

# GEORGIA STATE HEALTH PLAN COMPONENT PLAN

## Comprehensive Inpatient Physical Rehabilitation Services (CIPR)

**Issue Date: March 2007**

HEALTH STRATEGIES COUNCIL  
& GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
Division of Health Planning  
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*Developed by the Inpatient Physical Rehabilitation Services  
Technical Advisory Committee of the Health Strategies Council*

Adopted by the HEALTH STRATEGIES COUNCIL on March 9, 2007  
Rules adopted by the BOARD of COMMUNITY HEALTH in December 2006

## PREFACE

This State Health Plan is a product of the Health Strategies Council and the Georgia Department of Community Health, which operate and are funded through and within the authority of O.C.G.A. Title 6. The purpose of the Plan is to identify and address issues and 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 27-member Governor-appointed Health Strategies Council. 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.

For purposes of the administration and implementation of the Georgia Certificate of Need (CON) program, criteria and standards for review as stated in the 111-2-2-.35 are derived from this State Health 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 State Health Plan which the review function has the legal authority to implement. The Rules are reviewed by the Health Strategies Council, prior to their adoption, 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 and Planning Process

The Department of Community Health, through its Division of Health Planning (“Department”), is responsible for managing the state’s health planning program and establishing standards and criteria for the granting of Certificates of Need. Two of the Department’s primary missions are to contain health care costs by avoiding unnecessary duplication of services and to establish and enforce quality-of-care standards. In addition, the Department is committed to ensuring that providers assume a share of the responsibility for the health care needs of low-income citizens and under-served or at-risk members of their local community. Financial access, clinical proficiency and community outreach are cornerstones of the Department’s mission.

The Health Strategies Council, a 27-member board appointed by the Governor, is responsible for developing Georgia’s component State Health Plans and addressing policy issues concerning access to health care services.

A component State Health Plan for Inpatient Physical Rehabilitation Services was first developed in 1985. In June 1989, a Technical Advisory Committee (TAC) was formed to revise the 1985 State Health Plan and Rules and was comprised of representatives from a wide range of stakeholders. The TAC developed two new component plans and attendant rules for inpatient rehabilitation services – the Component Plan and Certificate of Need Rules for Traumatic Brain Injury Facilities, which were adopted in May, 1990, and the Physical Rehabilitation Programs and Services Component Plan, which was adopted in October, 1994.

In 2005, over a decade after the adoption of these plans and rules, the Health Strategies Council’s Long Term Care Standing Committee agreed that the 1994 State Health Plan and Rules that govern the need for new or expanded inpatient physical rehabilitation services in the State of Georgia were outdated. In particular, the Standing Committee recommended that both the State Health Plan and Rules be reviewed to ensure that they adequately address the needs of patients, consumers, regulators, and purchasers and reflect current industry practices.

Membership on the TAC consisted of 19 members, representing a wide range of providers from each of the four planning areas for physical rehabilitation services. Members were affiliated with facilities and organizations from acute care hospitals with rehabilitation units, freestanding rehabilitation hospitals, state-operated rehabilitation hospitals, geriatric and pediatric hospitals, third-party payers, state agencies, consumer/patient advocates, and professional associations. In addition, the TAC members represented both “large” and “small” rehabilitation programs, providers serving unique patient populations such as children’s hospital or spinal cord injury programs, a variety of owners (for-profit, not for profit, and hospital authority), and both urban and rural providers.

The TAC held ten meetings from February 2005 until May 2006. Throughout the development of the Rules and this component plan, a wide array of data and research, both regional and nationally, was considered by the TAC and the Department. In addition, the public was given the opportunity to comment on the data and the proposals at each meeting. This planning document represents consensus from the TAC and was

presented in outline form to the Health Strategies Council at their May 19, 2006 meeting. The Rules, attached as Appendix D, were approved by the Health Strategies Council and the Board of Community Health and became effective in December 2006.

## **Demand for Services**

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 Georgia Department of Labor, the total population in Georgia is expected to grow 19.1 percent over the next ten years, placing the state's population at almost 10.2 million residents in 2012. According to a recent analysis by Deloitte Consulting, Georgia is experiencing a population explosion. Georgia is the fourth fastest growing state in the U.S. in terms of total population (behind California, Texas and Florida). Georgia will grow and age faster than any other state in the southeast.

Another substantial gain in population is anticipated in the 75 & over age group. This is attributed to both medical advances and lifestyle improvements that have increased life expectancy. As a direct result of this aging of the population, there will be an increased demand for health care services.

Inpatient Rehabilitation Facilities are intended to serve patients recovering from medical conditions that typically require an intensive level of rehabilitation in an inpatient setting. The number of inpatient rehabilitation facilities (IRF) has grown steadily over the past decade as have Medicare payments made to these facilities. According to a recent GAO Report, the number of IRFs in the United States grew from 907 in 1992 to 1,256 in 2003. The aging of the population will continue to add to the demographic shift in the population. Additionally, the longer life span of patients with chronic diseases and disability should also increase the need and demand for rehabilitation services. Because of the ongoing challenges to industry providers, planning for the development of inpatient rehabilitation services remains a difficult process.

### **Impact of Changing Reimbursement / National Trends**

Historically, rehabilitation facilities were reimbursed on a cost-based basis with discharge limits, however, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 established specific provisions for rehabilitation facilities. That changed in 1983 when landmark Medicare legislation mandated that hospital inpatient procedures be reimbursed according to a Prospective Payment System (PPS). The legislation had great impact on the acute rehabilitation industry, and it began an industry-wide shift of acute rehabilitation patients from PPS-reimbursed hospitals to the more favorable TEFRA-reimbursed acute rehabilitation facilities.

During 1990s, the rehabilitation industry experienced considerable changes due to shifting market forces. The driving forces of change were threefold and included a shift in payer type, from indemnity, fee-for-service insurers to managed care organizations (MCOs); changes in Medicare reimbursement methodologies mandated by the Balanced

Budget Act of 1997 (BBA), and the Centers for Medicare & Medicaid Services' Seventy-five Percent Rule.

### Balanced Budget Act

Passed in August 1997, the main objective of the Balanced Budget Act (BBA) was to reduce Medicare outlays. A component of the BBA, the prospective payment system (PPS), has had significant implications for the rehabilitation industry. The PPS for rehabilitation was intended to reduce the significant amount of money paid by Medicare to rehabilitation hospitals.

The BBA also instituted the PPS for rehabilitation facilities, an action the government took in an attempt to reduce some of the unnecessary shifting of patients between PPS facilities to the more favorable TEFRA-based reimbursement facilities. The conversion of acute rehabilitation from a cost-based reimbursement system to PPS was phased-in over a three-year period that was intended to begin on October 1, 2000, but was postponed until 2002. During that time, acute rehabilitation facilities were reimbursed under a blended rate schedule combining rates established under TEFRA and the PPS.

To counter the effects of reduced payments under the inpatient rehabilitation facility (IRF) PPS, the industry experienced a change in distribution of services from an inpatient focus, including acute and sub-acute settings within the rehabilitation industry to lower-cost, outpatient settings.

### Seventy-Five Percent Rule

One of the most challenging issues facing the inpatient physical rehabilitation services industry is the implementation of the 75% Rule. Originally issued in 1983, the 75 Percent Rule serves as a method for the Centers for Medicare & Medicaid Services (CMS) to be able to distinguish IRFs from other settings for payment purposes. The Rule also ensures that Medicare patients who may need less intensive services are not placed in IRFs. The Rule had not been actively enforced for many years. In June 2002, CMS officially suspended enforcement of the 75% Rule until the agency could investigate its impact and determine whether further changes were necessary.

The 75% Rule was most recently revised in 2004 and was to be implemented over a three-year period that started in July, 2005. The revised Rule states that in order for a facility to be classified as an IRF, it must show that during a 12-month period at least 75 percent of all its patients, including its Medicare patients, required intensive rehabilitation services for the treatment of at least one of the thirteen conditions listed in the rule. The Rule allows the remaining 25 percent of patients to have other conditions not listed in the rule. If an IRF does not comply with the requirements of the 75 percent rule, it may lose its classification as an IRF and would no longer be eligible for reimbursement at a higher rate. The 2004 final Rule also laid out a 3-year transition period during which enforcement of the rule was resumed, with the threshold percentage of patients meeting the condition requirements being lowered to 50 percent for the first year and subsequently rising in stages to reach 75 percent for the IRF's cost reporting period starting on or after July 2007. The final rule of the Deficit Reduction Act of 2005 extended the phase-on period of the 75% Rule by one year. For providers with cost reporting periods that start on or after July 1, 2006 and before July 1, 2007, the

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compliance threshold will be 60 percent. For providers with cost reporting periods starting on or after July 1, 2007 and before July 1, 2008, the compliance threshold will be 65 percent, while full compliance will be imposed for providers with cost reporting beginning on or after July 1, 2008.

The 75% rule is a major concern for the current and future status of the Rehabilitation industry. One of the main areas the rule will impact is the planning for inpatient rehab bed need. Industry experts, including members of the Health Strategies Council Inpatient Rehab TAC, suggest that bed need will be reduced.

Upon analysis of 2003 data of Medicare patients admitted to IRFs, the GAO found that the 75% rule had a negative impact on the rehabilitation industry. For example, if the Rule would have been implemented in 2003, data shows that less than 44 percent of the Medicare patients (222,316 of the 506,662 patients – See GAO “Table 1”) admitted in fiscal year 2003 would have been admitted for a primary condition that was stipulated on the list in the 75 percent rule. The GAO report notes that when co-morbidity conditions that were on the list were counted—as they would be during the transition period—the number of patients having a listed condition rose to 311,740 (62 percent) of IRF patients in that year. (See GAO “Table 1”) When the transition period is over on July 1, 2008, co-morbidities will not be counted towards classification and reimbursement.

**Table 1: Proportion of All IRF Medicare Patients Who Had Condition on List in Rule, by Condition as Defined by Impairment Group, Fiscal Year 2003**

Condition, as defined by impairment group	Total number of patients in impairment group	Patients whose primary condition was on list in rule		Patients whose primary or comorbid condition was on list in rule	
		Number	Percentage of patients in impairment group	Number	Percentage of patients in impairment group
Joint replacements	121,528	15,761	13.0	61,890	50.9
Stroke	85,516	85,516	100.0	85,516	100.0
Hip fracture	51,467	51,467	100.0	51,467	100.0
Other orthopedic conditions	40,359	0	0.0	11,168	27.7
Medically complex	29,148	0	0.0	6,363	21.8
Cardiac	28,011	0	0.0	4,296	15.3
Debility	27,208	0	0.0	5,784	21.3
Neurologic conditions	23,422	9,933	42.4	16,846	71.9
Spinal cord dysfunction	21,207	21,207	100.0	21,207	100.0
Brain dysfunction	17,733	15,694	88.5	16,885	95.2
Arthritis	16,195	5,372	33.2	7,874	48.6
Amputation	14,448	13,165	91.1	13,652	94.5
Pain syndromes	10,925	0	0.0	2,078	19.0
Pulmonary disorders	10,009	0	0.0	1,393	13.9
Other disabling impairments	5,258	0	0.0	1,113	21.2
Major multiple trauma	3,658	3,658	100.0	3,658	100.0
Burns	345	345	100.0	345	100.0
Congenital deformities	198	198	100.0	198	100.0
Developmental disability	27	0	0.0	7	25.9
<b>Total (overall percentage)</b>	<b>506,662</b>	<b>222,316</b>	<b>43.9</b>	<b>311,740</b>	<b>61.5</b>

Source: GAO analysis of CMS IRF-PAI data.

Source: GAO Report to the Senate Committee on Finance and the House Committee on Ways and Means. April 2005. MEDICARE: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities.



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Further analysis of 2003 Medicare data also showed that only 6 percent of IRFs would have been able to meet the requirements of full implementation of the 75% rule at the end of the transition period (based solely on a primary condition). In addition, as the threshold level increased from 50 percent to 75 percent and both primary and comorbidity conditions were counted, progressively fewer IRFs were able to meet the higher threshold levels (See GAO report "Table 2"). Because more than 80 percent of IRFs were able to meet a 50 percent threshold based on the primary conditions or comorbid conditions of the patients they admitted in 2003, many IRF stakeholders have petitioned and encouraged CMS to extend the 50% threshold transition period. It is likely that bed need projections could be greatly influenced by any future updates to the rule by CMS.

**Table 2: IRFs That Met Varying Threshold Levels for Medicare Patients Admitted with Any of 13 Conditions on List in Rule in Fiscal Year 2003**

<b>Compliance threshold</b>	<b>Percentage of IRFs that met threshold based on either primary condition or related comorbid conditions</b>	<b>Percentage of IRFs that met threshold based solely on primary condition</b>
50 percent	85	39
60 percent	62	20
65 percent	50	14
75 percent	27	6

Source: GAO analysis of CMS IRF-PAI data.

Source: GAO Report to the Senate Committee on Finance and the House Committee on Ways and Means. April 2005. MEDICARE: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities.

Because the number of IRFs expected to meet the compliance thresholds are expected to decline through the transition to the 75% Rule implementation, many IRF officials and stakeholders in the industry are concerned that inpatient admissions may have to be limited in order to comply with the rule. In a study by the Moran Company, a health care policy research consulting firm, 88,000 patients have been unable to access IRFs between July 2004 and June 2006. Many facilities must deny access to Medicare and private patients in order to comply with the 75% Rule. The provider community and other officials anticipate a significant drop in patient access. Some statewide providers project a number of adverse impacts to industry providers including the reduction or elimination of beds. If indeed a reduction of bed need is projected nationally, Georgia should experience a similar reduction.

Medicare Reimbursement

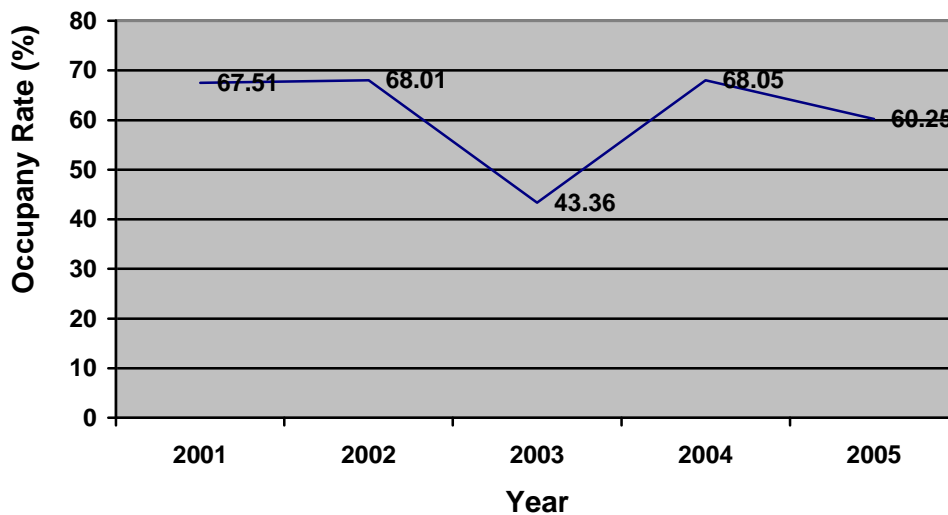
Medicare payments to IRFs grew from \$2.8 billion in 1992 to an estimated \$5.7 billion in 2003. Payments are projected to grow to almost \$9 billion per year by 2015. In August 2006, CMS issued a rule that will result in IRFs receiving a projected \$7 billion in payment from the Medicare program in fiscal year 2007. Because patients treated at IRFs require more intensive rehabilitation than is provided in other settings, such as an acute care hospital or a skilled nursing facility, Medicare pays for treatment at an IRF at

a higher rate than it pays for treatment in other settings. With the increase in total payments, CMS has projected significant savings during the first full year after implementation of the Seventy-five percent Rule. In a testimony the House Committee on Ways and Means, the American Medical Rehabilitation Providers Association (AMRPA) reported that the Medicare program originally estimated the implementation of the 75% Rule would reduce payment to IRFs by \$10 million in FY 2005 and \$30 million in FY 2006. In the President's budget for FY 2006, these estimates were revised to show a savings of \$50 million in FY 2005 and \$70 million in FY 2006.

### **Statewide Distribution and Access to Rehab Services**

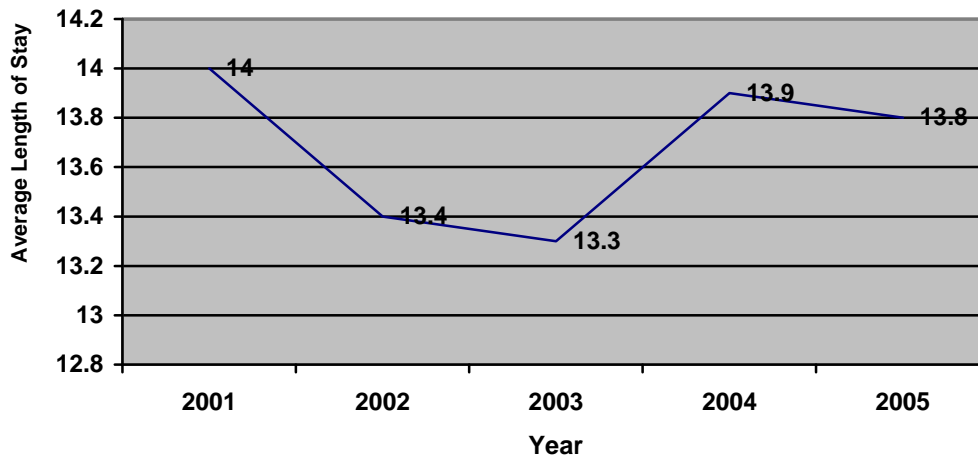
The following two charts summarize the trends in average occupancy rates and lengths of stay at IRFs in Georgia from 2001 – 2005. While the average length of stay of patients has not changed significantly, the average occupancy rates have declined substantially from 2001 (67.5%) to 2005 (60.25%), the most significant drop occurred in 2003 (43.36%). The number of beds has decreased from 960 in the year 2001 to 929 in 2005. These trends, along with the projected impact of the 75% Rule, further support the idea that the need for comprehensive inpatient physical rehabilitation services should continue to decline, and therefore the number of total beds should be adjusted accordingly to ensure health care dollars are spent efficiently. The TAC has recommended that instead greater care be taken towards the proper distribution and allocation of beds, so as to ensure adequate access.

**Georgia Comprehensive Inpatient Rehabilitation Facilities  
Average Occupancy Rates (2001-2005)**



Source: DCH, DHP Annual Hospital Questionnaire. As of 1/16/07

### Georgia Comprehensive Rehabilitation Facilities Average Length of Stay (2001-2005)



Source: DCH, DHP Annual Hospital Questionnaire. As of 1/16/07

### **Commission On Accreditation Of Rehabilitation Facilities (CARF)**

The Commission on Accreditation of Rehabilitation Facilities (CARF) is a private, not-for-profit third party accreditation body that accredits over 30,000 programs across the human health services continuum. Purchasers and providers of medical rehabilitation care choose CARF accreditation as a blueprint for rehabilitation services that demonstrate that their organizations' programs meet internationally recognized standards.

CARF requires organizations to demonstrate to a survey team conformance to standards highlighting the organization's values and approaches in the following areas: core values and mission; input from persons served and other stakeholders; individual-centered planning; design, and delivery; rights of the persons served; continuity of care; quality and appropriateness of services; leadership, ethics, and advocacy; planning and financial management; human resources; accessibility; health and safety; infrastructure management; outcomes management and performance improvement.

A quality organization, according to CARF, illustrates the following:

- Service design and delivery that is focused on the needs of the persons served and the organization's other stakeholders.
- Involvement of the persons served as partners in the individual planning process.
- An outcomes management system that is used to continuously improve the quality of individual programs and organizational practices.

The mission of CARF is to promote the quality, value, and optimal outcomes of services through a consultative accreditation process that centers on enhancing the lives of the

persons served. Since assuring access to high quality health care services has always been a staple of Georgia's CON standards, the Georgia CON rules & standards for comprehensive inpatient physical rehabilitation services require facilities to be CARF accredited.

## Rationale for Revision to Standards

### **Standard: Need**

*111-2-2-.35(3)(a) The need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall be determined and applied as follows:*

- 1. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Adult Program in a planning region shall be determined using the following demand-based need projection:*
  - (i) Determine the comprehensive inpatient physical rehabilitation utilization rate per 1,000 for the current year for each planning region by dividing the total number of inpatient physical rehabilitation discharges from licensed providers of inpatient rehabilitation in the planning region for patients aged 18 and over by current year projected resident population (aged 18 and over) for the planning region and multiplying by 1,000. The source of current year discharge data for purposes of this rule include data collected pursuant to O.C.G.A. § 31-7-280(c)(14), or in the Department's discretion, discharge data collected on the most recent Annual Hospital Questionnaire. The source for current and horizon year resident population shall be resident population projections from the Governor's Office of Planning and Budget. For the first Horizon Year projection using this rule, and for the first horizon year projection only, the utilization rate per 1,000 for each planning region shall be reduced by 16 percent to account for anticipated utilization reduction after full implementation of the Center for Medicare and Medicaid Services' (CMS) 75% rule.*
  - (ii) Calculate the projected horizon year discharges for each planning region by multiplying the planning region utilization rate obtained in Step (i) by the horizon year resident population projection (aged 18 and over) for that planning region.*
  - (iii) Determine the comprehensive inpatient physical rehabilitation average length of stay for the current year for each planning region by dividing the total number of inpatient physical rehabilitation discharge days of care from licensed providers of inpatient rehabilitation in the planning region for patients aged 18 and over by the current year inpatient rehabilitation discharges determined in Step (i).*

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- (iv) Multiply the projected discharges obtained in Step (ii) by the current year's average length of stay (aged 18 and over) determined in Step (iii) to determine the horizon year projected patient days for each planning region.*
  - (v) Divide the product obtained in Step (iv) by the number of calendar days in the horizon year to obtain the average projected daily census in each planning region.*
  - (vi) Divide the result obtained in Step (v) by .85 to determine the number of projected beds utilizing an 85% capacity standard for each planning region.*
  - (vii) Determine the current inventory of comprehensive inpatient physical rehabilitation beds for adults in the planning region from Departmental data. For all CIPR providers, which have been licensed as a Rehabilitation Hospital by the Department of Human Resources, the current inventory of CIPR beds shall reflect the number of beds reported as CON-authorized in the Facility Inventory prior to the date of adoption of these rules augmented from that time forward only by increases in bed capacity approved through the CON process (or by exemptions thereto) and by decreases due to a provider ceasing to provide such services for a period in excess of 12 months. For purposes of this rule, the initial inventory shall not include the beds of licensed Long Term Care Hospitals; the beds of such facilities shall be included in the applicable Long Term Care Hospital inventory.*
  - (viii) If the projected bed need in Step (vi) is greater than the current inventory of adult CIPR beds in the planning region, the application for the Certificate of Need should reflect a number of beds equal to or lesser than the resulting unmet bed need.*
2. *The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Pediatric Program in a planning region shall be determined using the following demand-based need projection:*
- (i) Determine the comprehensive inpatient physical rehabilitation utilization rate per 1,000 for the current year for each planning region by dividing the total number of inpatient physical rehabilitation discharges from licensed providers of inpatient rehabilitation in the planning region for patients aged 17 and under by current year resident population (aged 17 and under) for the planning region. The source of current year discharge data for purposes of this rule include data collected pursuant to O.C.G.A. § 31-7-280(c)(14), or in the Department's discretion, discharge data collected on the most recent Annual Hospital Questionnaire.*
  - (ii) Calculate the projected horizon year discharges for each planning region by multiplying the planning region utilization*

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*rate obtained in Step (i) by the horizon year resident population projection (aged 17 and under) for that planning region.*

- (iii) Determine the comprehensive inpatient physical rehabilitation average length of stay for the current year for each planning region by dividing the total number of inpatient physical rehabilitation discharge days of care from licensed providers of inpatient rehabilitation in the planning region for patients aged 17 and under by the current year inpatient rehabilitation discharges determined in Step (i)*
- (iv) Multiply the projected discharges obtained in Step (ii) by the current year's average length of stay (aged 17 and under) determined in Step (iii) to determine the horizon year projected patient days for each planning region.*
- (v) Divide the product obtained in Step (iv) by the number of calendar days in the horizon year to obtain the average projected daily census in each planning region.*
- (vi) Divide the result obtained in Step (v) by .85 to determine the number of projected beds utilizing an 85% capacity standard for each planning region.*
- (vii) Determine the current inventory of comprehensive inpatient physical rehabilitation beds for pediatric patients in the planning region from Departmental data. For all CIPR providers, which have been licensed as a Rehabilitation Hospital by the Department of Human Resources, the current inventory of CIPR beds shall reflect the number of beds reported as CON-authorized in the Facility Inventory prior to the date of adoption of these rules augmented from that time forward only by increases in bed capacity approved through the CON process (or by exemptions thereto) and by decreases due to a provider ceasing to provide such services for a period in excess of 12 months. For purposes of this rule, the initial inventory shall not include the beds of licensed Long Term Care Hospitals; the beds of such facilities shall be included in the applicable Long Term Care Hospital inventory.*
- (viii) If the projected bed need in Step (vi) is greater than the current inventory of pediatric CIPR beds in the planning region, the application for the Certificate of Need should reflect a number of beds equal to or lesser than the resulting unmet bed need.*

**Rationale: Need**

The CIPR need projection methodology from the 1994 Component Plan was designed to identify potential inpatient physical rehabilitation cases using a prospective demand-based projection model. Using diagnostic categories identified in the 1994 plan the old methodology used discharge rates that had been calculated using a 1987 study of hospital discharges for specific diagnostic groups. The diagnostic groups that were identified in the 1994 Component Plan were thought to be cases which might benefit from an inpatient physical rehabilitation bed. The discharge rates in each diagnostic group were then adjusted using specific demand factors, expected average lengths of stay, and projected into the horizon year under the presumption that patients with such a diagnosis would need an inpatient physical rehabilitation bed. This type of demand-based projection formula is prospective in nature in that the discharge rates for each diagnostic group were used to project beds regardless of actual utilization in an inpatient physical rehabilitation bed. This type of projection methodology met the concerns identified in the 1994 Component Plan. The 1994 plan and rules did not specify the manner in which demand factors and expected average lengths of stay would be updated by the Department.

It was the consensus of the 2006 TAC that the need projection methodology should be modified in a manner that determined demand for inpatient rehabilitation beds utilizing actual utilization. The need projection methodology was modified and a new projection methodology was proposed as described above in order to use a model that was experiential in nature. Such a model would better account for changes in the inpatient physical rehabilitation market due to changes in federal regulation and changing patterns of utilization.

In order to account for reductions in inpatient physical rehabilitation utilization anticipated as a result of implementation of the federal "75% Rule" criteria, the TAC agreed to reduce projected inpatient physical rehabilitation cases at adult programs by 16% during the first year. See 42 C.F.R. §412.23(b)(2). Without the reduction, it was feared that the projection methodology would overstate the projected need for inpatient physical rehabilitation beds. The 16% reduction factor was derived from a national study of the affect of the rule on inpatient physical rehabilitation programs. See "Utilization Trends in Inpatient Rehabilitation: Update Through Q III 2005", The Moran Company, December 2005. It was also agreed that the affects of the 75% Rule would not apply to pediatric programs and a reduction factor should not be implemented in the need projection methodology for pediatric beds.

**Standard: Adverse Impact**

*111-2-2.35(3)(b) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall document that the establishment or expansion of its program will not have an adverse impact on existing and approved programs of the same type in its planning region. An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall have an adverse impact on existing and approved programs of the same type if it will:*

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1. *decrease annual decrease annual utilization of an existing program, whose current utilization is at or above 85%, to a projected annual utilization of less than 75% within the first twelve months following the acceptance of the applicant's first patient; or*
2. *decrease annual utilization of an existing program, whose current utilization is below 85%, by 10 percent over the twelve months following the acceptance of the applicant's first patient.*

**Rationale: 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 is not in line with sound planning principles. Members agreed that services should be developed in an orderly and comprehensive manner with a goal of minimizing adverse impact on the existing delivery system.

TAC members spent a considerable amount of time discussing this standard. Members felt that all applicants seeking to offer new or expanded services should address the impact of any proposed service on existing programs particularly those that have maintained high utilization rates within the planning area. Those existing providers that maintain occupancy levels over 85% should not be adversely impacted where existing occupancy levels would fall below 75%. At the same time, members said that providers whose current utilization is below 85% should not sustain an adverse impact of 10% or greater.

**Standard: Exception to Need**

111-2-2.35(3)(c) *The Department may grant the following exceptions:*

1. *The Department may grant an exception to the need methodology of 111-2-2-.35(3)(a)1 and to the adverse impact standard of 111-2-2-.35(3)(b) for an applicant proposing a program to be located in a county with a population of less than 75,000 and to be located a minimum of 50 miles away from any existing program in the state.*
2. *The Department may grant an exception to the need methodologies of either 111-2-2-.35(3)(a)1 or 111-2-2-.35(3)(a)2 and to the adverse impact standard of 111-2-2-.35(3)(b) to remedy an atypical barrier to Comprehensive Inpatient Physical Rehabilitation Programs based on cost, quality, financial access or geographic accessibility or if the applicant's annual census demonstrates 30 percent out of state utilization for the previous two years.*
3. *The Department may grant an exception to the need methodologies of 111-2-2-.35(3)(a)(1) or 111-2-2-.35(3)(a)(2) in a planning area which has no existing provider provided that the applicant demonstrates a need for the service based on patient origin data.*



**Rationale: Exception to Need**

In certain circumstances it is prudent to allow the development of services in the absence of a numerical need. TAC members agreed that it would be appropriate to allow smaller communities to develop services as a mechanism to assure statewide access.

TAC members agreed that there should be some minimum population considerations when proposing to offer these specialized services; however they noted that providers should be able to offer the services in smaller communities in order to provide greater access, particularly to rural counties of the state. They emphasized that any new program should be at least fifty miles away from any existing program so as not to adversely impact the existing provider. Members said that there are instances where children, in particular cannot be transported to larger cities for care or where it is more convenient for patients to be treated closer to their families. For these and other reasons, an exception to need to allow development of services would be appropriate.

Furthermore, the Department and the TAC agreed that an additional exception to the need standard can be justified to remedy an atypical barrier to inpatient physical rehabilitation services based on cost, quality, financial access, or geographic accessibility. The Department uses rigorous need methodologies to contain health care costs and to avoid the unnecessary duplication of services, equipment and facilities which also supports quality-of-care standards. In rare instances, the objective need methodology may not detect underlying or subtle problems in service delivery. For this reason, regulatory guidelines frequently establish mechanisms to seek alternative ways to address these gaps in service delivery. The TAC sanctioned the concept of creating an exception to the need standard for applicants who seek to address atypical barriers to care based on any one of four value-based criteria: cost, quality, financial access or geographic accessibility. The exception also exempts the applicant from complying with the adverse impact requirements. In any submission to seek consideration under the exception provisions, the burden of proof is placed on the applicant to demonstrate that these accessibility problems exist.

**Standard: Minimum Bed Size**

*111-2-2-.036(3)(d) A new Comprehensive Inpatient Physical Rehabilitation Program shall have the following minimum bed sizes based on type of program offered:*

- 1. A new Comprehensive Inpatient Physical Rehabilitation Adult Program shall have a minimum bed size of 20 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 20 beds ~~or~~ in an acute-care hospital, and 40 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program.*

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2. *A new Comprehensive Inpatient Physical Rehabilitation Pediatric Program shall have a minimum of 10 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 10 beds in an acute-care hospital, and 40 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program.*

**Rationale: Minimum Bed Size**

The TAC agreed that the recommended bed size standards were acceptable for freestanding pediatric and adult hospitals that already offer comprehensive inpatient service; pediatric and adult acute care hospitals and new pediatric and adult freestanding hospitals. Therefore, TAC members agreed that these minimum numbers would be appropriate.

**Standard: Accreditation**

*111-2-2.03(3)(e)An applicant for a new Comprehensive Inpatient Physical Rehabilitation Program shall demonstrate the intent to meet the standards of the Commission on Accreditation of Rehabilitation Facilities (CARF) applicable to the type of Program to be offered within 18 months of offering the new service.*

*111-2-2.03(3)(f)An applicant for an expanded Comprehensive Inpatient Physical Rehabilitation Program shall be accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF") for the type of Program which the applicant seeks to expand prior to application. The applicant must provide proof of such accreditation.*

**Rationale: Accreditation**

The TAC agreed and proposed that new facilities should be accredited within 18 months of offering a new service. The TAC members discussed and agreed that this time frame would be appropriate and would allow facilities to implement a new service and become accredited in a reasonable time.

**Standard: Licensure**

*111-2-2.03(3)(g)An applicant for a new freestanding rehabilitation hospital shall demonstrate the intent to meet the licensure Rules of the Georgia Department of Human Resources for such hospitals.*

*111-2-2.03(3)(h)An applicant for an expanded freestanding rehabilitation hospital shall demonstrate a lack of uncorrected deficiencies as documented by letter from the Georgia Department of Human Resources.*

**Rationale: Licensure**

TAC members unanimously agreed that existing facilities should have no uncorrected licensure deficiencies in order to be approved for an expansion.

**Standard: Utilization Review**

*111-2-2.03(3)(i)An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall have written policies and procedures for utilization review. Such review shall consider, but is not limited to, factors such as medical necessity, appropriateness and efficiency of services, quality of patient care, and rates of utilization.*

**Rationale: Utilization Review**

The TAC agreed that utilization review is an important component of any rehabilitation service and that all applicants should demonstrate that they have policies and procedures regarding utilization review.

**Standard: Referral Arrangements**

*111-2-2.03(3)(j)An applicant for a new or expanded freestanding rehabilitation hospital shall document the existence of referral arrangements, including transfer agreements with an acute-care hospital(s) within the planning region to provide emergency medical treatment to any patient who requires such care. If the nearest acute-care hospital is in an adjacent planning region, the applicant may document the existence of transfer agreements with that hospital in lieu of such agreements with a hospital located within the planning region.*

**Rationale: Referral Arrangements**

The TAC agreed that referral arrangements are important for freestanding rehabilitation hospitals. In order to ensure that the referral arrangements are nearby to handle any emergency situations, the TAC recommended that the arrangements be made with a hospital within the planning region at an absolute minimum.

**Standard: Financial Accessibility**

*111-2-2.03(3)(k)An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall foster an environment that assures access to services to individuals unable to pay and regardless of payment source or circumstances by the following:*

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1. *providing evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis;*
2. *providing a written commitment that un-reimbursed services for indigent and charity patients in the service will be offered at a standard which meets or exceeds three percent of annual gross revenues for the service after Medicare and Medicaid contractual adjustments and bad debt have been deducted; and*
3. *providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to individuals unable to pay based on the past record of service to Medicare, Medicaid, and indigent and charity patients, including the level of un-reimbursed indigent and charity care.*

111-2-2.03(3)(l) **Reserved.**

**Rationale: Financial Accessibility**

The TAC agreed that the rule and standard should be changed to reflect a standardized approach to financial accessibility. Therefore, the language of this criterion was changed to reflect language the same as all other clinical health services. The substance of the rule was not changed.

**Standard: Provision of Data**

*111-2-2.03(3)(m) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall agree to provide the State Health Department with requested information and statistical data related to the operation of such a Program on a yearly basis, or as needed, and in a format requested by the Department.*

**Rationale: Provision of Data**

The TAC agreed that the provision of data to the Department is an important component of the Department's health planning efforts and should be required of all applicants.

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