House Health, Welfare and Institutions Certificate of Public Need Taskforce
November 14, 2006

The third meeting of the House Health, Welfare and Institutions Certificate of Public Need Taskforce was held November 14, 2006 at 2:00 p.m. in House Room C of the General Assembly Building. Following a call to order, an introduction and opening remarks by Chairman Delegate Harry R. Purkey, four speakers offered presentations.

Financial Status of Hospitals in Virginia - Mr. Dick Walker, Virginia Health Information

Mr. Dick Walker, of Virginia Health Information (VHI), gave a presentation on the financial status of selected hospitals in Virginia. VHI is a non-profit, public/private partnership charged with collecting, analyzing and disseminating health care data for the purpose of promoting informed decision making by Virginia consumers and purchasers and enhancing the quality of health care delivery within the state. The organization works through contracts with the State Health Commissioner, private organizations and sales and service entities. VHI ranks health care providers on a number of indicators, including financial data. COPN licensure survey data was added in 1998.

Among the findings reported by Mr. Walker were:

- Net Worth Trends in Virginia Hospitals: while total liabilities have increased, total assets have increased at a greater rate, resulting in an increase in net worth among Virginia hospitals from 1993 to 2005. During this time, Virginia hospitals' net worth has increased by 7.14% annually, after adjustment for inflation.
- Asset Trends in Virginia Hospitals: Fixed assets have decreased from 1993 to 2005, while other assets including instruments of credit, trust funds, investments of cash, etc. have increased during the same period.
- Income Trends: Net patient revenue and total operating expenses have increased from 1993 to 2005. Operating income has increased 4.11% annually, after adjustment for inflation, during this same period.
- Profit Margins: Though both operating and total margins declined sharply from 1997 to 2003, both figures have increased steadily from 2003 to 2005
- Total margins: While total margins have varied, the median total margin between 1993 and 2005 was 6.5%. In 2005, 20.24% of hospitals lost money while 57% had total margins of 5% or more.

Strategic Health Care Trends - Mr. Frederick Hessler, Managing Director, Health Care Group, Citigroup

Mr. Frederick Hessler, Managing Director, Health Care Group, Citigroup, gave a presentation on Strategic Health Care Trends in the United States. Major environmental trends affecting health care over the next 3 to 5 years identified by Mr. Hessler included:

- Payment sources under pressure, especially government payors including federal Medicare, state Medicaid programs, and private commercial insurance programs
- Slowing and shifting demands

- Quality and patient safety initiatives including clinical and information technology investment, workforce development and training, process flow redesign, facilities design, payor focus, and impact of transparency
- Increasing competitive forces (pure play companies)
- Resource constraints including capital and labor
- Escalating headline risks

Mr. Hessler also presented information drawn from a study facilitated by Citigroup, evaluating health care provider performance for approximately one quarter of all U.S. hospitals. Findings of this study included:

- Operating margins for hospitals across the nation have improved, at a rate of 2.86% in 2005. In Virginia, the improvement in operating margins in 2005 was closer to 5.1%.
- Despite the improvement in operating margins nationally and in Virginia in 2005, margin growth has been slow. Nationally, the rate was 19.7%. In Virginia, the rate of growth as been 4.8%
- While margins are improving overall, the scale of health care systems appears to be driving the strongest results. Specifically, large health systems with over $3 billion in assets have the largest growth, while those with between $1 billion and $3 billion have the next largest, and those with less than $1 billion have the least.
- Scale also affects supply costs of hospitals; overall, supply costs have declined since FY01, at a rate of -13.7%. For small hospitals, with less than $1 billion in assets, the decline has been at a rate of -14.7%, while medium-sized hospitals with assets of $1 billion to $3 billion have seen supply costs decline at a rate of -64.9%. Large hospitals with assets of over $3 billion have actually seen an increase in supply costs at a rate of 3.3%
- Scale also generates a cost of capital advantage for hospitals. Since FY01, the total cost of debt for hospitals has declined by -16.7%. For small hospitals, the cost has declined at a rate of -19.9%, while large hospitals have seen the cost of debt decline at a rate of -21.1%. Medium-sized hospitals have actually seen the cost of debt increase since FY01 at a rate of 12%.
- Scale may create a sustainable advantage for health care systems, allowing the provider to achieve pricing leverage and revenue diversification, and to manage resource constraints.

For-Profit vs. Not-For-Profit Entity Status in Virginia - Mr. Mark Haskins, Virginia Department of Taxation

Mr. Mark Haskins of the Virginia Department of Taxation, offered a comparison of non-profit and for-profit status for hospitals. Specifically, Mr. Haskins noted:

- Nonprofit hospitals are exempt from the federal and Virginia income tax.
- Under § 501(c)(3) of the Internal Revenue Code, an organization may qualify for exemption from federal income tax if it is organized and operated exclusively for one or more of the following purposes: charitable, religious, educational, scientific, literary, testing for public safety, fostering national or international

amateur sports competition, or the prevention of cruelty to children or animals. Nonprofit hospitals qualify under the charitable purpose test.

- Nonprofit hospitals are not exempt from the tax imposed on the unrelated business taxable income of nonprofit organizations, which is imposed by § 511 of the Internal Revenue Code. An activity is unrelated business, and therefore subject to the unrelated business income tax, if it is (i) a trade or business; (ii) regularly carried on; and (iii) not substantially related to furthering the exempt purpose of the organization.
- Virginia generally conforms to the federal income tax treatment. Under Va. Code § 58.1-402(B)(5), however, taxpayers must add back any unrelated business taxable income to the extent that it was excluded from federal taxable income.
- Effective July 1, 2004, the statutory retail sales and use tax exemption for Nonprofit Hospitals was repealed. Effective July 1, 2004, all nonprofit 501(c)(3) and 501(c)(4) organizations, including nonprofit hospitals, were exempt provided they met certain criteria established by the 2003 General Assembly. This exemption is a broad-based exemption generally covering all purchases of tangible personal property.
- For-profit hospitals enjoy a more limited exemption based on specific statutory item-by-item exemptions.

Recommendations Regarding Changes to Certification of Public Need Laws - Mr. Eric Bodin, Director, COPN Program, Virginia Department of Health

Mr. Eric Bodin, Director of the Virginia Department of Health's COPN Program offered specific recommendations regarding changes to Virginia's Certificate of Public Need Laws. These changes

- eliminate "lithotripsy" and "nuclear imaging, except for the purpose of nuclear cardiac imaging" from requirements of COPN, and replace the term "gamma knife surgery" with term "stereotactic radiosurgery" throughout.
- eliminate "relocation at the same site of 10 beds or 10 percent of the beds, whichever is less, from one existing physical facility to another in any two year period ..." from definition of "project."
- increase expenditure amount/threshold for "project" to be reviewable from $5 million to $15 million and increase expenditure amount/threshold for project to be reported from $1 million to $5 million
- strike "Virginia Health Planning Board" from definition section
- add the requirement that a person must register purchase within 30 days of become contractually obligated to acquire *replacement* medical equipment for the purpose of provision of enumerated services
- add radiation therapy, stereotactic radiosurgery, neonatal special care, obstetrical, medical rehabilitation, and psychiatric services and long-term care and acute care hospitals to the list of facilities for which the Commissioner shall approve, authorize and accept applications for the issuance of a certificate in response to a request for applications only and for which the Board of Health is required to adopt regulations establishing standards for the approval of RFAs; regulations are

to take into account limitations on access to these facilities and shall be based on analysis of need for increases in supply of these facilities

- add the requirement that failure to comply with a condition on certificate of public need shall be grounds for denial of future applications until such time as the applicant is able to demonstrate full compliance with conditions
- adds a new section G to section §32.1-102.4, requiring any facility seeking or holding a certificate to report certain information relating to patient volumes, revenues and charity care and requirement that failure to report will render the facility, the facility's parent corporation, and the facility/parent corporation's owners ineligible to apply for additional certificates until all reporting is made current and will result in capacity at non-reporting services being excluded from calculations of need.
- allow an applicant to submit application electronically
- add the requirement that if an application is found to be complete, the Department must notify the application that the application has been accepted for review but that if the application is not complete, the department must inform the applicant of the information needed to complete the application, that the application will not be accepted for the current review cycle and of the dates of the next review cycle and changes language in subsection D of 32.1-102.6 to indicate that if the application is not complete *upon submission* the application shall be refiled (was "within 40 days")
- reduce the number of days after the expiration of the health planning agency's review period that the Department must wait before proceeding as though the agency has approved the application (where there has been no recommendation or the agency has not completed its review) from 10 to 5.
- add a requirement that once the informal fact finding hearing is scheduled, it shall not be scheduled unless rescheduled by the AO upon showing of special unavoidable circumstances by the party seeking to reschedule with the concurrence of all parties.
- adds a requirement that deliberations at the informal fact finding conference will be based upon the record as established at the 60th day of the review cycle, plus specified materials, and to change the date for closing of record from 30 days after the date for holding IFFC to 45 days after IFFC is concluded
- Change the closing date of record in cases where no IFFC is held from earlier of date established for holding the IFFC or date department determines IFFC is not necessary to date department determines IFFC not necessary; adds requirement that only the Commissioner's decision may be added to record after that date.
- add a requirement that commencing project without certificate may be grounds for refusing to issue certificate as well as license for project.

Next Meeting

The next meeting of the House Health, Welfare and Institutions Certificate of Public Need Task Force will be held December 15, 2006 in House Room C of the General Assembly Building.