



# **GEORGIA STATE HEALTH PLAN COMPONENT PLAN**

## **SHORT-STAY GENERAL HOSPITAL BEDS**

**HEALTH STRATEGIES COUNCIL  
AND  
GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
DIVISION OF HEALTH PLANNING**

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Effective April 1, 2003

## PREFACE

This Component Plan is a product of the Health Strategies Council and the Georgia Department of Community Health/Division of Health Planning, pursuant to the provisions of O.C.G.A. 31-5A-1 et seq. and 31-6-1, et seq. The purpose of the Plan is to identify and address issues that affect the operation of general hospitals and to recommend goals, objectives and system changes to achieve official state health policies.

This Plan has been produced through an open, public participatory process developed and monitored by the Health Strategies Council appointed by the Governor. The Plan is effective upon approval by the Council and the Board of Community Health and supersedes all related sections of previous editions of the State Health Plan and any existing related Component Plan.

For purposes of the administration and implementation of the Georgia Certificate of Need (CON) program, criteria and standards for review (as stated in the Rules Chapters 272-1, 272-2 and 272-3) are derived from this Component Plan. The Rules, which are published separately from the Plan and which undergo a separate public review process, are an official interpretation of any official Component Plan which the Regulatory Review Section of the Office of General Counsel has the legal authority to implement. The Rules are reviewed by the Health Strategies Council, prior to their adoption by the Board of Community Health, for their consistency with the Plan. The Rules, as a legal document, represent the final authority for all Certificate of Need review decisions.

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## **INTRODUCTION**

### **A. STATEMENT OF PUBLIC POLICY FROM THE DEPARTMENT OF COMMUNITY HEALTH**

The Department of Community Health was created in 1999 by the Georgia General Assembly in response to a growing concern about fragmentation of health care delivery at the state level. The legislation outlined several purposes for the Department including the development of a state health care infrastructure that would be more responsive to the consumers it serves while improving access to high quality services. The Department takes this charge very seriously.

The Department is responsible for managing the state's health planning program, which establishes standards and criteria for awarding Certificates-of-Need to health care facilities and certain specialized diagnostic or treatment services. Since the formation of the Department of Community Health, most components of the State Health Plan have been revised to reflect the new regulatory focus and policy integration. The Department works to contain health care costs by avoiding unnecessary duplication of services, equipment and facilities, and helps to enforce quality-of-care standards. The Department is committed to ensuring that providers assume a share of the responsibility for the health care needs of low-income citizens and underserved or at-risk members of their local community. Assurance of financial and geographic access, quality of care, promotion of market responsive services and safeguarding of the state's teaching and critical access hospitals and safety net infrastructure are among other key policy concerns of the Department.

### **B. PLANNING PROCESS**

During the mid-1980's, several changes occurred that impacted the health care industry in general and the delivery of inpatient hospital care in particular. Among the changes were drastic modifications in the way hospitals were reimbursed for inpatient hospital care. The Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) changed its reimbursement mechanism to incentivize the delivery of care in outpatient settings. Nationwide, this action resulted in the exponential growth of outpatient care services.

Like other hospitals around the nation throughout the 1980's and 1990's, Georgia hospitals experienced decreased inpatient days and increased use of outpatient services. Technological advances also greatly changed the way patient care was delivered. Growth of outpatient procedures as a result of changing financing strategies and modern technological advances had the most direct impact on the decline of inpatient services. As a result of technological innovations, more surgical procedures could be performed in shorter periods of time and fewer resources would be needed to support patients. Increasing penetration of Health Maintenance Organizations (HMO), which advocated the use of primary and preventive health care services and the provision of health care services in outpatient settings, along with the utilization of support services including home health services and skilled nursing facilities further decreased the need for and duration of inpatient hospital services.

Now in the 2000's, hospitals are treating increasingly large numbers of sick patients. Long-range population trends project that people will be living longer but will be sicker and will consume greater healthcare resources. This consumption of services not only will be evident in the hospital setting, but also will undoubtedly present a tremendous challenge to the state's workforce in all healthcare settings. While there has been a shift in the provision of services to outpatient settings, hospital care still accounts for the largest portion of healthcare dollars. Much of this utilization can be attributed to hospital births, emergency room visits and a growing and aging population.

Georgia's Short Stay General Hospital Component Plan and corresponding rules that govern the need for and operation of short stay general hospital services were adopted in 1983. The State Health Planning Agency, now the Department of Community Health/Division of Health Planning, had attempted to update the Short Stay General Hospital Component Plan and Rules during the 1990's. Controversy surrounding the Certificate of Need program resulted in a failure to produce a revised planning document and corresponding rules.

The hospital guidelines of the 1980's address the need for hospital beds and assume continued growth in the utilization of inpatient services. Furthermore, they rely on three methodologies to determine the need for hospital service; one methodology (institution-specific bed need) examines the need for beds within the four walls of the hospital; another (area-wide specific bed need) considers need for beds within a

service area and yet another (county-wide bed need) is triggered when there is only one hospital facility in a county. Use of these different methodologies has not always proven to be the most efficient way to determine need for inpatient hospital beds and services.

Considering the multitude of changes that have occurred in the health care industry over the last decade, the old hospital plan and rules needed significant revision, to better reflect current health care practices and to more adequately respond to the future needs of consumers and purchasers. In addition to the state's inelastic methodologies, Georgia's approach to planning for hospital services has heretofore not been conducted in a manner that allows state regulators to adequately factor changing values and service behavior in the decision making process. Many activities, including the events of September 11, 2001, challenged Georgia hospitals to examine hospitals' readiness to address catastrophic events and to ensure that there are sound healthcare policies and infrastructure in place to meet such challenges.

Revision and adoption of a component plan is a deliberate process by the Health Strategies Council and involves the establishment of a Technical Advisory Committee (TAC). The Health Strategies Council, (hereafter, Council) a 27-member board appointed by the Governor, is responsible for developing Georgia's State Health Plan and addressing policy issues concerning access to health care services through an open public participatory process. At its September 2001 meeting, the Health Strategies Council voted to convene a TAC to evaluate and make recommendations to develop a Component Plan and Certificate of Need Rules for Short Stay General Hospital Services. Final action to appoint the TAC was taken at the Council's February 2002 meeting. TAC members represent varied geographic regions of the state and are members of a wide variety of constituent groups, including state agencies, consumers, advocates, provider groups, and payors. James Peak, Chief Executive Officer of Memorial Hospital & Manor in Bainbridge, Georgia and member of Health Strategies Council, chaired the TAC. It was comprised of 22 members. (See Appendix A)

The TAC was asked to develop a new component plan and related guidelines to govern the establishment, replacement or expansion of short stay general hospital beds. They were asked to consider the best ways to balance consumer and payer concerns, health system viability, minimize gaps in service delivery, ensure continuity of care, quality of care and support the roles of critical access, safety net, and teaching hospitals. They were also encouraged to develop mechanisms to support the role of trauma

centers and to incentivize health system efficiencies and innovation, including consolidation of services, along with a wide range of access considerations (both geographic and financial). The Council charged the TAC with producing two work products:

- A proposed new component plan for consideration by the Council that would address the development, delivery and maintenance of short stay general hospital services in the coming years.
- A set of proposed rules for consideration by the Council and the Board of Community Health.

Members undertook this charge enthusiastically and responsibly. They met from March 2002 through November 2002 and scrutinized a plethora of statewide data and planning materials. They closely examined other state methodologies and planning processes. They synthesized these materials and gleaned the concepts and processes that they felt would provide the most value to the citizens of the state. In reviewing materials from other states, they extracted the following concepts and unanimously agreed that they should be represented in the core criteria of Georgia's planning documents:

- Establishment of utilization targets for existing bed capacity (generally ranging from 65%-80% with some leeway for smaller, rural hospitals);
- Promotion of financial and geographic access, including commitment to provision of indigent and charity care;
- Determination of numerical need, based on population cohorts (anticipating lower utilization among younger and mid-life individuals with greater usage for older adults); and
- Ensuring access to a system of care for all residents of the state as well as minimizing the potential impact on community resources.

These concepts were in harmony with Georgia values and planning principles. Members were particularly impressed by some of the criteria that were outlined in the acute care hospital plans from several states including North Carolina, New Hampshire, Vermont and Maryland. Members noted that these state plans were comprehensive and addressed several of the core principles that they had identified as important in the planning process, including the following:

- Role of Emergency Department Services (ED)
- Favorable Considerations or Exceptions to Need (in select circumstances)
- Trauma Services (recognition of hospitals that provide these high level services)
- System Consolidation (Incentivize clinical excellence and system efficiencies)

- Indigent/CharityCare/Uninsured/Underinsured (ensure financial access)
- Numerical Need (objective criteria, including utilization based on population cohorts)
- Peak Demand (emergency diversion, known trends, disaster planning)
- Non-Resident (tourists) Use of Services
- Workforce Issues (critical workforce shortages)
- Utilization/Efficiencies of Services (Length of Stay)
- Geographic Access
- Population Assumptions (age cohorts and population diversity)
- Planning Horizon
- Technology (Dynamics of Change in Health Care Environment)
- Adverse Impact on Existing Providers
- Patient Safety/Quality/Peer Review/Medical Errors
- Financial Viability of New and Existing Providers
- Community Linkages (collaboration, transfer and referral systems, regionalized systems of care)
- Manageability/Clarity of Rules (minimize burden on providers)

This list of planning concepts was augmented and refined at each meeting. In addition, division staff, under the TAC's direction, met with clinical experts to discuss the role of the emergency department and to better gauge its relationship to hospital capacity. These discussions surmised that where emergency room volume rises, capacity problems are likely to worsen. Clinical experts surmised that, nationwide, more than 60% of all hospitals emergency departments and three out of four urban emergency departments perceive that they are at or over capacity. The TAC spent a considerable amount of time discussing the role of hospital emergency rooms since they represent the most critical access point into the health care delivery system.

The TAC's collective planning processes provided the backbone for the development of the state's Short-Stay General Hospital Plan and Rules. The TAC and Division staff developed several preliminary versions of draft guidelines. Following significant committee and staff input, the TAC put forth a draft set of guidelines that were distributed for public comment.



After four committee meetings and a draft development of guidelines, the TAC appointed a subcommittee to convene a Public Forum. This subcommittee's responsibility was to preside at a forum to allow the public to present their ideas and suggestions for consideration into the hospital plan development and guidelines process. While time was provided at each meeting of the TAC for public input, it was hoped that this public forum would provide another venue for additional input and suggestions into this important area. The Public Forum was held at a rural hospital in Dodge County, a centrally located county in the state. Over twenty persons attended, eight of who presented oral comments. Others provided feedback through written submissions.

Throughout the public planning process to develop a revised general hospital plan and rules, the TAC held six (6) planning meetings and one public forum. Several draft documents were disseminated to TAC members and the public. The Department's legal team also provided guidance to the Division and the TAC in the final development of the rules. This planning document represents a consensus from the Short Stay General Hospital Technical Advisory Committee and was presented for consideration at the Council's meeting in November 2002. Upon the adoption of the recommendations and concepts that are outlined in this plan, by the Health Strategies Council, the proposed rules were forwarded to the Board of Community Health for posting for public comment. The TAC feels confident that their planning processes and recommended guidelines are sound and have been endorsed by a wide range of statewide constituents.

## II.

### OVERVIEW

#### A. OVERVIEW OF NATIONAL HOSPITAL TRENDS

At the time the last hospital plan was written, national occupancy rates and admissions and healthcare costs were beginning to rise. HMOs were privately administered and not a major consumer product in Georgia. Additionally, the impact of prospective payment systems in Medicare financing, and increased use in ambulatory surgery centers had not yet been forecasted. Since that time, managed care plans have greatly influenced the way providers and consumers behave in the healthcare market and consumer enrollment in managed care plans grew well into the late 1990s. According to the American

Hospital Association, nationwide managed care penetration grew from 16% in 1988 to 31% in 1996 and inpatient days declined by 21 percent. Since 1980, volume for inpatient admissions significantly dropped while outpatient visits increased by more than 150 percent.

In response to the changes in hospital service delivery, hospitals downsized inpatient beds and shifted resources to outpatient settings between 1980 and 2000. Other hospitals completely closed their doors because of lower utilization and increased financial risks associated with new payment systems. Some hospitals leveraged resources by consolidating and becoming major hospital systems. These consolidated systems were able to better negotiate reimbursement rates of pay and counter the impact of continued budget cuts in Medicare as a result of the Balanced Budget Act of 1997 (BBA), and managed care payment systems. Other smaller community hospitals, particularly those hospitals in rural areas, were unable to absorb the financial impact of policy changes and reduced reimbursement rates for hospital care.

Over the past twenty years, many environmental and policy issues have influenced the way care is delivered in the hospital setting. Changes in the financing of hospital care through public and private insurance programs have drastically modified the delivery of healthcare. Many states have deregulated Certificate of Need (CON) Laws that were set in place in 1979. CON was instituted as a mechanism to assure access, control costs and limit the unnecessary duplication of health services. Of the states that regulated hospital services through CON, some have placed less restrictive laws in effect, while others maintained comprehensive laws. Georgia is one of twenty-seven states that continue to comprehensively regulate hospital services. Today, many states are reviewing the effectiveness of the CON process. Those states that implemented sunset provisions in their CON laws have recently considered reversing their decisions in order to control the costly post-CON saturation of new hospitals, surgery centers, and diagnostic centers. States that have continued to regulate hospital expansions and construction are in the process of updating their CON guidelines to implement provisions that are more responsive to current industry trends and healthcare market forces.

Controlling the rising costs of healthcare is of grave concern to state and federal health officials. In an effort to ensure that resources are effectively allocated in the most efficient manner, health policy makers have attempted to implement strategies through CON guidelines and other legislative regulations. Because healthcare in the United States is a trillion dollar industry, monitoring healthcare costs is a major

area of political discussion. The costs savings associated with DRG payments and managed care brought about new insights for regulators in the healthcare market. Although the delivery of care in outpatient services is increasing and hospital inpatient services have decreased, hospitals continue to represent the largest share (34%) of the health care dollar.

Quality of care is important to healthcare consumers, providers and employers. Consumers and payers continue to raise questions about the quantity and quality of services that they receive for the dollars they are spending on healthcare. National attention is focused on quality of care and consumer report cards are popular tools for guiding consumer decision-making. Consumer product knowledge and direct-to-consumer advertising of pharmaceuticals and other medical advances add to healthcare expense. Consumer product knowledge increases as medical information and advice become more readily available via Internet access.

In the early 1990s, employers and insurers forced consumers into managed care plans. Managed care was credited for decreasing the double-digit healthcare inflation average experienced in the 1980s to single digit averages. The savings redeemed from managed care plans were attributed to streamlining consumer product choice and the provision of incentives that encouraged provider's to limit excess services by assigning primary care physicians as gatekeepers to specialized services. Reports document that there has been an inverse relationship between managed care penetration and the need for inpatient hospital services.

In the late 1990's consumers and providers began to rebel against tight restrictions placed on managed care policies that negatively impacted provider and patient relationships. Several changes became evident: legislatures intervened by forcing insurance plans to provide basic types of coverage and to limit service constraints, consumers chose less stringent plans that offered more flexibility in choice of physicians and products, and managed care plans responded by becoming less restrictive on product types and expanding networks. These changes gave consumers more power and control when making healthcare choices. Comprehensive consumer rights laws empowered healthcare consumers to litigate changes in managed care planning and policy. There is a growing consensus that managed care plans can no longer produce health care savings that were experienced in the 1990s. Other forces, such as increases in an aging population, will drive up the demand and potentially the cost of inpatient care.

Before managed care penetrated insurance plans, the nation was experiencing an increase in healthcare inflation in double digits. The BBA added yet another policy change that would decrease the reimbursement rate for hospitals caring for Medicare patients. Continued reductions in reimbursement rates for Medicare and Medicaid patients have had a domino effect on the healthcare industry. These changes have resulted in administrative policy changes, changes in clinical practice protocols and have presented great challenges to health policy planners. The American Hospital Association reports that one in four hospital discharge planners have trouble placing Medicare patients in skilled nursing facilities, especially patients that require expensive drug therapy, ventilator care, or other special services. For example, during 1997 to 2000, in many areas of the state, the number of home health agencies decreased and the numbers of skilled nursing facility days also decreased. Decreasing resources at a time of increasing need creates hardships for providers, patients and their families. These challenges add to the complexity of assuring access to appropriate services for all Georgia residents while protecting the state's safety net providers (those facilities that serve a disproportionate number of the state's most vulnerable patients).

Changes in the structure of Medicaid, Medicare and other health care financing have considerable impact on most safety net providers due to their unique patient mix. Safety net providers, as defined by the Institute of Medicine's Committee on Changing Market, Managed care, and the Future Viability of Safety Net Providers, are those providers that exhibit two characteristics: they provide care to patients regardless of their ability to pay and have a disproportionate patient mix of uninsured, Medicaid and other vulnerable patients. While, Medicaid is a major payer for many safety net providers, many states have incorporated managed care purchasing strategies into public insurance programs in an attempt to control costs and expand coverage. The recent changes in Medicaid financing to more cost containing strategies, similar to those of managed care plans, have placed providers at a substantial financial risk and have opened the doors for competition for insured patients. Many safety net providers are placed at a significant disadvantage when trying to compete with providers who have more resources.

Teaching, specialty and other hospitals serving a disproportionate share of uninsured and low-income individuals are considered core safety net providers in the State of Georgia because they offer unique services to the community and assume a greater financial burden to operate their facilities and to care for patients that enter their doors. Teaching hospitals provide training to future medical professionals

and serve a large proportion of uninsured and low-income individuals. Health care payers have supported the extra costs demanded from treating patients with complex health care needs, training the state's existing and future health professionals and caring for a disproportionate level care to uninsured patients. For major teaching hospitals, Medicaid is associated with at least 20 percent of costs. Defining the state's safety net providers was a major challenge for TAC members. They agreed that preserving the state's safety net providers is a sound policy standard of social and economic value.

Rural hospitals are heavily dependent upon reimbursement for care by public payers and were made more vulnerable by the enactment of the BBA and subsequent policy changes. As major employers and providers of health and social services, rural hospitals provide a unique resource to their community. Rural hospitals are often smaller than urban hospitals and have modest assets, which often prohibit their ability to make large investments in technology and to attract critical staff for the provision of hospital services. The population in rural Georgia can be described as one that is declining in number. It also has large aging communities and populations with low household incomes, high rates of poverty and high rates of uninsured.

By setting policies that are favorable to rural hospital needs either through exemption of certain laws or tailoring policies to address their unique circumstances, most states make accommodations in policies for rural hospitals to support what is realized to be a critical resource in rural communities. In 1997, the Medicare Rural Hospital Flexibility Program was established to create critical access hospitals. This legislation allowed hospitals in rural counties to streamline services and to provide full capacity care with resources scaled to community needs. Despite the continued population growth in the State of Georgia, many counties in the state are heavily rural. More than 100 counties in Georgia can be classified as rural, based on population and density. State leaders have long standing policies to support rural hospitals. The TAC agreed that it is important to ensure the viability of rural hospitals. They have recommended provisions in the plan and rules that recognize the unique role and value of rural hospitals.

Hospital use rates are dependent upon the composition of the population. The American Hospital Association reports that increases in population and aging have the greatest impact on inpatient days. Recently published data by the National Center for Health Statistics (NCHS) support findings that patients over 65 years of age use services at a significantly higher rate than other age groups. National discharge

data shows that persons over the age of 65 years were three times more likely to use inpatient services than all other age groups in 2000. Growth of population in general is the most pressing force on inpatient demand. Increases in population have a greater impact on the utilization of inpatient services than any other factor. The American Hospital Association reported that for every 10% increase in population there is a 9.8% increase in inpatient days. While population dynamics contribute to increased inpatient days, factors associated with per capita income, managed care, and outpatient surgeries are all reported to decrease the number of inpatient days. Increased per capita income is known to be associated with factors that contribute to overall better health, such as access to ongoing primary and preventive care services. Over the years, managed care trends and resources associated with increases in per capita income have led to controlled hospital utilization rates. Managed care backlash and economic downturn may make these associations unclear.

Hospital bed capacity has recently been challenged at a time of unprecedented emergency room diversions and the events of September 11, 2001. Patient safety and hospital readiness have been on the forefront of health planning in the United States ever since the terrorist attack. The events brought the roles of hospital and service workers into a new light. Hospitals were looked upon with a new importance, particularly as it relates to planning for catastrophic events and bioterrorism preparedness. Hospital capacity became a major concern for community officials across the nation. A sound healthcare infrastructure remains at the focal point of the healthcare agenda. The Georgia General Assembly passed Senate Bill 385 in an effort to ensure a plan that would immediately be enforced in the event of a bioterrorism attack. In this bill, hospitals would be under the control of the state and used as necessary to provide services in an emergency response.

Emergency room visits are one of the main drivers for inpatient utilization. According to the *National Hospital Ambulatory Medical Care Survey, 2000*, emergency room utilization in the United States has increased by 14 percent since 1997 and approximately 12 percent of emergency room visits result in hospitalization. Hospitals divert patients to other emergency departments when they can no longer accept all or specific types of patients by ambulance. In a survey conducted by the Lewin Group, an affiliate of the American Hospital Association, the most common reasons for emergency department diversions are the lack of critical care beds, staffing shortages and lack of general acute care beds. The emergency department is a point of critical access of care for most uninsured patients and diversions are a symptom of

hospital capacity constraints. Emergency department services are recognized as critical services that should be accessible to residents across the state, especially since the emergency department is a major point of access for inpatient care in the state.

Pharmaceutical and technological advances add another dimension to the way care is delivered in a hospital setting. Advances in technology have made traditional procedures less invasive, and reduced recovery time and length of stay. A growing number of medical procedures that in the past were delivered in an inpatient setting are now transferred to outpatient centers. The counter to technological advancement is the early detection of illnesses requiring more interventions that demand hospital care. Newer and safer interventions may also increase the pool of patients that may receive surgeries that were perceived as “inoperable” in the past. New technological advances aid in increasing the expected average life years and, in turn, increase the number of aging population.

Defining optimal capacity is a growing dilemma as communities seek to address future inpatient services in an environment of managed care backlash, emergency department demand, trauma system development, continued reductions in Medicare and Medicaid reimbursement, technological advances, workforce shortages, rising healthcare costs, and a growing and aging population. Nationally, hospital occupancy rates are reportedly lower than industry expectations. Occupancy rates serve as an approximate measure for efficiency and needed space. Growing concerns about hospitals’ ability to handle catastrophic events coupled with the ongoing challenge of emergency room capacity are forcing health planners to take a different approach to defining optimal capacity. The penetration of managed care, use of outpatient procedures, and positive health outcomes associated with increased per capita income have historically offset this need. Ongoing budget cuts to fund public programs are challenging hospitals to operate business in a more efficient manner with less financial resources. Physician malpractice lawsuits, legislation, consumer empowerment, and increased direct-to-consumer advertising are environmental factors complicating efforts to control healthcare spending.

Medical errors in hospitals have been under the scrutiny of the public eye as the administrative limitations of managed care programs and their affect on consumer and provider relationships have surfaced. Legislative support of consumer choice and rights has prompted a litigation-friendly environment against physicians covering emergency departments and providing surgical services. As medical errors are

scrutinized by jurors and awards for medical malpractice claims increase, pressures on physician performance change the environment for patient and physician relationships. Increasing malpractice costs make it more difficult for hospitals and physician groups to financially operate. Next to hospital services, physician services are the next most costly service in healthcare. Cost continue to rise due to increase in malpractice premiums attributed to medical errors. Malpractice claims, such as misdiagnosis in emergent cases, have created more cautious physicians who assume less risk by providing excessive medical services.

Further exacerbating the challenges for providers is the health professional workforce shortage. Many medical schools and nursing programs reported a decline in the number of enrollees and admission applications. Georgia is currently working to address and alleviate some of the future workforce shortages. Lack of general interest, increasing opportunities in the information technology field, competitive salary in other job sectors, and diminishing support in the workplace environment are all factors that have made the healthcare industry less appealing than it was twenty years ago. A major concern for hospitals, as well as the TAC, is the supply of adequate staffing to support for current and future population needs.

## **B. SUMMARY OF TRENDS IN GEORGIA HOSPITALS**

Georgia hospitals have faced financial and regulatory circumstances similar to those nationwide. Hospital capacity is being challenged by low occupancy rates and staffing shortages. Georgia is not unique in its need to acquire more skilled health professionals to care for patients. Over the last two decades, Georgia hospitals have been impacted by declines in staffing levels, decreases in reimbursements, multiple hospital closures, increases in outpatient volume, decreases in inpatient volume, increases in emergency room visits, competition for a shrinking pool of private payers, and phenomenal growth in population and diversity.

In an effort to develop a working strategy for the development of a plan and rules that would govern the future development of Georgia hospitals, TAC members reviewed current statewide hospital data. Although many national trends fit Georgia's overall picture, there are some unique environmental circumstances that impact Georgia's healthcare industry. These differences include the demographic make-up of the 159 counties in the state, increased rates of morbidity and mortality from diseases, a



populous metropolitan area encompassing almost 40% of the States' population, and concentrated economic resources. These indicators challenge Georgia policy makers to ensure the most efficient utilization of limited healthcare resources in a manner that is cost effective and accessible to all citizens of Georgia.

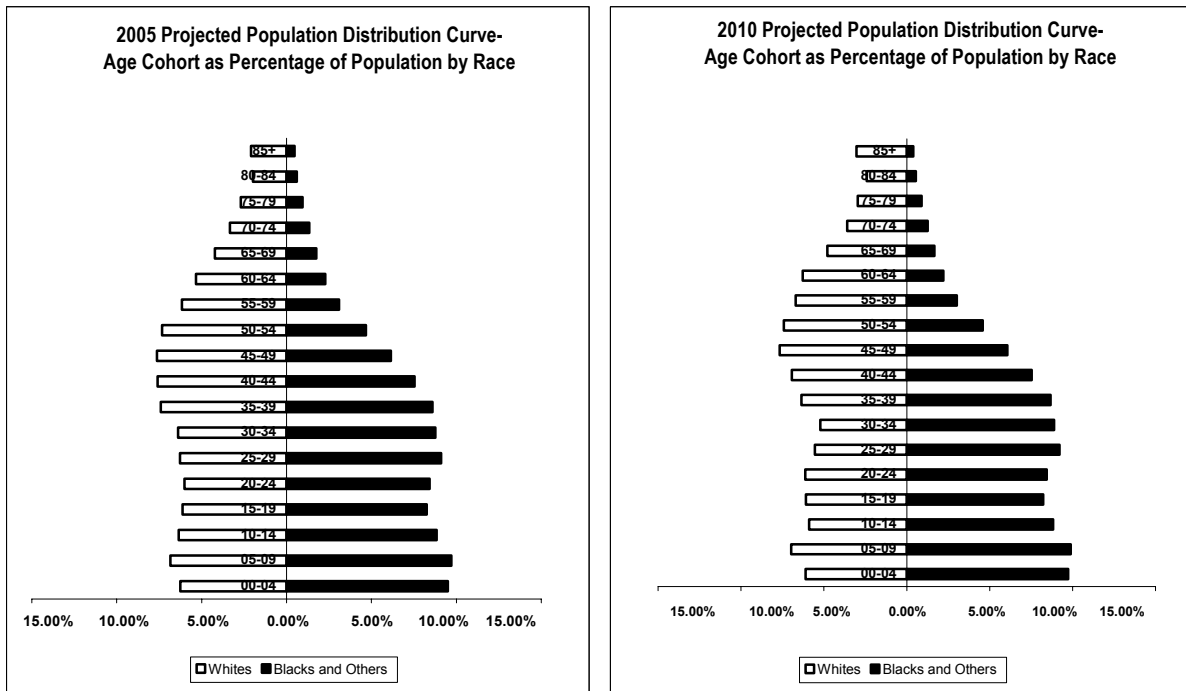
In 1980, Georgia hospitals were experiencing growth in the number of inpatient days and CON guidelines were implemented to manage the healthcare environment of the 1980s. Occupancy rate goals were based on the prediction that hospital inpatient days would continue to rise, which was a reality in the healthcare market at the time. Bed need was determined by a methodology based on population assumptions of Georgia in 1980. Much has changed in Georgia in twenty years, especially in the healthcare industry. Diagnostic devices have changed the way diseases are managed and therapeutic technological advances have changed the way that care is delivered. Many diseases that would traditionally require invasive procedures are now addressed with less invasive protocols that reduce the recovery time for patients. Occupancy goals, once viewed as ascertainable in the eighties, are unrealistic in a healthcare market driven by payers that encourage minimal use of products and services. Diminishing managed care influence, the increased need for trauma service networks, emergency room capacity constraints, a fragile safety net system, a large proportion of rural counties throughout the state, a rapidly growing metropolitan area, workforce shortages, and an aging and diverse population are all real factors that contribute to the complexity of statewide decision-making and policy development. The TAC addressed many of these issues and made some specific recommendations to address them in ways that would continue to provide the residents of the State of Georgia with appropriate access to high quality care, while at the same time minimizing cost and ensuring health system efficiencies.

## **I. Population and Diversity**

A key indicator of increased demand for inpatient services is population growth. Georgia's growing population is expected to result in higher inpatient utilization and as this growing population ages, the demand for inpatient services also will increase. According to the 2000 US Census, Georgia's population increased by 26.4% from 1990 to 2000. Georgia is now one of the ten most populous states with an estimated population of 8.1 million. Almost 40% of this population resides in the metropolitan Atlanta area. Complimenting the general population growth is the increase in diversity. The demographic composition of

African-American and other racial minority groups is one-third of the total population and growing. Between 1990 and 2000 ethnic groups with low population estimates have grown anywhere from 100% to over 300%. Diversity will add another challenge to the delivery of care for residents. Different cultural norms and behaviors impact when and how patients will access health care services. The following chart illustrates some diversity projections for Georgia in 2005 and 2010, based on projected Civilian Non-Institutional population.

**Figure 1: Projected Population Distribution By Age Cohorts And Race For 2005 and 2010**



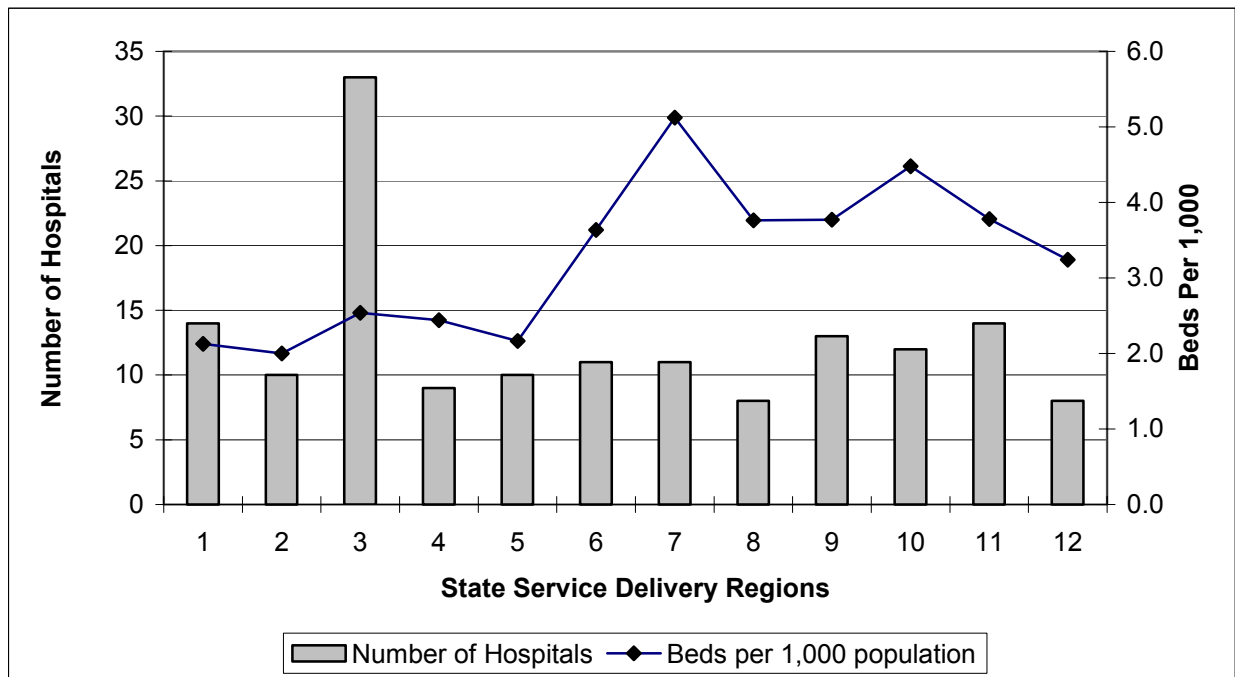
Source: 2005 Civilian Non-Institutional Population, Division of Health Planning; Population projections provided by the Office of Planning and Budget (9/2002)

## II. Bed Capacity and Inpatient Utilization

A report issued by the Institute For the Future indicates that nationwide, between 30 and 80 general acute care hospitals have closed each year. In the State of Georgia, since 1980, 13 rural hospitals and 7 urban hospitals have closed. Only six new hospitals have been authorized to open; four of those were approved in 1982. A listing of hospital closures in Georgia occurring between 1980 and 2002 appears as Appendix C.

As of February 2003, there are 152 hospitals operating in the State of Georgia. A list of current operational hospitals appear as Appendix D. Total bed capacity decreased from 25,575 beds in 1980 to 23,531 beds in 2001, an 8% decrease in total beds. Since 1980, total inpatient days have decreased by almost 29% from 5,842,232 days in 1980 to 4,172,426 days in 2001. Figure 2 illustrates the distribution of hospitals in 2001 by State Service Delivery Region (SSDR). A map of the state's service delivery regions appear as Appendix E. Area 3, encompassing metro-Atlanta area, is the most populous region of the state. Metro-Atlanta has a lower number of available beds per population (2.5 per 1,000) when compared to other less populated regions of the State. Area 7 has the largest number of available beds in the state (5.1 per 1,000) in comparison to its population.

**Figure 2: Distribution of Beds in Georgia By State Service Delivery Region, 2001**



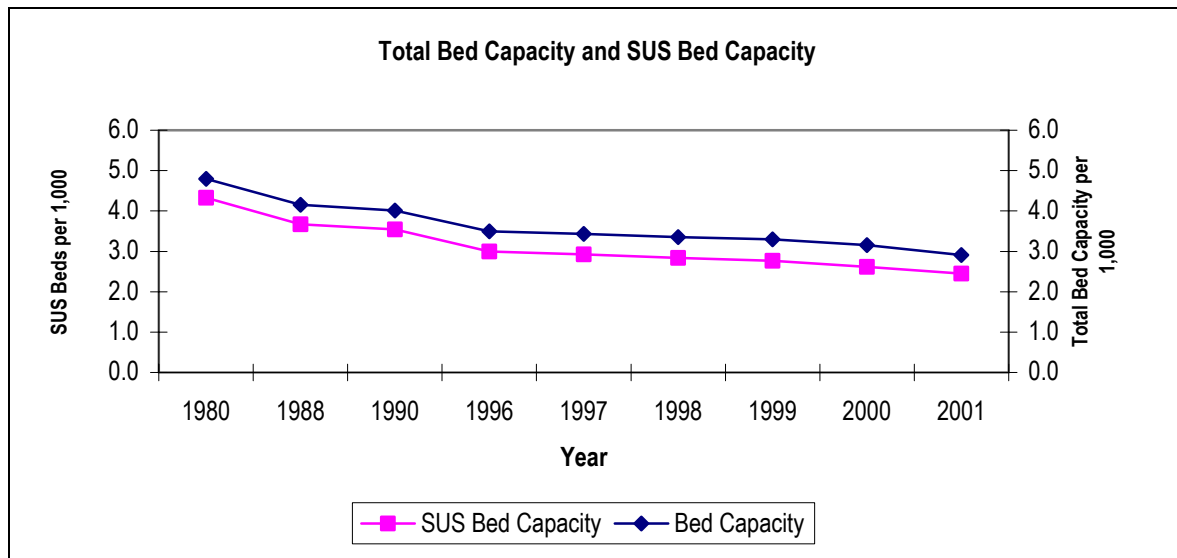
Source: Annual Hospital Survey, 2001, General Utilization Report by SSSDR, Georgia Department of Community Health, Division of Health Planning

### III. Georgia Workforce and Hospital Set-Up and Staffed Bed Capacity

Hospital staffing vacancies have increased over the years. Inadequate staffing places patient safety and hospital services at risk. With rising demand for more skilled health care professionals, national attention has been focused on the healthcare workforce crisis. Staffing vacancies and their impact on hospitals vary across the state. Georgia is currently addressing healthcare workforce issues through a standing workforce committee. Georgia hospitals estimate a 15% vacancy rate for nursing staff.

Set-up and staffed (SUS) bed capacity has declined from 4.3 beds per 1,000 population to 2.6 beds per 1,000 population, a 40% decrease in the rate of SUS beds to population. Total SUS beds decreased in 1980 from 23,104 beds to 20,286, a decrease of 12% in total SUS bed capacity. The workforce shortage and population growth both contribute to decreased set-up and staffed capacity. Figure 3 illustrates the trend in total beds and set-up and staffed bed capacity since 1980.

Figure 3: Set Up and Staffed Beds and Total Capacity Beds, 1980-2001

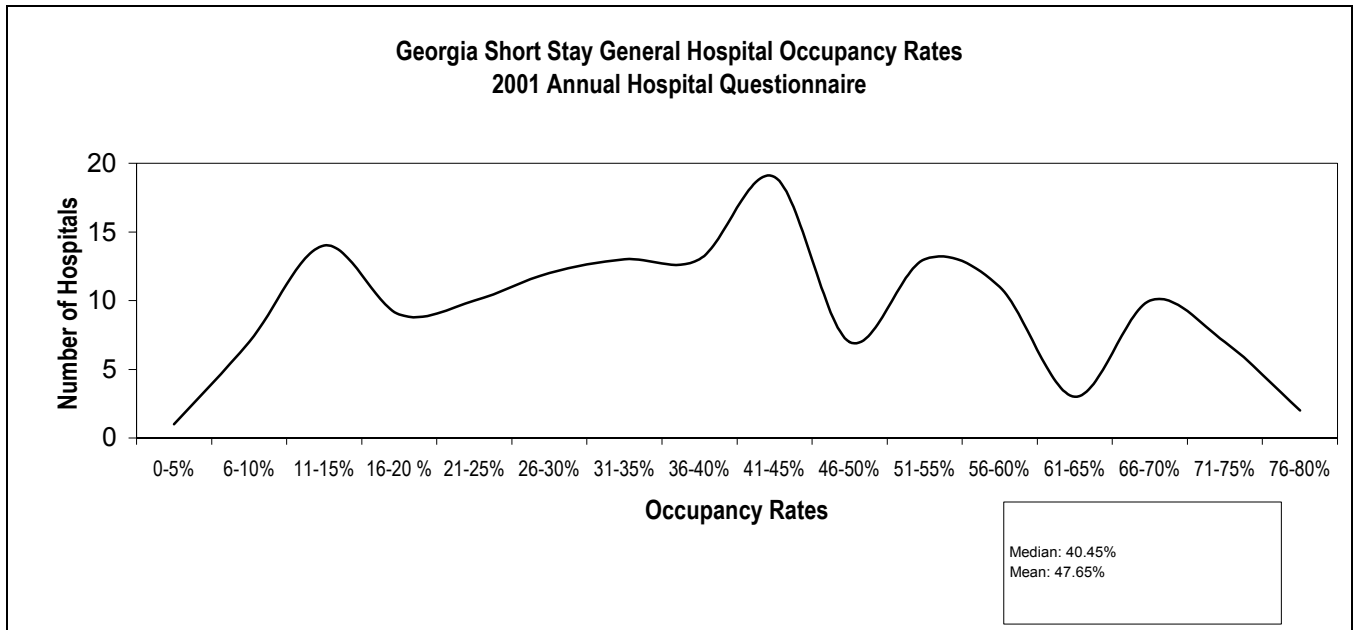


Source: Annual Reports, 1980-1990, Annual Hospital Survey, 1996-2001, General Utilization Report, Georgia Department of Community Health, Division of Health Planning

#### **IV. Georgia Hospital Inpatient Occupancy Rates**

In 1980, Georgia hospitals experienced occupancy rate averages of approximately 62% and occupancy rates were expected to increase. However, prospective payment mechanisms were introduced into the systems. Increased utilization of ambulatory surgery centers became the new force driving the system. Since 1980, occupancy rates in Georgia hospitals decreased by almost 14%, from 62% in 1980 to 48.5% in 2001. Much of the decrease is related to changes in public and private financing mechanisms. Occupancy rates in Georgia hospitals reached their lowest point in 1998 at 44% of total bed capacity. In 1999, occupancy rates began to slightly increase and have continued to increase in 2001. Figure 4 demonstrates the varying occupancy rates in Georgia hospitals in 2001. Today, most hospitals in Georgia have occupancy rates that hover between 41-45%. A small number of hospitals operate between 66-80% of capacity. Similar to national trends, some hospitals in the state have consolidated to form provider networks and hospital systems. Georgia's public and private insurance plans have influenced many hospitals to shift resources from inpatient to outpatient settings. While hospital occupancy rates have increased slightly in the state. It is difficult to determine if these rates will remain steady or if they will increase in the future.

**Figure 4: Hospital Occupancy Rates in 2001**



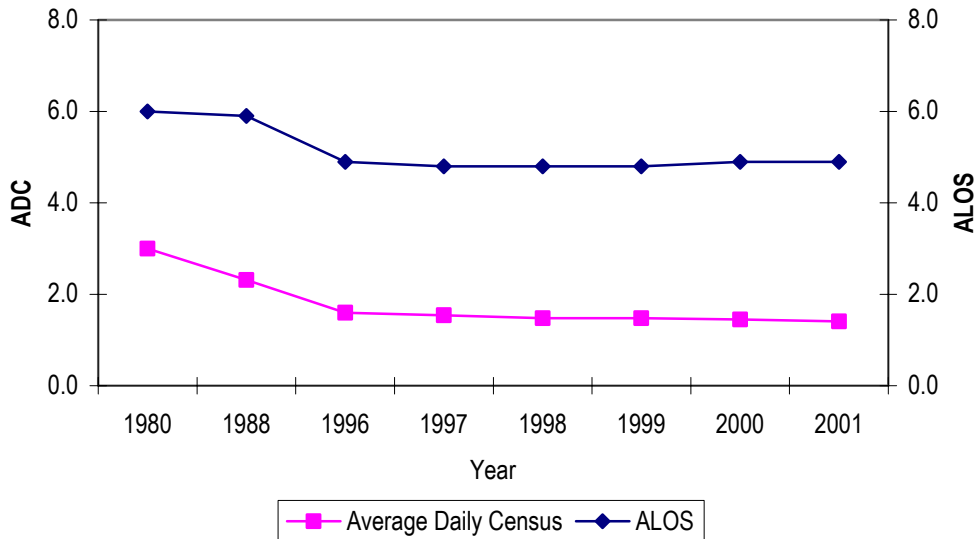
Source: Annual Hospital Survey, 2001, Hospital General Utilization Report, Georgia Department of Community Health, Division of Health Planning

## V. Georgia Trends in Average Daily Census and Length of Stay

Average daily census and average length of stay have leveled but are significantly lower than they were during the 1980s. According to the American Hospital Association, average length of stay is hovering at 5.2 days per patient nationally. In 1980, the average length of stay in Georgia hospitals was 6 days per patient and average daily census was 3.0 patients per 1,000 population. In 2001, Georgia's average length of stay declined to 4.9 days per patient and the average daily census was 1.5 patients per 1,000 population.

**Figure 5: Trends in Average Daily Census and Average Length of Stay, 1980-2001.**

### Trends in Average Daily Census and Average Length of Stay



Source: Annual Reports, 1980-1990, Annual Hospital Survey, 1996-2001, Hospital General Utilization Report, Department of Community Health, Division of Health Planning

## VI. Emergency Room Visits

According to the American Hospital Association, emergency room visits are a major driver of increases in the number of hospital admissions. The emergency department is one of the major points of access for inpatient care in short-stay general hospitals. Emergency departments are required to provide care to all presenting patients regardless of their ability to pay. Given such a mandate, they are often overcrowded.

Despite cost containment strategies, emergency department visits continue to increase in Georgia hospitals. This causes an extreme drain on emergency room resources since care delivered in emergency rooms are provided by clinical specialists and represent among the highest level of service in hospital settings. In most cases, clinicians in hospital emergency rooms are saddled with patients who are presenting for services, which could be more appropriately provided in primary or urgent care settings. In 2001, more than 45% of all emergency department visits resulted in hospital admissions. In 2000, the admission rate was 43.1% and even lower in 1999. According to data collected by the Department of Community Health/Division of Health Planning, over the past four years Georgia has experienced an

increase in the number of patients that present to the emergency room for care. Emergency room visits and patients needing emergent care are expected to increase. Increasing rates of emergency room diversions also impacted hospitals' ability to provide appropriate services. The growing emergency room diversion crisis added to the committee's concern for patient safety and the need to provide adequate resources to serve local communities.

**Figure 6: Emergency Room Visits Statewide and Admissions from ER Visits, 1998-2001.**

<b>Year</b>	<b>Total ER Visits Per 1,000</b>	<b>Percent of Admissions from the ER</b>
1998	420	44.7
1999	434	41.6
2000	408	43.5
2001	421	45.1

Source: Annual Hospital Survey, 1998-2001, Emergency Room and Outpatient Visits Report, Georgia Department of Community Health, Division of Health Planning

## **VII. Medicare and Medicaid**

Medicare, Medicaid and public insurance reimbursement mechanisms are essential to the viability of hospitals in Georgia. In 2001, 89 hospitals were eligible for Disproportionate Share Hospital Payments under the Indigent Care Trust Fund. On average, Medicare beneficiaries compose 38.5% of patient admissions and Medicaid and PeachCare beneficiaries compose 17.7% of patient admissions. Uncompensated indigent care accounted for 3.6% of adjusted gross revenue and charity care was 1.74% of adjusted gross revenue in 2001. Budget restraints continue to threaten the viability of many hospitals that serve uninsured and low-income individuals. TAC members wanted to ensure access to health care services for low-income and other vulnerable populations. They agreed to award providers that have historically served Georgia's indigent and uninsured population with some measure of acknowledgement of this commitment by including a favorable consideration standard in the hospital rules.



With these environmental considerations in mind, the TAC sought to develop guidelines to address the dynamic hospital service delivery industry. The following guidelines have been designed to balance access, cost, quality and system efficiency considerations.

## GUIDELINES

### **Short-Stay General Hospital Beds**

#### **(a) Applicability**

*The law and the rules of the Department of Community Health/Division of Health Planning, require a Certificate of Need (CON) prior to the establishment of a new, replacement or expanded hospital facility. This standard was fine-tuned to ensure that applicants are informed of the instances where the rules would specifically not apply.*

1. A Certificate of Need will be required prior to the establishment of a new hospital, replacement of an existing hospital, or expansion of an existing hospital.
2. The provisions in these rules do not apply to the following situations:
  - (i) bed replacements in existing hospital facilities which do not require a capital or equipment expenditure over the applicable dollar threshold; or
  - (ii) changing the physical location of existing beds within an existing facility regardless of cost; provided, however, that any project in excess of the applicable capital or equipment expenditure dollar threshold must be reviewed in accordance with the review considerations set forth in Rule 272-2.08; or
  - (iii) projects that are otherwise exempt from review pursuant to O.C.G.A. 31-6-47 (a) (15).
3. An existing hospital seeking an expansion to be used for new institutional health services, including perinatal services, rehabilitation services, or psychiatric and substance abuse services, must meet the applicable service specific rules found in this Chapter and, as a threshold matter, meet the need standards set forth in 272-2-.09 (8)(c)(2)(iii) but shall not be required to meet the other requirements in Rule 272-2-.09(8).
4. A hospital that has been approved through the certificate of need process to use a certain number of short-stay hospital beds for long-term acute care (LTAC) beds shall have such LTAC beds removed from the official inventory of available short-stay beds once the LTAC is certified by Medicare; provided, however, that such beds will revert to the hospital's official inventory of available short-stay beds at any point that the LTAC ceases operation or is no longer certified by Medicare. An application to use existing short-stay hospital beds for LTAC beds shall not be subject to the guidelines in Rule 272-2-.09(8).

## **Rationale: Applicability**

Throughout the drafting of these rules members of the Short Stay General Hospital Technical Advisory Committee (TAC) urged Division staff to clarify when the short stay general hospital rules would not be triggered. Several references carry over from the previous rules and specifically delineate the two instances where these rules would not apply including 1) bed replacements in existing facilities which do not trigger the equipment or capital expenditure threshold or 2) any renovation regardless of cost provided that the General Consideration guidelines would still be met. Further, this section clarifies that bed additions in conformity with the statute (10 beds or 10% of capacity in cases where the hospital had been operating at higher utilization for two years) are not covered by these rules.

The Division has historically contended that facilities should be given some flexibility to realign services within their facilities to more appropriately respond to changes in their market and to better meet the needs of their local communities. If the applicant is seeking to make bed replacements or renovations, they would not be required to meet the need methodology. The application would be reviewed using the Department's General Consideration guidelines. If the applicant currently offers the service, existing acute care beds can be redistributed.

However, if the applicant is seeking a new institutional health service and new beds (expansion) to provide that service, the applicant would be required to meet the numerical need for expansion short-stay beds as a threshold matter. Other provisions of the short-stay rules would not be applied in these instances. If the applicant meets the need for the additional beds, then the review would turn to the service-specific standards, which would govern any award of a new institutional health service.

TAC members also urged Division staff to clarify how Medicare-designated long-term acute care (LTAC) beds will be treated in the inventory since short-stay hospital beds have been used to create LTACs. These guidelines now explicitly authorize an existing hospital to use existing beds to create an LTAC program and the rules now specifically require that approved LTAC beds be removed from the official inventory of available short-stay beds once Medicare certifies the LTAC. These beds would revert back to the hospital's official inventory of available short-stay beds at any point that the LTAC ceases operation or is no longer certified by Medicare. TAC members wanted to ensure clarity around the development of LTAC programs and that beds were being counted in the most appropriate way for inventory purposes.

### **(b) Definitions**

*The new rules detail a number of key concepts and policy considerations through the definitions section. These bases and/or conceptual framework for the definitions are referenced, as appropriate, in the Rationale discussions elsewhere in the document.*

1. "Age cohorts" for purposes of these rules refers to the following age groups: persons 0 to 17; persons 18 to 64; and persons 65 and older.
2. "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.

3. "Children's hospital" means a hospital in which 90% or more of the patients served by the hospital are 17 or less years of age.
4. "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.
5. "Expansion" means the addition of available beds or CON approved beds for an existing hospital.
6. "Health planning area" or "planning area" means the twelve (12) state service delivery regions as defined in O.C.G.A. 50-4-7.
7. "Horizon year" means the last year of a five (5) year projection period for need determinations.
8. "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 365. The optimal occupancy rate is variable based on the following:
  - a. For hospitals located in a rural county, 65%;
  - b. For hospitals located in a non-rural county, 75%; and
  - c. For teaching or children's hospitals, 70%.
9. "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.
10. "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.
11. "Rural county" means a county with a population of 35,000 or less based on the most recent decennial census, as defined in O.C.G.A. 31-7-94.1(c)(3).
12. "Safety net hospital" is defined as a hospital that meets at least two (2) of the following criteria:
  - (a) the hospital is a children's hospital or a teaching hospital;
  - (b) the hospital is designated by the Department of Human Resources as a trauma center;
  - (c) Medicaid and PeachCare inpatients admissions constitute 20% or more of the total hospital inpatients admissions;
  - (d) Uncompensated charges for indigent patients constitute 6% or more of hospital adjusted gross revenue; or
  - (e) Uncompensated charges for indigent and charity patients constitute 10% or more of hospital adjusted gross revenue

13. "Short stay hospital" or "hospital" is defined as a facility with an average length of stay of less than 30 days.

14. "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.

15. "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.

### **(c) Standards**

#### **STANDARD: NEW HOSPITALS- SIZE AND NEED METHODOLOGY**

*TAC members wanted to ensure that any methodology that evaluated the need for new hospitals would be responsive to current industry changes, including age cohorts, technological advances, financing strategies or clinical and other operating realities. Their discussions centered around several critical planning components including: planning horizon, optimal occupancy rates, access to services, peak hospital use, including out-of-state and trauma network development and target service area populations. Members also defined rural and non-rural areas of the state.*

1. A new hospital must be at least 50 beds in size if located in a rural county and at least 100 beds in size if located in a county other than a rural county.

2. The need for a new, replacement or expanded hospital shall be determined through application of an appropriate numerical need methodology designed to access need for the specific purpose sought in the application.

(i) 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:

A. Calculate the use rate for current hospital services in the target service area population by dividing the patients days for each age cohort by the population for each age cohort for same year as patient days were calculated.

B. 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.

C. Divide the results of the calculations in Step B by 365 and sum these numbers to determine a baseline bed need.

D. 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 patients 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.

E. 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.

F. 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.

G. 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.

(ii) A new hospital shall be approved only if the total target service area population is at least 50,000 persons.

#### **Rationale for Standard: New Hospitals- Size and Need Methodology**

The TAC agreed that the recommended bed size for a new hospital in a rural county should be 50 beds and 100 beds in a non-rural county. TAC members said that economies of scale and population differences warrant different considerations. The TAC discussed the economic realities of operating a hospital at this time and considered future bed need. They agreed that rural hospitals are usually located in small communities with declining and aging populations. Because of the significantly smaller patient base that they draw on, members agreed that a smaller bed size would be more appropriate and would be more sustainable. They recommended a bed capacity of 50 beds for rural hospitals. Non-rural hospitals, on the other hand, have higher population densities and should sustain a larger bed capacity. Members agreed that these thresholds should only apply to new hospitals.

The numerical need for a new, replacement or expanded hospital should be determined through the application of an objective need methodology. TAC members agreed that the formula for new hospitals should utilize a demand-based forecasting model since it would provide the best indicator of need for new hospital services. They agreed that the examination of service utilization within a target area through the delineation of age cohorts would provide a good indication of the demand expectations of these age cohorts. The use of services by these population groups would provide a crucial planning tool about the future need for services based on current demand.

TAC members agreed that the need methodology should also include a factor that takes into account an out-of-state use rate. Members said that out-of-state use should be factored into the need methodology since some facilities care for large numbers of such patients and in many instances, out-of-state residents can consume large amount of resources. The committee agreed that the periodic and regular influx of patients could have an impact on the local health system's ability to render high quality care. In addition to out-of-state residents, members said that the target service area population should be specifically defined as the total population of all counties that are in part or in whole within a ten mile radius of the planned location of the new, expanded or replacement hospital. This radius provides a more accurate representation of the available capacity within the service area since patients would be able to access services from any existing providers or from the proposed site. The target service area population and the related radius should be used to determine population, utilization and capacity issues; the mileage component should not be used as a proxy for adverse impact protection of any existing provider.

Members spent a considerable amount of time discussing the horizon year for hospital planning. They agreed that there should be one planning horizon for all hospital types, regardless of the size or location of the hospital. While the nationwide planning horizon average varied from three to ten years, TAC members felt that five (5) years remains the most appropriate time period to plan for these services. They said that population growth is unpredictable and that it would be too unreliable to base facility needs on hypothetical forecasts too far into the future.

Members said that optimal occupancy rates should be established for all new hospitals in order to ensure that all capacity is being utilized within the planning area before any new need could be established. They agreed that the size of the facility should have no impact on the occupancy targets but acknowledged that there are rural and specialty hospital differences. They said that rural hospitals would likely have greater swings in occupancy though potentially less routine occupancy. TAC members agreed that optimal occupancy for rural hospitals should be set at 65% of available beds. For children's hospitals, the optimal occupancy should be 70% and, for non-rural hospitals, the target should be set at 75%. These occupancy targets will promote planning and development focused on operational efficiency and responsiveness to future community demand.

TAC members said that the bed capacity should be determined through the use of those beds that were approved or authorized beds in the Certificate of Need process. Only CON bed capacity should be used in any of the hospital bed need calculations. Licensed or set-up-and-staffed beds may represent something less than the total available capacity (i.e., CON approved beds). As a general rule, before any new beds are added, the state should consider the use of available beds.

TAC members agreed that there should also be a minimum population base of 50,000 people in order to seek the development of new hospital services. The group discussed whether the guidelines should require that a new hospital should be some minimum distance from any existing hospitals, but agreed that the new methodology coupled with the adverse impact criteria in the new rules should effectively address this concern. This new approach signifies a change from past regulatory review practice.

## **STANDARD: NEED FOR REPLACEMENT HOSPITALS AND EXPANDED HOSPITAL SERVICES**

*TAC members in their deliberations agreed that replacement hospitals and hospitals seeking to expand services should be treated differently from new hospital development. They spent a substantial amount of time balancing the merits of why expansion or replacement facilities should be treated differently and how replacement hospitals should be concretely defined. Members were explicitly clear that a replacement facility could replace itself only at the numerical need level, provided it meets strict location and patient origin criteria.*

(iii) 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:

- A. 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.
- B. 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.
- C. Sum the number of patients resulting from Step B and divide by 365 to determine a baseline bed need rate.
- D. 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 patients 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.
- E. 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.
- F. Compare the results of Step E 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.



## **Rationale for Standard: Need for Replacement Hospitals or Expanded Hospital Services**

The committee spent a considerable amount of time discussing the criteria for replacement hospitals. The TAC, by an overwhelming consensus, agreed that a replacement hospital (other than those meeting the exceptions criteria) would be required to meet the numerical need methodology and replace itself only at the amount specified by the numerical need methodology. They also recommended some very specific location requirements. Members agreed that a replacement hospital should only be allowed to replace itself within a three-mile radius of the existing facility. This would ensure that the replacement hospital would serve essentially the same patient base as it had previously served.

If, however, property could not be located within the three-mile limit, TAC members said that a replacement hospital could be approved outside that boundary, provided that the applicant locate the replacement facility in the same county as the existing facility and the applicant provide documentation that it will serve substantially the same patient population as it had previously served. TAC members said that, beyond the three-mile radius, a hospital should not be permitted to replace itself outside of its existing county of operation since to do so would allow the hospital to potentially reinvent itself in another geographic location. Because there was some concern that hospitals would seek replacement facilities to capture a more affluent patient base or a patient population that had access to health insurance resources, TAC members recommended that an applicant seeking a replacement site (beyond the authorized three-mile radius) be required to substantiate that the replacement hospital would serve substantially the same patient base through the use of patient zip code and payer mix data in detailing patient origin characteristics.

TAC members did struggle with the prospect that the county boundary restriction (for those replacements beyond the three mile radius) may be artificially restrictive and may cause an undue burden on older facilities that would consider replacing their aging facilities. The group requested that the department monitor applications for replacement hospitals to analyze trends and possible constraints.

Like the requirements for a new hospital, TAC members agreed that an institution-specific methodology, which looks at age cohorts and hospital use by examining the county hospital utilization rates by age cohort, would also forecast projected demand for services by particular patients. Members said that out-of-state use should be factored into the need methodology for replacement and hospitals seeking to expand since some facilities care for large numbers of out-of-state patients. In many instances, these patients consume large amount of resources. The committee agreed that the periodic and regular influx of patients would have an impact on the health system's ability to render high quality care. The committee agreed that the methodology for replacement hospitals should account for non-resident utilization.

The committee recommended relying primarily on patient discharge data provided by the Georgia Hospital Association under contract with the Department of Human Resources/Division of Public Health, pursuant to O.C.G.A. 31-7-280 et seq. This data is a more accurate reflection of actual utilization as compared to the Annual Hospital Questionnaires that are provided to the Department and used in the past. Once the baseline occupancy is determined, based on actual utilization, the need methodology incorporates the optimal occupancy provisions to determine appropriate facility capacity.

## **STANDARD: EXCEPTION TO NEED**

*Throughout this plan and rules development process, TAC members expressed support for the state's trauma centers, teaching hospitals and critical access hospitals. All of these facilities provide significant contributions to the state. In light of the tremendous burden that trauma centers assume, including the rapid mobilization of high level services and staff, and the mission of teaching hospitals, who in addition to supporting their teaching mission also provide a significant amount of indigent care, these entities should be provided some added consideration in the Certificate of Need review process. TAC members also acknowledged the role that sole community providers and critical access hospitals play in their local communities and said that they too should receive an exception to the need standard in certain limited instances. Further, these facilities would also be exempted from addressing the adverse impact standard.*

3. The Department may allow an exception to need and adverse impact standards outlined in Rule 272-2-.09(8)(c)(2) and (4) for a facility meeting any one of the following criteria:

- (i) The facility is an existing facility designated by the Department of Human Resources as a trauma center;
- (ii) The facility is an existing teaching hospital;
- (iii) The facility is a sole community provider and more than 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
- (iv) 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.

### **Rationale for Standard: Exception to Need**

At the onset of this process, the Department and the Health Strategies Council expressed support for trauma centers in the state. As of June 2002, there were fifteen (15) designated trauma centers in the State of Georgia; Four (4) Level I facilities; Seven (7) Level II facilities; Three (3) Level III facilities; and One (1) Level IV facility.

TAC members agreed that hospitals providing trauma services offer a critical health service to the residents of the state and their continued operation require a tremendous commitment of resources. The TAC wholeheartedly agreed that trauma centers should be supported and incentivized to maintain this designation. They unanimously agreed that an applicant that has been designated as a trauma center by the Georgia Department of Human Resources should be exempted from meeting both the numerical need methodology and the adverse impact standard. The committee agreed that all trauma centers, regardless of their level designation, would be afforded this consideration for exception to need.

Members felt that trauma centers should be afforded every opportunity to develop appropriate systems of care to provide the range of services that would be needed for the community. In some

instances, there may not be a numerical need for additional services but the intensity and breadth of service offerings of the trauma center would make the addition of beds appropriate to meet peak demand outside of documented need. The TAC reiterated that only those centers, in existing hospitals that have already been designated as trauma centers at the time of the application, would be considered under the exception to need standard.

At the onset of this process, the Department and the Health Strategies Council expressed support for the state's teaching hospitals. Members said that teaching hospitals provide valuable training opportunities for the state's current and future clinical workforce. In addition, they conduct research, provide a disproportionate amount of care for poor and uninsured people, and provide highly specialized clinical care to the most severely ill and injured patients. As such, teaching facilities may require additional beds to address needs that could not be addressed in the numerical need methodology. The TAC reiterated that only those existing teaching hospitals that have already been designated at the time of the application would be considered under the exception to need standard.

Data from the Georgia Board for Physician Workforce (GBPW) indicate that there are eleven (11) teaching programs in the state. TAC members agreed that since the GBPW works with other national accrediting bodies to ensure that Georgia's teaching programs are meeting appropriate clinical requirements, that they should be the source for this determination. They also agreed that the state's training programs should be afforded every opportunity to maintain their accreditation and funding status and their clinical competencies. The committee recommended that the Division look to the GBPW for confirmation about teaching hospital designations in the State of Georgia.

During the course of the committee's deliberations, members said that there are some instances where county governments provide substantial financial support to local hospital health systems. Members agreed that if an applicant is a sole community provider and is receiving more than 20% of the capital cost of any new, replacement or expanded facility from the county governing authority (or a group of county governing authorities) that the applicant would receive an exception to the need and adverse impact standards. Members said that this sizable investment by county government reflects commitment to economic development and a desire to make communities more attractive places to live and work. Any such involvement by the county government should be recognized and supported.

The Medicare Rural Hospital Flexibility Program authorized by Section 4201 of the Balanced Budget Act of 1997 is a program under which limited-service hospitals known as critical access hospitals (CAH) are designated. Under this program, all hospitals receiving critical access hospital status must reduce the number of licensed beds to 15 acute care beds, with up to 25 beds if the facility offers a Swing Bed program. This program was developed to encourage the creation of rural networks, promote the concept of regionalization of health services and improve access to health services for rural residents of the state. CAH hospitals receive enhanced reimbursement for inpatient and outpatient services. The designation process also provides incentives to reduce acute care services but still maintain emergency and other essential services.

In the state of Georgia, final designation of a hospital as a CAH is contingent upon a facility survey conducted by the Department of Human Resources/Office of Regulatory Services. Under the current system, all designated CAH facilities maintain their maximum evaluated bed capacity. There is no Certificate of Need (CON) application required to reopen beds, provided the cost to do so does not exceed

the annual capital expenditure threshold that governs the CON program. An increase in the number of beds beyond CAH limits would automatically disqualify the hospital from participating as the CAH hospital. See Appendix B for a list of hospitals that currently are designated as critical access hospitals in the State of Georgia.

Rural hospitals are an integral part of their communities providing access to healthcare and contributing heavily to local communities by serving as an economic engine. Because of the important functions that these hospitals serve in their rural communities, TAC members agreed that if a CAH wanted to replace itself it should be exempted from meeting the need methodology and adverse impact standards but should only be allowed to replace itself at a maximum bed capacity of 25 beds. TAC members received input from current CAH administrators and other experts to support the contention that CAHs would be able to sustain themselves at this maximum bed size capacity.

## **STANDARD: ADVERSE IMPACT**

*Adverse impact guidelines protect the human and financial investment that has been made by the state and existing providers. Starting a new program to the detriment of existing programs, particularly the state's safety net providers and teaching institutions is not in line with sound planning principles. In all of its deliberations, the TAC agreed that certain providers should be afforded some protection given their training and indigent and charity care missions. Members agreed that hospital services should be developed in an orderly and comprehensive manner with a goal of minimizing adverse impact on the existing delivery system. Adverse impact should be addressed both from a facility-specific and a system-wide perspective. All hospitals covered by the short-stay hospital beds rules are subject to the adverse impact standard (with the exception of those applicants specifically noted as not being subject to the adverse impact standards).*

4. (i) 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.

(ii) 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 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.

(iii) 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 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.

#### **Rationale for Standard: Adverse Impact**

TAC members agreed that all applicants seeking new, replacement or expanded services should address the impact of any proposed services on existing hospital services within the target service area. Because cost, quality and access to care are areas of critical importance to the Department and to the TAC, members noted that all applicants should address how any new, replacement or expanded hospital services would specifically impact existing facilities in the target service area population. The burden to substantiate this impact is placed on the applicant. Members agreed that both positive and negative impacts should be clearly delineated in the application.

TAC members agreed that safety net providers within the planning area (state service delivery region as defined in O.C.G.A. 50-4-7) of an applicant hospital should be afforded some stipulated protection. Safety net providers are defined as hospitals meeting at least two key criteria – a higher than routine rate of indigent and charity care, a higher than routine rate of service Medicaid and PeachCare populations, trauma center designation, and teaching or children’s hospitals. In order to determine whether a safety net provider has been negatively impacted, an applicant should present analyses detailing 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 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.

TAC members recognized the vital role of the state’s teaching hospitals and said that their missions should not be in any way compromised. Teaching hospitals provide valuable training opportunities for the state’s current and future clinical workforce. Additionally, they conduct research, provide a disproportionate amount of care for poor and uninsured people and provide highly specialized clinical care to the most severely ill and injured patients. TAC members agreed that the training programs in Georgia’s hospitals should not be adversely impacted by the establishment of a new, expanded or replacement facility to the extent that existing training programs could not sustain a sufficient number and variety of patients to maintain an appropriate number of providers, provider competencies and the training program’s accreditation and funding status.

Adverse impact on any teaching hospital in the state is measured by a projected total decrease of 5% or more in its average annual utilization, as measured by patient days for the preceding two calendar years. Because volume of patients is a critical capacity consideration, TAC members unanimously agreed that these programs should not sustain significant losses to their needed patient volumes. New, expanded or replacement programs should be based on a clear need for services and a determination that such development will not have an adverse impact on any of the state's designated teaching hospitals.

#### **STANDARD: FAVORABLE CONSIDERATION**

*TAC members agreed that there might be circumstances where competing applications may have comparable characteristics. When competing applications are all worthy of merit and only one applicant can be given approval, the applicant that has historically provided increased access to care should be given favorable consideration.*

5. 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.

#### **Rationale for Standard: Favorable Consideration**

The favorable consideration standard is triggered only in instances where there are competing applications. In the case of competing but otherwise generally comparable applications, an applicant that has historically provided the higher annual percentage of unreimbursed care to indigent and charity care patients and the higher annual percentage of services to Medicare, Medicaid and PeachCare patients should be awarded the state's approval. This is an issue of accessibility to appropriate services. The TAC has endorsed the Department's mission of improving health status and health outcomes for all Georgians by continuing to require providers to minimize barriers to the accessibility of health care services. The Department may give special consideration, when considering competing applications, to the applicant that has a stronger record of serving these eligible patient populations.

#### **STANDARD: FINANCIAL ACCESS TO CARE**

*TAC members agreed that financial access to care is a key component of the state's planning process. Further, they agreed that the equitable distribution of the indigent care burden among providers is the corollary to the equitable access to hospital and health care services for all citizens without regard to the ability to pay. Assessment of a hospital's commitment to assure financial access to services should be multifaceted.*

6. 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:

- (i) 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;
- (ii) providing a written commitment that services for indigent and charity patients will be offered at a standard which meets or exceeds three percent (3%) of annual, adjusted gross revenues for the hospital;
- (iii) providing a written commitment to participate in the Medicare, Medicaid and PeachCare programs;
- (iv) providing a written commitment to participate in any other state health benefits insurance programs for which the hospital is eligible; and
- (v) 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.

#### **Rationale for Standard: Financial Accessibility**

Providers in the State of Georgia are expected to adhere to these standards as critical criteria for receiving any business or operational approval from the state. Providing full access, free from financial or any other discrimination, is central to Georgia's health care purchasing and regulatory mission. The Department noted that these delineated provisions are a part of a standard template that all applicants must address to demonstrate how they plan to meet the expectation of providing care to the state's indigent and low-income and uninsured patients. The TAC endorsed the Department's mission and agreed that all applicants should minimize barriers to appropriate health care services. TAC members unanimously recommended the inclusion of this accessibility standard.

Applicants for new, replacement or expanded services would be required to provide evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis, including providing services to individuals regardless of race, sex, ability to pay. The TAC recommended that applicants should provide written commitment that services for indigent and charity care patients will be offered at a standard which meets or exceeds three percent (3%) of annual adjusted gross revenues for the hospital. The TAC agreed that this standard is critical to ensuring access to care for patients who might not otherwise have access to such services. Applicants also must provide full access to services, regardless of ability to pay or payment source, and are required to agree to participate in any state sponsored or operated health insurance program. In evaluating the past record of performance of the applicant, the Division should consider the record of the applicant and any affiliates. Failure to meet an existing or previous indigent care commitment and/or failure to serve the Medicaid or indigent population at or above a level commensurate with the community served by the applicant and/or its affiliates may be grounds for denial of an application. The Department will use data from the three most recent prior years to make this determination.

#### **STANDARD: QUALITY OF CARE**

*TAC members said that providing the highest quality care to the residents of the state is among the state's and the TAC's highest priorities. In an effort to promote improved health outcomes for families, all providers should be expected to maintain some minimal quality standards.*

7. (i) An applicant for a replacement or expanded hospital shall document that the hospital is fully accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) 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 JCAHO or another appropriate 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.

(ii) 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.

#### **Rationale for Standard: Quality of Care**

The state and the TAC have an interest in ensuring that all hospitals provide the highest quality of care to patients. Compliance with licensure and certification standards, both national and state, correlates to the successful operation and management of hospitals and indicates that a facility has met certain performance standards. The Joint Commission on Accreditation of Health Care Organization (JCAHO) is the nation's major hospital accrediting body. Accreditation by this or another nationally recognized accrediting body is usually acknowledged as a quality "seal of approval". Because these standards reflect state-of-the-art performance expectations, organizations that meet them improve their ability to provide quality patient care. JCAHO performs on-site visits and establish standards that address all aspects of hospital care including, but not limited to, patient advocacy, governance, and administration, quality of care, quality assurance and medical records. Accreditation may also be a condition of reimbursement for certain insurers and other payers. JCAHO accreditation provides deemed status for state licensure regulations.

This standard also calls for no history of significant licensure deficiencies and no history of conditional level Medicare and/or Medicaid certification deficiencies in the past three years. This standard represents a broad approach to cover several facets of quality and to ensure that the applicant has no recent history of providing inadequate quality of care



Because the process of securing JCAHO or other national accreditation can be a costly undertaking for hospitals, the Department has recognized that some hospitals prefer to seek state licensure without accreditation. In these cases, the applicant would be required to provide sufficient documentation to prove that the hospital has no history of significant state licensure deficiencies and no history of conditional level Medicare and/or Medicaid deficiencies in the past 5 years and has no outstanding licensure and Medicare and Medicaid certification deficiencies. The Department is committed to working with the Department of Human Resources/Office of Regulatory Services to ensure that applicants have a history of compliance with licensure and other operating standards. Committee members agreed that applicant hospitals should have no formal licensure sanctions in place.

Members further agreed that quality assurance standards should be included in all hospital guidelines. Nationally, the rise in medical errors causes much concern to patients, providers and payors. Requiring that providers participate in a statewide or national external reporting and peer review system will help to ensure patient safety and medical errors receive appropriate attention. Further, the hospital could benefit from any outcome data that could be used to compare itself to industry benchmarks, which would address such areas as patient outcomes, consumer satisfaction, and consumer demand.

TAC members agreed that applicants seeking new, expanded or replacement facilities be required to provide evidence of availability of resources for the provision of services. This provision mirrors that of the State of Vermont. The rules require applicants to provide evidence that they can fully support, with human resources and capital, the beds that they are attempting to acquire.

The Department is fully committed to ensuring that providers offer the highest possible quality of patient care. Recognizing that the nation and the state are both experiencing critical workforce shortages, the Department has required that the applicant document a plan to obtain and maintain staff and service quality standards necessary to promote effective patient care and clinical outcomes. Because the current supply of health care professionals in Georgia is inadequate to meet current demand, providers are spending increasingly large amounts of money for agency and contract professionals. Despite this strategy, many providers are still operating with huge vacancy rates. Added to this reality is the fact that health care service utilization remains high and is expected to grow exponentially in this decade. The Department and the TAC want applicants to plan for services in a comprehensive manner recognizing staff limitations and keeping the best interest of patients at the forefront of the process.

## **STANDARD: CONTINUITY OF CARE**

*TAC members agreed that hospital services are only one point of care in the continuum of health care services and these services should be coordinated within and outside of the walls of the institution.*

8. (i) An applicant for a new, replacement or expanded hospital shall document a plan to operate an emergency room licensed by the Department of Human Resources.

(ii) 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:

A. Estimated geographic boundaries of primary and secondary service areas and the primary and outpatient providers in these areas;

B. Demographic and income characteristics of the service area by age, gender and racial compositions;

C. Anticipated payer sources by population totals and percentages to include public payers and indigent and charity care services;

D. Patient access to the full continuum of care, including discharge planning and long-term care options;

E. The projected financial and economic impact that the project will have on the community;

F. 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;

G. The manner in which the facility coordinates or will coordinate with the existing health care system;

H. The manner(s) in which the hospital will make available the necessary ancillary and support services; and

I. The manner in which the hospital will support the operation of any affiliated critical access hospitals, if applicable.

(iii) 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.

(iv) 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.

#### **Rationale for Standard: Continuity of Care**

The TAC spent a considerable amount of time discussing this standard. At the onset of the discussion, members said that if the applicant could not offer emergency services, they would be required to institute very stringent affiliation and referral agreements. After significant discussion about the state of current hospital emergency departments, including diversions, patient needs, workforce considerations and

system capacity, members agreed that because emergency rooms are expensive to maintain, they did not want to provide an avenue for some hospitals to be authorized not to offer these critical services and to offer only those services that would be most profitable. In the end, the group agreed that all hospitals should operate emergency room services. The TAC and the Department clearly stated their opposition to the operation of “boutique” hospitals, single service facilities that have resulted in financial and continuity of care problems in other states.

Throughout the TAC’s deliberations, members said that hospitals within the same service area should communicate with each other to create collaborative efforts and coordinated care and services to discourage the episodic and inappropriate use of services. Community linkages and coordination could include agreements with other related community service providers. TAC members wanted to encourage providers to work together to provide the highest quality care for the residents of the state. They agreed that regional facilities should support the work of the state’s critical access hospitals to provide coordinated care at the local community level. Members said that increased local communication could result in enhanced quality and accessibility of care to patients and their families, decreased healthcare cost and improved system efficiencies. While the TAC recognized that this type of behavior could not be driven by a state rule, they were adamant that providers should be encouraged to communicate with each other in the best interest of the healthcare system and patients. Further, providers should be responsive to local communities by better understanding the communities’ needs.

The Department’s expectations that providers should be committed to the provision of care without regard to the patient’s ability to pay means that the hospital should have similar expectations for physicians who operate in their facilities. It does the patient no good to have the hospital adhere to this policy if the physician is going to require private pay or other financial resources. The applicant must agree to act in good faith to fulfill the terms and commitments set forth in these standards.

## **STANDARD: CONSOLIDATION OF RURAL HOSPITALS**

*TAC members wished to promote health system efficiencies and enhanced quality while ensuring that good faith efforts would not leave unintended consequences. Members unanimously agreed that rural hospitals should be able to consolidate hospital facilities in certain instances.*

9. (i) 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.

(ii) 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:

A. The available beds for the proposed consolidated facility must not exceed the total number of available beds of the existing facilities proposed for consolidation;

- B. 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;
- C. 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;
- D. 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
- E. The applicant(s) must comply with all other provisions of this chapter with exception of the need and adverse impact standards set forth in Rule 272-2-.09(8)(c)(2) and (4).

#### **Rationale for Standard: Consolidation of Rural Hospitals**

Because many rural hospitals have aging physical plants and inadequate technological capabilities, members agreed that consolidation for facilities located in a single rural county or in contiguous counties should be allowed and encouraged. This initiative would, among other things, potentially improve rural hospitals ability to update medical technology, physical infrastructure, maximize local system efficiencies and promote patient access to a high quality array of services.

Members agreed that given the multitude of changes that are occurring in the industry, it might be advantageous for providers to close some hospitals and consolidate services to better serve local communities. Consolidated facilities would have to be located in the same rural counties of the previous provider(s). The single consolidated facility could be located at an existing site or at a new site in one of the existing county(ies). The new facility would be required to show that it will serve essentially the same patient base as the previously existing facilities and would be required to describe the impact of consolidating services on the local community(ies) in the application process. The applicant would be able to maintain the available bed capacity of the existing facilities. In order to incentivize this option for rural hospitals, applicants would not be required to address the numerical need methodology or adverse impact standard.

#### **STANDARD: CONSOLIDATION OF NON-RURAL HOSPITALS**

*In an effort to promote system efficiencies, encourage access and cost-containment in both rural and non-rural areas of the state, the Department recommended the inclusion of a standard to authorize the consolidation of non-rural hospitals.*

10. (i) 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.

(ii) 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:

A. 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 Rule 272-2-.09(8)(c)(2)(iii)

B. 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;

C. 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;

D. 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

E. 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.

#### **Rationale for Standard: Consolidation of Non-Rural Hospitals**

The TAC and the Department spent some time discussing this option. The Department said that this option should be explored and made available to all providers in the state since it is an opportunity to enhance system efficiencies, decrease cost and provide a higher quality of care to residents. Applicants seeking consolidation under this option must be operating hospitals located in the same non-rural county. They would be required to submit a Certificate of Need application and would be required to consolidate into one single location within the county in which they are currently operating. The consolidation could occur at the existing site of either of the facilities or at a new site. The applicant would be required to address the need methodology and 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 each of the existing facilities.

TAC members agreed that applicants would be required to address the overall impact, including the adverse impact of the consolidated facility on the health care delivery system and show that any negative impact on existing or approved providers will be outweighed by the benefits of the proposal. Further, the TAC said that applicants would be required to show that the consolidated system represents the best mechanism to promote access to enhanced technology, improved physical plants, and access to high quality services. The TAC emphasized that the applicant could only offer those services that were previously approved for both applicants and that no new institutional health service could be offered without an approved Certificate of Need for that service.

TAC members examined several options to determine the best mechanism to ensure that facilities would have ample incentive to consider consolidation but would also be limited to a bed capacity that reflected actual utilization experiences. They considered whether each facility would be required to give up some minimum number of beds or whether they would be required to meet the numerical need methodology. TAC members did not want to allow the consolidated facility to maintain all beds from all of the existing facilities if the need methodology did not warrant that number of beds. Concerns were raised about having different requirements about bed retention for rural and non-rural hospital consolidation. The Department reiterated that the process is intended to incentivize clinical and operational efficiencies in both settings. Some members were concerned about the potential of creating large facilities that would be underutilized while other members recognized that many urban facilities could not meet utilization demands if they were forced to arbitrarily reduce bed size in a single consolidation. The Department examined the possibility of incorporating both numerical need and "floor" for bed reductions. This two-pronged approach is not possible because once a need methodology is required, the applicant is limited to the services (or bed counts) authorized by the need calculations. As such, there was agreement that the consolidated facility must not exceed the sum of the total number of beds for which each of the consolidating facilities would be authorized, based on the demand-based numerical need methodology.

## **GOALS, OBJECTIVES AND RECOMMENDED ACTIONS**

### **GOAL**

Ensure that inpatient hospital delivery systems are planned in an orderly and comprehensive manner and that systems can quickly and appropriately respond to changes in the health care environment.

### **OBJECTIVES**

- Improve access to hospital services by authorizing services based on a demand-based numerical need methodology;
- Ensure financial access to care by encouraging the provision of services to indigent patients and participation in Medicaid, PeachCare and other public reimbursement programs on a non-discriminatory basis;
- Minimize adverse impact on the state's safety net, teaching and critical access hospitals;
- Assure quality and patient safety through compliance with appropriate standards and guidelines;
- Encourage continuity of care;
- Contain costs in healthcare delivery by incentivizing system efficiencies;
- Promote planning within and among a wide range of systems of care;
- Balance need/expanded service activity within the context of existing investment and resource (human and capital) constraints.

### **RECOMMENDED ACTIONS**

The Short Stay General Hospital Technical Advisory Committee discussed and recommended the following actions:

- Implement Certificate of Need (CON) rules for inpatient hospital services consistent with this component plan and approve CON applications accordingly;
- Adopt an objective institution-based standard for determining need for inpatient hospital services;
- Streamline all other state health component plans that now rely on health planning areas (HPAs) to use State Service Delivery Regions (SSDRs), wherever possible;
- Encourage the Department to provide enhanced reimbursement to facilities with trauma center designation;

- Proceed with a parallel rule change that would move away from using Civilian Non-Institutional (CNI) population to using resident population in the numerical need methodology;
- Minimize the administrative burdens to care by allowing providers to work together to harness resources during emergency and disaster periods and
- Recommend that the TAC reexamine the issues surrounding replacement hospitals if there is evidence that the current guidelines are unduly burdensome.



## REFERENCES & RESOURCE MATERIALS

American Health Planning Association, National Directory of Health Planning, Policy and Regulatory Agencies, 13<sup>th</sup> Edition, January 2002.

American Hospital Association, "Trendwatch: Challenges Facing Rural Hospitals", Vol. 4, No. 1, June 2002.

American Hospital Association, "Trendwatch: Forces Driving Inpatient Utilization", Vol. 3, No. 3, November 2001.

American Hospital Association, "Trendwatch: Redefining Hospital Capacity", Vol. 2, No. 3, September 2000.

American Hospital Association, "Trendwatch: Teaching Hospitals-Social Missions at Risk", Vol. 4, No. 2, May 2002.

Department of Community Health, Division of Health Planning, (1996-2001), *Annual Hospital Survey*, Atlanta, GA. 2002

Department of Community Health, Division of Health Planning, (1998-1990), *Annual Hospital Reports*, Atlanta, GA.2002

Department of Community Health, Health Care Workforce Technical Advisory Committee of The Health Strategies Council, *Code Blue: Workforce in Crisis*, May 2001

Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Hospital Care Statistics Branch, *2000 National Hospital Discharge Survey: Table 3*, June 2002.

Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), *Advanced Data: National Hospital Ambulatory Medical Care Survey: 2000 Emergency Department Summary*, Number 326, April 2002.

Health Forum LLC, American Hospital Association, Hospital Statistics. 2002.

Institute For The Future, The Robert Wood Johnson Foundation, Health and Health Care 2010: The Forecast, The Challenge. January 2000.

Institute Of Medicine (IOM), Committee on the Changing Market, Managed Care, and The Future Viability of Safety Net Providers, America's Health Care Safety Net: Intact but endangered. National Academy Press 2000

The Lewin Group, American Hospital Association, "Survey of Emergency Department and Hospital Capacity", April 2002.

US Department of Commerce, Economics and Statistics Administration, US Census Bureau,  
"Population Change and Distribution: Census Brief", April 2001.

US Department of Commerce, Economics and Statistics Administration, US Census Bureau, *State and  
County Quick Facts*, [www.census.gov](http://www.census.gov), October 2002.

**GEORGIA STATE HEALTH PLAN  
COMPONENT PLAN**

**APPENDIX A**

**Members  
Short Stay General Hospital  
Technical Advisory Committee**

## GENERAL SHORT-STAY HOSPITAL TECHNICAL ADVISORY COMMITTEE

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CEO, Memorial Hospital and Manor, Bainbridge

**William G. Baker, Jr., M.D.**

Executive Director, Atlanta Regional Health Forum,  
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**Kurt Stuenkel, FACHE**

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**David Tatum**

Director, Governmental Relations

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**David M. Williams, M.D.**

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Member, Health Strategies Council

*\*shared appointment for MAG*

**Honorable Cardee Kilpatrick**

# **GEORGIA STATE HEALTH PLAN COMPONENT PLAN**

## **APPENDIX B**

### **Critical Access Hospitals In the State of Georgia (As of February 2003)**

## GEORGIA CRITICAL ACCESS HOSPITALS (as of February 2003)

COUNTY	HOSPITAL NAME	CITY	APPROVAL DATE
Bacon	Bacon County Hospital	Alma	01-Jul-02
Bleckley	Bleckley Memorial Hospital	Cochran	14-Oct-99
Butts	Sylvan Grove Hospital	Jackson	28-Aug-01
Calhoun	Calhoun Memorial Hospital	Arlington	01-Aug-00
Charlton	Charlton Memorial Hospital	Folkston	01-Mar-01
Clinch	Clinch Memorial Hospital	Homerville	21-Jul-00
Early	Early Memorial Hospital	Blakely	01-May-01
Effingham	Effingham Hospital	Springfield	15-May-00
Haralson	Higgins General Hospital	Bremen	01-Sep-01
Jasper	Jasper Memorial Hospital	Monticello	01-Jan-00
Jenkins	Jenkins County Hospital	Millen	07-Dec-00
Lanier	Louis Smith Memorial Hospital	Lakeland	01-Jul-02
Meriwether	Georgia Baptist Meriwether Hospital	Warm Springs	01-Apr-01
Miller	Miller County Hospital	Colquitt	24-Feb-00
Monroe	Monroe County Hospital	Forsyth	12-Sep-01
Morgan	Morgan Memorial Hospital	Madison	20-Dec-99
Peach	Peach Regional Medical Center	Fort Valley	15-Nov-00
Putnam	Putnam General Hospital	Eatonton	25-Jan-01
Randolph	Southwest Georgia Regional Medical Center	Cuthbert	25-Jun-99
Screven	Screven County Hospital	Sylvania	10-Nov-00
Stewart	Stewart Webster Hospital	Richland	01-Dec-01
Tattnall	Tattnall Community Hospital	Reidsville	01-Mar-02
Telfair	Taylor Telfair Regional Hospital	Mcrae	01-Jan-00
Towns	Chatuge Regional Hospital	Hiawassee	01-May-02
Wheeler	Wheeler County Hospital	Glenwood	01-Nov-01
Wilkes	Wills Memorial Hospital	Washington	01-May-02
Worth	Pheobe Worth Medical Center	Sylvester	01-Sep-02

**Total: 27 Hospitals**

**Source: Georgia Department of Community Health/Division of Health Planning**

# **GEORGIA STATE HEALTH PLAN COMPONENT PLAN**

## **APPENDIX C**

### **List of General Hospital Closures In the State of Georgia (1980-2002)**

**GENERAL HOSPITAL CLOSURES IN GEORGIA**  
(1980-2002)

DATE CLOSED	COUNTY	FACILITY TYPE	FACILITY NAME	TOTAL BEDS CLOSED
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**CLOSED WITH ACTIVE CON**

19-Apr-02	Douglas	Non-Rural	Emory Parkway Medical Center	310
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**CLOSED WITH INACTIVE CON**

01-Jan-80	Seminole	Rural	Seminole Memorial Hospital	30
15-Jan-81	Fulton	Non-Rural	Mclendon Hospital	33
01-Aug-82	Taylor	Rural	Montgomery Hospital	16
01-Dec-83	Paulding	Non-Rural	Community Hospital of Paulding Co	18
13-Jul-87	Clay	Rural	Fort Gaines Hospital	35
15-May-88	Heard	Rural	Heard Community Hospital	29
31-Oct-88	Turner	Rural	Turner County Hospital	40
07-Nov-90	Terrell	Rural	Terrell Community Hospital	34
31-Jul-91	Fulton	Non-Rural	Bolton Hospital	184
01-Sep-91	Marion	Rural	Marion Memorial Hospital	30
22-Oct-92	Polk	Rural	Crest Medical Ctr Rockmart-Aragon	48
31-Oct-92	Pierce	Rural	Pierce County Hospital	22
30-Apr-94	Cherokee	Non-Rural	Woodstock Hospital	21
30-May-97	Chattooga	Rural	Chattooga Medical Center	31
12-Aug-99	Rabun	Rural	Ridgecrest Hospital	49
02-Nov-99	Carroll	Non-Rural	Bowdon Area Hospital	41
10-Dec-99	Fulton	Non-Rural	West Paces Medical Center	294
14-Mar-01	Hancock	Rural	Hancock Memorial Hospital	52
02-Jun-01	Dooly	Rural	Dooly Medical Center	25

**Total Facilities: 20**

Source: Georgia Department of Community Health/Division of Health Planning



# **GEORGIA STATE HEALTH PLAN COMPONENT PLAN**

## **APPENDIX D**

### **List of Operational Hospitals in the State of Georgia (As of February 2003)**

## List of General Hospitals in the State of Georgia (as of February 2003)

<b>HPA COUNTY</b>	<b>FACILITY NAME</b>	<b>ADDRESS</b>
13 Appling	Appling Hospital	PO Box 2070 Baxley, GA 31515-2070
13 Bacon	Bacon County Hospital	PO Box 1987 Alma, GA 31510-0987
6 Baldwin	Oconee Regional Medical Center	PO Box 690 Milledgeville, GA 31061-0690
4 Barrow	Barrow Community Hospital	PO Box 768 Winder, GA 30680-0768
1 Bartow	Emory Cartersville Medical Center (EMMC)	P O Box 200008 Cartersville, GA 30120-9001
12 Ben Hill	Dorminy Medical Center	PO Box 1447 Fitzgerald, GA 31750-1447
12 Berrien	Berrien County Hospital	PO Box 665 Nashville, GA 31639-0665
6 Bibb	Coliseum Medical Centers	350 Hospital Drive Macon, GA 31217-3871
6 Bibb	Macon Northside Hospital	PO Box 4627 Macon, GA 31208-4627
6 Bibb	Medical Center of Central Georgia	PO Box 6000 Macon, GA 31208-6000
9 Bleckley	Bleckley Memorial Hospital	PO Box 536 Cochran, GA 31014-0536
12 Brooks	Brooks County Hospital	PO Box 5000 Quitman, GA 31643-5000
10 Bulloch	East Georgia Regional Medical Center	PO Box 1048 Statesboro, GA 30459-1048
7 Burke	Burke Medical Center	351 Liberty Street Waynesboro, GA 30830-9686
5 Butts	Sylvan Grove Hospital	601 South 8th Street Griffin, GA 30224-4294
11 Calhoun	Calhoun Memorial Hospital	PO Drawer R Arlington, GA 31713-0496
13 Camden	Camden Medical Center	2000 Dan Proctor Drive St. Mary's, GA 31558-3810
10 Candler	Candler County Hospital	PO Box 597 Metter, GA 30439-0597
5 Carroll	Tanner Medical Center/Carrollton	705 Dixie Street Carrollton, GA 30117
5 Carroll	Tanner Medical Center/Villa Rica	PO Box 638 Villa Rica, GA 30180
1 Catoosa	Hutcheson Medical Center	100 Gross Crescent Circle Fort Oglethorpe, GA 30742
13 Charlton	Charlton Memorial Hospital	PO Box 188 Folkston, GA 31537
10 Chatham	Candler Hospital	5353 Reynolds Street Savannah, GA 31405
10 Chatham	Memorial Health University Medical Center	P O Box 23089 Savannah, GA 31403-8089
10 Chatham	St. Joseph's Hospital	11705 Mercy Boulevard Savannah, GA 31419-1791
3 Cherokee	Northside Hospital-Cherokee	P O Box 906 Canton, GA 30114-0906
4 Clarke	Athens Regional Medical Center	1199 Prince Avenue Athens, GA 30606-2793
4 Clarke	St. Mary's Hospital	1230 Baxter Street Athens, GA 30606-3791 11 Upper Riverdale Road SW Riverdale, GA 30274-2600
3 Clayton	Southern Regional Medical Center	2600
13 Clinch	Clinch Memorial Hospital	P O Box 516 Homerville, GA 31634-0516
3 Cobb	Emory-Adventist Hospital	3949 South Cobb Drive Smyrna, GA 30080-6300
3 Cobb	WellStar Cobb Hospital	3950 Austell Road Austell, GA 30106-1174
3 Cobb	WellStar Kennestone Hospital	677 Church Street NE Marietta, GA 30060-1148
3 Cobb	WellStar Windy Hill Hospital	2540 Windy Hill Road SE Marietta, GA 30067-8632
13 Coffee	Coffee Regional Medical Center	PO Box 1248 Douglas, GA 31533-1248
11 Colquitt	Colquitt Regional Medical Center	P O Box 40 Moultrie, GA 31776-0040
12 Cook	Memorial Hospital of Adel	PO Box 450 Adel, GA 31620-0450
5 Coweta	Newnan Hospital	PO Box 997 Newnan, GA 30264-0997

5	Coweta	Newnan Hospital West	PO Box 2228 Newnan, GA 30264-2228
8	Crisp	Crisp Regional Hospital	PO Box 5007 Cordele, GA 31010-5007
1	Dade	Wildwood Lifestyle Center & Hospital	P O Box 129 Wildwood, GA 30757-0129
11	Decatur	Memorial Hospital of Bainbridge	1500 East Shotwell Street Bainbridge, GA 31717-4294
3	DeKalb	Children's Healthcare of Atlanta at Egleston	1405 Clifton Road NE Atlanta, GA 30322-1101
3	DeKalb	Decatur Hospital	450 North Candler Street Decatur, GA 30030-2626
3	DeKalb	DeKalb Medical Center	2701 North Decatur Road Decatur, GA 30033-5995
3	DeKalb	Emory Dunwoody Medical Center	4575 North Shallowford Road Atlanta, GA 30338-6499
3	DeKalb	Emory Northlake Regional Medical Center	1455 Montreal Road Tucker, GA 30084-8100
3	DeKalb	Emory University Hospital	1364 Clifton Road NE Atlanta, GA 30322-1061
3	DeKalb	South DeKalb Medical Center (DeKalb Medical Center at Hillandale)	2701 North Decatur Road Decatur, GA 30033
3	DeKalb	Wesley Woods Geriatric Hospital	1821 Clifton Road NE Atlanta, GA 30329-5102
9	Dodge	Dodge County Hospital	P O Box 4309 Eastman, GA 31023-4309
11	Dougherty	Palmyra Medical Centers	PO Box 1908 Albany, GA 31702-1908
11	Dougherty	Phoebe Putney Memorial Hospital	PO Box 1828 Albany, GA 31702-1828
3	Douglas	Emory Parkway Medical Center	P O Box 570 Lithia Springs, GA 30122-0570
3	Douglas	WellStar Douglas Hospital	8954 Hospital Drive Douglasville, GA 30134-2282
11	Early	Early Memorial Hospital	630 Columbia Road Blakely, GA 31723-1798
10	Effingham	Effingham Hospital	P O Box 386 Springfield, GA 31329-0386
4	Elbert	Elbert Memorial Hospital	PO Box 939-41 Elberton, GA 30635-1830
7	Emanuel	Emanuel Medical Center	PO Box 879 Swainsboro, GA 30401-0879
10	Evans	Evans Memorial Hospital	P O Box 518 Claxton, GA 30417-0518
1	Fannin	Fannin Regional Hospital	2855 Old Highway 5 North Blue Ridge, GA 30513-6247
3	Fayette	Fayette Community Hospital	1255 Highway 54 West Fayetteville, GA 30214-4521
1	Floyd	Floyd Medical Center	P O Box 233 Rome, GA 30162-0233
1	Floyd	Redmond Regional Medical Center	P O Box 107001 Rome, GA 30164-7001 1200 Baptist Medical Center Drive Cumming, GA 30041-7659
3	Forsyth	Northside Hospital Forsyth	
2	Franklin	Cobb Memorial Hospital	PO Box 589 Royston, GA 30662-0589
3	Fulton	Atlanta Medical Center	303 Parkway Drive Atlanta, GA 30312-1212
3	Fulton	Children's Healthcare of Atlanta at Scottish Rite	1001 Johnson Ferry Road NE Atlanta, GA 30342-1600
3	Fulton	Crawford Long Hospital of Emory University	550 Peachtree Street NE Atlanta, GA 30365-2225
3	Fulton	Emory Johns Creek Hospital	Duluth, GA
3	Fulton	Grady Memorial Hospital	80 Jesse Hill, Jr. Drive, S.E. Atlanta, GA 30303-3050
3	Fulton	Hughes Spalding Children's Hospital	80 Butler Street SE Atlanta, GA 30335-3050
3	Fulton	Kindred Hospital-Atlanta	705 Juniper Street NE Atlanta, GA 30365-1391
3	Fulton	North Fulton Regional Hospital	3000 Hospital Boulevard Roswell, GA 30076-9930
3	Fulton	Northside Hospital	1000 Johnson Ferry Road NE Atlanta, GA 30342-1611
3	Fulton	Piedmont Hospital	1968 Peachtree Road NW Atlanta, GA 30309-1285 5665 Peachtree Dunwoody Road NE Atlanta, GA 30342-1764
3	Fulton	Saint Joseph's Hospital of Atlanta	
3	Fulton	South Fulton Medical Center	1170 Cleveland Avenue East Point, GA 30344-3665

3	Fulton	Southwest Hospital And Medical Center	501 Fairburn Road SW Atlanta, GA 30331-2099
1	Gilmer	North Georgia Medical Center	PO Box 2239 Ellijay, GA 30540-0025
13	Glynn	Southeast Georgia Regional Medical Center	PO Box 1518 Brunswick, GA 31521-1518
1	Gordon	Gordon Hospital	P O Box 12938 Calhoun, GA 30703-7013
11	Grady	Grady General Hospital	PO Box 360 Cairo, GA 31728-0360
4	Greene	Minnie G. Boswell Memorial Hospital	1201 Siloam Road Greensboro, GA 30642-2811
3	Gwinnett	Emory Eastside Medical Center	P O Box 587 Snellville, GA 30078-0587
3	Gwinnett	Gwinnett Medical Center	PO Box 348 Lawrenceville, GA 30046-0348
3	Gwinnett	Joan Glancy Memorial Hospital	PO Box 348 Lawrenceville, GA 30046-0348
2	Habersham	Habersham County Medical Center	P O Box 37 Demorest, GA 30535-0037
2	Hall	Northeast Georgia Medical Center	743 Spring Street NE Gainesville, GA 30501-3899
1	Haralson	Higgins General Hospital	PO Box 655 Bremen, GA 30110-0655
2	Hart	Hart County Hospital	P O Box 280 Hartwell, GA 30643-0280 1133 Eagle's Landing Parkway Stockbridge, GA 30281-5099
3	Henry	Henry Medical Center	
6	Houston	Houston Medical Center	P O Box 2886 Warner Robins, GA 31099-2886
6	Houston	Perry Hospital	P O Drawer 1004 Perry, GA 31069-1004
12	Irwin	Irwin County Hospital	710 North Irwin Avenue Ocilla, GA 31774-5098
4	Jackson	BJC Medical Center	70 Medical Center Drive Commerce, GA 30529-1084
6	Jasper	Jasper Memorial Hospital	898 College Street Monticello, GA 31064-1298
13	Jeff Davis	Jeff Davis Hospital	P O Box 1200 Hazlehurst, GA 31539-1200
7	Jefferson	Jefferson Hospital	P O Box 528 Louisville, GA 30434-0528
7	Jenkins	Jenkins County Hospital	931 East Winthrope Avenue Millen, GA 30442-1839
12	Lanier	Louis Smith Memorial Hospital	852 West Thigpen Avenue Lakeland, GA 31635-1099
9	Laurens	Fairview Park Hospital	PO Box 1408 Dublin, GA 31040-1408
10	Liberty	Liberty Regional Medical Center	PO Box 919 Hinesville, GA 31310-0919
12	Lowndes	Smith Northview Hospital	4280 North Valdosta Road Valdosta, GA 31602-6814
12	Lowndes	South Georgia Medical Center	PO Box 1727 Valdosta, GA 31603-1727
2	Lumpkin	Chestatee Regional Hospital	227 Mountain Drive Dahlonega, GA 30533-1606
8	Macon	Flint River Community Hospital	P O Box 770 Montezuma, GA 31063-2502
7	McDuffie	McDuffie Regional Medical Center	521 Hill Street SW Thomson, GA 30824-2922
5	Meriwether	Georgia Baptist Meriwether Hospital	PO Box 8 Warm Springs, GA 31830-0008
11	Miller	Miller County Hospital	PO Box 7 Colquitt, GA 31737-0007
11	Mitchell	Mitchell County Hospital	PO Box 639 Camilla, GA 31730-0639
6	Monroe	Monroe County Hospital	PO Box 1068 Forsyth, GA 31029-1068
4	Morgan	Morgan Memorial Hospital	PO Box 860 Madison, GA 30650-0860
1	Murray	Murray Medical Center	PO Box 1406 Chatsworth, GA 30705-1406
8	Muscogee	Doctor's Hospital (Columbus)	P O Box 2188 Columbus, GA 31902-2188
8	Muscogee	St. Francis Hospital	P O Box 7000 Columbus, GA 31908-7000
8	Muscogee	The Medical Center	P O Box 951 Columbus, GA 31902-0951
3	Newton	Newton General Hospital	5126 Hospital Drive NE Covington, GA 30014
3	Paulding	WellStar Paulding Hospital	600 West Memorial Drive Dallas, GA 30132-4118

6	Peach	Peach Regional Medical Center	P O Box 1799 Fort Valley, GA 31030-1799
1	Pickens	Mountainside Medical Center	PO Box 730 Jasper, GA 30143-0730
1	Polk	Polk Medical Center	424 North Main Street Cedartown, GA 30125-2698 PO Box 1297 Macon Highway Hawkinsville, GA 31036-7297
9	Pulaski	Taylor Regional Hospital	
6	Putnam	Putnam General Hospital	P O Box 4330 Eatonton, GA 31024-4330
2	Rabun	Rabun County Memorial Hospital	PO Box 705 Clayton, GA 30525-0705
8	Randolph	Southwest Georgia Regional Medical Center	109 Randolph Street Cuthbert, GA 31740-1398
7	Richmond	Doctor's Hospital of Augusta	3651 Wheeler Road Augusta, GA 30909-6426
7	Richmond	Medical College of Georgia Hospitals and Clinics	1120 Fifteenth Street Augusta, GA 30912-0006
7	Richmond	St. Joseph Hospital of Augusta	2260 Wrightsboro Road Augusta, GA 30904-4726
7	Richmond	University Hospital	1350 Walton Way Augusta, GA 30901-2629
3	Rockdale	Rockdale Hospital & Health Systems	1412 Milstead Avenue NE Conyers, GA 30012-3899
7	Screven	Screven County Hospital	215 Mims Road Sylvania, GA 30467-2097
11	Seminole	Donalsonville Hospital, Inc.	PO Box 677 Donalsonville, GA 31745-0677
5	Spalding	Spalding Regional Hospital	PO Box V Griffin, GA 30224-0047
2	Stephens	Stephens County Hospital	2003 Falls Road Toccoa, GA 30577-9700
8	Stewart	Stewart Webster Hospital	PO Box 190 Richland, GA 31825-0190
8	Sumter	Sumter Regional Hospital, Inc.	100 Wheatley Drive Americus, GA 31709-3799
10	Tattnall	Tattnall Community Hospital	Route 1, Box 261 Reidsville, GA 30453-9726
9	Telfair	Taylor Telfair Regional Hospital	PO Box 150 McRae, GA 31055-0150
11	Thomas	John D. Archbold Memorial Hospital	PO Box 1018 Thomasville, GA 31799-1018
12	Tift	Tift Regional Medical Center	PO Box 747 Tifton, GA 31793-0747
10	Toombs	Meadows Regional Medical Center	PO Box 1048 Vidalia, GA 30475-1048
2	Towns	Chatuge Regional Hospital	PO Box 509 Hiawassee, GA 30546-0509
5	Troup	West Georgia Medical Center	PO Box 1567 LaGrange, GA 30241-1567
2	Union	Union General Hospital	214 Hospital Circle Blairsville, GA 30512-3102
5	Upson	Upson Regional Medical Center	PO Drawer 1059 Thomaston, GA 30286-0013
4	Walton	Walton Medical Center	PO Box 1346 Monroe, GA 30655-1346
13	Ware	Satilla Regional Medical Center	PO Box 139 Waycross, GA 31502-0139
6	Washington	Washington County Regional Medical Center	PO Box 636 Sandersville, GA 31082-0636
13	Wayne	Wayne Memorial Hospital	PO Box 408 Jesup, GA 31598-0408
9	Wheeler	Wheeler County Hospital	PO Box 398 Glenwood, GA 30428-0398
1	Whitfield	Hamilton Medical Center	P O Box 1168 Dalton, GA 30722-1168
7	Wilkes	Wills Memorial Hospital	PO Box 370 Washington, GA 30673-0370
11	Worth	Phoebe Worth Medical Center	PO Box 545 Sylvester, GA 31791-0545

**152 Facilities**

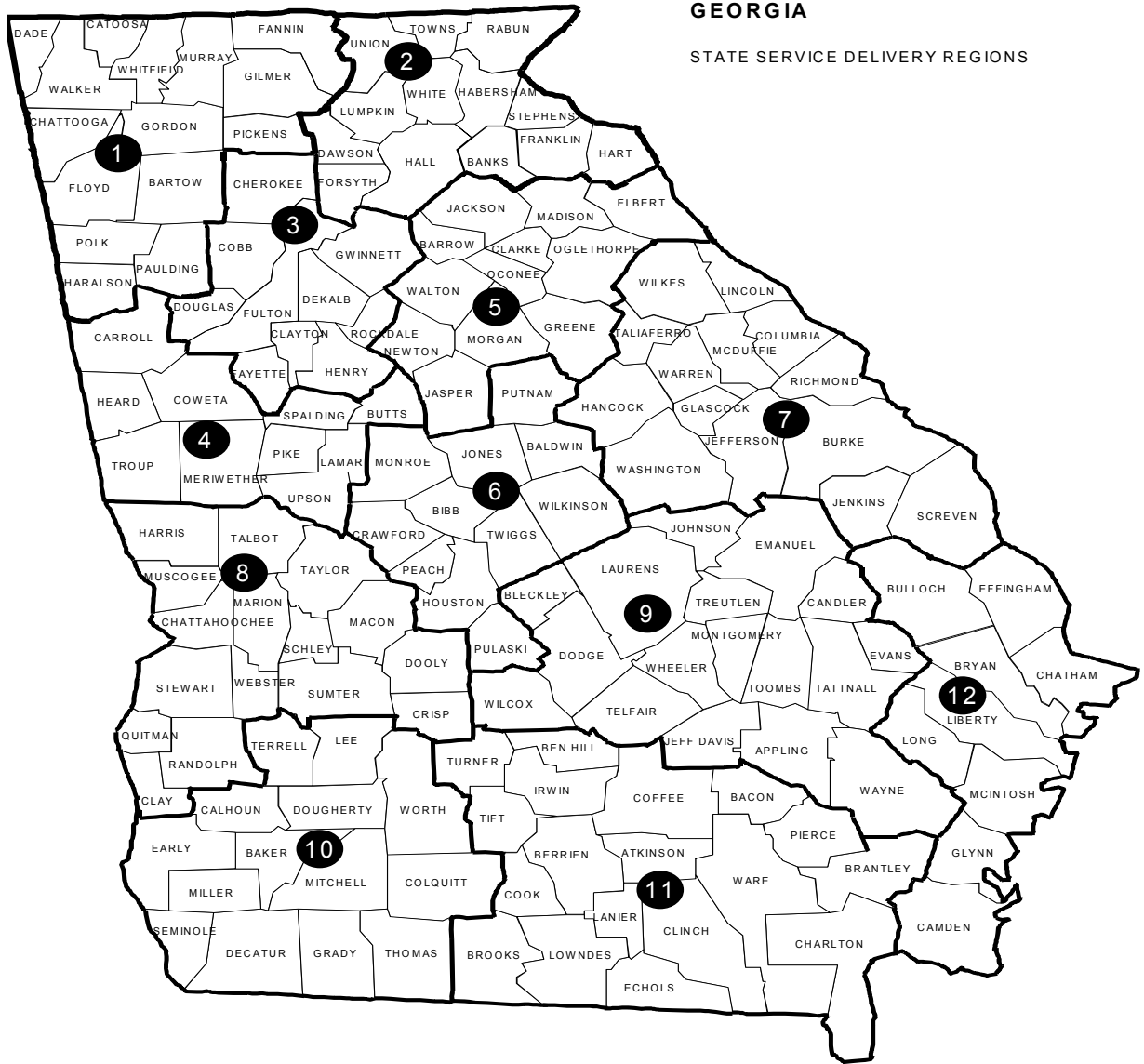
# **GEORGIA STATE HEALTH PLAN COMPONENT PLAN**

## **APPENDIX E**

### **State Service Delivery Regions**

# GEORGIA

## STATE SERVICE DELIVERY REGIONS



# **GEORGIA STATE HEALTH PLAN COMPONENT PLAN**

## **APPENDIX F**

### **Rules Short Stay General Hospital Beds**



**RULES OF THE  
GEORGIA DEPARTMENT OF COMMUNITY HEALTH / DIVISION OF HEALTH PLANNING  
272-2-.09 Standards and Criteria. Amended**

**(8) Short-Stay General Hospital Beds**

**(a) Applicability**

1. A Certificate of Need will be required prior to the establishment of a new hospital, replacement of an existing hospital, or expansion of an existing hospital.
2. The provisions in these rules do not apply to the following situations:
  - (i) bed replacements in existing hospital facilities which do not require a capital or equipment expenditure over the applicable dollar threshold; or
  - (ii) changing the physical location of existing beds within an existing facility regardless of cost; provided, however, that any project in excess of the applicable capital or equipment expenditure dollar threshold must be reviewed in accordance with the review considerations set forth in Rule 272-2.08; or
  - (iii) projects that are otherwise exempt from review pursuant to O.C.G.A. 31-6-47 (a) (15).
3. An existing hospital seeking an expansion to be used for new institutional health services, including perinatal services, rehabilitation services, or psychiatric and substance abuse services, must meet the applicable service specific rules found in this Chapter and, as a threshold matter, meet the need standards set forth in 272-2-.09 (8)(c)(2)(iii) but shall not be required to meet the other requirements in Rule 272-2-.09(8).
4. A hospital that has been approved through the certificate of need process to use a certain number of short-stay hospital beds for long-term acute care (LTAC) beds shall have such LTAC beds removed from the official inventory of available short-stay beds once the LTAC is certified by Medicare; provided, however, that such beds will revert to the hospital's official inventory of available short-stay beds at any point that the LTAC ceases operation or is no longer certified by Medicare. An application to use existing short-stay hospital beds for LTAC beds shall not be subject to the guidelines in Rule 272-2-.09(8).

**(b) Definitions**

1. "Age cohorts" for purposes of these rules refers to the following age groups: persons 0 to 17; persons 18 to 64; and persons 65 and older.
2. "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.
3. "Children's hospital" means a hospital in which 90% or more of the patients served by the hospital are 17 or less years of age.

4. "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.
5. "Expansion" means the addition of available beds or CON approved beds for an existing hospital.
6. "Health planning area" or "planning area" means the twelve (12) state service delivery regions as defined in O.C.G.A. 50-4-7.
7. "Horizon year" means the last year of a five (5) year projection period for need determinations.
8. "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 365. The optimal occupancy rate is variable based on the following:
- (a) For hospitals located in a rural county, 65%;
  - (b) For hospitals located in a non-rural county, 75%; and
  - (c) For teaching or children's hospitals, 70%.
9. "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.
10. "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.
11. "Rural county" means a county with a population of 35,000 or less based on the most recent decennial census, as defined in O.C.G.A. 31-7-94.1(c)(3).
12. "Safety net hospital" is defined as a hospital that meets at least two (2) of following criteria:
- (a) the hospital is a children's hospital or a teaching hospital;
  - (b) the hospital is designated by the Department of Human Resources as a trauma center;
  - (c) Medicaid and PeachCare inpatients admissions constitute 20% or more of the total hospital inpatients admissions;
  - (d) Uncompensated charges for indigent patients constitute 6% or more of hospital adjusted gross revenue; or
  - (e) Uncompensated charges for indigent and charity patients constitute 10% or more of hospital adjusted gross revenue
13. "Short stay hospital" or "hospital" is defined as a facility with an average length of stay of less than 30 days.

14. "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.

15. "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.

**(c) Standards**

1. A new hospital must be at least 50 beds in size if located in a rural county and at least 100 beds in size if located in a county other than a rural county.

2. The need for a new, replacement or expanded hospital shall be determined through application of an appropriate numerical need methodology designed to access need for the specific purpose sought in the application.

(i) 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:

A. Calculate the use rate for current hospital services in the target service area population by dividing the patients days for each age cohort by the population for each age cohort for same year as patient days were calculated.

B. 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.

C. Divide the results of the calculations in Step B by 365 and sum these numbers to determine a baseline bed need.

D. 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.

E. 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.

F. 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.

G. 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.

(ii) A new hospital shall be approved only if the total target service area population is at least 50,000 persons.

(iii) 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:

A. 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.

B. 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.

C. Sum the number of patients resulting from Step B and divide by 365 to determine a baseline bed need rate.

D. 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.

E. 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.

F. Compare the results of Step E 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.

3. The Department may allow an exception to need and adverse impact standards outlined in Rule 272-2-.09(8)(c)(2) and (4) for a facility meeting any one of the following criteria:

(i) The facility is an existing facility designated by the Department of Human Resources as a

trauma center;

(ii) The facility is an existing teaching hospital;

(iii) The facility is a sole community provider and more than 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

(iv) 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.

4. (i) 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.

(ii) 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 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.

(iii) 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 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.

5. 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.

6. 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:
  - (i) 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;
  - (ii) providing a written commitment that services for indigent and charity patients will be offered at a standard which meets or exceeds three percent (3%) of annual, adjusted gross revenues for the hospital;
  - (iii) providing a written commitment to participate in the Medicare, Medicaid and PeachCare programs;
  - (iv) providing a written commitment to participate in any other state health benefits insurance programs for which the hospital is eligible; and
  - (v) 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.
  
7. (i) An applicant for a replacement or expanded hospital shall document that the hospital is fully accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) 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 JCAHO or another appropriate 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.
  - (ii) An applicant for a new, replacement or expanded hospital shall:
    - A. 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;
  
    - B. 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

C. Document a plan for obtaining and maintaining staff and service quality standards necessary to promote effective patient care and clinical outcomes.

8. (i) An applicant for a new, replacement or expanded hospital shall document a plan to operate an emergency room licensed by the Department of Human Resources.

(ii) 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:

A. Estimated geographic boundaries of primary and secondary service areas and the primary and outpatient providers in these areas;

B. Demographic and income characteristics of the service area by age, gender and racial compositions;

C. Anticipated payer sources by population totals and percentages to include public payers and indigent and charity care services;

D. Patient access to the full continuum of care, including discharge planning and long-term care options;

E. The projected financial and economic impact that the project will have on the community;

F. 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;

G. The manner in which the facility coordinates or will coordinate with the existing health care system;

H. The manner(s) in which the hospital will make available the necessary ancillary and support services; and

I. The manner in which the hospital will support the operation of any affiliated critical access hospitals, if applicable.

(iii) 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.

(iv) 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.

9. (i) 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.

(ii) 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:

A. The available beds for the proposed consolidated facility must not exceed the total number of available beds of the existing facilities proposed for consolidation;

B. 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;

C. 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;

D. 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

E. The applicant(s) must comply with all other provisions of this chapter with exception of the need and adverse impact standards set forth in Rule 272-2-.09(8)(c)(2) and (4).

10. (i) 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.

(ii) 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:

- A. 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 Rule 272-2-.09(8)(c)(2)(iii)
- B. 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;
- C. 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;
- D. 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
- E. 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.