

**Department of Community Health**

**Technical Advisory Committee**

**Recommendations for Updating the**

**Certificate of Need State Health Plan's**

**Specific Review Considerations for Perinatal Services**

**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 Perinatal Services, 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 a seven-month period, the Committee examined the definitions and standards for perinatal services 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 Perinatal Services at Ga. Comp. R. & Regs., r. 111-2-2-.24.

## 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 perinatal services. The Committee met seven times over seven 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 regulatory standards.** The Committee emphasized the importance of consistency throughout the CON State Health Plan's range of regulated services, where possible. To support this goal, the Committee examined other relevant rules in Georgia and CON programs in other states to offer recommendations to improve upon the Department's regulatory approaches to perinatal services in Georgia.
- **Aligning with contemporary best practices in health care.** The Committee recommended aligning CON definitions with national guidelines set forth by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), and with the Georgia Department of Public Health.
- **Emphasizing public health.** Committee members underscored the importance of perinatal health within Georgia's broader public health framework, particularly recognizing the efforts to strengthen current planning initiatives for Regional Perinatal Centers.

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

## Committee Membership

The Committee consisted of eleven members:

### **Jason Stevens, Committee Chair**

Senior Vice President, Deputy General Counsel  
Wellstar MCG

### **Julie Ballantine**

Director, Strategic Planning  
Northside Hospital

### **Mike Banna**

Vice President, Strategic &  
Financial Planning  
Children's Healthcare of Atlanta

### **Keisha Renee' Callins, M.D., MPH**

OB/GYN, Community Health Care  
Systems, Inc.  
Professor, Mercer University  
School of Medicine  
Affiliate Physician, Liberty  
Regional Medical Center

### **Darcy Craven**

Chief Executive Officer  
Archbold Medical Center

### **Kaitlyn Kopp**

Director, Government Relations  
Department of Public Health

### **David Levitt**

Levitt Healthcare Affiliates

### **Chadburn Ray, M.D.**

Professor, OB/GYN  
Augusta University Medical College  
of Georgia

### **Lalitha Sivaswamy, M.D.**

Chair & Service Line Leader  
Pediatric Neurology  
Atrium Health Navicent Medical  
Center

### **LaDon Toole**

Chief Executive Officer  
Memorial Hospital and Manor

### **Mattie Feasel Wolf, M.D., MsC**

Assistant Professor of Pediatrics,  
Division of Neonatal-Perinatal  
Medicine  
Emory University School of  
Medicine

## Meeting Dates

Over seven months, the Committee met seven times to review the Specific Review Considerations for Perinatal Services. The Committee met on the following dates:

July 8, 2025

August 27, 2025

October 3, 2025

November 3, 2025

December 10, 2025

January 26, 2028

January 28, 2026

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**Committee Recommendations on Updates to Specific Review Considerations for Perinatal Services**

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### Recommended Updates to Definitions in the Specific Review Considerations for Perinatal Services

The Committee conducted a comprehensive review of each definition in Ga. Comp. R. & Regs., r. 111-2-2-.24. The Committee emphasized the importance of ensuring that Georgia's definitions are consistent with those definitions used by other regulatory authorities, as appropriate, and reflect current standards of care.

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

- (a) "Basic Perinatal Services (Level I)" means providing basic inpatient care for pregnant women and newborns without complications; managing perinatal emergencies; consulting with and referring to specialty and subspecialty hospitals; identifying high-risk pregnancies; providing follow-up care for new mothers and infants; and providing public/community education on perinatal health.

A definition for "Basic perinatal services" is found in Georgia Code, O.C.G.A. 31-6-2(3), which is consistent with this definition.

No changes were recommended.

- (b) "Most recent year" means the most current twelve-month period within a month of the date of completion of an application or within a month of the date of completion of the first application when applications are joined. If the Department has conducted a survey within six (6) months of the date of completion of the first application when applications are joined, the Department may consider the most recent year to be the report period covered by the prior survey.

No changes were recommended.

- (c) "Neonatal Intensive Care Service (Subspecialty/Level III)" means a hospital service that meets the requirements for a Neonatal Newborn Care Service and meets the definition of a Subspecialty Perinatal Hospital Service as contained in the most recent edition of the Recommended Guidelines for Perinatal Care in Georgia, as published by the Council on Maternal & Infant Health.

The Committee was in favor of referencing the guidelines used by the Georgia Department of Public Health.

The Committee recommended the following updated definition:

"Neonatal Intensive Care Service (Subspecialty/Level III)" means a hospital service that meets the requirements for a Neonatal Newborn Care Service and meets the requirements for Level III Neonatal Intensive Care Unit in the most recent edition of the American Academy of Pediatrics' Standards for Neonatal Levels of Care.

The Committee was in favor of incorporating the perinatal levels of care used by the Georgia Department of Public Health.

The Committee recommended adding the following definition:

(c.1) "Neonatal Intensive Care Service (Level IV)" means a hospital service that meets the requirements for a Neonatal Newborn Care Service and meets the requirements for Level IV Neonatal Intensive Care Unit in the most recent edition of the American Academy of Pediatrics' standards for Neonatal Levels of Care.

(d) "Neonatal Intermediate Care Service (Specialty/Level II)" means a hospital service that meets the requirements for a Neonatal Newborn Care Service and meets the definition of a Specialty Perinatal Hospital Service as contained in the most recent edition of the Recommended Guidelines for Perinatal Care in Georgia, as published by the Council on Maternal & Infant Health.

The Committee was in favor of referencing the guidelines used by the Georgia Department of Public Health.

The Committee recommended the following updated definition:

"Neonatal Intermediate Care Service (Specialty/Level II)" means a hospital service that meets the requirements for a Neonatal Newborn Care Service and meets the requirements for Level II Special Care Nursery in the most recent edition of the American Academy of Pediatrics' standards for Neonatal Levels of Care.

(e) "Neonatal Newborn Care Service (Basic/Level I)" means a hospital service which meets the minimum standards contained in Chapter 111-8-40 of the Rules of the Healthcare Facility Regulation Division, such chapter being entitled "Newborn Service. Amended." titled "Maternal and Newborn Services."

The Committee was in favor of referencing the guidelines used by the Georgia Department of Public Health.

The Committee recommended the following updated definition:

"Neonatal Newborn Care Service (Basic/Level I)" means a hospital service which meets the Requirements for Level I Well Newborn Nursery in the most recent edition of the American Academy of Pediatrics' standards for Neonatal Levels of Care.

(f) "Obstetric Service" means a hospital service that meets the minimum standards contained in Chapter 111-8-40 of the Rules of the Healthcare Facility Regulation Division, such chapter being entitled "Maternity and Obstetric Service. Amended." titled "Maternal and Newborn Services."

The Committee was in favor of referencing the guidelines used by the Georgia Department of Public Health.

The Committee recommended the following updated definition:

"Obstetric Service" means a hospital service that meets the minimum standards for maternal care in the most recent edition of the American College of Obstetricians and Gynecologists' standards for

Levels of Maternal Care.

- (g) "Official Inventory" means the inventory for each hospital of Basic Perinatal Service and Neonatal Intermediate and Intensive Care Service beds maintained by the Department based upon responses to the Annual Hospital Questionnaire (AHQ) and/or its Perinatal Addendum and any Certificate of Need approved beds after the period covered by the AHQ and with the following provisions:
1. the official inventory for each facility will remain unchanged for the year following the last day of the report period on each hospital's completed AHQ and/or its Perinatal Addendum unless the Department approves a change of bed capacity through the Certificate of Need process; and
  2. the capacity of existing freestanding birthing centers will not be counted as part of the official inventory of available services when computing unmet numerical need for Basic Perinatal Services in a planning area.

No changes were recommended.

- (h) "Perinatal physician training program" refers to obstetrics and gynecology, family practice and pediatrics disciplines.

The Committee recommended adding types of training programs and adding "neonatal medicine" to the list of disciplines.

The Committee recommended the following updated definition:

"Perinatal physician training program" refers to one or more of the following: any residency program, fellowship program, or other training program that involves training and ultimate expertise in branches of all obstetrics and gynecology, neonatal medicine, family practice, and pediatrics disciplines.

- (i) "Planning Areas" means fixed sub-state regions for reviewable services as defined in the State Health Component Plan for Perinatal Services.

The Committee reviewed the defined regions. (See Exhibit 1.)

No changes were recommended.

- (j) "Regional Perinatal Center" (RPC) means those hospitals designated by the Department of Public Health to serve a defined geographic area to provide the highest level of comprehensive perinatal health care services for pregnant women, their fetuses and neonates of all risk categories. The RPC accepts patients in need of these services from its region regardless of race, creed, religion, ability to pay, or funding source. The RPC provides consultation and transport for patients requiring special services; coordination and assurance of follow-up medical care for maternal and neonatal patients requiring special care; educational support to ensure quality care in institutions involved in perinatal

health care; compilation, analysis, and evaluation of perinatal data from the center and referring hospitals and coordination of perinatal health care within the region.

No changes were recommended.

- (k) "Urban County" means a county with a projected population for the horizon year of 100,000 or more and a population density for that year of 200 or more people per square mile. All other counties are "rural."

No changes were recommended.

The Committee recommended adding a definition for "nurse midwifery training program," which appears in Rule 111-2-2-.24(3)(c), but is not defined. To develop this definition, the Committee relied on guidance from the Georgia Board of Nursing. The Georgia Board of Nursing advised that certified nurse midwives are regulated under its authority and must be certified by the American Midwifery Certification Board, which recognizes educational programs accredited by the Accreditation Commission for Midwifery Education.

The Committee recommended adding the following definition:

"Nurse midwifery training program" refers to any program accredited by the Accreditation Commission for Midwifery Education.

### Recommended Updates to Standards in the Specific Review Considerations for Perinatal Services

The Committee conducted a comprehensive review of each standard in Ga. Comp. R. & Regs., r. 111-2-2-.24. In this section, the existing standard is presented, followed by the Committee's recommendations.

(a) The need for a new or expanded Obstetric Service, Neonatal Intermediate Care Service and Neonatal Intensive Care Service shall be determined through application of a Numerical Need method and an assessment of the aggregate occupancy rate of existing services.

1. The numerical need for a new or expanded Obstetric Service in a planning area shall be determined through the application of a demand-based forecasting model. The model is outlined in the steps listed below, and all data elements relate to each planning area:

(i) Calculate the average obstetric utilization rate (UR) by dividing **the obstetric days (OBDays) reported by hospitals for the two most recent 12-month reporting periods of the Annual Hospital Questionnaire and/or its Perinatal Addendum** by the female population ages 15 to 44 (FP) for the corresponding years:

$$UR = \frac{OBDays_1 + OBDays_2}{FP_1 + FP_2}$$

(ii) Multiply the obstetric utilization rate by the projected female population ages 15 to 44 (PFP) for the horizon year to determine the number of projected obstetric days (POBDays):

$$POBDays = UR \times PFP$$

(iii) Calculate the number of projected obstetric beds (POBBeds) by dividing the number of projected obstetric days by 273.75 (the result of 365 days multiplied by the occupancy standard of seventy-five percent (75%)) with any fraction rounded up to a whole bed:

$$POBBeds = \frac{POBDays}{273.75}$$

(iv) Determine the net numerical unmet need (UN) for new or additional obstetric beds by subtracting the number of beds in the Official Inventory (OI) from the number of projected obstetric beds:

$$UN = POBBeds - OI$$

2. The numerical need for a new or expanded Level II Neonatal Intermediate Care Service in a planning area shall be determined through the application of a demand-based forecasting model. The model is outlined in the steps below, and all data elements relate to each planning area:

(i) Calculate the average resident live-birth rate (ABR) using **the sum of the resident live births (RB) for the three most recent calendar years available from the Department of Public Health or other official source** divided by the corresponding years' female population ages 15 to 44 (FP):

$$ABR = \frac{RB_1 + RB_2 + RB_3}{FP_1 + FP_2 + FP_3}$$

- (ii) Determine the number of projected resident live births (PRB) for the horizon year by multiplying the average resident live-birth rate by the estimated female population ages 15 to 44 (PFP) for the horizon year:

$$PRB = ABR \times PFP$$

- (iii) Calculate the projected number of neonatal intermediate care patient days (PN2Days) in the horizon year by multiplying **the average number of patient days (N2Days) in neonatal intermediate care beds reported by hospitals for the two most recent 12-month reporting periods of the Annual Hospital Questionnaire and/or its Perinatal Addendum** by the number of projected resident live births divided by the actual number of resident live births (RB) available from the Department of Public Health or other official source for the most recent calendar year:

$$PN2Days = N2Days \times \frac{PRB}{RB}$$

- (iv) Project neonatal intermediate care bed need (N2Beds) into the horizon year by dividing the projected patient days for neonatal intermediate care services by 292 (the result of 365 days multiplied by the occupancy rate of eighty percent (80%)) with any fraction rounded up to a whole bed:

$$N2Beds = \frac{PN2Days}{292}$$

- (v) To determine unmet numerical bed need (UN), subtract the official inventory (OI) from the projected neonatal intermediate care bed need:

$$N2Beds = POBBeds - OI$$

3. The numerical need for a new or expanded Level III Neonatal Intensive Care Service in a planning area shall be determined through the application of a demand-based forecasting model. The model is outlined in the steps below, and all data elements relate to each planning area:

- (i) Calculate the average resident live-birth rate (ABR) using **the sum of the resident live births (RB) for the three most recent calendar years available from the Department of Public Health or other official source** divided by the corresponding years' female population ages 15 to 44 (FP):

$$ABR = \frac{RB_1 + RB_2 + RB_3}{FP_1 + FP_2 + FP_3}$$

- (ii) Determine the number of projected resident live births (PRB) for the horizon year by multiplying the average resident live-birth rate by the estimated female population ages 15 to 44 (PFP) for the horizon year:

$$PRB = ABR \times PFP$$

- (iii) Calculate the projected number of neonatal intensive care patient days (PN2Days) in the horizon year by multiplying **the average number of patient days (N2Days) in neonatal intensive care beds reported by hospitals for the two most recent 12-month reporting periods of the Annual Hospital Questionnaire and/or its Perinatal Addendum** by the number of projected resident live births divided by the actual number of resident live births (RB) available from the Department of Public Health or other official source for the most recent calendar year:

$$\text{PN2Days} = \text{N2Days} \times \frac{\text{PRB}}{\text{RB}}$$

- (iv) Project neonatal intensive care bed need (N2Beds) into the horizon year by dividing the projected patient days for neonatal intensive care services by 292 (the result of 365 days multiplied by the occupancy rate of eighty percent (80%)) with any fraction rounded up to a whole bed:

$$\text{N2Beds} = \frac{\text{PN2Days}}{292}$$

- (v) To determine unmet numerical bed need (UN), subtract the official inventory (OI) from the projected neonatal intensive care bed need:

$$\text{UN} = \text{N2Beds} - \text{OI}$$

4. Prior to approval of a new or expanded Obstetric Service, Neonatal Intermediate Care Service or Neonatal Intensive Care Service in a planning area, the aggregate occupancy rate for all similar services in that planning area shall equal or exceed seventy-five percent (75%) for an Obstetric Service and eighty percent (80%) for a Neonatal Intermediate Care Service or Neonatal Intensive Care Service for each of the two (2) most recent years.

Over several meetings, the Committee discussed the Department's methodology for projection need for perinatal services. The Committee reviewed the variables in the Department's methodology, methodologies used in other states, and actual utilization and projections over the past ten years.

The Committee expressed support for the Department's current approach of applying different occupancy thresholds for the different levels of care, agreeing that higher levels of care warrant higher occupancy thresholds.

A majority of members recommended adopting consistent historical time periods across all levels of care within the methodology, rather than relying on data from differing time periods. Those time periods are in bold in standard (a). There was no consensus on which time period should be recommended.

Among those favoring consistency, opinions differed on whether a longer or shorter historical period should be used. Some argued that a three-year period would better capture broader health planning trends. Others preferred a two-year period for a more immediate response to shifts in demand for services.

One member disagreed with the need to standardize the historical time period across all levels of care reasoning that the shorter time period used for subspecialty neonatal intensive care, in particular, is consistent with the need to more quickly adapt to rapid increases in demand for patient care year over year, compared to other levels of care.

While members expressed differing views on the time period that would best serve Georgia's health care needs, the Committee also observed that these distinctions are likely theoretical. A review of the historical data revealed that significant year-to-year fluctuations in utilization and population have not occurred in recent years, which reinforced confidence in the reliability of the current approach.

No changes were recommended.

- (b) Exceptions to need may be considered by the Department as follows:

1. To provide that an applicant for new basic perinatal services shall not be subject to the need

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standard of section (3)(a)1. or the aggregate occupancy standard of section (3)(a)4. of this Rule if:

- (i) The proposed new service would be located in a county where only one civilian health care facility or health system is currently providing basic perinatal services; and
  - (ii) There are not at least three (3) different health care facilities in a contiguous county providing basic perinatal services.
- 2. To allow expansion of an existing Level I or Level II or Level III service, if the actual utilization of that service has exceeded 80 percent occupancy over the most recent two years; or
  - 3. To remedy an atypical barrier to perinatal services based on cost, quality, financial access, or geographic accessibility. An applicant seeking such an exception shall have the burden of proving to the Department that the cost, quality, financial access, or geographic accessibility of current services, or some combination thereof, result in a barrier to services that should typically be available to citizens in the planning area and/or the communities under review. In approving an applicant through the exception process, the Department shall document the bases for granting the exception and the barrier or barriers that the successful applicant would be expected to remedy.

With the recommendation to formally recognize Level IV NICU services in these rules, the Committee also recommended affording Level IV NICU services an opportunity to expand when utilization demonstrates sufficient demand, by adding the language below. To guide such determinations, the Committee recommended retaining the 80 percent utilization threshold as a reasonable and appropriate benchmark for assessing expansion needs.

The Committee also considered stakeholder concerns about recognizing Level IV NICU services and creating a pathway for expanding these particular services without establishing a separate numerical need methodology at Rule 111-2-2-.24(3)(a) above. The Committee clarified that it does not intend to recommend an additional numerical need methodology for Level IV NICU services. Members felt strongly that designation of this most intensive perinatal service should remain solely within the purview of the Department of Public Health. On balance, the Committee supported recognizing hospitals that achieve this designation and permitting them to expand when occupancy levels warrant, consistent with the access principles underlying CON regulations.

The Committee recommended adding the following standard:

(b.1) The Department may allow an expansion of an existing Level IV service if the actual utilization of that service has exceeded 80 percent occupancy over the most recent two years.

- (c) An applicant for a new or expanded Basic Perinatal Service or Neonatal Intermediate Care or Neonatal Intensive Care Service shall document the impact on existing and approved services in the planning area with the goal of minimizing adverse impact on the delivery system and as follows:
    - 1. An existing perinatal physician training program shall not be adversely impacted by the establishment of a new or expanded perinatal service to the extent that the existing service could not sustain a sufficient number and variety of patients to maintain an appropriate number of
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providers and provider competencies and the training program's accreditation and funding status;

2. An existing nurse midwifery training program shall not be adversely impacted by the establishment of a new or expanded perinatal service to the extent that the existing service could not sustain an appropriate number of providers and provider competencies to sustain a sufficient number and variety of patients to maintain the training program's accreditation; and
3. An existing regional perinatal center shall not be adversely impacted by the establishment of a new or expanded perinatal service to the extent that the existing service could not sustain a sufficient volume and case mix of patients including both low risk and high risk deliveries to maintain its regional center status.

The Committee supported the Department's current approach to documenting the impact on the specific types of service providers and pipelines identified in this standard. The Committee considered stakeholder requests to clarify that the term "regional perinatal center" used here refers to the Department of Public Health's designation and associated perinatal areas. After reviewing the existing definition for "Regional Perinatal Center" found at Rule 111-2-2-.24(2)(j), which references a hospital's designation by the Department of Public Health, the Committee determined that the meaning of the term is sufficiently clear and does not require revision as used in this rule.

No changes were recommended.

(d) An applicant for a new or expanded Basic Perinatal Service or Neonatal Intermediate Care Service or Neonatal Intensive Care Service shall foster an environment that assures access to services to individuals unable to pay and regardless of payment source or circumstances by the following:

1. providing evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis;
2. providing a written commitment that unreimbursed services for indigent and charity patients will be offered at a standard which meets or exceeds three percent (3%) of annual gross revenues for the entire facility after Medicare and Medicaid contractual adjustments and bad debt have been deducted;
3. providing a written commitment to participate in the Medicaid program;
4. providing a written commitment to participate in any other public reimbursement programs available for perinatal services for which the hospital is eligible; and
5. providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to individuals unable to pay based on the past record of service to Medicare, Medicaid, and indigent and charity patients, including the level of unreimbursed indigent and charity care.

The Committee discussed the Department's process of verifying whether an applicant is financially accessible, which includes a review of past performance on any existing indigent and charity care commitments. In its deliberations, the Committee also reviewed historical patterns of indigent and charity care provision among hospitals in Georgia authorized to provide perinatal services. Notably, in

2024, 67 out of 70 hospitals met or exceeded the standard threshold of providing uncompensated care greater than or equal to three percent of their adjusted gross revenues.

The Committee recommended that subsection 5 of this standard be revised to specify a three-year historical time period for documenting an applicant's demonstrated performance of providing financially accessible access care to various patient populations to ensure consistency in the evaluation of applications.

The Committee recommended the following updated standard:

5. providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to individuals unable to pay based on the past record of service to Medicare, Medicaid, and indigent and charity patients, including the level of unreimbursed indigent and charity care for the three most recent reporting periods of the Hospital Financial Survey.

(e) The desired minimum bed size for a Basic Perinatal Service, Neonatal Intermediate Care Service or Neonatal Intensive Care Service is as follows:

1. At least four beds for a new Basic Perinatal, Neonatal Intermediate Care, or Neonatal Intensive Care Service.
2. The Department may grant an exception to these standards when the Department determines that unusual circumstances exist that justify such action.

The Committee reviewed Department data on the distribution of beds and utilization by level of care across Georgia, as well as comparative approaches to minimum bed size requirements in other Certificate of Need states.

The Committee expressed support for the Department's current approach of requiring a 4-bed minimum bed size for perinatal services. The Committee acknowledged the diverse range of perinatal needs and service delivery models across the state. The Committee emphasized the need to maintain flexibility for providers to tailor services to the unique needs of their communities.

No changes were recommended.

(f) An applicant for a new or expanded Basic Perinatal Service or Neonatal Intermediate Care Service or Neonatal Intensive Care Service shall provide evidence of ability to meet the following continuity of care standards:

- (1) document a plan whereby the hospital and its medical staff agree to provide a full array of perinatal services to the community, including but not limited to community education and outreach, prenatal, intrapartum, postpartum, newborn, and postnatal services;
- (2) As appropriate, provide a formal transfer agreement with at least one hospital within reasonable proximity that provides services to high-risk mothers and babies.

The Committee recommended adding language to address specific challenges faced when transporting patients, and to emphasize the importance of keeping mothers and infants together whenever possible

during transfers. The Committee's recommendations included adding language to clarify when a transfer is considered to be initiated, using language consistent with other CON regulations. For improved clarity, the Committee specified in subsection 5 that the responsibility for documenting transfer time rests with the transferring facility. The Committee's discussion focused on the importance of having consistency across the Department's regulations and strengthening adherence to recognized best practices in perinatal care.

Stakeholder comments encouraged the Committee to consider adding a requirement that an applicant's plan include language that affirmatively confirms that any patient transfer will comply with the equipment requirements necessary to support the specific level of care of the patients being transported. In considering this suggestion, the Committee acknowledged the importance of ensuring that facilities maintain appropriate transport equipment for the level of care provided. However, Committee members noted that these requirements are already governed by other regulations, including Department of Public Health's perinatal designation standards, EMS licensing requirements, and hospital accreditation standards. The Committee concluded that adding this requirement to the CON framework would be redundant and less rigorous than existing mechanisms for oversight.

The Committee recommended the following updated standard:

- (2) An applicant for a Basic Perinatal Service or Neonatal Intermediate Care Service shall provide a formal transfer agreement with at least one hospital within reasonable proximity that provides Neonatal Intermediate Care Service or higher;

The Committee recommended adding the following standards:

- (3) document a plan that includes logistics to support the transport of transfer patients, both from the facility where the patient or patients originate and to the facility where the patient or patients are transferred, within thirty (30) minutes of the time when a transferring provider initiates the transfer, including agreements with ground and air ambulance services with specialty transport units;
- (4) document a commitment to preserve the mother-infant dyad during patient transfers when possible.
- (5) Documentation of each transfer time, from the time the transferring provider initiates the transfer until the time of arrival of the patient/s at the receiving provider, shall be maintained by the transferring provider.

(g) An applicant for a new or expanded Basic Perinatal Service or Neonatal Intermediate Care Service or Neonatal Intensive Care Service shall provide evidence of the ability to meet the following quality of care standards:

1. evidence that qualified personnel will be available to ensure a quality service to meet licensure, certification and/or accreditation requirements;
2. written policies and procedures for utilization review consistent with state, federal and other accreditation standards. This review shall include assessment of medical necessity for the service, quality of patient care, and rates of utilization;
3. written statement of its intent to comply with all appropriate licensure requirements and

operational procedures required by the Healthcare Facility Regulation Division; and evidence that there are no uncorrected operational standards in any existing Georgia hospitals owned and/or operated by the applicant or the applicant's parent organization. Plans of correction in the applying facility must be included in the application.

The Committee recommended updating subsection 1 of standard (g) to strengthen quality of care requirements related to securing staff at different levels of care, as shown below. 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.

Stakeholder comments received requested that the Committee recommend adding specific language prohibiting the diversion of human resources from existing programs, as emphasized above. In considering this suggestion, Committee members were confident that the requirement for providing a credible plan for staffing inherently obligates an applicant to demonstrate that it will not compromise other service providers. The Committee further noted that imposing formal restrictions would not be consistent with applicable law and could limit employment opportunities and operational flexibility, including the use of variable staffing models and cross-training within perinatal services.

The Committee recommended the following updated standard:

1. a credible plan that includes sufficient staffing levels and qualifications to meet licensure, certification and/or accreditation requirements for the proposed level of care;

(h) An applicant for a new or expanded Basic Perinatal Service or Neonatal Intermediate Care Service or Neonatal Intensive Care Service shall document an agreement to provide Department requested information and statistical data related to the operation and provision of services and to report that data to the Department in the time frame and format requested by the Department.

The Committee recommended adding language to specify the information, statistical data, and time frames to which the applicant would be required to agree, in order to promote consistency and transparency in expectations for applicants and the Department.

The Committee recommended the following updated standard:

An applicant for a new or expanded Basic Perinatal Service or Neonatal Intermediate Care Service or Neonatal Intensive Care Service shall document an agreement to provide Department requested information and statistical data related to the operation and provision of services and to report that data to the Department in the time frame and format requested by the Department, pursuant to O.C.G.A. § 31-6-70.

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**Exhibit 1**

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