

GEORGIA STATE HEALTH PLAN COMPONENT PLAN

Long Term Care Hospitals

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HEALTH STRATEGIES COUNCIL
& GEORGIA DEPARTMENT OF COMMUNITY HEALTH
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*Developed by the Inpatient Physical Rehabilitation Services
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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-.36 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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TABLE OF CONTENTS

Introduction and Planning Process	5
Demand for Services / National Trends	6
Medicare Reimbursement	7
Statewide Access and Distribution	8
Quality Oversight	9
Rationale for Standards	10
Standard: Need	10
Rationale: Need	11
Standard: Adverse Impact	11
Rationale: Adverse Impact	12
Standard: Exception to Need	12
Rationale: Exception to Need	13
Standard: Minimum Bed Size	13
Rationale: Minimum Bed Size	13
Standard: Accreditation	13
Rationale: Accreditation	14
Standard: Licensure	14
Rationale: Licensure	14
Standard: Utilization Review	14
Rationale: Utilization Review	14
Standard: Transfer Agreements	15
Rationale: Transfer Agreements	15
Standard: Indigent and Charity Care	15
Rationale: Indigent and Charity Care	16
Standard: Data Collection	16
Rationale: Data Collection	16
References	17

Appendices

Appendix A – Members of the Technical Advisory Committee

Appendix B – Long Term Care Hospitals

Appendix C – Planning Area Map

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. In 2005, 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. Over the course of its deliberations, the TAC observed that Rehabilitation services and Long-Term Acute Care services often overlap, but have different reimbursement classifications. In order to address these differences, the TAC recommended that a subcommittee be formed in order to develop separate service-specific rules for Long Term Acute Care Hospitals. The subcommittee held meetings between December 2005 and February 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 / National Trends

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 to 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. In a separate report by Deloitte Consulting in 2006, by 2025 the share of elderly people in every state (except Alaska, California, and the District of Columbia) will exceed fifteen percent. 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.

Long Term Care Hospitals (LTCHs) typically provide post-acute medical care and rehabilitative care for patients with co-morbidities and clinically complex patients including comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. LTCHs can be either freestanding facilities or located in hospitals, when they are, they are referred to as hospitals within hospitals (HwHs). LTCHs can substitute for both hospital and post-acute care. They can substitute for the end of an acute hospital stay. Freestanding Skilled Nursing Facilities (SNFs) are the principal post-acute alternative to LTCHs. Patients who would be most likely to use LTCHs often use SNFs and when patients use LTCHs, the probability of using an SNF declines---suggesting that SNFs and LTCHs are used as substitutes.

Nationally, the number of LTCHs has more than tripled between 1993 and March 2005. LTCHs are unevenly distributed across the country. According to the Medicare Payment Advisory Commission (MedPAC), the five states (Rhode Island, Massachusetts, Louisiana, Texas, and Connecticut) with the greatest number of LTCH beds per thousand Medicare beneficiaries account for 39 percent of the available beds but on 12 percent of the Medicare beneficiary population. The table below illustrates the growth of Long Term Care Hospitals from 2001-2004.

**Table 1: Number of US Long Term Care Hospitals by Group
(2001-2004)**

LTCH Group	2001	2003	2004	Average Annual Change 2001-2004 (%)
All LTCHs	273	319	357	9
Urban	253	293	324	9
Rural	20	26	33	18
Freestanding	159	172	190	6
HwHs	114	147	167	14
Non – profit	84	100	117	12
For profit	152	189	208	11
Government	37	30	32	-5

Source: MedPAC Report to Congress: Medicare Payment Policy, March 2006

Medicare Reimbursement

The regulatory distinction between long-term care hospitals and acute care hospitals is the length of stay. Medicare requires that the average length of stay be more than twenty-five (25) days. Before October 2002, LTCHs were paid based on the guidelines of the Tax Equity and Fiscal Responsibility Act (TEFRA). LTCHs were paid on the basis of their average costs per discharge, subject to an annually adjusted limit calculated for each facility. Under TEFRA, the change in payment per case was at or below the change in cost per case. In 2003, LTCHs began to be paid under a prospective payment system (PPS) based on a patient's diagnosis. After the PPS implementation, payment per case began to rise rapidly. Medicare payments to LTCHs increased from \$398 million in 1993 to about \$3.3 billion in 2004. As shown in Table 2, there has been an increase in the number of cases and payment per case as Medicare spending increased. The average length of stay (ALOS) declined after PPS implementation.

**Table 2: Volume of Cases and Medicare Spending
Under the LTCH Prospective Payment System
(2001-2004)**

	2001	2003	2004	Average Annual Change 2001-2004 (%)
Number of Cases	86,049	110,509	122,320	12
Medicare Spending	\$1.7 billion	\$2.4 billion	\$3.3 billion	25
Payment per case	\$22,452	\$25,076	\$30,180	10
Length of stay (in days)	32.1	29.2	28.7	-4

Source: MedPAC LTCH services: Assessing payment adequacy and updating payments

The numbers of HwHs and freestanding LTCHs both increased following the implementation of the LTCH PPS in 2003, but the rate of growth in HwHs was more than twice the rate for freestanding facilities. As of October 2005, there 376 LTCHs in the CMS database, 176 of which were HwHs. Medicare regulations specify that an LTCH is an HwH when it is “co-located” with another Medicare hospital provider, generally an acute care hospital. The LTCH can occupy the same space as another hospital, be in a separate building on the same campus, or be a satellite facility. The LTCH must prove that it separate in medical and administratively from its associated acute care facility. These regulations are required to demonstrate that the LTCH is a separate entity and is not serving as a “step-down” unit of the acute care hospital. If it were used as a step-down unit, Medicare would then be reimbursing the facility under two payment systems, the Inpatient Prospective Payment System (IPPS) and the LTCH PPS for what is essentially one episode of care. In order prevent incidences of duplicate payments; CMS implemented the 25 percent payment threshold policy in fiscal year 2004. The 25% payment threshold policy is a payment adjustment relating to the percentage of patients discharged from a HwH or satellite that were admitted from its associated acute care hospital prior to receiving a full episode of treatment at the acute care facility.

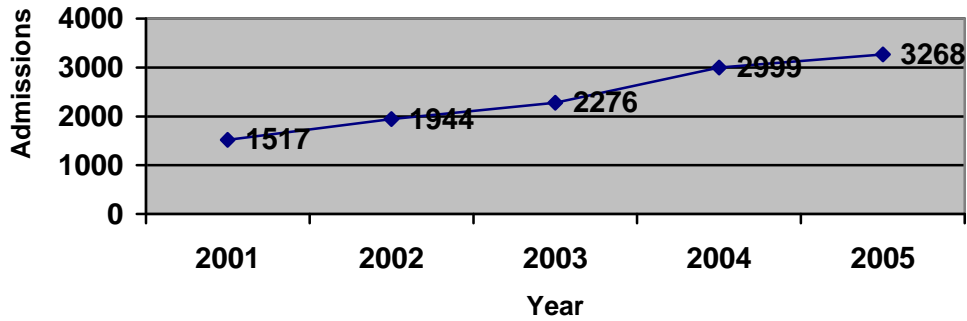
LTCHs are the highest paid hospitals in the Medicare program. CMS estimates LTCH payments will be \$5.2 billion in 2007, an approximately 60% increase of spending in 2004. Among its varied efforts to curb spending overall and increasing payments to LTCHs specifically, CMS issued a proposed LTCH PPS rule in 2006. The rule proposes keeping payments to LTCHs in rate year (RY) 2007 at the same rate as RY2006 payments. MedPAC determined that keeping payments at the 2006 level would increase program efficiency without affecting the ability of LTCHs to furnish high quality care to Medicare beneficiaries.

Statewide Access and Distribution

The following chart illustrates the increase of admissions to the State’s Long Tem Care Hospitals over the data reporting period of 2001 to 2005. The most dramatic increase occurred between 2003 and 2004, the number of admissions increased by 24%. This is

consistent with the implementation of the LTCH PPS. Likewise, the number of facilities in Georgia increased steadily each year, from 10 in 2001 to 14 in 2005.

Georgia Long Term Care Hospital Admissions (2001-2005)



Source: Division of Health Planning Annual Hospital Questionnaire (01/19/07)

Also consistent with the national trend, LTCHs in Georgia seem to be concentrated in one area, the metropolitan Atlanta area. Currently, eight of the fourteen facilities are in the metropolitan Atlanta area, four in Fulton County alone. This impacts Medicare reimbursement in that, beneficiaries living near a LTCH are more likely to use them, and being in an acute hospital with an HwH LTCH increases the possibility that the beneficiary will use the LTCH. In contrast, in parts of the state that lack LTCHs, LTCH-type patients may receive hospital-level treatment at acute hospitals or inpatient rehabilitation facilities with significantly lower payments per beneficiary discharge.

Quality Oversight

Long Term Care Hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). They do not have a specific accreditation program and accredited in the same manner as acute care hospitals. By JCAHO standards, LTCHs are not required to have an emergency department, an intensive care unit, a radiology department, a pharmacy, or a laboratory. They are evaluated on their performance in the following categories:

- Ethics, Rights, and Responsibilities
- Provision of Care
- Medication Management
- Surveillance, Prevention, and Control of Infection
- Leadership
- Management of Environment of Care
- Management of Human Resources
- Management of Information
- Medical Staff

In Georgia, LTCHs are licensed by the Department of Human Resources and must meet the same licensure standards as acute care hospitals.

Rationale for Standards

The following criteria and standards outline the guidelines for the development of Long Term Care Hospitals as recommended by the Technical Advisory Committee for approval by the Health Strategies Council and the Board of Community Health.

Standard: Need

111-2-2-.36(3)(a) The need for new or expanded Long Term Care Hospital in a LTCH planning region shall be determined using the following need projection:

1. Determine the total discharges from general acute care hospitals less LTCH discharges, and less perinatal and neonatal discharges, and less psychiatric and substance abuse discharges, and less comprehensive inpatient physical rehabilitation discharges for the planning region in which the Long Term Care Hospital is or will be located. The source of 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.

2. Calculate the discharge rate for each planning region by dividing the number of current acute care discharges obtained in Step 1 in each planning region by the corresponding year's resident population projection from the Governor's Office of Planning and Budget in each planning region.

3. Calculate the projected discharges for each planning region by multiplying the discharge rate obtained in Step 2 by the horizon year resident population projection for that planning region and then reduce that figure by 6 percent to account for overlap with rehabilitation facilities.

4. Calculate gross beds needed in the horizon year as follows:

(i) Multiply the projected discharges obtained in Step 3 by a utilization factor of 1.3% to determine the projected number of acute care discharge who may benefit from services at a LTCH.

(ii) Multiply the product obtained in Step 4(i) by the average LTCH length of stay for the most recent previous three-year period. Beginning with the first need calculation and continuing until the third complete year of survey data collected pursuant to this rule, the Department shall use 28.1 as a proxy for the average LTCH length of stay for the previous three years.

(iii) Divide the product obtained in Step 4(ii) by 365 to determine the projected daily LTCH census.

(iv) Divide the result obtained in Step 4(iii) by .85 to determine the number of projected LTCH beds utilizing an 85% capacity standard.

5. Determine the current inventory of LTCH beds in the planning region from Departmental data. For all long term care hospital providers, which have been licensed as a Long Term Care Hospital by the Department of Human Resources, the current inventory of LTCH 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 rehabilitation hospitals even if such hospitals have a reported average length of stay of greater than 25 days for Medicare patients; the beds of such facilities shall continue to be included in the applicable Comprehensive Inpatient Physical Rehabilitation inventory.

6. If the projected LTCH bed need in Step 4(iv) is greater than the current inventory of LTCH 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

TAC members agreed that the need projection methodology for long term care hospital beds should use a demand-based formula. The need projection methodology outlined above projects the need for LTCH beds by first identifying actual acute care hospital discharges and then applying a demand factor of 1.3% to that total to identify the prospective number of acute care discharges which may benefit from a LTCH bed. The TAC agreed that 1.3% represented a valid demand factor in light of current utilization data and expected trends proposed by TAC members.

The TAC agreed that there is overlap between utilization at LTCH and Inpatient Physical Rehabilitation providers. Since the demand-based methodology outlined above does not use actual LTCH utilization as a baseline, the overlap must be applied using expected utilization patterns. The overlap between existing providers of LTCH and Inpatient Physical Rehabilitation services can be determined and was calculated at 6% using recent utilization data. The TAC agreed that 6% represented a valid factor with which to reduce the projected utilization for LTCH beds to account for overlap with providers of inpatient physical rehabilitation.

Standard: Adverse Impact

111-2-2.36(3)(b)An applicant for a new or expanded Long Term Care Hospital shall document that the establishment or expansion of its hospital will not have an adverse impact on an existing and approved long term care hospital in its planning region. An applicant for a new or expanded Long Term Care Hospital shall have an adverse impact on existing and approved hospitals of the same type if it will:

Long Term Care Hospitals
Component Plan

1. *decrease annual utilization of an existing hospital, 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 hospital, whose current utilization is below 85%, by ten percent over the twelve months following the acceptance of the applicant's first patient.*

The applicant shall provide evidence of projected impact by taking into account existing planning region market share of hospitals of the same type and future population growth or by providing sufficient evidence that the current population is underserved by the existing Long Term Care Hospitals within the planning region.

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-.36(3)(c) The Department may grant an exception to the need methodology of 111-2-2-.36(3)(a) and to the adverse impact standard of 111-2-2-.36(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; or to remedy an atypical barrier to the services of an Long Term Care Hospital based on cost, quality, financial access or geographic accessibility. The Department may grant an exception to the need methodologies of either 111-2-2-.36(3)(a) and to the adverse impact standard of 111-22-.36(3)(b) if the applicant's annual census demonstrates 30 percent out of state utilization for the previous two years.

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.

Standard: Minimum Bed Size

111-2-2-.36(3)(d) A new or expanded Long Term Care Hospital shall have the following minimum bed sizes:

- 1. A new freestanding LTCH shall have a minimum bed size of forty (40) beds.*
- 2. A new Hospital-within-a-Hospital LTCH shall have a minimum bed size of twenty (20) beds.*
- 3. The minimum number of beds for the expansion of an existing Long Term Care Hospital, including satellite locations, shall be ten (10) beds or ten percent (10%) of the total current licensed bed total of current Long Term Care Hospital, whichever is less.*

Rationale: Minimum Bed Size

The TAC agreed that the recommended bed size standards were acceptable to ensure that economies of scale are taken into account in developing new and expanded long term care hospitals.

Standard: Accreditation

111-2-2-.36(3)(e) An applicant for a new Long Term Care Hospital shall demonstrate the intent to meet the standards of the Joint Commission on the Accreditation of Healthcare Organizations within twenty-four (24) months of accepting its first patient. An applicant for an expanded Long Term Care Hospital

shall be JCAHO-certified as of the date of its application and shall furnish proof of the certification as a part of the Certificate of Need application process.

Rationale: Accreditation

The TAC agreed and proposed that new facilities should be accredited within 24 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. Twenty-four months was considered reasonable because it takes a complete year of data regarding admission length before Medicare will certify a facility as “long term care.”

Standard: Licensure

111-2-2.36(3)(f) An applicant for a new Long Term Care Hospital shall demonstrate the intent to meet the Licensure Rules of the Georgia Department of Human Resources for such hospitals. An applicant for an expanded Long Term Care Hospital shall demonstrate a lack of uncorrected deficiencies as documented by letter from the Georgia Department of Human Resources.

Rationale: Licensure

The provisions of licensure rules and regulations are to assess the minimal standards for services delivered. Quality is a function of many variables, including but not limited to: a) the education, experience and understanding of health care providers and the availability of these providers to assure appropriate staffing; b) the process of service delivery, including the provision of appropriate levels of care to meet specific patient care needs; c) institutional capacity to deliver services in an efficient and cost-effective manner; d) licensure and certification to survey compliance with established standards; and e) the ability of a health care program to satisfy the expectations of the community to deliver quality care according to established community standards.

Standard: Utilization Review

111-2-2.36(3)(g) An applicant for a new or expanded Long Term Care Hospital 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 long term care hospital and that all applicants should demonstrate that they have policies and procedures regarding utilization review.

Standard: Transfer Agreements

111-2-2.36(3)(h) An applicant for a new or expanded Long Term Care 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: Transfer Agreements

The TAC agreed that transfer arrangements are important for freestanding long term care hospitals. In order to ensure that the transfer 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: Indigent and Charity Care

111-2-2.36(3)(i) An applicant for a new or expanded Long Term Care Hospital shall foster an environment that assures access to services to individuals unable to pay and regardless of payment source or circumstances by the following:

- 1. providing evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis;*
- 2. providing a written commitment that 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;*
- 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;*
- 4. providing documentation of current or proposed charges and policies, if any, regarding the amount or percentage of charges that charity patients, self pay patients, and the uninsured will be expected to pay; and*
- 5. agreeing to participate in the Medicare and Medicaid programs if such programs reimburse for such services.*

111-2-2.36(3)(j) Reserved.

Rationale: Indigent and Charity Care

The provision of services on a nondiscriminatory basis, particularly to the indigent and uninsured or underinsured population, has become a growing concern. Many indigent and uninsured or underinsured individuals cannot afford to purchase inpatient rehabilitation services. The purpose of this standard is to ensure that equity will occur in the provision of inpatient rehabilitation services to those individuals who cannot afford such care.

Standard: Data Collection

111-2-2.36(3)(k) An applicant for a new or expanded Long Term Care Hospital shall agree to provide the 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: Data Collection

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.

References

1. Division of Health Planning Annual Hospital Questionnaire – LTAC Utilization and Capacity Report 2001-2005.
2. Division of Health Planning Inventory of LTACHs and LTAC Hospitals within Hospitals
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4. Testimony to the House Subcommittee on Health Committee on Ways and Means. Herb Kuhn, Director, Center for Medicare Management. March 15, 2006.
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6. “Economic Analysis of Hospital Providers in the State of Georgia, Executive Summary.” Deloitte Consulting on behalf of Georgia Hospital Association, Georgia Alliance of Community Hospitals, HCA Southeast Division, Georgia Safety Net Coalition, & VHA Georgia, Inc., October, 2004.
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