

Virginia Nursing Home Certificate of Public Need (COPN) Process

How Beds Are Introduced and How to Move or Purchase Existing Beds to Add Value to Your Portfolio



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Virginia Certificate of Public Need (COPN) Learning Objectives

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- ❑ Review history of Certificate of Public Need (COPN).
- ❑ Determine situations that require a COPN.
- ❑ Explain how nursing home Bed Needs are determined.
- ❑ Examine how nursing home beds can be added to your facility.
- ❑ Overview of Virginia's COPN Planning Districts (PD).
- ❑ Review Bed Need projections by PDs – Years 2022 and 2023.
- ❑ Examples of strategic opportunities to add value to your facility.
- ❑ Should we renovate our existing facility or build new?
- ❑ Discuss Medicaid reimbursement implications to consider.
- ❑ Criteria for COPN approval.
- ❑ Overview of the COPN application process and timing.
- ❑ How to build a COPN team for success.
- ❑ Defend your COPN application. (Matt Cobb, Partner | Williams Mullen)



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A Brief History of COPN

- ❑ The enactment of Medicare and Medicaid in the 1960's led to a federal law in the early 1970's, which led to the Virginia COPN program being created in 1973.
- ❑ The purpose of this law and regulations were to control costs and improve access to care.
- ❑ The federal mandate was repealed in 1986, but Virginia's program remains.
- ❑ Virginia's COPN program requires health care providers seeking to open or expand a health care facility or service to receive approval. The health care provider must prove that the community needs the requested services.
- ❑ In the mid 1980's, the Health Commissioner rapidly approved-almost all nursing home applications, particularly if situated in small, rural communities. This period was then followed by a moratorium on approvals of all COPN applications for new nursing home beds (1986) because most of the Commissioner's approvals authorized numerous inefficient 60 bed nursing homes.



A Brief History of COPN (cont.)

- ❑ By the late 1990's, Virginia adopted a RFA (request for application) process for new nursing home beds, as well as a batching cycle process which governed the review process for all regulated health services, including nursing homes.
- ❑ Virginia also adopted the Registration of Capital Expenditures not involving new or expanded health care services. This included substantial rehabilitation of buildings, new parking garages, etc.
- ❑ For planning purposes, and particularly for health planning purposes, Virginia is divided into 22 planning districts.



Situations That Require a COPN



Virginia law requires applicants to obtain a COPN prior to the development of a "project" (VA Code § 32.1-102.1:3). Below are "projects" that would require a COPN:

- ☐ Establishment of a new nursing home
- ☐ Relocation of beds from one nursing home to another
- ☐ Addition of nursing home beds (RFA)
- ☐ Large capital expenditures above an annual, inflation adjusted threshold.

Currently the COPN capital threshold for registration of projects is \$7,061,144 and the COPN capital threshold for projects requiring a COPN is \$21,219,588.



Requirements for Notification of Proposed Acquisition

- ☐ At least 30 days before any person is contractually obligated to acquire an existing medical care facility, the cost of which is \$600,000 or more, that person shall provide written notification to the commissioner and the regional health planning agency that serves the area in which the facility is located.
- ☐ Such notification shall identify the:
 - Name of the medical care facility
 - Current and proposed owner
 - Cost of the acquisition
 - Services to be added or deleted
 - Number of beds to be added or deleted, and
 - Projected impact that the cost of the acquisition will have upon the charges of the services to be provided in the medical care facility.
- ☐ The commissioner shall provide written notification to the person who plans to acquire the medical care facility within 30 days of receipt of the required notification.



How Nursing Home Bed Need is Determined



RFA Bed Need Projections are established by the State Medical Facilities Plan (SMFP), which is based on a four-part test:

- ✓ Having a positive formula-generated need projection, and;
- ✓ Having a median annual occupancy percentage of non-federal, Medicaid-certified nursing homes for the most recent report year of 93% or higher, and;
- ✓ Having an average annual occupancy percentage of non-federal, Medicaid-certified nursing homes for the most recent reporting year of 90% or higher, and;
- ✓ Having no uncompleted nursing home beds authorized within the last three year that will be Medicaid-certified.



The most recent Bed Need Projections by Virginia Department of Health (VDH) were published in 2020 and are for the year 2022. The next RFA Bed Need Projections are due sometime soon, and have been held up for unknown reasons, probably attributable to the pandemic.

- Population projections in 3 years
- Nursing home use rates - 2014



How Nursing Home Bed Need is Determined (cont.)



In order to qualify for an RFA, a planning district must have a projected need for additional beds and the *median* annual occupancy of all existing non-federal, Medicaid-certified nursing homes in the planning district was at least 93%, and the *average* annual occupancy of all existing non-federal, Medicaid-certified nursing homes in the planning district was at least 90% for the most recent year for which bed utilization had been reported to the VDH (most nursing home beds are dually certified).



The most recent RFA authorized new beds in 2019; 30 additional beds were approved for PD 18. It is anticipated that the upcoming RFA will also reflect at least one planning district having need for additional beds.



How Nursing Home Beds Can Be Added to Your Facility

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BEDS CAN BE ADDED TO YOUR FACILITY IN THREE (3) WAYS:

1. **Determined need for additional beds (RFA) – Four-part test**

These criteria may be outdated and may not appropriately capture the true need for nursing home beds, population projections, and nursing home use rates (example: Northern VA – PD8).

2. **Relocation of nursing home beds within a planning district.**

This method is typically successful and can be difficult for another provider to prevent.



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How Nursing Home Beds Can Be Added to Your Facility (cont.)

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3. **Bed Transfer Statute (move beds over planning district)**

A process for the Commissioner to accept and approve the transfer of nursing home beds from one planning district to another if certain criteria are met:

- There is a State Medical Facilities Plan (SMFP) calculated surplus of beds in the planning district from which the beds are being transferred from;
- There is a similarly calculated need for beds in the planning district to which the beds are being transferred to;
- The transfer of the nursing home beds will not create a need for beds in the planning district from which they are being transferred from; and
- The beds will be used for patients without regard of their ability to pay.



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Continuing Care Retirement Communities (CCRC)

Proposals for the development of new nursing facilities or the expansion of existing facilities by continuing care retirement communities (CCRC) will be considered when:

1. The facility is registered with the State Corporation Commission as a continuing care provider pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia;
2. The number of nursing facility beds requested in the initial application does not exceed the lesser of 20% of the continuing care retirement community's total number of beds that are not nursing home beds or 60 beds;
3. The number of new nursing facility beds requested in any subsequent application does not cause the continuing care retirement community's total number of nursing home beds to exceed 20% of its total number of beds that are not nursing facility beds; and
4. The continuing care retirement community has established a qualified resident assistance policy.
5. CCRCs are also able to participate in RFAs, bed relocations, and bed transfers.

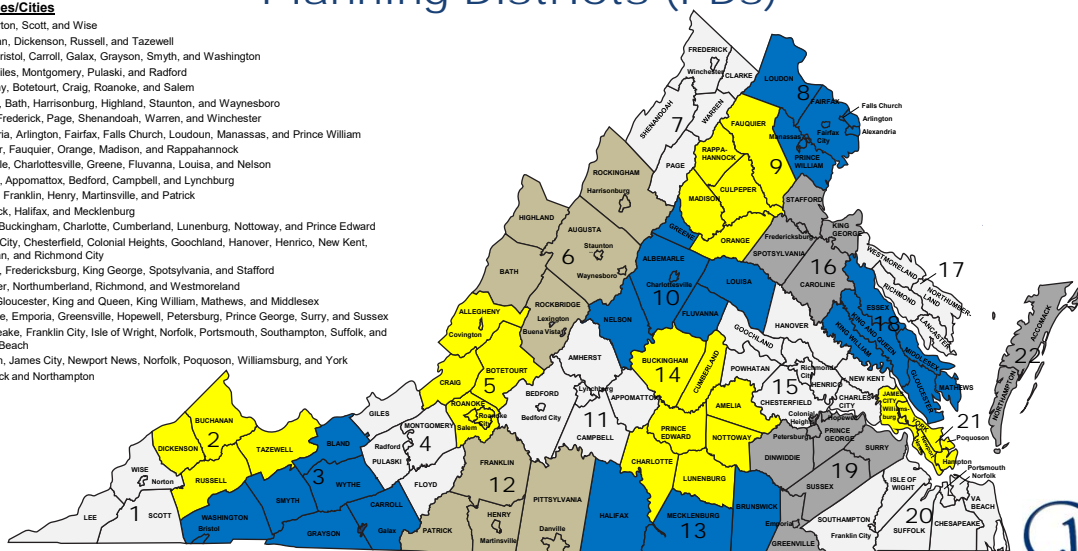


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Planning Districts (PDs)

PD Counties/Cities

1. Lee, Norton, Scott, and Wise
2. Buchanan, Dickenson, Russell, and Tazewell
3. Bland, Bristol, Carroll, Galax, Grayson, Smyth, and Washington
4. Floyd, Giles, Montgomery, Pulaski, and Radford
5. Alleghany, Botetourt, Craig, Roanoke, and Salem
6. Augusta, Bath, Harrisonburg, Highland, Staunton, and Waynesboro
7. Clarke, Frederick, Page, Shenandoah, Warren, and Winchester
8. Alexandria, Arlington, Fairfax, Falls Church, Loudoun, Manassas, and Prince William
9. Culpeper, Fauquier, Orange, Madison, and Rappahannock
10. Albemarle, Charlottesville, Greene, Fluvanna, Louisa, and Nelson
11. Amherst, Appomattox, Bedford, Campbell, and Lynchburg
12. Danville, Franklin, Henry, Martinsville, and Patrick
13. Brunswick, Halifax, and Mecklenburg
14. Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, and Prince Edward
15. Charles City, Chesterfield, Colonial Heights, Goochland, Hanover, Henrico, New Kent, Powhatan, and Richmond City
16. Caroline, Fredericksburg, King George, Spotsylvania, and Stafford
17. Lancaster, Northumberland, Richmond, and Westmoreland
18. Essex, Gloucester, King and Queen, King William, Mathews, and Middlesex
19. Dinwiddie, Emporia, Greenville, Hopewell, Petersburg, Prince George, Surry, and Sussex
20. Chesapeake, Franklin City, Isle of Wright, Norfolk, Portsmouth, Southampton, Suffolk, and Virginia Beach
21. Hampton, James City, Newport News, Norfolk, Poquoson, Williamsburg, and York
22. Accomack and Northampton



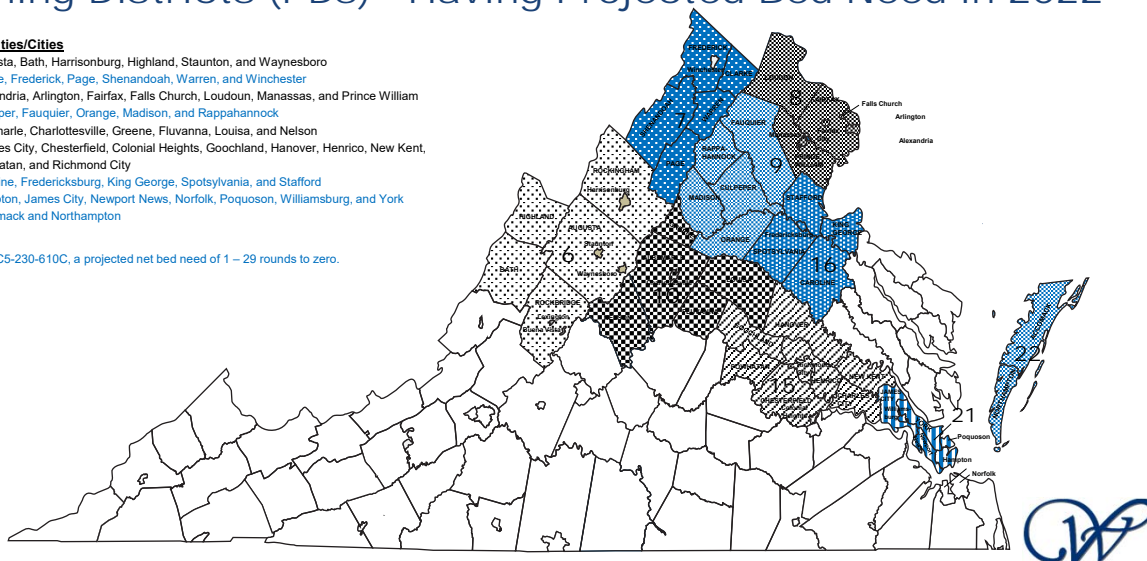
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Planning Districts (PDs) - Having Projected Bed Need in 2022

PD Counties/Cities

- 6. Augusta, Bath, Harrisonburg, Highland, Staunton, and Waynesboro
- 7. Clarke, Frederick, Page, Shenandoah, Warren, and Winchester
- 8. Alexandria, Arlington, Fairfax, Falls Church, Loudoun, Manassas, and Prince William
- 9. Culpeper, Fauquier, Orange, Madison, and Rappahannock
- 10. Albemarle, Charlottesville, Greene, Fluvanna, Louisa, and Nelson
- 15. Charles City, Chesterfield, Colonial Heights, Goochland, Hanover, Henrico, New Kent, Powhatan, and Richmond City
- 16. Caroline, Fredericksburg, King George, Spotsylvania, and Stafford
- 21. Hampton, James City, Newport News, Norfolk, Poquoson, Williamsburg, and York
- 22. Accomack and Northampton

* Per 12VAC5-230-610C, a projected net bed need of 1 – 29 rounds to zero.



Planning Districts (PDs) – Having Projected Bed Need in 2022 (cont.)

- ❑ These planning districts can add beds via the bed transfer process and are able to relocate already existing beds within the planning district.
- ❑ All other planning districts can generally relocate existing beds within their area and are also able to transfer existing beds to the listed PDs.



Bed Need by PD – 2022 and 2023

PD	Counties	Existing/ Approved Beds as of October 2022		2022 (*)	2023 (*)
1	Lee, Norton, Scott, and Wise	641		(81)	(77)
2	Buchanan, Dickenson, Russell, and Tazewell	519	(i)	(19)	(25)
3	Bland, Bristol, Carroll, Galax, Grayson, Smyth, and Washington	1,519		(184)	(169)
4	Floyd, Giles, Montgomery, Pulaski, and Radford	773		(1)	11
5	Alleghany, Botetourt, Craig, Roanoke, and Salem	2,198	(ii)	(224)	(124)
6	Augusta, Bath, Harrisonburg, Highland, Staunton, and Waynesboro	1,528	(iii)	84	90
7	Clarke, Frederick, Page, Shenandoah, Warren, and Winchester	1,055		21	(3)
8	Alexandria, Arlington, Fairfax, Falls Church, Loudoun, Manassas, and Prince William	4,540		284	452
9	Culpeper, Fauquier, Orange, Madison, and Rappahannock	766		24	50
10	Albemarle, Charlottesville, Greene, Fluvanna, Louisa, and Nelson	1,062		51	86
11	Amherst, Appomattox, Bedford, Campbell, and Lynchburg	1,560		(103)	(77)

(*) The Virginia Department of Health (VDH) projections for 2022 are based on application of the State Medical Facilities Plan (SMFP) nursing home bed need methodology formula and are official. The 2023 projections are by Premier Consulting Services, Inc. (Premier Consulting Services, Inc.) using the SMFP methodology updated for 2023 population projections and are not official.

i. Includes 30 beds approved for transfer to PD8

ii. Includes 52 beds approved for transfer to PD7 and 25 beds approved for transfer to PD8

iii. Includes 24 beds approved for transfer to PD6



Bed Need by PD – 2022 and 2023 (cont.)

PD	Counties	Existing/ Approved Beds as of October 2022		2022 (*)	2023 (*)
12	Danville, Franklin, Henry, Martinsville, and Patrick	1,905	(iii)	(48)	(23)
13	Brunswick, Halifax, and Mecklenburg	841		(26)	(20)
14	Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, and Prince Edward	662		(95)	(88)
15	Charles City, Chesterfield, Colonial Heights, Goochland, Hanover, Henrico, New Kent, Powhatan, and Richmond City	4,082		86	222
16	Caroline, Fredericksburg, King George, Spotsylvania, and Stafford	875	(iv)	25	65
17	Lancaster, Northumberland, Richmond, and Westmoreland	268		(16)	(14)
18	Essex, Gloucester, King and Queen, King William, Mathews, and Middlesex	550		(21)	(9)
19	Dinwiddie, Emporia, Greensville, Hopewell, Petersburg, Prince George, Surry, and Sussex	1,055		(112)	(98)
20	Chesapeake, Franklin City, Isle of Wright, Norfolk, Portsmouth, Southampton, Suffolk, and Virginia Beach	4,306		(120)	2
21	Hampton, James City, Newport News, Norfolk, Poquoson, Williamsburg, and York	1,828		10	58
22	Accomack and Northampton	281		11	12

(*) The Virginia Department of Health (VDH) projections for 2022 are based on application of the State Medical Facilities Plan (SMFP) nursing home bed need methodology formula and are official. The 2023 projections are by Premier Consulting Services, Inc. (PCS) using the SMFP methodology updated for 2023 population projections and are not official.

iii. Includes 24 beds approved for transfer to PD6

iv. Includes recently licensed 90 beds which have been approved for transfer to PD16 from PD14, PD20, and PD22.



Strategic Opportunities to Add Value to Your Facility ¹⁷

EXAMPLE 1:

Transfer beds from facility located in a PD that is under-bedded (beds can't leave PD)

- ❑ This option can be especially attractive when the PD contains two separate DMAS Peer Groups but with similar cost profiles.
- ❑ The current facility is large and has had excess capacity in their facility for many years. Current facility is outdated with few private rooms.
- ❑ The facility was recently purchased and leased to a new operator.
- ❑ Current owner of facility partnered with second operator to build a new facility in the same PD (cannot move beds out of this PD due to under-bedded status).
- ❑ Location of proposed facility is in highly desirable market and will contain more desirable private rooms.



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Strategic Opportunities to Add Value to Your Facility (cont.) ¹⁸

EXAMPLE 1 (cont.):

Transfer beds from facility located in a PD that is over-bedded (beds can't leave PD)

- ❑ Proposed facility will be in same PD but is included in Urban4 price-based peer group. Facility where beds are being transferred from is located in Rural2 price-based peer group. This will increase their Medicaid operating rate by \$40+ PPD.
- ❑ Reduced rent will likely result for operator of the original facility. This will also allow the operator to be more attractive by providing more private rooms for their residents.
- ❑ New facility will contain predominately private rooms in highly desirable, high demand market.



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Strategic Opportunities to Add Value to Your Facility (cont.)

EXAMPLE 2:

Buy beds from another owner by targeting facilities that value their beds at less than a buyer values them.

- ❑ Approach facilities located in over-bedded PDs – especially facilities that don't have related facilities in more attractive under-bedded PDs.
- ❑ Target facilities with historically low occupancy - opportunity to covert beds rarely used for cash and create private rooms.
- ❑ Continuing Care Retirement Community (CCRCs) – different standard for obtaining licensed nursing home beds and these operators often value these beds less than traditional nursing homes do.
 - We have seen several CCRCs sell, and others express a desire to downsize their nursing home bed capacity.
- ❑ Some or all the above, especially when cash may be desired by seller.



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Strategic Opportunities to Add Value to Your Facility (cont.)

EXAMPLE 3:

Convert underperforming assisted living beds to nursing home beds.

- ❑ Nursing homes that contain assisted living (AL) beds within the nursing home often can add material value to their facilities by converting these AL beds to nursing home beds.
- ❑ Decades ago, assisted living beds were often built within nursing facilities. These beds were built to eventually be converted to licensed nursing home beds, if or when market conditions warranted.
- ❑ Frequently these beds are filled with Auxiliary Grant (AG) residents (\$1,850 / \$1,609 per month or \$62 or \$54 ppd).
- ❑ Auxiliary Grant residents often qualify for nursing home care and convert to a nursing home payment rate. Facility will now receive approximately 4xs their current AG rate once the beds are converted to license nursing home beds.



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Strategic Opportunities to Add Value to Your Facility (cont.)

EXAMPLE 3 (cont.):

Convert underperforming assisted living beds to nursing home beds.

- ❑ Converting these beds from assisted living to nursing home beds often require little capital costs.
- ❑ Nursing home beds ("paper" only) can be purchased for around \$50K and are now worth approximately \$150K - \$250K after conversion to nursing home beds.



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Strategic Opportunities to Add Value to Your Facility (cont.)

EXAMPLE 4:

Transfer beds from several facilities to make a new facility in highly desirable market (PD8 – NOVA, PD15 - Richmond, and PDs 20 & 21 - Tidewater)

- ❑ We believe this could be a highly desirable option for many operators.
 - Almost all for-profit providers are now part of regional chains (almost no "Mom and Pops" left, and many national chains have become regional operators).
 - Many chains have facilities that could relocate under utilized beds from several facilities that are rarely used.
 - These beds could be combined to create a 90+ bed facility in a highly desirable under-bedded market.



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Strategic Opportunities to Add Value to Your Facility (cont.)

EXAMPLE 5:

Build a skilled unit with private beds to existing facility without adding beds.

- ❑ By creating 30 bed all private room skilled unit, this will add 60 private rooms to the facility.
- ❑ Operator may be able to later reconvert private rooms in original facility to semi-private rooms as licensed beds become available.



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Should We Renovate our Facility or Build New?

- ❑ This is a very common question we receive from providers.
- ❑ In the past, it was very common for providers to purchase older facilities with the intention of building a "replacement" facility to transfer these beds to. Health systems and governmental providers especially would almost give these beds away to a willing purchaser. Times have changed!
- ❑ This may no longer be a viable option given the material increase in prices for licensed nursing home beds and nursing homes. Even very "outdated" nursing homes are fetching top dollar.
- ❑ If an old and outdated facility is planning a major renovation of their facility, it may make sense for a provider to build new.
- ❑ Reasons why it may be better to build a new facility instead of performing major renovating on an older facility:
 - Historically we have found renovations almost always cost much more than originally anticipated.
 - Less disruptive and safer to existing residents to build a replacement facility and then transfer residents.
 - Medicaid capital reimbursement implications.



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Should We Renovate our Facility or Build New (cont.)?

OVERVIEW OF DMAS FAIR RENTAL VALUE (FRV) METHODOLOGY

- ❑ When building new, the facility should receive the highest possible Medicaid capital rate for their facility for their location.
- ❑ FRV rates are based on the following factor factors:
 - “Facility average age” as calculated by FRV Schedule R-1
 - Location of facility
 - Number of beds
 - Occupancy (88% occupancy floor)
 - Capital taxes and insurance (only historical costs that are reimbursed)
- ❑ “Facility average age” is the weighted average of all the capital assets of the facility (this is what you can manage).
 - Very difficult to make an “old” building reimbursed like a “new” facility when renovated, no mater how much you spend (RS Means limits)
- ❑ It is important to consider population and market forecasts when considering these options.



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Medicaid Peer Groups for Medicaid Payments (current)

PRICE-BASED PEER GROUPS

DIRECT PEER GROUPS

- Northern Virginia MSA (Urban3)
- Other MSAs (Urban4)
- Northern Rural (Rural1)
- Southern Rural (Rural2)

INDIRECT PEER GROUPS

- Northern Virginia MSA (Urban3)
- Other MSA (Urban4)
- Northern Rural (Rural1)
- Southern Rural (Rural2)
- Rest of State – 60 beds or less (Small)



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Peer Group Pay Differences – SY23

Peer Group	Direct Price	Indirect Price (with \$10.49 VBP Add-on)	Total
Urban3	159.33	121.65	280.98
Urban4	137.06	103.73	240.79
Rural1	128.69	103.12	231.81
Rural2	105.78	93.53	199.31

Several planning districts contain more than one Medicaid Peer Group. This could make inter-PD bed moves more financially rewarding (i.e., PD9: Fauquier-Urban4 and Orange County-Rural1)



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Criteria for COPN Approval

The COPN statute provides eight criteria used to determine if a project warrants COPN approval. Not all the items below apply to every project and the Commissioner has wide discretion to weight criteria differently.

§ 32.1-102.3. Certificate required; criteria for determining need.

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

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 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;



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Criteria for COPN Approval (cont.)

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. N/A - 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, ...



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Overview of the COPN Application Process and Timing

Batch Calendar and Groups

The program uses a structured batching process in order to avoid unnecessary duplication of medical care facilities and services and to provide an orderly process for resolving questions about the need to construct or modify facilities or services. The application process and project review can take six to seven months or more to complete. The [Certificate of Public Need Rules and Regulations](#) provides specific information for filing an application.

- There are six review cycles per year, each of which commences every two months.
- Parties have six opportunities per year to apply; if a window is missed, the project faces a delay of at least sixty days.
- Applicants need to adhere to the tightly structured filing deadlines.



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Overview of the COPN Application Process and Timing

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Letter of Intent

Letter of Intent

A Letter of Intent (LOI) starts off the review cycle in the COPN application process. Applicants submit a LOI to the Virginia Department of Health's Division of Certificate of Public Need (DCOPN). In some instances, the LOI must also be sent to the regional health planning agency (currently this only exists in Northern Virginia). LOIs must include the following items

- ✓ Project owner (legal entity name)
- ✓ Scope/bed capacity
- ✓ Type of service
- ✓ Location (county, city, and PD)



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Overview of the COPN Application Process and Timing

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Letter of Intent

COPN Application

- COPN application's deadlines are based on a batch cycle calendar. There are six (6) batch cycles per year and one (1) RFA batch cycle. *
- Applicants fill out specific form documents which are provided by DCOPN.
- There is an application fee of 1% of the proposed capital cost of the project. The minimum fee is \$1,000 and the maximum fee is \$20,000.

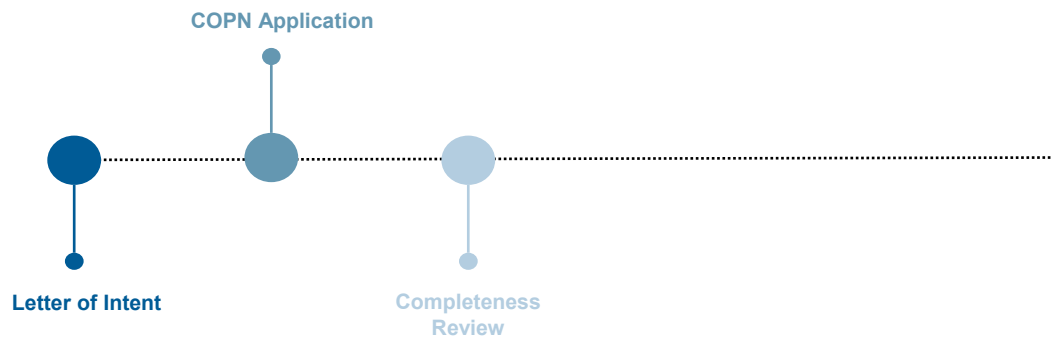
* VDH/DCOPN has not issued an RFA since May 19, 2020.



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Overview of the COPN Application Process and Timing

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Completeness Review

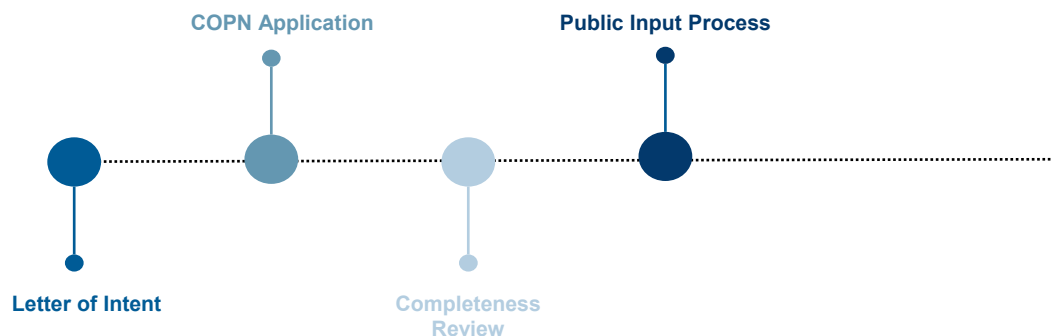
- DCOPN will review application to determine whether the application is complete.
- DCOPN has ten (10) days to review the application for completeness.
- DCOPN may have questions and/or request additional data.
- After the application is accepted for review, DCOPN has 120 days to decide whether a project advances to the next stage of the review cycle.
- If the DCOPN advises a denial of the project and an Informal Fact Finding Conference (IFFC) is requested, additional time is added to this review cycle. If not, the entire process should take approximately 180 days (or 6 months) from that time the LOI was submitted.



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Overview of the COPN Application Process and Timing

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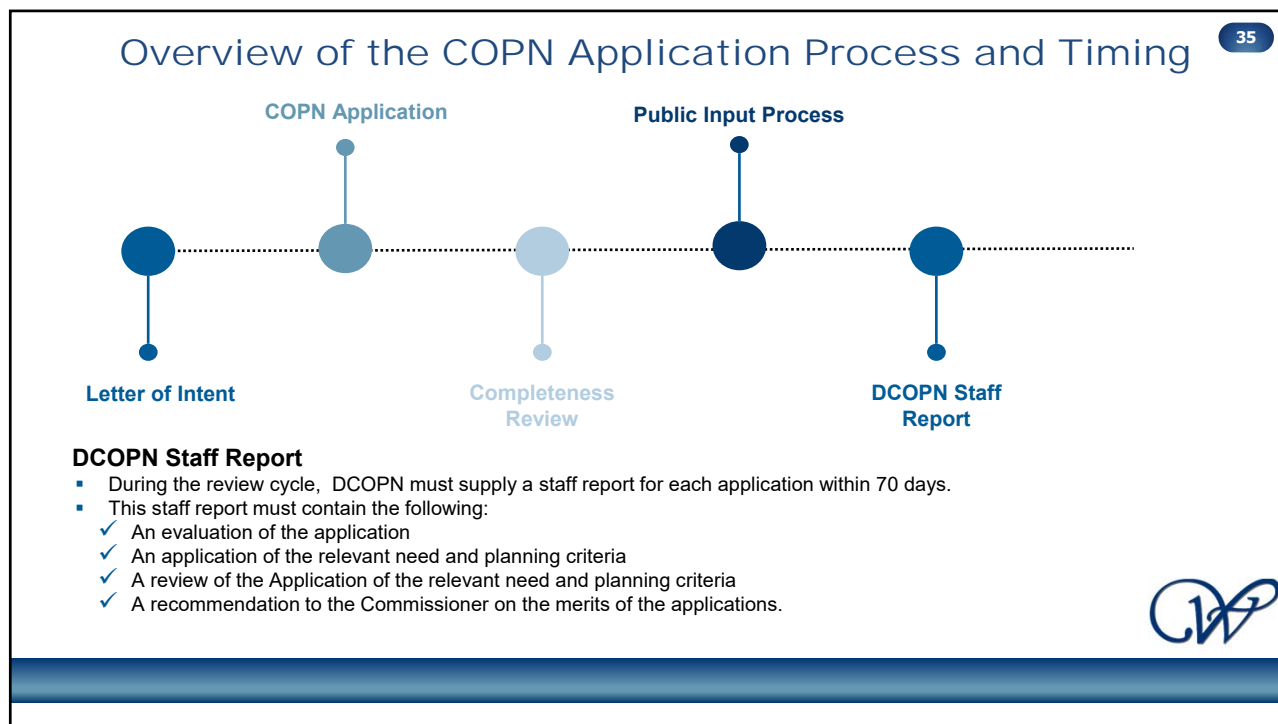


Public Input Process

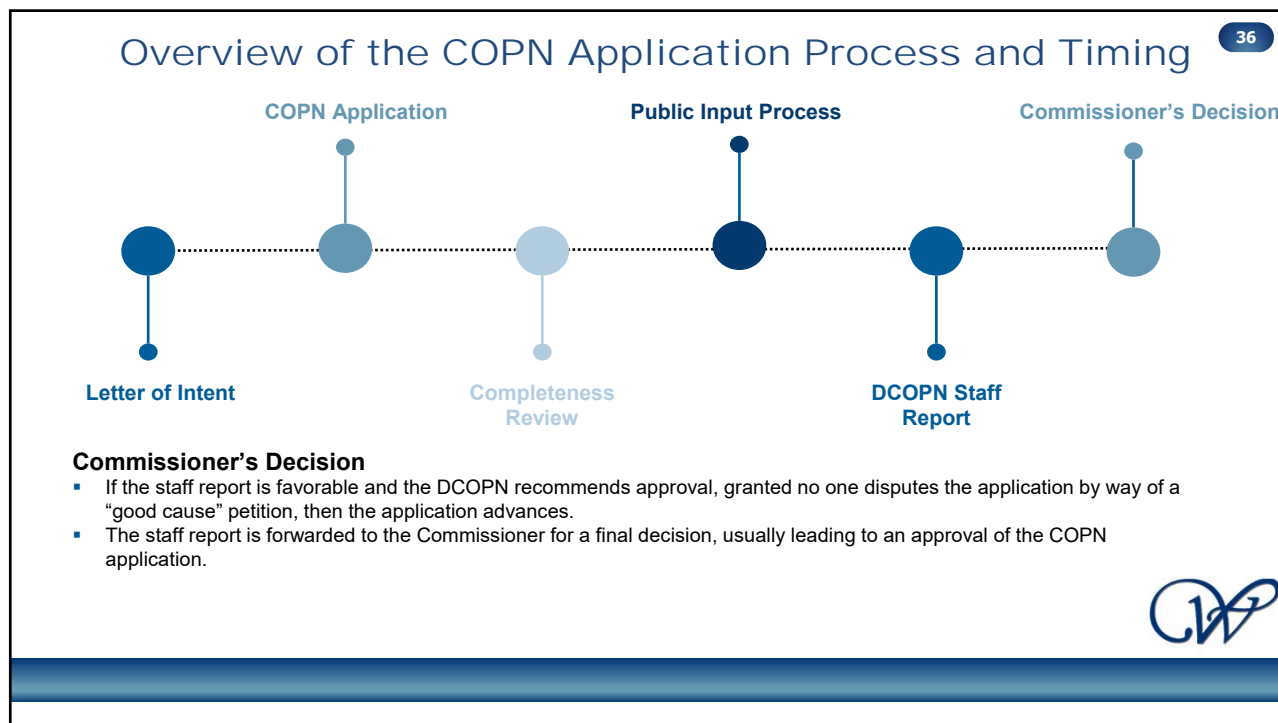
- The public has 45 days to provide input about the proposed project. The applicant, another provider, the locality, or other party may ask DCOPN and/or the regional health planning agency to hold a public hearing.
- Public hearings allow the applicant to present their plans and give the community an opportunity to provide feedback. After the hearing, if the regional health planning agency has been included in the review cycle, they may call for a board meeting to further review the project and give a recommendation to the Commissioner.



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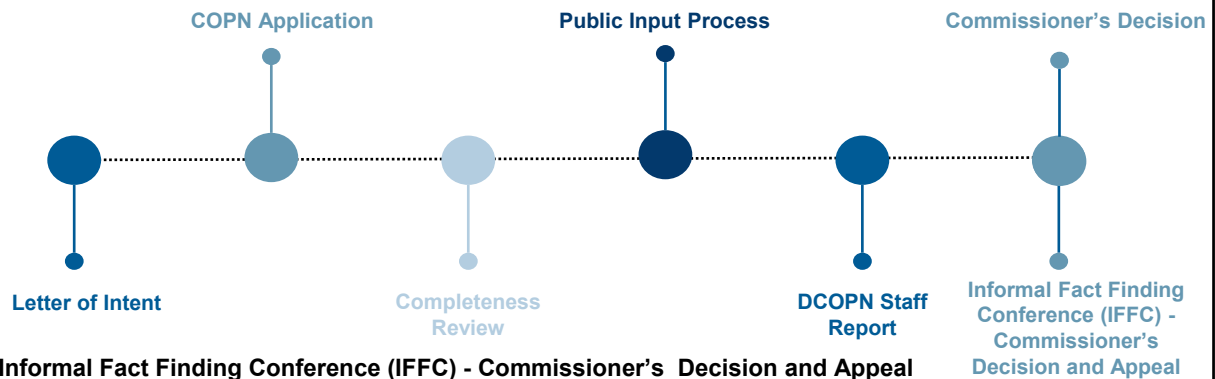
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Overview of the COPN Application Process and Timing

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Informal Fact Finding Conference (IFFC) - Commissioner's Decision and Appeal

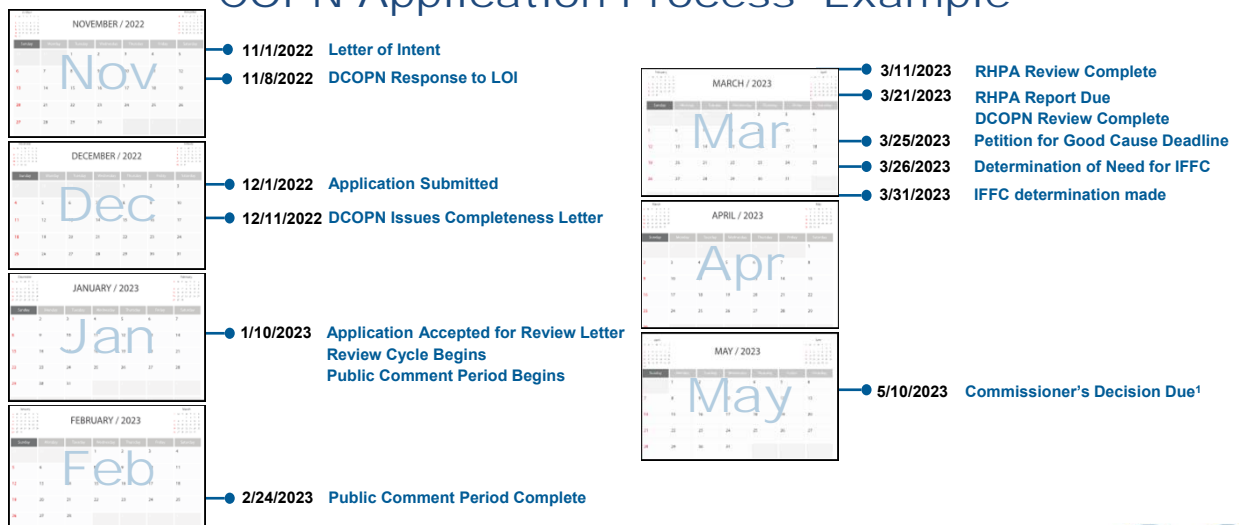
- If DCOPN recommends the project be denied, the applicant can request an IFFC, an administrative proceeding with an Adjudication Officer.
- An IFFC can also be initiated if any person submits a petition to be acknowledged as a "good cause" party to the proceedings.
- IFFCs consist of a presentation of witnesses, documents, and information and legal arguments.
- Legal counsel must be engaged on behalf of the applicant to help prepare for the proceedings and deliver legal arguments before an Administrative Hearing Officer. They also prepares closing arguments and any rebuttal arguments.
- At the conclusion of the IFFC, the Adjudication Officer provides a report with a recommendation for the Commissioner.



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COPN Application Process Example

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¹If IFFC is needed, then the ensuing dates and Commissioner's Decision will be determined by the court calendar and the contesting parties' legal representatives' schedules.



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Building a COPN Team for Success

The COPN process is very structured and contains potential challenges. The applicant must secure the expertise and commit the funds which are often at risk. It is important that providers who pursue COPN approval build a team of experts with the following skills:

- ❑ **COPN application expertise**
 - This person is needed to oversee the overall filing process and navigate all stages of the COPN process.
 - Manages other parties involved in the filing process (financial experts and architects).
 - Help access the merits and likelihood of success with the proposed application.
- ❑ **Architectural expertise**
 - Architects should be skilled in nursing facility construction and have a deep understanding of the regulations involving nursing home facility construction.
- ❑ **Financial expertise**
 - Financial projections and historical financial reporting will need to be submitted with the COPN application.



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Building a COPN Team for Success (cont.)

- ❑ **Financial expertise (cont.)**
 - All historical data should be supported by any publicly available financial data – no discrepancies (i.e., audited financial statements, Virginia Health Information (VHI) filings, Medicare and Medicaid cost reports, ...).
 - Financial projections should be compared to other surrounding facilities, especially facilities that may object to the COPN application.
 - Financial projections should be consistent with past operations and any material variances explained.
 - Financial consultant should be skilled in reimbursement related matters so that payment rates can be justified (i.e., CMI scores, Medicaid capital rates, PDPM Medicare rates, payor mixes, ...)
- ❑ **Legal expertise**
 - Applicants should engage counsel with material experience with the overall COPN process.
 - Legal counsel is engaged to prepare and present arguments on behalf of the applicant at IFFC and develop closing arguments and rebuttal arguments following the IFFC.



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Thank you for attending!

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Please note: This presentation contains general, condensed summaries of actual legal matters, statutes and opinions for information purposes. It is not meant to be and should not be construed as legal advice. Individuals with particular needs on specific issues should retain the services of competent counsel.

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DEFEND YOUR COPN APPLICATION

- > A COPN is valid for 12 months, but can be extended by the Commissioner as follows:
 - 12-Month extension: Extension may be granted upon demonstration that progress is being made towards completion of the project.
 - 24-Month extension: Extension may be granted when substantial and continuing progress is being made towards the development of the project.
 - 36-Month extension: Requires submission of a significant change request.
 - Indefinite extension: Submitted when the project is complete and makes the COPN permanent.

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DEFEND YOUR COPN APPLICATION

- > Appeals
 - If the Commissioner denies a COPN application, there are two options:
 - Submit a new COPN application; or
 - Appeal the decision to Circuit Court pursuant to the Administrative Process Act.
 - 30 days to file Notice of Appeal.
 - 30 days to file Petition for Appeal.
 - Appellate review process.
- > If the Commissioner approves a COPN application:
 - Appeals can only be brought by a party aggrieved who is a named party to the administrative proceeding; or
 - By a party that filed a Petition for Good Cause Standing.

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