state programs can assist in funding safety-net hospitals outside of a CON program.

  ("An Evaluation Of Illinois' Certificate Of Need Program," The Lewin Group, 9/15/07)

COPN helps hospitals maintain a full line of essential health services, some profitable (such as imaging) and others not (such as burn care and obstetrics).

Deregulating these profitable services and siphoning away commercially insured patients would make it harder for hospitals to continue providing less profitable services.

- Only 40% of hospitals with a maternity ward have a NICU and are able to provide basic NICU care & emergency services.

Without COPN, many providers would not be required to provide charity care.

The granting of a COPN is conditioned on the provision of charity care to the indigent and uninsured.

By tying project approval to charity care, the state is assured that there are providers located within all geographic areas that will treat indigent and uninsured patients.

- Even with COPN, many providers aren't required to provide charity care - only half of the certificates of public need that have been granted since 1999 (as of August 2016) came with a charity care contingency and of the certificates contingent on charity care the average amount required was only 2.9%

  http://www.vdh.virginia.gov/licensure-and-certification/the-certificate-of-public-need-program/

- The Virginia Hospital Association claims that hospitals provided nearly $600 million in charity care (2014), and that number was a 57% increase since 2001 - a fraction of the $1.43 billion claim.

- Only half of the certificates of public need that have been granted since 1999 (as of August 2016) came with a charity care contingency and of the certificates contingent on charity care the average amount required was only 2.9%.

  http://www.vdh.virginia.gov/licensure-and-certification/the-certificate-of-public-need-program/

- "While certificates of need are neither controlling costs nor increasing charity care, they continue to have lasting effects on the provision of health care services both in Virginia and in the other states that continue to enforce them. However, these effects have largely come in the form of decreased availability of services and lower hospital capacity."

  (Christopher Koopman and Thomas Stratmann, "Certificate-Of-Need Laws: Implications For Virginia," Mercatus Center, George Mason University, 2/24/15)

- "While there is little evidence to support the claim that certificates of need are an effective cost-control measure, many states continue to justify these programs using the rationale that they increase the provision of health care for the poor. To achieve this, 14 states – including Virginia – include some requirement for charity care within their respective CON programs. This is what economists have come to refer to as a 'cross subsidy.'"

  (Christopher Koopman and Thomas Stratmann, "Certificate-Of-Need Laws: Implications For Virginia," Mercatus Center, George Mason University, 2/24/15)

- "According to Virginia health information, there are only .54 Hospital beds per 1,000 residents in Loudoun County."

  (Matthew Glans, "Inova Benefits From CON Laws Hindering Competitors," The Fairfax Times, 9/16/15)

- "Virginia faces shortages in hospital capacity, with a relatively high hospital occupancy rate (70.5 Per 100 staffed beds) and below-average per capita rates of emergency departments (ed), staffed inpatient beds, and psychiatric care beds."

  (American College Of Emergency Physicians, www.emreportcard.org, Accessed 10/13/16)

- The report found Virginia had only 22.5 psychiatric care beds per 100,000 residents in 2014, a decrease from 25.1 beds in 2009.

  (American College Of Emergency Physicians, www.emreportcard.org, Accessed 10/13/16)

- "Virginia faces shortages in hospital capacity, with a relatively high hospital occupancy rate (70.5 Per 100 staffed beds) and below-average per capita rates of emergency departments (ed), staffed inpatient beds, and psychiatric care beds."

  (American College Of Emergency Physicians, www.emreportcard.org, Accessed 10/13/16)

- Over 80 rural hospitals have closed since 2010.

  (Ayla Ellison, "A State-By-State Breakdown Of 80 Rural Hospital Closures," Becker's Hospital Review, 4/19/16)

- Rural hospitals face challenges including "disproportionate share payment cuts and uneven adoption of Medicaid expansion."

  (Ayla Ellison, "The Rural Hospital Closure Crisis: 15 Key Findings And Trends," Becker's Hospital Review, 2/11/16)

- Between 1995 and 2005, the U.S. experienced a 5% decline in the number of community hospitals.

  ("The State Of Health Care In Pennsylvania," Pennsylvania Health Care Cost Containment Council, October 2007)

- Despite the decrease of General Acute Care Hospitals from 206 to 177 in Pennsylvania, the number of Long-Term Acute Care Hospitals increased from 4 to 24 and the number of Ambulatory Surgery Centers increased from 44 to 177.

  ("The State Of Health Care In Pennsylvania," Pennsylvania Health Care Cost Containment Council, October 2007)

- Regarding the decrease from 206 to 177: "In Pennsylvania, not all of the decline can be attributed to hospital closures. Eight GAC hospitals closed, 22 merged with another GAC, and four converted into another type of facility."

  ("The State Of Health Care In Pennsylvania," Pennsylvania Health Care Cost Containment Council, October 2007)

- New public policy and marketplace incentives are encouraging health systems to promote prevention and keep patients with chronic diseases out of the hospital. The shift to outpatient care, underway for decades, is accelerating in every state.

- 4 years following repeal in Ohio the state saw: 6 new open heart surgery units, 54 new imaging facilities, 75 new ambulatory surgery centers, 312 new inpatient psychiatric beds, 430 new rehabilitation beds and 847 new dialysis stations.

Impacts of deregulation can be seen in other states such as Ohio and Pennsylvania, which deregulated in 1995 and 1997, respectively.

Fifteen (15) hospitals located in low-income areas closed in the four years following repeal in Ohio.

The number of hospitals declined from 206 to 177 in the 10 years following repeal in Pennsylvania.

Ohio saw a 563% increase in ASCs (from 27 to 179) and a 748% increase in imaging centers (from 27 to 229) following repeal.

In Pennsylvania, the number of ASCs quadrupled from 44 to 177.

Piecemeal deregulation or repeal will lead to a proliferation of ambulatory surgery and imaging centers, and costs, and force hospitals to either shutter unprofitable, but essential, health services or shift a great portion of indigent care costs onto employers and commercially insured patients.

- UNC Research shows that of the 76 Rural Hospital Closures January 2010 – Present, 72% of the Rural Hospital Closures have been in states with CON laws (55 total) and only 28% of the Rural Hospital closures since 2010 have been in states without CON regulation.
- The implementation of the CMS Flex Program in 1997 allowed patients that had been driving to cities for care to receive care closer to home and contributed to health care closures in urban areas.

Federal And State Leaders Are Already Addressing and Emphasizing the Importance of Quality Health Care. Seeing The Need to Improve Care and Completion, Virginia Hospitals, Doctors, Officials and Other Stakeholders Developed A Plan Years Ago to Deregulate the Copn Program Without Negatively Impacting the Poor and Indigent Population. and, Under the Leadership of President Obama, Federal, State and Private Stakeholders are Working To Protect and Expand Access to Quality Care.

A 1993 Paper Asserted That Although COPN Regulations Are Supposed To Prevent Duplication Of Services And Limit Costs, Actual Practice Has Restricted Competition And Comprised Care. "For almost twenty years certificate-of-need (CON) regulations have protected existing hospitals from unrestricted competition in services. Although the explicit pur-pose of CON regulation was to prevent hospitals from duplicat-ing services and investing in costly excess capacity, it has been unsuccessful in accomplishing this goal."

(ES Campbell and GM Fournier, "Certificate-Of-Need Deregulation And Indigent Hospital Care," Journal Of Health Politics, Policy And Law, 1993)

A few years later, Virginia established the Joint Commission on Health Care to develop a plan to deregulate the COPN program.

(Virginia Hospital & Healthcare Association, COPN & Responsible Regulation, 11/1/04)

In 2000, The Joint Commission On Health Care Released A Three-Tier COPN Program Phase-Out Plan, Supported By All Stakeholders, That Did Not Jeopardize Access To Care For The Indigent An Uninsured, Established Higher Standards For Licensure And Oversight And Provided Strong Quality Protections. "Support for COPN deregulation rose decidedly in the late 90s and became prevalent as niche providers tried to win legislative exemptions to the COPN regulation. As debate heated up in the General Assembly over eradication of the program, a study was commissioned to determine the best way to eliminate the program for Virginia. The Joint Commission on Health Care (JCHC) was directed to come up with a plan to deregulate the COPN program. … The Joint Commission on Health Care came up with a three-tier phase-out of the COPN program that was supported by all the key stake-holders. … There are important reasons why this deregulation plan is supported by health care providers and policymakers."

(Virginia Hospital & Healthcare Association, COPN & Responsible Regulation, 11/1/04)

The Private Sector Has A Long Record Emphasizing Quality Over Quantity In Healthcare. "This shift to value-based payments had already been taking place in the private sec-tor before the ACA. About 20 percent of provider payments by Blue Cross insurers are through contracts that try to prioritize quality over quantity, their trade association reported last summer. Aetna says 28 percent of its reimbursements are now in valued-based contracts, and it expects that rate to jump to 75 percent by 2020."

(Jason Millman, "The Obama Administration Wants To Dramatically Change How Doctors Are Paid, " The Washington Post, 1/26/15)

A Public-Private Program In Delaware Is Expected To Save More Than $1 Billion Through 2020 By Rewarding Quality Care. "Delaware has embarked on a public-private plan that aims to save more than $1 billion on cost of care through 2020, in part by shifting at least 80% of health-care spending to payment models that reward care considered high-quality and efficient."

(Stephanie Armour, "Obama Promotes Health-Care Payments Based On Outcome, Not Volume," The Wall Street Journal, 3/25/15)

A Recent Mercatus Study Also Underscored "There Is No Scholarly Consensus That CON Laws Improve Hospital Quality."

(Thomas Stratmann and David Wille, "Certificate-Of-Need Laws And Hospital Quality," Mercatus Center At George Mason University, 9/27/16)