DOES VA MEDICAID EXPANSION CHANGE THE LANDSCAPE FOR COPN?

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INTRODUCTION

On June 1, 2018, Bon Secours, a Virginia health system, filed a letter of intent with the Virginia Department of Health (VDH) for a certificate of public need (COPN).[1] The health system wanted to establish a new hospital in the North Suffolk area of Hampton Roads.[2] Just six days later on June 7, 2018, Sentara Healthcare filed a similar letter of intent, detailing its plans to open a hospital at one of its medical center locations in Suffolk.[3] However, because of the similarities between the two proposals, in both services offered and location, the applications ultimately were pitted against each other—the Commissioner would only approve of one project going forward.[4] In this instance, Bon Secours won and Sentara conceded, stating, "[a]n opportunity to develop a hospital may arise in the future and we will take appropriate action at that time."[5]

This competition between medical entities is how COPN frequently operates in the Commonwealth of Virginia—the COPN program cultivates turf wars between health care entities attempting to enter the market or expand.[6] Originally enacted in 1973, Virginia's COPN

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[1] Elizabeth Simpson, *Sentara Announces Plan for a 24-Bed Hospital in Suffolk, Similar in Size to Bon Secours' Project*, VIRGINIAN-PILOT (June 18, 2018), https://pilotonline.com/news/local/health/article_70d5c492-7323-11e8-ab8e-d397003e2b17.html.

[2] *See id.*

[3] *See id.*

[4] *See id.; see also* Alex Perry, *Two Proposals, One Recommended*, SUFFOLK NEWS-HERALD (Oct. 22, 2018), https://www.suffolknewsherald.com/2018/10/22/two-proposals-one-recommended/.

[5] Press Release, Steve Julian, Sentara in Suffolk COPN Update, Sentara (Nov. 7, 2018), https://www.sentara.com/hampton-roads-virginia/support-sentara-in-suffolk.aspx.

[6] *See generally* VA. CODE ANN. § 32.1-102.3 (2019).

statute aimed "to promote comprehensive health planning in order to help meet the health needs of the public" and "to assist in promoting the highest quality of health care at the lowest possible cost."[7] Since its enactment, however, there has been a constant debate over whether the program is effective in achieving these goals.

Opponents to COPN argue that the regulations are overly restrictive and essentially eliminate a free market system for health care.[8] They argue that Virginia's COPN program limits competition, stifles innovation, and ultimately drives up health care costs while reducing access.[9] On the other hand, COPN supporters point out that health care, which is subject to a multitude of regulations, does not operate as a free market.[10] Thus, supporters suggest that Virginia's COPN program is a positive influence on health care because it incentivizes medical entities to provide charity care—often a condition of certificate approval—and protects hospitals and health systems from the burdens of uncompensated care, while also keeping costs low and access

[7] *See* Certificate of Public Need Workgroup, Final Report, Va. Dep't of Health 27 (Dec. 4, 2015), http://www.vdh.virginia.gov/content/uploads/sites/96/2017/10/Certificate-of-Public-Need-Workgroup-Final-Report.pdf.

[8] *See, e.g.*, Matthew D. Mitchell, *Certificate-of-Need Laws: Are They Achieving Their Goals,* Mercatus on Policy, MERCATUS CENTER (2017), https://www.mercatus.org/system/files/mercatus-mitchell-con-qa-mop-v1.pdf.

[9] *See, e.g., id.*

[10] *See, e.g.*, R. Brent Rawlings, *The Importance of COPN: Serving the Public Need, Supporting Virginia's Health Care System*, Focus, Va. Hospital & Healthcare Ass'n (2016), http://www.vhha.com/communications/wp-content/uploads/sites/16/2016/02/VHHA-January-February-FOCUS-Publication.pdf.

high.[11] With such polarizing views, Virginia's General Assembly has persistently grappled with the COPN program's future—should the program be left alone, reformed, or scrapped entirely?[12]

While debates on the COPN program have persisted for decades, the landscape of health care recently changed in Virginia. On May 30, 2018, Virginia's Senate voted to expand Medicaid coverage under the Affordable Care Act and, therefore, extend Medicaid eligibility to an additional 400,000 Virginians.[13] On November 1, 2018, enrollment under the expanded Medicaid began and by the end of the month over 100,000 Virginians enrolled through the government program; this enrollment was just the start, however, and projections estimate that 375,000 low-income residents will enroll in Medicaid by July 2020.[14] Although many people remain uninsured within the state, the Medicaid expansion has significantly increased the number of insured Virginians, thereby lessening the burdens of uncompensated care on hospitals and health systems.[15]

This paper discusses the future of Virginia's COPN program after Medicaid expansion. Following the launch of Medicaid expansion, many people wonder whether a smaller uncompensated care burden on hospitals and health systems will create more opportunities for a

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[11] *See, e.g., id.*

[12] *See* Final Report, *supra* note 7, at 11-13 (discussing the various studies and recommendations aimed at reforming or repealing Virginia's COPN program).

[13] Abby Goodnough, *After Years of Trying, Virginia Finally Will Expand Medicaid*, N.Y. TIMES (May 30, 2018), https://www.nytimes.com/2018/05/30/health/medicaid-expansion-virginia.html.

[14] Laura Vozzella, *Enrollment in Virginia's Expanded Medicaid Program is Beating Projections*, WASH. POST (Nov. 29, 2018), https://www.washingtonpost.com/local/virginia-politics/enrollment-in-virginias-expanded-medicaid-program-is-beating-projections/2018/11/29/a62bfce6-f281-11e8-aeea-b85fd44449f5_story.html?noredirect=on&utm_term=.a20dc3b74cd8.

[15] *See id.*

free market to exist in Virginia's health care regime, thereby compelling the repeal of Virginia's COPN program. However, this paper ultimately argues that such repeal would be premature, as hospitals and health systems still face uncompensated care burdens from the over 300,000 uninsured Virginians and lower reimbursement rates from Medicaid patients.[16] Instead, the COPN program should reform its charity care requirements to ensure that providers are able to meet the requirement with a greater population of insured Virginians.

The Paper will proceed in five parts. Part I will present the history of COPN, both nationally and in Virginia. Next, Part II will detail Virginia's COPN program and its State Medical Facilities Plan. Part III will discuss the current debate for and against the COPN program. In Part IV, this Paper will discuss the market irregularities that the health care industry faces and how Virginia's COPN program helps insulate hospitals from these market imbalances. Lastly, Part V will focus on the impact that the Medicaid expansion has on the COPN program, focusing particularly on the effects of the program's charity care requirements. This Paper will conclude that Virginia's COPN program should be reformed in light of Medicaid expansion, rather than repealed.

I. THE HISTORY OF COPN

Although Virginia uses the term "certificate of public need," the more common name throughout the United States is "certificate of need" (CON).[17] Currently, more than thirty-five

[16] *See* Katie O'Connor, *About 323,000 Will Remain Uninsured After Medicaid Expansion. Will Virginia's Free Clinics Still Be Able To Meet the Need?*, VA. MERCURY (Aug. 20, 2018), https://www.virginiamercury.com/2018/08/20/about-323000-will-remain-uninsured-after-medicaid-expansion-will-virginias-free-clinics-still-be-able-to-meet-the-need/.

[17] This paper will use "COPN" when referring to Virginia's program. However, all other discussions will use the more common "CON."

U.S. states and territories require some form of CON issuance before a health care entity can construct or expand a facility, offer a new service, or purchase certain equipment.[18] Understanding the history of CON laws provides context behind the rationale for the continuation of such laws today. Accordingly, this Part will present the history of CON laws in the United States and then discuss the origins of COPN in Virginia.

A. History in the United States

During the post-World War II era there was a perceived shortage and maldistribution of hospitals throughout the United States.[19] The Hospital Survey and Construction Act (the "Hill-Burton Act") was enacted in 1946 with the purpose in part "to survey the need for construction of hospitals, and to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people."[20] Essentially, the Hill-Burton Act aimed to promote local hospital planning by providing federal subsidies for hospital construction.[21]

At the same time, there was a concern over the rising costs of healthcare. On July 30, 1965, President Lyndon B. Johnson signed Medicare into law, facilitating health insurance

[18] Certificate of Need State Laws, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx (last visited Apr. 26, 2019).

[19] Lawrence J. Clark, et. al, *The Impact of Hill-Burton: An Analysis of Hospital Bed and Physician Distribution in the United States, 1950-1970*, 18 MED. CARE 532, 532 (May 1980).

[20] Hospital Survey and Construction Act, Pub. L. No. 79-725 § 2, tit. VI, 60 Stat. 1040, 1041-1049 (1946).

[21] *See id.*

coverage for 19 million Americans.[22] However, the initial five years of the Medicare program saw dramatic escalation of overall hospital costs, which became a major federal concern. Milton Roemer, who famously stated, "A built bed is a filled bed," theorized that a direct correlation exists between an oversupply of resources and a demand for those resources when third-party reimbursement is available.[23] Thus, Roemer's theories on oversupply and overutilization shifted the focus of health planning from a solution for hospital shortages to a health care cost-containment mechanism.[24]

Accordingly, policymakers actively supported health planning because it aimed to facilitate needed hospital development, while also mitigating high health care costs associated with oversupply.[25] The first CON statute was enacted in New York in 1966 and required that any hospital or nursing home receive state approval prior to initiating construction.[26] By 1973, twenty states had ratified similar CON laws,[27] and the federal government followed suit, passing

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[22] *See Johnson Signs Medicare Into Law, This Day in History*, HISTORY, https://www.history.com/this-day-in-history/johnson-signs-medicare-into-law (last visited Apr. 26, 2019).

[23] *See* Milton I. Roemer, M.D., *Bed Supply and Hospital Utilization: A Natural Experiment*, J. AM. HOSP. ASS'N at 36 (Nov. 1, 1961).

[24] *See* Emily Whelan Parento, *Certificate of Need in the Post-Affordable Care Act Era*, 105 KY. L.J. 201, 210 (2016-2017).

[25] *See id.* at 211.

[26] *See* Gerard R. Goulet, *Certificate-of-Need Over Hospitals in Rhode Island: A Forty-Year Retrospective*, 15 ROGER WILLIAMS U. L. REV. 127, 129 (Spring 2010) ("The underlying … premise of the regulatory scheme was that the major component of price increases in the health care sector was attributable to the non-payroll cost increases in rent, depreciation, interest, equipment and supplies which accompanied the overcapacity…").

[27] *See* Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143, 1144 (Oct. 1973).

the National Health Planning and Resource Development Act of 1974 (NHPRDA).[28] The Act came partly in response to Medicare and provided significant government funding for health planning activities, but only upon a state's adoption of a CON program. [29] Thus, every state except Louisiana had a CON program by 1980.[30]

The NHPRDA had lofty aims, but was short-lived. During the early 1980s, the political climate fostered deregulation[31] and the NHPRDA was ultimately repealed in 1987.[32] However, most of the states that had enacted CON statutes kept them, and, consequently, regulation shifted from federal regulation to state-based.[33] Today, more than thirty-five U.S. states and territories maintain CON laws, including Virginia.[34]

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[28] National Health Planning and Resource Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975).

[29] *See id.* ("The massive infusion of Federal funds into the existing health care system [that] contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources and consequently has not made possible equal access for everyone to such resources.")

[30] *See* James B. Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 Ind. L. Rev. 1025, 1055 (1986).

[31] *See id.* at 1026 ("With the advent of the Reagan administration in 1980, federal support for certificate of need fell on hard times. The administration entered office with an anti-regulatory platform and a strong interest in using market incentives rather than regulatory controls to restrain the rising costs of health programs.").

[32]Evan M. Melhado, *Health Planning in the United States and the Decline of Public-interest Policymaking*, 84 MILBANK Q. 359, 439 (2006).

[33] *See id.* ("Federal legislation that kept the [NHPRDA] alive with lower funding after September 30, 1982, included provisions that freed the states to depart from federal requirements regarding CON. The outright repeal … left the states without any federal funding for CON regulation or federal requirements for its conduct.").

[34] *See* Certificate of Need State Laws, *supra* note 18.

B. History in Virginia

In 1971, a Special Session of the General Assembly passed a joint resolution to establish a "Commission to study prepaid health care plans and costs of medical, surgical and hospital services and insurance."[35] The study resulted in various recommendations and the Virginia legislature considered two different options: (1) establish an independent health services cost review commission to set rates for all payors, including Medicaid and Medicare or (2) enact a COPN program.[36] The latter went forward and Virginia enacted its COPN statute on July 1, 1973, just one year prior to the enactment of the NHPRDA.

Virginia's COPN statute required owners of health care facilities to obtain state approval prior to undertaking "(1) a capital expenditure in excess of $150,000, (2) an alteration in bed capacity, or (3) a change in service."[37] Through its implementation, the Virginia legislature hoped to see a decrease in the cost of health care for consumers and a better distribution of health care facilities and services. The Virginia program received full designation for complying with the federal guidelines of the NHPRDA, which allowed Virginia to receive approximately $35 million annually in federal assistance.[38] When the NHPRDA was later repealed, Virginia began

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[35] *See* Certificate of Need in Virginia, JOINT LEGIS. AUDIT & REV. COMMISSION, VA. GEN. ASSEMBLY at 4 (Aug. 13, 1979), http://jlarc.virginia.gov/pdfs/reports/Rpt21.pdf.

[36] John N. Simpson, *Health Care: History of the Certificate of Need*, RICHMOND TIMES-DISPATCH (July 25, 2015), https://www.richmond.com/opinion/their-opinion/guest-columnists/health-care-history-of-the-certificate-of-need/article_9b2f5ceb-9341-547b-a511-2a4fee9d2408.html.

[37] *See* Certificate of Need in Virginia, *supra* note 35, at I.

[38] *See id.* at 1, 6.

studying the effectiveness of the COPN statute, thus generating numerous debates and recommendations.[39]

Since the 1980s, Virginia's COPN regulations have undergone frequent studies, which have resulted in varied recommendations—suggestions for the expansion of certain regulations, the deregulation of certain facilities and services, and full repeal.[40] However, after over forty years with only minor legislative changes, Virginia's COPN program remains in effect.[41]

II. VIRGINIA'S COPN PROGRAM

In Virginia, prior to establishing or expanding certain types of health care projects, the VDH Commissioner must determine that a public need exists for such project.[42] This determination is largely based on the State Medical Facilities Plan (SMFP).[43] This Part will first review Virginia's COPN program, focusing largely on the authority established under the COPN statute and the factors considered in granting a certificate; next, this Part will discuss the role of the SMFP.

A. COPN—Statutory Authority, Aims, and Conditions

Virginia's COPN program is one of the more comprehensive health planning programs in the United States, regulating medical care facilities, such as general hospitals, ambulatory surgical centers, and psychiatric care facilities, medical imaging technologies, and numerous

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[39] *See* Final Report, *supra* note 7, at 12-13.

[40] See *id*. The Work Group looks at the different studies from the 1980s including: The Baliles Commission, the 1996 Joint Commission on Health Care Study, the 1998 Special Joint Subcommittee study, and the 2000 Joint Commission on Health Care Deregulation Plan. *See id.*

[41] *See* VA. CODE ANN. § 32.1-102.3 (2019).

[42] *See id.*

[43] *See id.* § 32.1-102.3(B)(3) (2019).

other facilities and services.[44] Accordingly, health care entities wishing to expand or develop a facility or service likely must apply for a COPN. While this Paper does not detail Virginia's COPN application process, it should be noted that applying for a certificate in Virginia is a burdensome process. The application itself is very extensive, requiring months of preparation, a pile of paperwork, and often necessitating legal assistance.[45] There is also a fee for applying equal to 1 percent of the project's value, with a maximum cap of $20,000.[46] Additionally, the application process may become contentious as other parties may contest facts presented in an application[47] or submit competing applications.[48]

Although Virginia's COPN program is comprehensive and burdensome for the parties involved, the goals of the program attempt to justify these obstacles by improving health care throughout the state. There are three main aims of the COPN program: (1) to improve the patient's care experience in terms of quality and satisfaction; (2) to improve the health of all

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[44] *See* Matthew D. Mitchell, *Virginia's Certificate-of-Public-Need Law: A Comparison with Other States*, MERCATUS CENTER, GEORGE MASON UNIVERSITY at 4 (Apr. 18, 2018), https://www.mercatus.org/system/files/mitchell_-_testimony_-_virginias_certificate-of-public-need_law_a_comparison_with_other_states_-_v1.pdf.

[45] *See, e.g.*, Jonathan M. Joseph, *A Primer on Virginia's Certificate of Public Need Process,* Christian & Barton, LLP (2015) http://www.cblaw.com/uploads/files/Health-Care/COPN%20Virginia_ 2015.pdf (last visited Apr. 26, 2019).

[46] 12 VA. ADMIN. CODE § 5-220-10 (defining "application fees").

[47] *Id.* at § 5-220-240.

[48] *Id.* at § 5-220-220.

people in Virginia; and (3) to reduce the cost of health care.[49] Additionally, through conditions placed on approved certificates, the COPN program expands charity care within the state.[50]

Section 32.1-102.3 of the Virginia Code establishes the COPN program, stating, "No person shall commence any project without first obtaining a certificate issued by the Commissioner. No certificate may be issued unless the Commissioner has determined that a public need for the project has been demonstrated."[51] Through the statute, the VDH Commissioner is authorized to approve or deny certification for new projects.[52] The statute also details eight considerations for the Commissioner to utilize in determining whether to grant a certificate. [53] In addition to considering guidance established from the SMFP, the Commissioner

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[49] *See* Final Report, *supra* note 7 at 27; *see also* The IHI Triple Aim, INST. FOR HEALTHCARE IMPROVEMENT, http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx (last visited Apr. 26, 2016).

[50] *See* VA. CODE ANN. §§ 32.1-102.2(C), 32.1-102.4(F) (2019); 12 VA. ADMIN. CODE §§ 5-220-270(A), 5-220-420(A) (2019).

[51] *See* VA. CODE ANN. § 32.1-102.3.

[52] *See id.*

[53] *See id.* § 32.1-102.3(B). Although the eight factors are lengthy, it is important to consider these factors, as they provide more context on the purpose and function of Virginia's COPN program. *Id.* The eight factors include:

> (1) The extent to which the proposed service or facility will provide or increase access to needed services for residents of the area to be served, and the effects that the proposed service or facility will have on access to needed services in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care; (2) The extent to which the project will meet the needs of the residents of the area to be served, as demonstrated by each of the following: (i) the level of community support for the project demonstrated by citizens, businesses, and governmental leaders representing the area to be served; (ii) the availability of reasonable alternatives to the proposed service or facility that would meet the needs of the population in a less costly, more efficient, or more effective manner; (iii) any recommendation or report of the regional health planning agency regarding an application for a certificate that is required to be submitted to the Commissioner pursuant to subsection B of § 32.1-102.6; (iv) any

is directed to consider other factors, such as the extent to which a project ensures quality of services, increases health care access, reduces health care costs, and aids in providing charity care.[54] Thus, the Commissioner's considerations closely align with the overarching goals of Virginia's COPN program.[55]

As a condition for project approval, the COPN program often requires hospitals and other health care providers provide charity care. Under the COPN program, the Commissioner is authorized to condition the approval of a certificate upon agreement by the applicant to provide

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> costs and benefits of the project; (v) the financial accessibility of the project to the residents of the area to be served, including indigent residents; and (vi) at the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a project; (3) The extent to which the application is consistent with the State Medical Facilities Plan; (4) The extent to which the proposed service or facility fosters institutional competition that benefits the area to be served while improving access to essential health care services for all persons in the area to be served; (5) The relationship of the project to the existing health care system of the area to be served, including the utilization and efficiency of existing services or facilities; (6) The feasibility of the project, including the financial benefits of the project to the applicant, the cost of construction, the availability of financial and human resources, and the cost of capital; (7) The extent to which the project provides improvements or innovations in the financing and delivery of health services, as demonstrated by: (i) the introduction of new technology that promotes quality, cost effectiveness, or both in the delivery of health care services; (ii) the potential for provision of services on an outpatient basis; (iii) any cooperative efforts to meet regional health care needs; and (iv) at the discretion of the Commissioner, any other factors as may be appropriate; and (8) In the case of a project proposed by or affecting a teaching hospital associated with a public institution of higher education or a medical school in the area to be served, (i) the unique research, training, and clinical mission of the teaching hospital or medical school, and (ii) any contribution the teaching hospital or medical school may provide in the delivery, innovation, and improvement of health care for citizens of the Commonwealth, including indigent or underserved populations. *Id.*

[54] *Id.*

[55] *See supra* note 49 and accompanying text.

medical care to indigents at a reduced rate.[56] With this condition, the certificate holder must provide documentation to VDH exhibiting that the charity care conditions were met.[57] However, VDH can also approve of alternative means of satisfying the charity care requirements if a certificate holder is unable or fails to meet the conditions.[58] If the certificate holder fails to satisfy the conditions of compliance all together, such person will be subject to a civil penalty of up to $100 per violation per day until the date of compliance.[59] Certificates requiring charity care conditions occur frequently for all types of projects and services.[60]

B. The State Medical Facilities Plan

The SMFP is a planning document that is adopted by the Board of Health.[61] Under the Virginia Code, the Board of Health must appoint and convene an SMFP task force at least once every two years.[62] The task force must include no fewer than fifteen individuals consisting of VDH representatives, Division of COPN representatives, regional health planning agencies representatives, health care provider representatives, academic medical community

[56] *See* VA. CODE ANN. §§ 32.1-102.2(C), 32.1-102.4(F) (2019); 12 VA. ADMIN. CODE §§ 5-220-270(A), 5-220-420(A) (2019).

[57] VA. CODE ANN. § 32.1-102.4(F).

[58] *Id.*

[59] *Id.*

[60] *See Certificate of Public Need Program, Monthly Activity Report*, VA. DEP'T OF HEALTH (April 2019) http://www.vdh.virginia.gov/content/uploads/sites/96/2019/04/COPN-Monthly-Report-April-2019.xlsx.

[61] *See* VA. CODE ANN. § 32.1-102.1.

[62] *See id.* § 32.1-102.2:1.

representatives, medical technology experts, and health insurers.[63] The task force is instructed to review the current SMFP and update or validate the regulations therein at least every four years.[64]

The SMFP must include "(i) methodologies for projecting need for medical care facility beds and services; (ii) statistical information on the availability of medical care facilities and services; and (iii) procedures, criteria and standards for review of applications for projects for medical care facilities and services."[65] Ultimately the SMFP serves as a guide for health care facilities hoping to develop new facilities or services or expand existing ones.

The SMFP consists of a group of regulations in the Virginia Administrative Code. Notably, the SMFP lists five Guiding Principles in the Development of Project Review Criteria and Standards.[66] These Guiding Principles ensure that the project is meeting the aims of the state's COPN program. The Guiding Principles state:

1. The COPN program is based on the understanding that excess capacity or underutilization of medical facilities are detrimental to both cost effectiveness and quality of medical services in Virginia.
2. The COPN programs seeks the geographical distribution of medical facilities and to promote the availability and accessibility of proven technologies.
3. The COPN program seeks to promote the development and maintenance of services and access to those services by every person who needs them without respect to their ability to pay.
4. The COPN program seeks to encourage the conversion of facilities to new and efficient uses and the reallocation of resources to meet evolving community needs.

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[63] *Id.*

[64] *Id.*

[65] *Id.* § 32.1-102.1.

[66] 12 VA. ADMIN. CODE § 5-230-30 (2019).

5. The COPN program discourages the proliferation of services that would undermine the ability of essential community providers to maintain their financial viability.[67]

Beyond the guiding principles, the SMFP also contains review standards and criteria for approving a COPN project. For instance, regulations regarding the addition or expansion of PET services are included in the SMFP.[68] The first criterion needed for project approval is a showing of need; thus, the SMFP provides that "proposals for mobile PET or PET/CT scanners should demonstrate that, for the relevant reporting period, at least 230 PET or PET/CT appropriate patients were seen and that the proposed mobile unit will not significantly reduce the utilization of existing providers in the health planning district."[69] Through this language, it is clear that projects will only be approved when an actual need is evidenced in the area. The subsequent regulations then set staffing[70] and travel time[71] parameters for the PET scanner project. This example of a PET scanner is only one of many listed medical services or projects detailed in the SMFP.

III. THE CURRENT DEBATE

This paper does not seek to establish whether or not the COPN program is successful in achieving its three main aims—improving patient care, improving health of all Virginians, and reducing costs—as these arguments have been discussed extensively by industry players and

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[67] *Id.*

[68] *Id.* § 5-230-230.

[69] *Id.*

[70] *Id.* § 5-230-240.

[71] *Id.* § 5-230-250.

academics. However, to understand the current climate surrounding the COPN program, it is important to understand the arguments on each side.

While Virginia's COPN program has lofty aims, opponents argue that the regulations are ineffective and produce contrary results—increased costs with decreased access.[72] Skeptics contend that the COPN program continues due to political factors and the special interests of key health care players, such as large hospitals.[73] In her article on CON, Professor Emily Whelan Parento discussed this overriding cynicism towards CON programs, stating: "Among academic scholars, it is rare to find ardent, or even lukewarm defenders of CON programs. Although the arguments for the effectiveness of CON have not been conclusively disproven, the prevailing view reflects considerable skepticism about the ability of CON programs to achieve any of their intended aims."[74] Thus, to better understand the current debate over COPN, it is imperative to discuss these arguments over its potential shortcomings.

A. Does COPN Improve Patient Care?

The first goal of the COPN program is to improve patient care, which essentially aims to promote high quality health care. COPN supporters argue that procedural volume is linked to better outcomes.[75] In other words, as providers and facilities treat the same conditions or perform

[72] *See, e.g.*, Mitchell, *supra* note 8.

[73] *See* Matthew Mitchell & Steven Monaghan, *Virginia Policy Puts Special Interests Above Patients*, WASH. POST (Oct. 17, 2017), https://www.washingtonpost.com/blogs/all-opinions-are-local/wp/2017/10/17/virginia-policy-puts-special-interests-above-patients/?utm_term=.afbd625e47a2.

[74] *See* Whelan Parento, *supra* note 24, at 218-19.

[75] *See, e.g.*, *id.* at 222 (citing Margaret Gillingham & Kathleen Galbraith, *The Role of Certificate of Need Legislation: A Survey*, 19 J. PUB. BUDGETING, ACCT'G & FIN. MGMT. 372 (2007)).

the same procedures, they gain more experience and become more proficient, resulting in higher quality care.[76] This rationale has been largely upheld by the Virginia court system in cases where the VDH Commissioner relies on quality measures as a factor in determining whether to approve or deny certification.[77] In a 2000 Supreme Court of Virginia case, the Court upheld the Commissioner's decision to deny certification because "the establishment of an additional liver transplant facility at Sentara 'may erode the quality of other transplant centers by reducing the volume of liver transplants at the other centers.'"[78] Similarly, in 2014 the Virginia Court of Appeals upheld the Commissioner's decision to deny approval of a second neonatal intensive care unit when such denial was based in part on the Commissioner's concern that "sufficient volume would not exist to support proficiency and quality" at both facilities.[79]

On the other hand, opponents to COPN programs argue that the lack of competition inherent in the regulatory scheme ultimately lowers quality and patient satisfaction. In contrast to the volume-outcome quality link suggested by COPN supporters, opponents argue that the lack of competition provides shelter for the weaker providers without encouraging improvement; the

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[76] *See id.*; *see also* Martin Gaynor et. al, *The Volume-Outcome Effect, Scale Economies, and Learning-by-Doing*, 95 AMERICAN ECON. REV. 243, 243 (2005).

[77] It should be noted that the state courts give deference to the Commissioner's decision. *See Tidewater Psychiatric, Inc. v. Buttery*, 8 Va. App. 380, 386 ("The standard of review in COPN cases, generally is 'arbitrary and capricious.' … [W]hen an agency is acting within its statutory authority and is applying the basic law delegating that authority in rendering the decision, the issues are legal issues that fall within the specialized competence of the health commissioner, and the court should give deference to the commissioner's decisions unless they were 'arbitrary and capricious.'").

[78] *See* State Health Comm'r v. Sentara Norfolk Gen. Hosp., 260 Va. 267, 270 (Va. 2000).

[79] *See* Lewis-Gale Med. Ctr., LLC v. Romero, No. 1289-13-3, 2014 Va. App. LEXIS 158, *38-39 (Va. App., Apr. 29, 2014).

restrictions placed on market entry also limit high-quality providers from being challenged by competitors and improving further.[80] In a study produced by the Mercatus Center[81] at George Mason University, statistical findings indicated that rates for pneumonia, heart failure, and heart attacks were lower in hospitals located in states that did not have a CON program.[82] However, there are issues with studies that attempt to connect CON laws with quality—measuring quality based on the correlation between CON laws and outcomes fails to prove causation.[83] Additionally, it is difficult to determine if a relationship exists between CON laws and health care outcomes, as other studies have reached opposite conclusions[84] or shown that a relationship does not exist at all.[85]

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[80] *See* Maureen K. Ohlhausen, *Certificate of Need Laws: A Prescription for Higher Costs,* 30 ANTITRUST 52, 53 (2015).

[81] *About,* Mercatus Center, George Mason University, https://www.mercatus.org/about (last visited Apr. 26, 2019). The Mercatus Center at is a research, education, and outreach think tank that focuses on free-market research. *Id.* The center is largely funded by the conservative-leaning Charles Koch Foundation. *See* Erica L. Green & Stephanie Saul, *What Charles Koch and Other Donors to George Mason University Got for Their Money*, N.Y TIMES (May 5, 2018), https://www.nytimes.com/2018/05/05/us/koch-donors-george-mason.html.

[82] *See* Thomas Stratmann & David Wille, *Certificate-of-Need Laws and Hospital Quality*, Mercatus Working Paper, MERCATUS CENTER (Sept. 2016).

[83] *See, e.g.*, Mitchell, *supra* note 8, at 3.

[84] *See* Mary S. Vaugh-Sarrazin et al., *Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation*, 288 JAMA 1859, 1859 (2002) (finding that mortality was higher in states without certificate of need regulations compared with states with certificate of need regulation); *see also* Gaynor et. al, *supra* note 76, at 243 ("There is a large empirical literature documenting the existence of a positive correlation between the number of times a hospital performs a given surgical procedure and the rate of good health outcomes achieved by patients at that hospital receiving that procedure.").

[85] *See, e.g.*, Polsky et. al, *The Effect of Entry Regulation in the Health Care Sector: The Case of Home Health*, 110 J. PUBLIC ECON. 1, 11 (2014) ("We therefore conclude that removing CON for home health would have negligible system-wide effects on health care costs and quality.").

B. Does COPN Improve Health of All Virginians?

The second aim of Virginia's COPN program, improving health care for all Virginians, largely focuses on access. With its roots in facilitating hospital distribution, Virginia's COPN program attempts to distribute health care resources "in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care."[86] However, the COPN program limits the development or expansion of health care facilities and services; thus, opponents to Virginia's COPN program argue that, by definition, the program restricts supply and consequently reduces access.[87] In another Mercatus-initiated study, which used supply as a proxy for access,[88] it was reported that states with CON laws have 13 percent fewer hospital beds per 100,000 people than states without CON laws.[89] This study also showed that states with CON programs had fewer CT-scanners and MRI machines available, concluding that "CON regulation decreases the availability of each of these services."[90]

Contrastingly, supporters argue that the COPN program enhances access to all Virginians by distributing resources based on citizens' needs, rather than provider profitability. It has been seen that states that have eliminated their CON programs have subsequently reduced health care

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[86] VA CODE ANN. § 32.1-102.3(B)(1) (2019).

[87] *See* Mitchell, *supra* note 8, at 2.

[88] It should be noted that using supply as a proxy for access is not a precise metric. *See* Whelan Parento, *supra* note 24, at 228 ("Admittedly, supply of services is an imprecise metric at best, because the fact that providers are located in a given geographic area does not mean that they are willing to provide services to all patients.").

[89] Thomas Stratmann & Jacob W. Russ, *Do Certificate-of-Need Laws Increase Indigent Care?*, Mercatus Working Paper, MERCATUS CENTER at 3 (2014), https://www.mercatus.org/system/files/Stratmann-Certificate-of-Need.pdf.

[90] *See id.* at 12.

services in rural, inner city, and other areas with high or special needs.[91] Simultaneously, health care services in affluent areas or profitable specialties have dramatically increased.[92] Thus, supporters contend that the COPN program enhances the distribution of all services to all Virginians by basing distribution on need rather than opportunistic incentives.

C. Does COPN Reduce Health Care Costs?

The final aim of Virginia's COPN program is to reduce health care costs. As discussed previously, the COPN program was initiated in part as a cost-cutting mechanism. COPN supporters continue to argue that oversupply and overutilization of health care services and facilities drive up health care costs.[93] Additionally, supporters highlight that Virginia has lower per capita health care spending when compared to non-CON states.[94] However, studies have indicated that states with CON programs have increased per-unit health care costs due to a lack of competition.[95] In a joint statement to Virginia's General Assembly from 2015, the Federal Trade Commission and the Department of Justice stated "By potentially shielding incumbents from competition, COPN laws can permit providers with market power to charge higher prices. When health plans and other purchasers can choose among alternative providers, they can

[91] *See* South Carolina's Certificate of Need Program, South Carolina Hospital Association at 5-6 (Feb. 2009), https://www.scha.org/files/documents/CON09.pdf (noting that within four years of Ohio's deregulation fifteen hospitals in low-income areas were closed while more profitable services in more affluent areas grew significantly).

[92] *See id.*

[93] *See* Roemer, *supra* note 23, at 36.

[94] *See* Rawlings, *supra* note 10, at 2 ("[T]he Commonwealth has lower per capita health care expenses and costs than a majority of non-COPN states (10 of 16 such states, or 63 percent).").

[95] *See, e.g.*, Mitchell, *supra* note 8, at 4.

bargain more effectively."[96] Thus, likely the most significant argument against Virginia's COPN program is that it fails to lower costs.

IV. How Does Virginia's COPN Program Correct Market Imbalances?

In addition to the current debate over COPN's three main aims, supporters stress the health care market's deviations from competitive market conditions, and suggest that regulations are necessary to maintain key providers and services that may not be as lucrative as others. Additionally, proponents contend that CON laws enable increased charity care throughout the state.

A. Factors that Make Health Care an Ineffective Market

As discussed in the previous Part, opponents to CON laws favor deregulation because they want the health care market to have more competition. In former FTC Commissioner Maureen Ohlhausen's article, she explains this rationale: "[W]e want firms to face additional competition, so that customers can play firms against one another and obtain lower prices and better service. Competition also pressures firms to innovate, and beneficial innovation further improves our collective standard of living."[97] However, a free market driven by competition requires consumers who are able to make informed decisions on the quality and cost of the

[96] 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, Fed. Trade Commission & Dep't of Just. at 9 (Oct. 26, 2015). The joint statement was produced in response to a request from the 2015 Virginia Certificate of Public Need Work Group, which was commissioned by Virginia's General Assembly to "review the current certificate of public need process and the impact of such process on health care services in the Commonwealth, and the need for changes to the current certificate of public need process." Final Report, *supra* note 7 at 3. The joint statement ultimately recommended "the Work Group and the General Assembly consider whether Virginia's citizens are well served by its COPN laws, and, if not, whether they would benefit from the repeal or retrenchment of those laws."

[97] *See* Ohlhausen, *supra* note 80, at 51.

products they purchase, and many people contend that these factors are not present in health care.[98]

A leading, and likely the most persuasive, argument for CON is that health care is not a free market, and therefore requires regulations to correct market imbalances. Consumer choice is a necessity in a free market.[99] Consumers seek information about specific goods and services, draw comparisons between similar products, and make informed decisions prior to purchasing.[100] However, these characteristics of a functioning and efficient free market are largely absent from health care due to the urgent and inevitable nature of many health care needs and the third-party payor system of insurance.[101]

Author Chris Ladd wrote, "As I lie unconscious under a bus, I am in no position to shop for the best provider of ambulance services at the most reasonable price. All personal volition is lost. Whatever happens next, it will not be a market transaction."[102] This unpredictable and emergency nature of health care ultimately eliminates a consumer's ability to make an informed purchase.[103] Unlike most consumer choices, medical decisions are often emotional and driven by

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[98] *See* Lawrence Singer, Health Care Is Not a Typical Consumer Good and We Should Not Rely on Incentivized Consumers to Allocate It, 48 LOY. U. CHI. L.J. 703, 703-05, 710-12 (2017).

[99] *See id.*

[100] *See* George B. Sproles, Conceptualization and Measurement of Optimal Consumer Decision-Making, 17 J. CONSUMER AFF. 421, 423 (1983).

[101] Paul Krugman, Why Markets Can't Cure Healthcare, NY TIMES (July 25, 2009), https://krugman.blogs.nytimes.com/2009/07/25/why-markets-cant-cure-healthcare/.

[102] Chris Ladd, *There is Never a 'Free Market' In Health Care*, FORBES (Mar. 7, 2017), https://www.forbes.com/sites/chrisladd/2017/03/07/there-is-never-a-free-market-in-health-care/#5288e0ff1147.

[103] Kenneth J. Arrow, Uncertainty and the Welfare Economics of Medical Care, 53 AM. ECON. REV. (Dec. 1963), https://www.who.int/bulletin/volumes/82/2/PHCBP.pdf.

urgency.[104] In her dissent from the U.S. Supreme Court case, *National Federation of Independent Business (NFIB) v. Sebelius*, Justice Ginsburg noted the unique circumstances surrounding health care, stating, "The inevitable yet unpredictable need for medical care and the guarantee that emergency care will be provided when required are conditions nonexistent in other markets."[105] Even when situations are not urgent and consumers have the ability to seek out more information, an information divide persists.[106] Consumers fail to acquire the requisite knowledge to make an informed choice, as medical prices lack transparency and the products or services often require complex, science-based understanding.[107] Another unique factor of health care is that the consumers are typically not the individuals ordering or paying for the service.[108] Healthcare providers order certain services or products that are then paid for by government payors or insurance companies, often at rates not subject to negotiation.[109] Because of these factors, most patients are essentially removed from decisions regarding the cost and quality of

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[104] *See id.*

[105] 567 U.S. 519, 607-08 (2012).

[106] *See* Singer, *supra* note 98, at 710 ("The health care industry is not transparent with respect to price or quality, and its primary beneficiary – the patient – often lacks the capability and capacity to make informed choices.").

[107] *See id.*; David Blumenthal, *Creating Effective Health Care Markets*, The Commonwealth Fund (Sept. 7, 2018), https://www.commonwealthfund.org/blog/2018/creating-effective-health-care-markets ("At present, prices in the U.S. health care market are virtually unknowable. Quality data are scan, imperfect, and often confound even experts. Further, medicine is a complex science-based service").

[108] *See* Krugman, *supra* note 101.

[109] *See id.*

their health care. Therefore, proponents of CON argue that true competition cannot exist in health care.

B. How Do COPN Laws Insulate Hospitals From Market Imbalances?

In 1986, the federal government passed the Emergency Medical Treatment & Labor Act (EMTALA), which requires hospitals to treat people who enter an emergency room regardless of their ability to pay.[110] However, after the passage of EMTALA, there was a surge in emergency department usage and subsequent closings of hospitals, emergency departments, trauma centers, maternity wards, and tertiary referral centers that could not burden the uncompensated care.[111] Today, hospitals that remain open continue to struggle with the financial demands imposed by EMTALA.[112] In addition, the government's Medicaid and Medicare programs continuously reimburse hospitals and physicians at significantly reduced rates, often falling below the actual cost of care.[113] Thus, government regulations also place huge strain on hospitals and health systems, and supporters of CON argue that the regulations help level the playing field.[114]

The public needs a wide range of services, such as trauma care, burn care, obstetrics, and psychiatric care,[115] and hospitals offer these services regardless of profitability. Consequently,

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[110] *See* 42 U.S.C. § 1395dd (2012).

[111] *See* Edward Monico, *Is EMTALA That Bad?*, 12 Am. Med. Ass'n J. of Ethics 471, 472 (June 2010). The article notes that EMTALA's passage increased "ED use from 85 million to almost 115 million visits per year." *Id.* It then states that over 560 hospitals and 1,200 emergency departments were closed. *Id.*

[112] *See id.*

[113] *See* Rawlings, *supra* note 10, at 1 ("Reimbursement to hospitals and physicians from the 50-year-old Medicaid and Medicare programs continue to fall far short of the actual cost of care.").

[114] *See id.*

[115] These are examples of some of the less profitable services. *See id.* at 2.

hospitals rely on some of their more profitable services, such as cardiology and orthopedics,[116] to counterbalance the revenue loss from other departments. However, competition and the free market focus on profitability, rather than need; therefore, there is concern that health care deregulation could limit health care for the low-income or uninsured patient and for those needing less profitable treatments.[117] Expanding on this argument, the CEO of Bon Secours Health System, Toni Ardabell, stated:

> Any investor can come in and decide they're going to build a freestanding surgery center or freestanding radiology center, and never have to take a non-paying patient or a Medicaid patient or a Medicare patient. … They can really take the best payers or take cash or whatever scenario they set up. Whereas hospitals have to take every patient that comes through their emergency department.[118]

Thus, hospitals and health systems argue that Virginia's COPN is necessary for them to remain viable. The COPN program limits incumbents from oversaturating an area and significantly reducing profits from centers that offer other essential services.[119] Moreover, it is

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[116] *See* Brooke Murphy, *Which Physicians Generate the Most Revenue for Hospitals?*, BECKER'S HOSPITAL REVIEW (Apr. 12, 2016), https://www.beckershospitalreview.com/finance/which-physicians-generate-the-most-revenue-for-hospitals.html.

[117] *See* Rawlings, *supra* note 10, at 2 ("If health care facilities and services clustered around more populous, wealthy communities as a result of deregulation, it stands to reason that less affluent, smaller, rural communities and inner cities would face new barriers to health care access as resources are distributed to other areas of the state.").

[118] Katie O'Connor, *The Story Behind the Certificate of Need: What It Is, Why It Exists, and Why It Has Been a Thorn in Virginia's Side for Decades*, Va. Mercury (Jan. 8, 2019), https://www.virginiamercury.com/2019/01/08/the-story-behind-the-certificate-of-need-what-it-is-why-it-exists-and-why-it-has-been-a-thorn-in-virginias-side-for-decades/.

[119] *See id.*

not just private practitioners that must follow COPN regulations—these regulations apply to all health care players, including hospitals and health systems.[120]

C. Does COPN Increase Charity Care?

As discussed, hospitals often must treat patients regardless of ability to pay due to federal regulations. Virginia hospitals also must see patients regardless of their third-party payors; consequently, hospitals render huge discounted medical services to patients insured by Medicaid, which reimburses at rates far below the cost of providing care.[121] In fact, in 2017 Virginia hospitals absorbed more than $1.7 billion from underpayment for charity care and reimbursement and an additional $550 million from unpaid medical services.[122]

Unlike other states that employ extensive systems of public hospitals to provide indigent care,[123] Virginia operates only two state-run general acute-care hospitals: University of Virginia Medical Center and Virginia Commonwealth University Medical Center.[124] With a lack of state-

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[120] *See generally* VA. CODE ANN. § 32.1-102.3 (2019).

[121] Michael P. McDermott, *Commentary: Certificates of Public Need Protect Health Care Safety Net*, FREDERICKSBURG.COM (Feb. 19, 2019), https://www.fredericksburg.com/opinion/columns/commentary-certificates-of-public-need-protect-health-care-safety-net/article_6c19cd7c-7faf-5efe-b205-c6f79925f3d9.html.

[122] *See id.*

[123] Hospitals by Ownership Type, Henry J. Kaiser Family Foundation (2017), https://www.kff.org/other/state-indicator/hospitals-by-ownership/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Apr. 17, 2019). Some states have many public hospitals, including California with 65, Kansas with 60, Texas with 103. *Id.* Virginia only has two government-run hospitals, accounting for only 2.1% of its entire hospital population. *Id.*

[124] *See* Michael Martz, Private Hospitals Challenge 'Equity in State Funding' Given to UVa, VCU Health Systems, DAILY PROGRESS (Dec. 20, 2014), https://www.dailyprogress.com/news/local/private-hospitals-challenge-equity-in-state-funding-given-to-uva/article_1d4bfc94-88ab-11e4-922b-ffe8d4b4a7e1.html.

run facilities, Virginia relies on private providers to care for its indigent population and the COPN program helps accomplish this need.

Safety net providers are "providers that organize and deliver a significant level of both health care and other health-related services to the uninsured, Medicaid, and other vulnerable populations."[125] In Virginia, the hospitals have financial policies in place to assist uninsured and low-income patients and are often responsible for providing safety net care to such patients requiring emergency services.[126] One of the most prominent justifications for Virginia's COPN programs is that providers, safety-net hospitals in particular, require protection from competition in order to maintain sufficiently profitable services; these services are essential in insulating them against the uncompensated care provided to the indigent. The Commissioner also has the ability to condition certificates on the provision of indigent or charity care. Consequently, the burden of uncompensated care gets partially distributed amongst many healthcare providers, rather than falling solely on safety net providers.

V. DOES MEDICAID EXPANSION ELIMINATE THE NEED FOR COPN?

The decision to expand Medicaid in Virginia significantly changed the state's healthcare landscape. This expansion potentially increased insurance availability to 400,000 low-income adults in the state.[127] With more people insured, the burdens of uncompensated care should

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[125] Definition of Safety Net Hospitals, Office of the Assistant Secretary for Planning a Evaluation, U.S. DEP'T OF HEALTH & HUMANS SERVS. (June 1, 2013), https://aspe.hhs.gov/report/environme ntal-scan-identify-major-research-questions-and-metrics-monitoring-effects-affordable-care-act-safety-net-hospitals/c-definition-safety-net-hospitals.

[126] Health Safety Net Providers, VIRGINIA HEALTH CARE FOUNDATION, https://www.vhcf.org/who-and-how-we-help/medical/health-safety-net-providers/ (last visited March 22, 2019).

[127] *See* Vozzella, *supra* note 14.

consequently lessen. Thus, many question the future of Virginia's COPN program. This Part will first evaluate whether COPN should persist now that the burdens of indigent care are lessening. It will then discuss other measures the COPN program can take to better support the health care industry in Virginia.

A. Virginia Medicaid Expansion

The Affordable Care Act (ACA), enacted in 2013, originally sought to expand Medicaid coverage in each state. The plan was to provide Medicaid coverage to individuals making up to 133 percent of the federal poverty level (FPL).[128] The Supreme Court's decision in *NFIB v. Sebelius*, however, stripped the ACA's mandatory state expansion by ruling it unconstitutional under the spending clause;[129] as a result, Medicaid expansion became voluntary for the states.[130] Upon the initiation of Medicaid expansion in 2014, twenty-four states and Washington D.C. immediately opted for coverage—Virginia, however, was not one of those states.[131] Four years later, in 2018, Virginia legislators opted in to Medicaid expansion, and it is projected that 400,000 Virginians will qualify for and seek Medicaid coverage as a result.[132]

B. What Does Medicaid Expansion Mean for COPN?

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[128] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Healthcare and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified in scattered sections of Title 26 and Title 42 of the U.S.C.).

[129] 567 U.S. 519, 585-87 (2012).

[130] *Id.* at 587. ("Some states may indeed decline to participate. … Other States, however, may voluntarily sing up, finding the idea of expanding Medicaid coverage attractive.")

[131] Donald Moulds, et. al, *A New Group of States Look to Expand Medicaid*, COMMONWEALTH FUND (Aug. 27, 2018), https://www.commonwealthfund.org/blog/2018/states-look-expand-medicaid.

[132] *See* Vozzella, *supra* note 14.

In light of Medicaid expansion, many wonder whether COPN is even necessary. Will it set unrealistic conditions on providers to deliver charity care in unobtainable numbers? Will this correct some of the market imbalances placed on hospitals in ways that favor adopting more competitive approaches to health care in the state?

i. Charity Care Conditions After Medicaid Expansion

Providers are concerned about meeting charity care conditions, as many more indigent patients will qualify for Medicaid. Currently, providers that are unable to meet the charity care conditions of their certificates are required to pay a penalty.[133] Recently, however, HB 2766 was passed.[134] This bill directs the Commissioner to conduct a triennial review of COPN charity care conditions to determine whether the conditions are appropriate or need revision.[135] It further instructs the Commissioner to communicate the "appropriateness" of those conditions and develops a process by which a COPN holder may seek amendment.[136] This measure seems appropriate, given the backdrop of decreased charity care demands in the state. However, the Commissioner may want to take immediate measures as well to lessen the risk of penalties for providers.

Now that more Virginians are covered under Medicaid, the Commissioner should reevaluate all contested charity care conditions after a year of Medicaid expansion. In other words, through 2019 providers should continue attempting to reach the charity care percentages established by the Commissioner's conditions; at the end of the year, however, the providers

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[133] *See* VA. CODE ANN. § 32.1-102.4(F) (2019).

[134] 2019 Session, General Assembly H-2766.

[135] *See id.*

[136] *See id.*

should deliver reports indicating their ability to achieve such numbers and proposed reductions in the demand for charity care with supportive reasoning. The Commissioner can then choose to accept such plans or eliminate them. Whereas the Commissioner is instructed to review the charity care conditions every three years under the new bill, Medicaid expansion necessitates immediate review of the conditions before penalties are imposed. Thus, the Commissioner should review all contested conditions now and subsequently begin a triennial review process.

ii. Is COPN Necessary Given the Reduced Strain on Hospitals?

While Medicaid expansion undeniably decreases the burdens on health care providers to provide uncompensated charity care, state legislators should consider COPN reform, rather than COPN repeal, in response. Hospitals still face considerable burdens. Hospitals continue to provide charity care, as not all Virginians will gain coverage under Medicaid expansion.[137] Additionally, hospitals now face the added financial strain of two taxes that effectively support the Medicaid expansion.[138] Hospitals also receive many Medicaid patients (now more than ever), and Medicaid continues to pay at reduced reimbursement rates.[139] Thus, eliminating COPN regulations due to a reduced burden on hospitals would be premature and ill-considered.

Although Medicaid expansion does lessen the uninsured population in Virginia, it does not cover all Virginians. Prior to Medicaid expansion, there were approximately 718,000

[137] *See* O'Connor, *supra* note 16.

[138] *See* Laura Vozzella & Gregory S. Schneider, *Virginia General Assembly Approves Medicaid Expansion to 400,000 Low-Income Residents*, WASH. POST (May 30, 2018), https://www.washingtonpost.com/local/virginia-politics/virginia-senate-approves-medicaid-expansion-to-400000-low-income-residents/2018/05/30/5df5e304-640d-11e8-a768-ed043e33f1dc_story.html?utm_term=.a1c9a81f4f83 .

[139] *See* Rawlings, *supra* note 10, at 1.

uninsured people in Virginia.[140] The Medicaid expansion anticipated covering 400,000 of those uninsured.[141] However, this leaves over 300,000 Virginians without insurance, and those individuals will continue to rely on hospital emergency departments for care.[142] In addition, Trump's elimination of the individual mandate will likely lead to an increase in the number of uninsured persons nationally, particularly given the inevitable cost increases of health insurance premiums that result. In fact, it is predicted that between 2.8 million to 13 million fewer people will carry insurance due to the elimination of the individual mandate.[143] Thus, regardless of the Medicaid expansion, hospitals likely will continue to struggle with uncompensated care because a large cohort of Virginians will remain uninsured.

Medicaid expansion was supported by hospitals throughout Virginia because of the reduction in uncompensated care, but the hospitals are not ridding themselves entirely from the financial strain of charity care.[144] In promoting Medicaid expansion, the hospitals reluctantly agreed to pay two new taxes—the first aims to raise $306 million to cover Virginia's share of the Medicaid expansion, and the second seeks to raise $284 million which will be matched by the

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[140] *See* O'Connor, *supra* note 16.

[141] *See* Vozzella & Schneider, *supra* note 138.

[142] *See* O'Connor, *supra* note 16. The article cites the executive director of the Virginia Health Care Foundation, Deborah D. Oswalt, who said "[Medicaid expansion] is going to make a huge difference in the lives of so many uninsured Virginians. It's fabulous, but we cannot just think, 'O.K., problem solved.'" *Id.*

[143] *See* Christine Eibner & Sarah Nowak, *The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors*, COMMONWEALTH FUND (July 11, 2018), https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors.

[144] *See* Vozzella, *supra* note 14 ("This will reduce uncompensated care, which is a strain on hospitals.").

federal government and used to raise Medicaid reimbursement rates.[145] Thus, hospitals will continue to feel the financial burdens of uncompensated care—though this burden will now shift to supporting the insured in Virginia.

Lastly, Medicaid pays very low reimbursement rates, often falling below the cost of the care.[146] While the new tax on hospitals intends to increase the reimbursement rate for Medicaid services from 71 percent to 88 percent, [147] this value still falls below the actual cost of the service. Thus, hospitals, which cannot discriminate based on third-party payors, must continue to provide services at prices below cost for Medicaid patients.

It is inaccurate to state that Medicaid expansion corrects the market imbalances placed on hospitals. While the burdens of uncompensated care should decrease, hospitals will continue to feel the financial burden of both charity care and the Medicaid expansion. Thus, repealing the COPN program for such reasons would fail to account for these factors.

C. Medicaid Expansion Supports COPN Reform, Not Repeal

Because Medicaid expansion does not remove the financial strain placed on hospitals and will continue to require charity care, eliminating the COPN program in light of Medicaid expansion would be untimely. Instead of repeal, however, the Virginia legislature should

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[145] *See* Michael Martz, *U.S. Approves New Taxes To Be Paid by Virginia Hospitals As State Moves Toward Medicaid Expansion*, RICHMOND TIMES-DISPATCH (Sept. 19, 2018), https://www.richmond.com/news/virginia/government-politics/u-s-approves-new-taxes-to-be-paid-by-virginia/article_accae296-10b6-570a-98af-5e342f0560d4.html. Note that certain hospitals, including public hospitals, children's hospitals, rehabilitation and critical-access hospitals will be exempt from the tax. *See* Tyler Arnold, *New "Bed Tax" Will Pay for Virginia Medicaid Expansion*, VA. WATCHDOG (Sept. 25, 2018), https://www.watchdog.org/virginia/new-bed-tax-tax-will-pay-for-virginia-medicaid-expansion/article_454f765e-c0f5-11e8-a1c1-df9bfc40f851.html.

[146] *See* Rawlings, *supra* note 10, at 1.

[147] *See* Martz, *supra* note 145.

consider reform measures that could boost the original three aims of the COPN program—increased quality, increased access, and reduced cost.

First, as discussed previously, the Commissioner should be required to review the charity guidelines for all conditioned certificates to ensure that the charity care conditions are consistent following the Medicaid expansion. However, uninsured individuals are not the only medically underserved population in the state. In fact, approximately half of the communities in Virginia, especially those in inner city and rural areas, lack access to essential health services and providers.[148] Thus, the Commissioner could expand charity care conditions to include all people within medically underserved areas, regardless of whether such patients are able to pay or not, thereby motivating health care facilities and providers to engage and extend services to these areas.

The legislature could also adopt standards that reward providers who meet objective cost and quality metrics. For instance, in Kentucky's state health plan, hospitals that meet certain CMS quality thresholds or those that participate in federal value-based payment programs are deemed to be consistent with the state's health plan, which ultimately gives them preference in seeking certification.[149] While Virginia's eight considerations listed in the COPN statute aim to incentivize quality and cost reduction,[150] the Commissioner is given broad discretionary authority in weighing such factors. Thus, Virginia's COPN program should consider

[148] *See* Underserved Areas, VIRGINIA HEALTH CARE FOUNDATION, https://www.vhcf.org/who-and-how-we-help/workforce-initiatives/underserved-areas/ (last visited Apr. 26, 2019).

[149] *See* Whelan Parento, *supra* note 24, at 251-52.

[150] *See* VA. CODE ANN. § 32.1-102.3 (2019).

implementing quality and cost-reduction strategies that would give preferential treatment to providers meeting these metrics in a more objective fashion.

Conclusion

Medicaid expansion largely changed the scene for health care providers in Virginia. Whereas many providers, specifically hospitals and health systems, struggled with managing uncompensated care burdens, Medicaid expansion will likely alleviate some of this financial strain. However, this will not correct the market imbalances that currently are a factor in maintaining Virginia's COPN program. Hospitals and health systems will continue to carry financial burdens, as many Virginians remain uninsured and these providers face new burdens with additional taxes. Maintaining Virginia's COPN program, at least until Virginia's Medicaid expansion landscape is more established, is likely the appropriate action for Virginia's General Assembly. In the meantime, the legislature should consider certain reform measures to increase access and quality and reduce costs throughout the state.