

March 23, 2026

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Health Systems Agency of Northern Virginia  
3040 Williams Dr. Suite 200  
Fairfax, VA 22031

Virginia Department of Health  
Division of Certificate of Public Need  
9960 Mayland Drive – Suite 401  
Henrico, Virginia 23233

**RE: Response to Opposition Letter by Paul Savoca-COPN Request No VA-8833**

Dear COPN Review Staff,

On behalf of Fairfax Colon & Rectal Surgical Center, LLC (“FCRSC”), we respectfully submit this response to the opposition letter submitted regarding COPN Application No. VA-8833. While we recognize and respect the experience of the opposing physician, the assertions made in the letter are factually inaccurate, unsupported by data, and not aligned with the governing standards of the Virginia State Medical Facilities Plan (SMFP).

We address the key claims below:

**1. Mischaracterization of Public Need**

The assertion that the proposed project is “in no way contributing to public need” is inconsistent with both regional utilization patterns and the SMFP framework governing outpatient surgical services.

- Planning District 8 (PD-8) continues to demonstrate sustained growth in outpatient procedural demand, particularly for colonoscopy and anorectal surgery.
- The proposed project does not introduce new services, but rather repositions existing, high-demand procedures into a more efficient and accessible outpatient setting.
- Our physicians currently perform a substantial procedural volume, a portion of which is constrained by hospital block time limitations and scheduling delays.

#### Quantitative Context:

At the time of application, FCRS performed over 4,200 procedures annually across approximately 3,700 patients, reflecting a high-volume, established surgical practice with consistent demand. This procedural volume represents care that is currently dependent on limited hospital-based scheduling capacity, contributing to inefficiencies and access constraints.

The proposed ASC is designed to appropriately accommodate and streamline this existing demand in a lower-cost, more accessible outpatient environment.

#### Conclusion:

The project directly addresses measurable access constraints and improves timely availability of care, which are core elements of COPN-defined public need.

### 2. Inaccurate Representation of Existing Capacity

The claim that multiple facilities within a limited geographic radius adequately meet demand does not reflect functional capacity or real-world access limitations.

- Hospital-based operating rooms and endoscopy suites are prioritized for higher-acuity cases and are subject to block time restrictions.
- Patients frequently experience delays due to scheduling constraints, even when facilities exist geographically nearby.
- Existing facilities are not demonstrably underutilized; rather, they are operating within expected efficiency ranges.

#### Conclusion:

Geographic proximity alone does not equate to access. The relevant standard is timely, functional availability, which remains constrained.

### 3. Unsupported Allegation of “Cherry Picking”

The assertion that FCRSC intends to selectively treat commercially insured patients is incorrect and directly contradicted by both our application and our longstanding practice patterns.

FCRSC is committed to:

- Accepting Medicare, Medicaid, and Tricare
- Providing care to uninsured patients, including charity care
- Maintaining policies that ensure access regardless of ability to pay

#### Quantitative Context:

Our existing payer mix reflects meaningful participation in government programs, and the ASC will enhance access for these populations by improving efficiency and reducing system barriers. FCRSC's current payer mix includes approximately:

- Medicare: 15%
- Medicaid: 3%
- Tricare: 3.4%
- Charity Care: 1.4%

The proposed ASC will maintain this payer inclusivity, with a projected government payer mix of approximately 22.8%.

FCRSC has already committed to providing a minimum of 2.5% of gross revenue dedicated to indigent care consistent with community expectations.

#### Conclusion:

The characterization of "cherry picking" is unsupported and inconsistent with both our commitments and historical operations.

#### 4. Misleading Statements Regarding Care for Uninsured Patients

The statement that our practice discharges patients due to inability to pay is not accurate.

- FCRS has a demonstrated history of treating uninsured and underinsured patients.
- We participate broadly in government payer programs and maintain policies to ensure medically necessary care is provided.
- The inclusion of 1.4% *documented* charity care, with an increased commitment of a minimum 2.5% of gross revenue dedicated to indigent care in addition to broader access efforts, reflects this commitment.
- The proposed ASC will enhance our ability to deliver cost-effective care across all patient populations.

#### Conclusion:

These claims are not supported by evidence and do not reflect our actual clinical practices.

#### 5. Financial Impact on Existing Providers

The suggestion that the proposed ASC will negatively impact not-for-profit hospitals is inconsistent with established healthcare delivery models.

- Ambulatory surgical centers improve system efficiency by shifting appropriate lower-acuity procedures out of hospital settings.
- This allows hospitals to better allocate resources toward higher-acuity and complex care.
- The proposed services are clinically appropriate for outpatient delivery and are widely recognized as more cost-effective in ASC settings.
- The proposed ASC will absorb a meaningful portion of existing outpatient procedural demand currently performed in hospital settings, thereby improving system-wide efficiency and capacity allocation.

Additionally, our group has historically contributed meaningful surgical and referral volume to local hospitals, and this project is designed to complement, not displace, those relationships.

#### Conclusion:

The project aligns with broader healthcare system goals of efficiency, cost containment, and appropriate site-of-service utilization.

### 6. Context and Prior Involvement

While we respect the opposing physician's experience, it is important to provide relevant context. The opposing physician was previously affiliated with Fairfax Colon & Rectal Surgery and was directly involved in the early planning and development considerations of an ambulatory surgical center model similar to the one proposed in this application. While perspectives may evolve over time, this prior involvement underscores that the concept of a dedicated colorectal-focused ASC is neither novel nor inherently inconsistent with community need.

Additionally, the opposition letter does not include supporting data, utilization analysis, or reference to SMFP criteria, and instead reflects subjective opinion rather than objective evaluation.

#### Conclusion:

The opposition should be considered in context and weighed against the data-driven analysis provided in the application.

### Final Summary

The proposed Fairfax Colon & Rectal Surgical Center:

- Improves access to high-demand outpatient procedures
- Enhances efficiency and reduces costs through appropriate site-of-service care
- Expands access for all payer populations, including government and uninsured patients
- Aligns with SMFP criteria and healthcare policy trends
- Supports, rather than undermines, the broader healthcare delivery system

For these reasons, we respectfully request that the opposition letter be evaluated in light of the objective data, documented commitments, and regulatory standards governing COPN review.

We appreciate your consideration and remain available to provide any additional information.

Sincerely,

A handwritten signature in black ink, appearing to read 'MDL', followed by a long horizontal flourish.

Michael Delac, CMPE  
Chief Operating Officer

Fairfax Colon & Rectal Surgery, PC & Fairfax Colon & Rectal Surgical Center, LLC

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