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## Client Advisory Proposed Revisions to State Medical Facilities Plan Acute Care Institutions

Earlier this month, the Virginia Department of Health released proposed revisions to the State Medical Facilities Plan (“SMFP”) that may affect your plans for inpatient beds and operating rooms. The Department has also announced a 30-day comment period on the revised SMFP beginning March 3, 2008, which will provide the public with an opportunity to submit written comments. Once the comment period has closed on April 4, 2008, the Department will consider all comments for possible incorporation into the draft. At the end of that process, a final draft will be taken to the Board of Health and submitted for approval. The Department has not set an effective date for the final draft at this time, but July 1, 2008 may be likely.

Most of the proposed revisions are consistent with the changes developed during the SMFP Task Force, which last met in December 2006. The revisions contain additional definitions and some clean up of the regulatory language in addition to the following proposals relevant to the Hospital industry:

**Inpatient Beds.** The Commissioner will consider approving new inpatient beds if the average annual occupancy for the relevant reporting period is 65% at “midnight census” for intensive care beds and 80% at “midnight census” for medical/surgical or pediatric beds, which is a reduction from the current average annual occupancy of 85%. The revisions also treat medical/surgical beds separately from pediatric beds when determining need for these separate categories.

The formula for determining need for medical/surgical beds remains essentially unchanged, except for the lower 80% occupancy standard and consideration of the districts current inventory of licensed beds. Both the current and proposed calculations use a projected population cohort of 18 years or older and rely upon an average use rate calculated over the last three reported years to apply to projected population in five years to identify bed need. The proposed revisions remove references to hospitals in rural or non-rural areas, eliminating the lower volume standard used for rural hospitals.

The proposed changes also treat all new pediatric beds as a distinct service and not just for designated pediatric units. The new calculations consider the population of the planning district that is less than 19 years of age, instead of the current population less than 15 years of age. Otherwise, the formula is the same as the formula for medical/surgical beds.

The need formula for intensive care beds is the same as all other acute care categories, except the average annual occupancy expectation for the smaller units with intensive care beds is 65% for the relevant reporting period.

In applications requesting the expansion or relocation of beds to an off-site location, the proposed regulations require that the project “results in improved distribution of existing resources to meet the community needs.” The SMFP regulations would continue to require proof that a proposed relocation would not materially harm existing providers located within a thirty minute driving time of the new hospital site. The draft SMFP would also recognize the existing service area population’s access to medical services at neighboring facilities following a relocation.

**Long-Term Acute Care Hospital (LTACH).** The revisions do not create a separate category for planning and licensing for long-term acute care beds, and continues to include all LTACH beds with medical/surgical inpatient beds. Approval would require converting existing inpatient beds to LTACH beds or the existence of an identified need. Conversion would require delicensing, although the beds may revert to hospital inpatient beds if unused for 12 months or the LTACH closes its doors.

The revised SMFP requires that CMS certify all LTACHs. However, late last year, Congress imposed a moratorium on CMS certification and payment to any new LTACHs. This moratorium also prohibits increases in bed size of existing LTACHs, with exceptions for states that have only one or two LTACHs and situations in which another LTACH has closed or decreased its bed size. LTACHs already under development when the moratorium legislation passed will be allowed to continue and qualify for certification.

**General Surgical Services.** Surgical services encompass both inpatient operating room procedures and ambulatory surgery center procedures. Under the proposed revisions, outpatient surgery is defined to mean those surgical procedures provided to patients not expected to require overnight hospitalization but who require treatment in a medical care facility exceeding the normal capability found in a physician's office. Although provided in a hospital or outpatient surgical center, outpatient surgery does not include services provided in outpatient departments, emergency rooms, or procedure rooms of hospitals, or physicians' offices. The proposed regulations now define an operating room as “a room used solely or principally for the provision of surgical procedures, especially those involving anesthesia, multiple personnel, recovery room access and a fully controlled environment.” The proposals exclude services in designated procedure rooms and surgical services in operating rooms dedicated exclusively for cesarean sections, trauma, or cardiac surgery from the operating room visit totals.

**Need for Surgical Services.** In determining the future need for new inpatient general purpose or outpatient operating rooms, the Department considers the total operating room visits in the most recent three years, the sum of the planning district’s population for the same three years, the projected population of the planning district five years from the current year, and the average hours per operating room visit in the last year (including set-up and clean-up).

The Department will consider a proposed relocation of operating rooms within the planning district if the move improves availability and distribution of service. This means making general surgical services available within 30 minutes driving time one way for 95% of the population of the planning district. The SMFP proposed that all surgical services be under the direction and supervision of one or more qualified physicians.

**Other Revisions.** The revisions also include revised volume standards for purposes of determining need for new or additional diagnostic services, open heart and cardiac catheterization services, and lithotripsy.

The SMFP will continue to require authorization of projects involving large capital expenditure, proposed at \$15 million or above, up from the current \$5 million. Facilities must continue to demonstrate need, cost effectiveness, and a cost benefit analysis for the project. The capital expenditure rules apply to all medical facilities that seek to renovate, modernize, or expand their current building as well as acquiring equipment not addressed elsewhere in the SMFP.

In reviewing competing applications, the Commissioner will consider the applicants' demonstrated history of completing projects on time and within the approved costs; lower capital costs and operating expenses; consistent compliance with state licensure and federal certification laws; few documented complaints; and un-reimbursed services to the indigent and providing needed but unprofitable services while taking into account the demands of the particular service area.

Finally, the proposed regulations recognize a need for institutional expansion for all medical care facilities in planning districts with excess supply on the grounds that a facility has exceeded its current service capacity to provide such a service or due to its geographic remoteness. This recognition does not translate into justification for the need to establish a new service.

Depending on needs in your location, there may still be opportunities for continued expansion of inpatient beds, operating rooms, or other service lines. Please contact Mellette PC if you have any questions about the impact of the proposed SMFP on future projects or how you can comment and propose changes before the proposals become final.