

**Department of Community Health**

**Technical Advisory Committee**

**Recommendations for Updating the**

**Certificate of Need State Health Plan**

**Specific Review Considerations for Short-Stay General Hospital Beds**

**January 2026**

## **Introduction**

Pursuant to O.C.G.A. § 31-6-21(a), the Georgia Department of Community Health (Department) must review and update the Certificate of Need (CON) State Health Plan every five years beginning in 2025 to ensure the plan meets the evolving needs of the state.

The CON State Health Plan serves as the guiding framework for evaluating facilities and services, including the need methodologies, standards, and rationale used to evaluate projects involving facilities and services requiring a CON.

In 2025, in accordance with O.C.G.A. §§ 31-6-21(c) and 50-4-4, the Department established a Technical Advisory Committee (Committee), in consultation with the Board, to review the CON rules for Short-Stay General Hospital Beds, one of 15 CON-regulated services.

The Department structured the committee with broad-based membership that represents a wide range of geographic areas. Committee membership consists of individuals with expertise in health care planning, regulation, provider best practices, and training and workforce development. Careful consideration was given to selecting representatives from large and small institutions in urban and rural locations across the state.

Over an eight-month period, the Committee examined the definitions and standards for short-stay general hospital beds and developed draft recommendations. The draft recommendations were released for stakeholder feedback in January 2026. In its final deliberations, the Committee considered those comments, which are addressed throughout this report.

This report documents the Committee's deliberations and sets forth its final recommendations for updating the Specific Review Considerations for Short-Stay General Hospital Beds at Ga. Comp. R. & Regs., r. 111-2-2-.20.

## Executive Summary

The CON Program has served as a foundation of Georgia's health care policy since its establishment in 1979, following earlier federal initiatives under the Social Security Act Amendments of 1972. Since its inception, the program has undergone numerous revisions to remain aligned with changing health care priorities in the state.

Most recently, in 2024, House Bill 1339, which was signed by Governor Kemp on April 19, 2024, amended O.C.G.A. § 31-6-21(c) to require the Department to review and update the State Health Plan every five years beginning in 2025.

In response, the Department convened a Technical Advisory Committee in 2025 to review and provide recommendations to update the specific review considerations for short-stay general hospital beds. The Committee met seven times over eight months, engaging in in-depth discussions about the applicability and implications of existing definitions and standards. Drawing on the expertise of its diverse membership, the Committee recommended updates to ensure the regulatory standards reflect with the state's contemporary health care needs and practices.

Several overarching themes emerged from the Committee's deliberations that are reflected in its recommendations:

- **Harmonizing with existing regulations.** The Committee emphasized the need for consistency throughout the CON State Health Plan and related regulations, where possible. To support this goal, the Committee examined relevant statutes and hospital regulations in Georgia and other states to identify opportunities to improve consistency and strengthen Georgia's regulatory approach to short-stay general hospital beds.
- **Consideration for the difference between health care delivery in rural and non-rural areas.** Members underscored the unique concerns for hospital development between rural and non-rural areas of the state. Committee members noted challenges in rural communities related to population size, patient volume, financial resources, and workforce availability.
- **Preserving hospital viability in shifting marketplaces.** Members discussed new considerations for hospitals that exist since the time of the last update. Specifically, regarding CON rules, members addressed the planning and financial implications of the shift from traditional inpatient care to outpatient services and the need to deliberately plan for workforce recruitment and retention.

The Committee's recommendations reflect a commitment to modernizing Georgia's CON standards for short-stay general hospital beds, ensuring alignment with recognized guidelines, and supporting the delivery of quality, cost-efficient, accessible care across the state.

## Committee Membership

The Committee consisted of nine members:

**Bill Lee, Committee Chair**  
Chief Operating Officer  
Evans Memorial Hospital

**Dawn Benson, Esq.**  
Senior Vice President  
General Counsel  
Phoebe Health System

**Ed Grimsley, M.D.**  
Professor  
Internal Medicine Mercer  
University School of Medicine

**Robin Rau**  
Chief Operating Officer  
Miller County Hospital

**Linda Berger**  
Director, Strategy & Planning  
Northeast Georgia Health System

**Shelly Harrell**  
Chief Operating Officer  
Fairview Park Hospital

**Theresa Rohr-Kirchgraber, M.D.,  
FACP, FAMWA**  
Clinician and Professor  
AU/UGA Partnership

**Chet Bhasin**  
Executive Director  
Board of Healthcare Workforce

**Christine MacEwen, Esq.**  
Corporate Counsel  
Piedmont Healthcare

## Meeting Dates

Over eight months, the Committee met seven times to review the Specific Review Considerations for Short-Stay General Hospital Beds. The Committee met on the following dates:

June 30, 2025

August 25, 2025

September 22, 2025

October 21, 2025

November 17, 2025

January 5, 2026

January 26, 2026

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**Committee Recommendations on Updates to  
Specific Review Considerations for Short-Stay General Hospital Beds**

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**Recommended Updates to Definitions in the Specific Review Considerations for  
Short-stay General Hospital Beds**

The Committee conducted a comprehensive review of each definition in Ga. Comp. R. & Regs., r. 111-2-2-.20. The Committee emphasized the importance of ensuring consistency across Department regulations and with definitions used by other state regulatory agencies.

In this section, the existing definition is presented, followed by the Committee's recommendations.

- (a) "Age cohorts" for purposes of these Rules refers to the following age groups: persons zero (0) to seventeen (17); persons eighteen (18) to sixty-four (64); and persons sixty-five (65) and older.

No changes were recommended.

- (b) "Available beds" or "CON approved beds" means the total number of beds authorized for use by a hospital or group of hospitals based on capacity approved or authorized through the Certificate of Need process.

No changes were recommended.

- (c) "Children's hospital" means a hospital in which ninety percent (90%) or more of the patients served by the hospital are seventeen (17) or less years of age.

No changes were recommended.

- (d) "Critical Access Hospital" means a hospital designated as a critical access hospital pursuant to the state's rural health plan and the guidelines of the Medicare Rural Hospital Flexibility Program authorized by section 4201 of the Balanced Budget Act of 1997.

No changes were recommended.

- (e) **Reserved.**

- (f) "Expansion" means the addition of available beds or CON approved beds for an existing hospital.

No changes were recommended.

- (g) "Health planning area" or "planning area" means the twelve (12) state service delivery regions as defined in O.C.G.A. § 50-4-7.

No changes were recommended.

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(h) "Horizon year" means the last year of a five (5) year projection period for need determinations.

No changes were recommended.

(i) "Optimal Occupancy Rate" means a target or expected level of use of available beds as calculated based on the annual patient days divided by the available beds multiplied by three hundred sixty-five (365). The optimal occupancy rate is variable based on the following:

1. for hospitals located in a rural county, sixty-five percent (65%);
2. for hospitals located in a non-rural county, seventy-five percent (75%); and
3. for teaching or children's hospitals, seventy percent (70%).

No changes were recommended.

(j) "Patient days" means the number of days of inpatient services based on the most recent full year of hospital discharge data or the annual hospital questionnaire.

No changes were recommended.

(k) "Replacement" means new construction to substitute another facility for an existing facility. New construction may be considered a replacement only if the replacement site is located three (3) miles or less from the facility being replaced or, in the case of the facility proposing a replacement site beyond the three mile limit, if the replacement site is located within the same county and would serve substantially the same patient population, based on patient origin by zip code and payer mix, as the existing facility.

The Committee recommended increasing the allowable distance for a replacement facility from three miles to five miles for consistency with recent statutory updates.

The Committee recommended the following updated definition:

"Replacement" means new construction to substitute another facility for an existing facility. New construction may be considered a replacement only if the replacement site is located five (5) miles or less from the facility being replaced or, in the case of the facility proposing a replacement site beyond the five mile limit, if the replacement site is located within the same county and would serve substantially the same patient population, based on patient origin by zip code and payer mix, as the existing facility.

(l) "Rural county" means a county having a population of less than 50,000 according to the United States decennial census of 2010 or any future such censuses, as defined in O.C.G.A. § 31-7- 94.1(c)(2).

No changes were recommended.

(m) "Safety net hospital" is defined as a hospital that meets at least two (2) of following criteria:

1. the hospital is a children's hospital or a teaching hospital;

2. the hospital is designated by the Healthcare Facility Regulation Division as a trauma center;
3. Medicaid and Peach Care inpatient admissions constitute twenty percent (20%) or more of the total hospital inpatient admissions;
4. Uncompensated charges for indigent patients constitute six percent (6%) or more of hospital adjusted gross revenue; or
5. Uncompensated charges for indigent and charity patients constitute ten percent (10%) or more of hospital adjusted gross revenue

No changes were recommended.

- (n) "Short stay hospital" or "hospital" is defined as a facility with an average length of stay of less than thirty (30) days.

No changes were recommended.

- (o) "Target service area population" means the total populations of all counties, which are in part or in whole, within a ten (10) mile radius of the planned location of a new, expanded, or replacement hospital.

No changes were recommended.

- (p) "Teaching hospital" means a hospital designated as a teaching hospital by the Georgia Board for Physician Workforce, which serves as a sponsoring or major participating hospital for a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and maintains a written affiliation agreement with an accredited medical school located in Georgia or is owned and operated by an accredited medical school in Georgia.

The Committee discussed updating this definition to reflect the renaming of the Georgia Board for Physician Workforce as the Georgia Board of Health Care Workforce.

The Committee recommended the following updated definition:

"Teaching hospital" means a hospital designated as a teaching hospital by the Georgia Board for Health Care Workforce, which serves as a sponsoring or major participating hospital for a program of graduate medical education accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and maintains a written affiliation agreement with an accredited medical school located in Georgia or is owned and operated by an accredited medical school in Georgia.

## **Recommended Updates to Standards in the Specific Review Considerations for Short-stay General Hospital Beds**

The Committee conducted a comprehensive review of each standard in Ga. Comp. R. & Regs., r. 111-2-2-.20. In this section, the existing standard is presented, followed by the Committee's recommendations.

- (a) A new hospital must be at least fifty (50) beds in size if located in a rural county and at least one hundred (100) beds in size if located in a county other than a rural county.

Over several meetings, the Committee discussed the Department's minimum bed size requirement for new hospitals. This included a review of data on existing CON-authorized hospital bed size across Georgia, utilization trends, and comparative approaches in other states.

The Committee did not reach consensus on updating the minimum bed size requirement for hospitals in rural counties. Some members recommended decreasing the number of required minimum beds. These members were concerned that many rural communities would not be able to support a 50-bed hospital due to the limited population, patient volume, financial resources, and workforce. These members recommended updating the standard to require that new rural hospitals have a minimum of twenty-five (25) beds, a threshold they deemed reasonable as it aligns with the federal bed size requirement for critical access hospitals.

Other members supported retaining the existing 50-bed minimum. They noted that new exemptions from CON review and approval for qualifying rural hospitals eliminate the need to meet the minimum bed size requirements of this standard, which applies to hospitals seeking a CON. These members also cautioned that decreasing the 50-bed requirement could encourage the development of rural hospitals in close proximity to existing hospitals that are already vulnerable, potentially causing negative financial impacts to these facilities.

No changes were recommended.

- (b) The need for a new, replacement or expanded hospital shall be determined through application of an appropriate numerical need methodology designed to assess need for the specific purpose sought in the application.
1. The numerical need for a new hospital shall be determined through application of a demand-based forecasting model. The model is outlined in the steps below:
    - (i) Calculate the use rate for current hospital services in the target service area population by dividing the patient days for each age cohort by the population for each age cohort for same year as patient days were calculated.
    - (ii) Project the horizon year use rate for hospital services in the target service area population by multiplying the use rate for current hospital services by age cohort by the horizon year population by age cohort.

- (iii) Divide the results of the calculations in Step (ii) by 365 and sum these numbers to determine a baseline bed need.
  - (iv) Adjust the baseline bed need by adding a factor to account for use of the hospital services located within the target service area population by persons from out of state. The factor shall be determined by calculating the patient days for the hospitals in the target service area that may be attributed to persons from out of state as a percentage of total patient days, and then dividing that percentage into the baseline bed need. In addition, if the target service area population includes any county or counties outside the state of Georgia, the projected bed need of the out-of-state counties should be calculated by applying the projected rate of beds needed per 1,000 for in-state counties in the target service area population to the prorated portion of population in out-of-state counties.
  - (v) Divide the baseline bed need by the optimal occupancy rate, as determined by the size of the proposed new facility, to project the total number of beds needed for the target service area population.
  - (vi) Calculate the number of available beds for the target service area population by adding all of the short stay beds located in the counties, including those outside of Georgia if applicable, which are in part or in whole within a ten (10) mile radius of the planned location of the new hospital.
  - (vii) Subtract the number of available beds from the total number of beds needed for the target service area population to determine the net number of beds needed.
2. A new hospital shall be approved only if the total target service area population is at least 50,000 persons.
  3. The numerical need for a replacement or expanded hospital shall be determined through application of a demand- based forecasting model. The model is outlined in the steps below:
    - (i) Calculate the county use rate for the current hospital's services by dividing the patients days for Georgia residents by county within each age cohort by the population by county for each age cohort for the same year as patient days were calculated.
    - (ii) Project the horizon year use rate for the hospital's services by multiplying each county use rate by age cohort by the horizon year population of each county by age cohort.
    - (iii) Sum the number of patients resulting from Step (ii) and divide by three hundred and sixty-five (365) to determine a baseline bed need rate.
    - (iv) Adjust the baseline bed need rate by adding a factor to account for use of the hospital's services by persons from out of state. The factor shall be determined by calculating the patient days for the hospital that may be attributed to persons from out of state as a percentage of total patient days, and then dividing that number into the baseline bed need.
    - (v) Divide by optimal occupancy rate, as determined by the size of the proposed facility, to project the total number of beds needed for the replacement or expanded hospital.

- (vi) Compare the results of Step (v) with the number of beds requested for the replacement or expanded hospital and, if appropriate, the number of available beds to determine whether the proposed replacement or expanded hospital meets the need standards.

The Committee reviewed the variables in the Department's methodology, as well as methodologies used in other states. The Committee expressed support for the Department's current approach to projecting need for short-stay general hospital beds.

No changes were recommended.

- (c) A The Department may allow an exception to need and adverse impact standards outlined in Ga. Comp. R. & Regs., r. 111-2-2-.20(3)(b) and (d) for a facility meeting any one of the following criteria:
1. The facility is an existing facility designated by the Department of Public Health as a trauma center;
  2. The facility is an existing teaching hospital;
  3. The facility is a sole community provider and more than twenty percent (20%) of the capital cost of any new, replacement or expanded facility is financed by the county governing authority, as defined in O.C.G.A. § 1-3-3(7), of the home county or the county governing authorities of a group of counties; or
  4. The facility is a designated critical access hospital and is seeking replacement of its existing facility at a size not to exceed twenty-five (25) CON approved beds; or
  5. The facility is an existing short-stay general hospital meeting one of the following conditions:
    - (i) A facility in an urban county or rural county seeking to add short-stay general hospital beds in response to the closure of a short-stay general hospital located within a five (5) mile radius;
    - (ii) A facility in a rural county seeking to add short-stay general hospital beds in response to the closure of a short-stay general hospital located in the same rural county or a contiguous county; or
    - (iii) A facility in an urban county seeking to add short-stay general hospital beds in response to the closure of a short-stay general hospital located in a contiguous rural county.

To qualify for an exception under Ga. Comp. R. & Regs., r. 111-2-2-.20(3)(c)5, the existing hospital must demonstrate that it will serve substantially the same patient population based on patient origin and payor mix data as the closed hospital, to be determined in the sole discretion of the Department. The expansion under Ga. Comp. R. & Regs., r. 111-2-2-.20(3)(c)5 may be for up to twenty percent (20%) of capacity of the applicant hospital and the application for a certificate of need under this exception shall be filed no more than eighteen (18) months after the closure of the short-stay general hospital. Notwithstanding the foregoing, the exception set forth in Ga. Comp. R. & Regs., r. 111- 2-2-.20(3)(c)5 may be requested by an applicant only one (1) time in response to the closure of a particular short-stay general hospital unless such applicant provides written justification in support of a second request that is granted by the department in its sole discretion, if such justification was submitted within no more than eighteen (18) months after closure of that hospital.

The Committed expressed support for modifying the exception under subsection 1 by adopting a different approach to exceptions for trauma centers in non-rural and rural counties. The Committee supported a stipulation that an existing facility in a non-rural county be designated as a Level I or Level II trauma center in order to seek the exception. However, an existing facility located in a rural county designated as a Level I, II, III, or IV trauma center may seek the exception. Members discussed the differing availability of trauma services and the overall viability of providers across the state.

The Committee recommended the following updated language:

1. The facility is an existing facility located in a non-rural county designated by the Department of Public Health as a Level I or Level II trauma center, or an existing facility located in a rural county designated by the Department of Public Health as a Level I, II, III, or IV trauma center;

(d)

1. An applicant for a new, replacement or expanded hospital shall demonstrate the expected effects of the proposed services on other hospitals within the target service area population, including how any enhanced competition will have a positive impact upon the cost, quality, and access to the services proposed; and in the case of applications for a new, replacement or expanded hospital where competition between providers will not have a favorable impact on cost, quality and access, the applicant shall be required to document that its application will not have an adverse impact.
2. An applicant for a new, replacement or expanded hospital shall document in its application that the new, replacement or expanded facility is not predicted to be detrimental to safety net hospitals within the planning area. Such demonstration shall be made by providing an analysis in the application that compares current and projected changes in market share and payer mix for the applicant and any safety net hospitals. Impact on an existing safety net hospital shall be determined to be adverse if, based on the utilization projected by the applicant, any existing safety net hospital would have a total decrease of ten percent (10%) or more in its average annual utilization, as measured by patient days for the two most recent and available preceding calendar years of data.
3. An applicant for a new, replacement or expanded hospital shall document in its application that the new, replacement or expanded facility is not predicted to be detrimental to any teaching hospitals in the state. Such demonstration shall be made by providing an analysis in the application that compares current and projected changes in market share and payer mix for the applicant and any teaching hospitals. Impact on an existing teaching hospital shall be determined to be adverse if, based on the utilization projected by the applicant, any existing teaching hospital would have a total decrease of five percent (5%) or more in its average annual utilization, as measured by patient days for the two most recent and available preceding calendar years of data.

The Committee expressed support for requiring documentation of the expected impact of the proposed services on other hospitals, as outlined in this rule. However, Committee members were divided on the best approach to measuring this impact.

The Committee discussed revising the reference to annual utilization in terms of “patient days” as the benchmark metric in this standard. The Committee determined that a decrease in annual utilization

measured in terms of “adjusted patient days”, or a reduction in commercial payor mix would better reflect and measure actual impact. The Committee noted that “adjusted patient days” should exclude patient lengths of stay in excess of 30 days. The Committee also determined that a total decrease of five percent (5%) or more in annual utilization or commercial payor mix is a reasonable threshold and appropriate for consistency with subsection 3.

The Committee also considered stakeholder concerns regarding the recommendation to require an analysis of the impact on the commercial payor mix of an existing safety-net or teaching hospital. Stakeholders cautioned that this requirement could introduce uncertainty and lead to prolonged litigation over how applicants and opponents should document impact. After extensive discussion, the committee determined that the proposed analysis remains appropriate and reinforces its intent to measure adverse impact in a manner that protects safety-net and teaching hospitals consistent with modern practice. Members asserted that deterioration in the commercial payor mix, on which these hospitals depend to support safety net and teaching functions, is often a more accurate measure of adverse impact than adjusted patient days, which may include a disproportionate number of uninsured and government funded patients. The Committee concluded that adding this test is neither less certain nor more likely to lead to litigation than the existing standard.

The Committee was divided on the manner in which applicants should be required to document impact. Some members expressed support for adding a stipulation that the Department obtain an independent third-party analysis of the proposed project’s impact for an objective, consistent, and transparent evaluation. Other members supported the idea of an objective evaluation, but expressed concern that requiring a third-party analysis would be overly arduous and costly. All members acknowledged that a third-party review would require additional resources, and likely add cost and time to the application and/or review process.

The Committee recommended the following updated language for subsections 2 and 3:

2. An applicant for a new, replacement or expanded hospital shall document in its application that the new, replacement or expanded facility is not predicted to be detrimental to safety net hospitals within the planning area. Such demonstration shall be made by providing an analysis in the application that compares current and projected changes in market share and payer mix for the applicant and any safety net hospitals. Impact on an existing safety net hospital shall be determined to be adverse if, based on the utilization projected by the applicant, any existing safety net hospital would have a total decrease of five percent (5%) or more in its average annual utilization, as measured by adjusted patient days, excluding any patient length of stay in excess of 30 days, or a reduction in commercial payor mix of more than 5% based on the two most recent and available preceding calendar years of data.
3. An applicant for a new, replacement or expanded hospital shall document in its application that the new, replacement or expanded facility is not predicted to be detrimental to any teaching hospitals in the state. Such demonstration shall be made by providing an analysis in the application that compares current and projected changes in market share and payer mix for the applicant and any teaching hospitals. Impact on an existing teaching hospital shall be determined to be adverse if, based on the utilization projected by the applicant, any existing teaching hospital would have a total decrease of five percent (5%) or more in its average annual utilization, as measured by adjusted patient days, excluding any patient length of stay in excess of 30 days, or

a reduction in commercial payor mix of more than 5% based on –the two most recent and available preceding calendar years of data.

- (e) In considering applications joined for review, the Department may give favorable consideration to whichever of the applicants historically has provided the higher annual percentage of unreimbursed care to indigent and charity patients and the higher annual percentage of services to Medicare, Medicaid and Peach Care patients.

No changes were recommended.

- (f) An applicant for a new, replacement or expanded hospital shall foster an environment that assures access to individuals unable to pay, regardless of payment source or circumstances, by the following:
1. providing evidence of written administrative policies that prohibit the exclusion of services to any patient on the basis of age, race, sex, creed, religion, disability or the patient's ability to pay;
  2. providing a written commitment that services for indigent and charity patients will be offered at a standard that meets or exceeds three percent (3%) of annual, adjusted gross revenues for the hospital;
  3. providing a written commitment to participate in the Medicare, Medicaid and Peach Care programs;
  4. providing a written commitment to participate in any other state health benefits insurance programs for which the hospital is eligible; and
  5. providing documentation of the past record of performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to Medicare, Medicaid, and indigent and charity patients.

The Committee discussed updating subsection 5 of this standard to specify a three-year historical time period for documenting an applicant's demonstrated performance in providing services to Medicare, Medicaid and indigent and charity patients to ensure consistency in the evaluation of applications.

The Committee recommended the following updated language:

5. providing documentation of the past record of performance of the applicant over the past three years, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to Medicare, Medicaid, and indigent and charity patients.

(g)

1. An applicant for a replacement or expanded hospital shall document that the hospital is fully accredited by the Joint Commission or another nationally recognized accrediting body, and also

shall provide sufficient documentation that the hospital has no history of significant licensure deficiencies and no history of conditional level Medicare and/or Medicaid certification deficiencies in the past three (3) years and has no outstanding licensure and Medicare and/or Medicaid certification deficiencies. In the event that the hospital is not accredited by the Joint Commission or another nationally recognized health care accreditation body and relies solely on state licensure, the applicant should provide sufficient documentation that the hospital has no history of significant licensure deficiencies and no history of conditional level Medicare and/or Medicaid certification deficiencies in the past five (5) years and has no outstanding licensure and Medicare and/or Medicaid certification deficiencies.

2. An applicant for a new, replacement or expanded hospital shall:

- (i) provide a written commitment that the applicant presently participates, or in the case of a new hospital, will participate, in a statewide or national external reporting and peer review process related to patient safety and control of medical errors;
- (ii) provide evidence of the availability of resources, including health care providers, management personnel and funds for capital and operating needs, for the provision of the hospital services; and
- (iii) document a plan for obtaining and maintaining staff and service quality standards necessary to promote effective patient care and clinical outcomes.

The Committee discussed revising subsection 1 of this standard to reflect best practices and standards of care, including a requirement to demonstrate a plan for staff development and retention in subsection 2(iii). In its discussion the Committee emphasized the importance of maintaining workforce stability and underscored the need for applicants to demonstrate the ability to staff new and expanded programs without diverting human resources from existing programs.

The Committee received comments recommending the addition of specific language prohibiting the diversion of human resources from existing programs. In considering this suggestion, the Committee acknowledged that healthcare workforce shortages are, and will continue to be, a significant challenge. However, the Committee asserted that imposing restrictions that could limit employment opportunities for workers or employers would not be reasonable or consistent with applicable law. The Committee expressed confidence that its recommendation to require a reasonable and credible plan for staffing inherently demands broad, sustainable workforce development and recruitment strategies, and that such a plan could not be satisfied by an approach reliant on shifting staff away from existing programs.

The Committee recommended the following updated language:

- 1. An applicant for a replacement or expanded hospital shall document that the hospital is fully accredited by CMS or a CMS deemed accreditation organization, and shall also provide sufficient documentation that the hospital has no history of significant licensure deficiencies and no history of an Immediate Jeopardy finding by CMS or a CMS deemed accreditation organization in the past three (3) years and no Condition Level finding in the past three years that was not closed on the initial follow up on-site survey. In the event that the hospital is not accredited by the Joint Commission or another nationally recognized health care accreditation body and relies solely on state licensure, the applicant should provide sufficient documentation that the hospital has no history of significant licensure deficiencies and no history of conditional level Medicare and/or

Medicaid certification deficiencies in the past five (5) years and has no outstanding licensure and Medicare and/or Medicaid certification deficiencies.

2. (iii) document a reasonable and credible plan for obtaining and maintaining staff and service quality standards necessary to promote effective patient care and clinical outcomes, including staff development and retention plans.

(h)

1. An applicant for a new, replacement or expanded hospital shall document a plan to operate an emergency room licensed by the Healthcare Facility Regulation Division.

The Committee discussed updating the term “emergency room” and clarifying that all new and expanded programs must provide emergency services on a continuous basis. Members determined that the term “emergency services” is more consistent with current regulatory usage and better reflects the scope of care provided. In light of stakeholder feedback, the Committee also recommended updating the original language in the rule to clarify that the Healthcare Facility Regulation Division of the Department does not separately license emergency services.

Members of the Committee emphasized the importance of reinforcing the requirement that new and expanded programs maintain continuous emergency services and expressed strong agreement that hospitals failing to do so should be at risk of losing their ability to operate. The Committee discussed the most appropriate time period for defining continuous service. While many members were in favor of a 6-month period, the Committee ultimately determined that a 12-month period aligns more closely with the existing regulatory framework, reduces potential confusion, acknowledges that temporary closures may be unavoidable due to circumstances beyond a hospital’s control, and addresses concerns raised by stakeholders.

The Committee recommended the following updated language:

1. An applicant for a new, replacement or expanded hospital shall document a plan to operate emergency services. If an operational hospital fails to, or ceases to, provide emergency services for a consecutive time period of twelve (12) months, the Department may revoke a CON.

2. An applicant for a new, replacement or expanded hospital shall provide a description of the proposed service area for the hospital and document a community planning process that addresses primary care relationships and the range of transfer and referral activities across the range of care levels. The descriptions and community planning process should address:
  - (i) Estimated geographic boundaries of primary and secondary service areas and the primary and outpatient providers in these areas;
  - (ii) Demographic and income characteristics of the service area by age, gender and racial compositions;
  - (iii) Anticipated payer sources by population totals and percentages to include public payers and

- indigent and charity care services;
- (iv) Patient access to the full continuum of care, including discharge planning and long-term care options;
  - (v) The projected financial and economic impact that the project will have on the community;
  - (vi) Strategies related to physician recruitment and medical staffing to include the hospital's plan to ensure that the care provided by physicians and other clinicians is made available to patients without regard for ability to pay;
  - (vii) The manner in which the facility coordinates or will coordinate with the existing health care system;
  - (viii) The manner(s) in which the hospital will make available the necessary ancillary and support services;
  - (ix) The manner in which the hospital will support the operation of any affiliated critical access hospitals, if applicable.

The Committee emphasized the importance of making sure that new projects include discharge planning in patient care.

The Committee recommended adding the following standard to subsection 2:

- The manner in which the hospital will address standard post-discharge pathways, including, but not limited to, documented relationships and plans for patient discharge to skilled nursing facilities, long-term care, home health, primary care providers, therapy providers, outpatient services, and other services.

3. An applicant for a new, replacement or expanded hospital shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the hospital.

The Committee discussed updating the reference to “charges” to “reimbursement” for alignment with current hospital practices. In considering stakeholder concerns about maintaining confidentiality of reimbursement rates, the Committee concluded that the requirement to demonstrate the availability of funds can be satisfied through a review of aggregate data, which preserves confidentiality while meeting the intent of the standard.

The Committee recommended the following updated language to subsection 3:

3. An applicant for a new, replacement or expanded hospital shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the cost and aggregate reimbursement for providing health services by the hospital.

4. An applicant for a new, replacement or expanded hospital shall demonstrate that proposed charges for services shall compare favorably with charges for other similar hospital services in the planning area when adjusted for annual inflation. When determining the accuracy of an applicant's projected charges for hospital services, the Department may compare the applicant's history of charges if applicable, with other hospitals in the planning area(s) previously served by the applicant or its parent company.

No changes were recommended.

The Committee also discussed requiring new, replacement, or expanded hospitals to meet the price-transparency standards of the Centers for Medicare & Medicaid Services.

The Committee recommended adding the following standard:

5. An applicant for a new, replacement or expanded hospital shall demonstrate that it publishes pricing information that complies with requirements by the Centers for Medicaid and Medicare Services, including public posting of standard charges in both machine-readable and consumer-friendly formats.

(i)

1. To respond to changes in the health care delivery system and to promote improved efficiency, access and cost-containment, the Department may authorize the consolidation of two or more hospitals located in one rural county or in contiguous rural counties. A proposal to consolidate hospitals into a single, new consolidated hospital requires a Certificate of Need and must comply with the following criteria.
2. Two or more existing facilities, each of which are operational at the time of approval and each of which are located in the same rural county or in contiguous rural counties, may seek a consolidation to create a single consolidated facility at an existing site or a new site within the same rural county or one of the same rural counties. The applicant or applicants for such a consolidated facility must be able to meet the following conditions:
  - (i) The available beds for the proposed consolidated facility must not exceed the total number of available beds of the existing facilities proposed for consolidation;
  - (ii) The applicant(s) for the proposed consolidated facility must show, using patient origin data, that the proposed new facility and/or location is reasonably projected to continue to meet the utilization needs of those populations that historically utilized the existing facilities;
  - (iii) The applicant(s) must explain the impact of consolidation on the service area's health care delivery system and show that any negative impacts on existing and approved providers will be outweighed by the benefits of the proposal;
  - (iv) The applicant must submit documentation demonstrating that the consolidation will promote the most efficient handling of patient needs; improve the ability to update medical technology

infrastructure; maximize efficiency for capital and physical plant needs; and improve consumer access to enhanced quality and depth of services; and

- (v) The applicant(s) must comply with all other provisions of this Rule with exception of the need and adverse impact standards set forth in Ga. Comp. R. & Regs., r. 111-2-2-.20(3)(b) and (d).

No changes were recommended.

(j)

1. To respond to changes in the health care delivery system and to promote improved efficiency, access and cost-containment, the Department may authorize the consolidation of two or more hospitals located in one non-rural county. A proposal to consolidate hospitals into a single, new consolidated hospital requires a Certificate of Need and must comply with the following criteria.
2. Two or more existing facilities, each of which are operational at the time of approval and each of which are located in the same non-rural county, may seek a consolidation to create a single consolidated facility at an existing site or a new site within the same non-rural county. The consolidating facilities must apply as co-applicants. The applicant or applicants for such a consolidated facility must be able to meet the following conditions:
  - (i) The available beds sought for the proposed consolidated facility must not exceed the sum of the total number of beds for which each of the consolidating facilities would be authorized, at the time the application is filed, pursuant to the demand-based forecasting model for determining need set forth in Ga. Comp. R. & Regs., r. 111-2-2-.20(3)(b)3.
  - (ii) The applicant(s) for the proposed consolidated facility must show, using patient origin data by zip code, that the proposed new facility and/or location is reasonably projected to continue to meet the utilization needs of those populations that historically utilized the existing facilities;
  - (iii) The applicant(s) must explain the impact of consolidation on the facilities to be consolidated existing service area(s) health care delivery system and show that any negative impacts on existing and approved providers will be outweighed by the benefits of the proposal;
  - (iv) The applicant must submit documentation demonstrating that the consolidation will promote the most efficient handling of patient needs; improve the ability to update medical technology infrastructure; maximize efficiency for capital and physical plant needs; and improve consumer access to enhanced quality and depth of services;
  - (v) The consolidating facilities must not seek to offer in a consolidation application any new clinical health service at the proposed new site not offered in each or all of the facilities to be consolidated.

The Committee supported incorporating additional provisions whereby proposed consolidations would not need to comply with the need and adverse impact standards. Additionally, the Committee supported adding a requirement that consolidated facilities agree to not seek to offer a new clinical health service for a period of two years, to ensure that the original objectives of the proposed project are maintained.

The Committee recommended adding the following standards:

- The applicant(s) must comply with all other provisions of this Rule with exception of the need and adverse impact standards set forth in Ga. Comp. R. & Regs., r. 111-2-2-.20(3)(b) and (d);
- The consolidating facilities must provide documentation of an agreement to not seek to offer a new clinical health service at the proposed site for a period of two (2) years after the consolidation is fully implemented.

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**Exhibit 1**

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# STATE SERVICE DELIVERY REGIONS

Amended Effective July 1, 2005

