STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

2024-2027 STATE HEALTH PLAN ADMINISTRATIVE CODE

CHAPTER 410-2-4 FACILITIES

TABLE OF CONTENTS

410-2-4-.01	Introduction
410-2-4-.02	Acute Care (Hospitals)
410-2-4-.03	Nursing Homes
410-2-4-.04	Limited Care Facilities – Specialty Care Assisted Living Facilities
410-2-4-.05	Assisted Living Facilities
410-2-4-.06	Adult Day Care Programs
410-2-4-.07	Home Health
410-2-4-.08	Inpatient Physical Rehabilitation
410-2-4-.09	Swing Beds
410-2-4-.10	Psychiatric Care
410-2-4-.11	Substance Use
410-2-4-.12	Ambulatory Surgery
410-2-4-.13	Renovations
410-2-4-.14	Replacements
410-2-4-.15	Inpatient Hospice Services
410-2-4-.16	Freestanding Emergency Departments (FEDs)

410-2-4-.01 Introduction.

This chapter focuses on existing health care facilities and the need for additional facilities. Methodologies for many facilities, i.e., general hospitals, nursing homes, specialty care assisted living facilities, rehabilitation, psychiatric and substance abuse, are specific in nature and project a finite number of beds needed. Swing beds, Long Term Acute Care Hospital beds, and Critical Care Access Hospital beds are allowed for hospitals which meet the criteria as specified in the appropriate Federal Directive. The home health methodology is based on upon a minimum level of utilization.

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective May 18, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.02 Acute Care (Hospitals).

(1) Introduction. In this section, the methodology for computing acute care bed need will be described, and criteria for making adjustments to the computed bed need will be discussed.

(a) Definition: Hospital.

1. Defined as printed in Rules of Alabama State Board of Health Division of Licensure and Certification Chapter 420-5-7 (effective August 26, 2013):

(i) "Hospital" means a health institution planned, organized and maintained for offering to the public, facilities and beds for use in the diagnosis and treatment of patients requiring in-patient medical care, out-patient medical care, or other care performed by or under the supervision of physicians due to illness, disease, injury, deformity, abnormality, or pregnancy.

(2) Purpose

(a) The purpose of the bed need methodology is to identify the number of acute general hospital beds needed at least three years into the future to assure the continued availability of quality hospital care for residents of the state of Alabama. Such number, as identified later in this section, shall be the basis for statewide health planning and certificate of need approval, except:

1. in circumstances that pose a threat to public health, and/or

2. when the SHCC makes an adjustment based on criteria specified later in this section.

(3) Methodology

(a) The planning area used in this methodology is the county with the exception of certain counties which are grouped together into one planning area due to a current or previous lack of an extant hospital in the area: Calhoun/Cleburne, Fayette/Lamar, Houston/Henry, Lee/Macon, Marengo/Choctaw/ Perry, Montgomery/Lowndes, and Tallapoosa/Coosa.

(b) The methodology involves:

applying recent utilization data

to

projected population

and

using desired occupancy rates

to

determine needed beds.

(c) Hospital annual reports (Form BHD 134-A) for the past three years, are used in computing a three-year weighted average daily census (ADC) to provide the utilization measure. The weighted average emphasizes the most current census levels while taking into consideration census for the previous two years.

(d) Desired occupancy rates for each of eight service categories are those which were established under the National Guidelines for Health Planning. These are:

Medical/Surgical(M/S)	80%
M/S in Small Hospitals (under 4,000 total admissions/yr.)	75%
Obstetrics	75%
Pediatrics	
0-39	65%
40-79	70%
80 or more beds	75%
ICU-CCU	65%
Other	75%

(e) Computations by Service Category

1. Compute Average Daily Census (ADC) for each of last three years.

$$ADC = \frac{\text{Patient Days in Service Category}}{\text{Days Operational in Year (normally 365)}}$$

2. Compute Weighted Average ADC (Weighted ADC).

(Current Year minus 2 Years ADC x 1) +
(Previous Year ADC x 2) + (Current Year ADC x 3)

3. Compute Projected ADC.

Projected ADC = Weighted ADC x 3 Years above Current Year Projected Population Current Year Population

4. Compute Projected Beds Needed.

Beds Needed = Projected ADC in Service Category Desired Occupancy Rate for Service Category

(f) Summation Across Service Categories

1. Compute Total Beds Needed

Beds Needed = Medical/Surgical Beds Needed
+ Obstetrical Beds Needed
+ Pediatric Beds Needed
+ ICU-CCU Beds Needed
Other Beds Needed

2. Compute Net Beds Needed or Excess

Net Beds Needed (Excess) = Beds Needed
- Existing Beds

3. All CON Authorized beds shall be considered as Existing Beds for the purposes of need calculations for this section.

(4) Criteria for Plan Adjustments

(a) The SHCC may make adjustments to the needed beds determined by the methodology described above if evidence is introduced to the SHCC in each of the criteria, which follow, the exception to this is section 410-2-4-.02(5):

1. Evidence that residents of an area do not have access to necessary health services. Accessibility refers to the individual's ability to make use of available health resources. Problems which might affect access include persons living more than 30 minutes travel time from a hospital, the lack of health manpower in some counties, and individuals being without the financial resources to obtain access to healthcare facilities; and

2. Evidence that a plan adjustment would result in health care services being rendered in a more cost-effective manner. The SHCC, by adopting the bed need methodology herein, has decided that beds in excess of the number computed to be needed are not cost-effective. Therefore, the burden of proof that a plan adjustment would satisfy this criteria rests with the party seeking that adjustment; and

3. Evidence that a plan adjustment would result in improvements in the quality of health care delivered to residents of an area. Many organizations, including the Division of Licensure and Certification within the Alabama Department of Public Health, the Professional Review Organization for the State, the Joint Commission on Accreditation of Health Care, and major third-party payers, continually address the issue of the quality of hospital care. Evidence of substandard care in existing hospital(s) within a county and/or evidence that additional hospital beds would enhance quality in a cost-effective way could partially justify a plan adjustment.

(i) In applying these three (3) plan adjustment criteria, special consideration should be given to requests from hospitals which have experienced average hospital-wide occupancy rates in excess of 80% for the most recent two-year period. It is presumed that the patients, physicians, and health plans using a hospital experiencing high occupancy rates have rendered positive judgments concerning the accessibility, cost-effectiveness, and/or quality of care of that hospital. Thus, the 80% occupancy standard adds a market-based element of validity to other evidence, which might be given in support of a plan adjustment for an area.

(ii) Numbers of beds do not always reflect the adequacy of the programs available within hospitals. In applying the three plan adjustment criteria to specific services, consideration should be given to the adequacy of both numbers of beds and programs offered in meeting patient needs in a particular county.

(5) Bed Availability Assurance for Acute Care (Hospitals)

(a) On occasion, existing acute care hospitals are located in counties having significant population growth and/or hospitals with broad geographical service areas/statewide missions. These existing acute care hospitals are experiencing a shortage of acute care beds due to population growth and other demographic factors such as the aging baby boomers. The shortage of acute care beds is expected to only worsen. This shortage of acute care beds is causing patient transfers to be refused and ambulances to be turned-away (diverted) to more distant facilities or causing delays in transfers from the ER to an inpatient bed, which is not in the best interests of patients or the provision of quality and cost-effective health care. The Acute Care Bed Need Methodology is based on a county-planning area and is an average of all days of the month and all months of the year. It may not always adequately take into consideration the census level and acute care bed

availability of an individual acute care hospital and the significant inpatient bed pressures on the existing hospital, patients, and medical staff.

(b) In order to assist those existing acute care hospitals that are experiencing high census levels, existing acute care hospitals may qualify to add acute care beds if the existing acute care hospital can demonstrate an average weekday acute bed (including observation patients) occupancy rate/census (Monday through Friday at midnight, exclusive of national holidays) for two separate and distinct periods of thirty (30) consecutive calendar days of the most recent twelve (12) month period at or above the desired average occupancy rate of eighty percent (80%) of total licensed acute care beds for that hospital.

(c) For existing acute care hospitals achieving the occupancy rate in paragraph 2, those hospitals may seek a CON to add up to ten percent (10%) of licensed bed capacity (not to exceed 50 beds), rounded to the nearest whole, or alternatively up to thirty (30) beds, whichever is greater (which shall be at the applicant's option). Such additional beds will be considered an exception to the bed methodology set forth elsewhere in this Section, provided, however, that any additional beds authorized by the CON Board pursuant to this provision shall be considered for purposes of other bed need methodology purposes. In addition to such additional information that may be required by SHPDA, a hospital seeking a CON for additional beds under this section must provide, as part of its CON application the following information:

1. Demonstration of compliance with the occupancy rate in paragraph 2 (average of at least an 80% weekday occupancy rate for two (2) separate and distinct periods of thirty (30) consecutive calendar weekdays of the most recent 12-month period);

2. The application for additional acute care beds does not exceed ten percent (10%) of licensed acute care bed capacity (not to exceed 50 beds), rounded to the nearest whole, or alternatively up to thirty (30) acute care beds, whichever is greater.

3. The existing acute care hospital has not been granted an increase of beds under this section within the preceding twelve-month period, which time begins to run upon the issuance of a certificate of occupancy issued by the Alabama Department of Public Health; and

4. The hospital must have been licensed for at least one year as a general acute care hospital.

(d) Any acute care beds granted under this section can only be added at or/upon the existing campus of the applicant acute care hospital.

(6) Planning Policy. In a licensed general acute care hospital, the temporary utilization of inpatient rehabilitation beds, inpatient or residential alcohol and drug abuse beds, or inpatient psychiatric beds for medical/surgical purposes will not be considered a conversion of beds provided that the temporary utilization not exceed a total of twenty percent (20%) in any one specialty unit, as allowed by federal Medicare regulations in a facility's fiscal year.

(7) Long Term Acute Care Hospitals (LTAC)

(a) According to the Federal Centers for Medicare and Medicaid Services (CMS), a hospital is an excluded [from the Prospective Payment System] long term acute care hospital if it has in effect an agreement [with CMS] to participate as a general medical surgical acute care hospital and the average inpatient length of stay is greater than twenty-five (25) days. Ordinarily, the determination regarding a hospital's average length of stay is based on the hospital's most recently filed cost report. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current average length of stay, data from the most recent six-month period is used.

(b) Long term acute care hospitals provide a hospital level of care to patients with an acute illness, injury or exacerbation of a disease process that requires intensive medical and/or functional restorative care for an extended period of time, on average twenty-five (25) days or longer. Generally, high technology monitoring or complex diagnostic procedures are not required. A long-term acute care hospital's primary patient service goal is to improve a patient's medical and functional status so that they can be successfully discharged to home or to a lower level of care. These patients generally do not meet admission criteria for nursing homes, rehabilitation, or psychiatric facilities.

(c) Alabama has an excess of licensed general acute care hospital beds, some of which could be used for long-term hospital care. Therefore, a general acute care hospital may apply for a certificate of need to convert acute care beds to long-term acute care hospital beds if the following conditions are met:

1. The hospital can satisfy the requirements of a long term acute care hospital as outlined above.

2. The long-term acute care hospital can demonstrate that it will have a separate governing body, a separate chief executive officer, a separate chief medical officer, a separate medical staff, and perform basic functions of an independent hospital.

3. The long term acute care hospital has written patient transfer agreements with hospitals other than the host hospital to show that it could provide at least seventy-five percent (75%) of the admissions to the long term acute care hospital, based on the total average daily census for all participating hospitals.

4. The transfer agreements are with other hospitals in the same county and/or with hospitals in a region.

(d) To assure financial feasibility, the conversion of acute care beds to long-term acute care hospital beds shall be for a minimum of twenty-five (25) beds.

(e) Needs Assessment.

1. The bed need for the proposed long term acute care hospital shall be for no more than five percent (5%) of the combined average daily census (ADC) of all the acute care hospitals in the region of the proposed LTACH for the most recent annual reporting period.

2. As an alternative an applicant may justify bed need based on a detailed assessment of patient discharges after stays of twenty-five (25) days or more.

3. An individual hospital's ADC or discharges shall not be used more than once in the computation of need for long term acute care hospital beds.

4. Due to accessibility issues all regions regardless of need methodology shall be permitted one LTACH facility with a maximum of twenty-five (25) beds, which has proven financially feasible.

(f) The hospital must also comply with all statutes, rules, and regulations governing the Certificate of Need Review Program in Alabama.

(8) Pediatric Hospitals. Any licensed freestanding pediatric hospital or wholly owned subsidiary may make application for a Certificate of Need based on the latest obtainable pediatric data. The data submitted as part of the application shall be verified by the SHPDA staff prior to consideration by the Certificate of Need Review Board.

(9) Critical Access Hospitals (CAH).

(a) An existing hospital in Alabama must meet the following criteria to be considered for certification by CMS as a CAH (a new Certificate of Need is not required unless the application is for a new CAH or the hospital where the CAH is to be located has been closed longer than twelve (12) months):

1. Is a public, nonprofit, or for-profit Medicare-certified hospital currently in operation and located in one of the following:

(i) A rural area as defined by the Office of Management and Budget (i.e., outside a Metropolitan Statistical area);

(ii) A rural census tract of a Metropolitan Statistical Area (MSA) determined under the most recent version of the Goldsmith Modification Formula;

(iii) An area designated as Rural by law or regulation of the State of Alabama or in the state's rural Health Plan as approved by the federal Centers for Medicaid and Medicare Services;

(iv) A hospital would qualify as a rural referral center or as a sole community hospital if the hospital were located in a rural area.

2. Hospitals, which closed on or after November 29, 1989, or are currently licensed health clinics or health centers that were created by downsizing a hospital, may reopen as a CAH;

3. Is located more than a 35-mile drive (or 15-mile drive in areas with mountainous terrain or with only secondary roads available) from another hospital or CAH, or is designated by the state as being a Necessary Provider of Health Care Services to area residents;

4. Makes available 24-hour emergency care services that the State determines are necessary for ensuring access to emergency care in each community served by the critical access hospital;

5. Provides not more than twenty-five (25) beds for acute inpatient care (which in the case of a swing bed facility can be used interchangeably for acute or SNF-level care) and the hospital may also provide up to ten (10) rehabilitation and ten (10) psychiatric beds so long as these are operated as separate units;

6. Maintains an average annual patient stay of no more than ninety-six (96) hours;

7. Meets critical access hospital staffing requirements;

8. Is a member of a rural health network and has an agreement with at least one full-service hospital (Affiliate) in the network for:

- patient referral and transfer
- development and use of communications systems
- provision of emergency and non-emergency transportation

9. Has an agreement regarding staff credentialing and quality assurance with one of the following:

(i) a hospital that is a joint member in the rural health network;

(ii) a peer review organization or equivalent entity; or

(iii) another appropriate and qualified entity identified in the state rural health plan.

10. Federal statutes and eligibility requirements governing the CAH Program allow states to designate an existing hospital as a Necessary Provider of Health Care Services for its area residents if it meets all requirements for a CAH except the mileage between hospitals requirement. Alabama will utilize this statutory provision and designate Necessary Provider of Health Care Services for existing hospitals located in a county considered “at risk” for losing primary health care access. Alabama has reviewed numerous indicators of under-service in communities to determine criteria most appropriate for Alabama. Five criteria have been selected.

If the hospital meets one or more of these criteria, Alabama’s Bureau of Health Provider Standards, Division of Provider Services, in consultation with the Office of Primary Care and Rural Health, will declare the facility a Necessary Provider of Health Care Services:

Criteria 1. The hospital is located in an area designated as a Health Professional Shortage Area.

Criteria 2. The hospital is located in an area designated as Medically Underserved.

Criteria 3. The hospital is located in a county with an unemployment rate higher than the statewide rate of unemployment.

Criteria 4. The hospital is located in a county with a percentage of population age 65 years and older greater than the state's average.

Criteria 5. The hospital is located in a county where the percentage of families with incomes below 200% of the federal poverty level is higher than the state average for families with incomes below 200% of the federal poverty level.

Any existing hospital, which otherwise satisfies CAH criteria except the mileage requirement but does not meet at least one of the above criteria for certification as a Necessary Provider of Health Services, may appeal to Alabama's State Health Officer. Evaluation of appeals will be based on submission of objective information, which demonstrates the presence of extenuating circumstances which may adversely impact an area's access to health care if the existing hospital is not declared a Necessary Provider of Health Services. Based on evidence presented, the State Health Officer may decide to issue a variance from established criteria and declare the appealing hospital a Necessary Provider of Health Care Services.

(i) In order to meet the federal CAH requirements as to the number of beds, an existing hospital may distinguish "authorized" and "licensed" general acute care and swing beds as in the rules established by the ADPH and SHPDA.

(ii) The "Medicare Prescription Drug, Improvement and Modernization Act" (Public Law H.R. 1 and S. 1 June 27, 2003) is an extensive revision to the Medicare program and contains provisions relating the Critical Access Hospital Program found in Section 405 of the Act. These provisions allow more flexibility for hospitals converting to CAH status.

(10) Rural Emergency Hospitals

(a) A Rural Emergency Hospital (REH) is a specialized hospital that provides outpatient services, does not operate any inpatient beds, and meets all of the requirements for licensure under Ala. Admin. Code r. 420-5-23, which is incorporated herein by reference.

(b) Any hospital seeking to convert from either a Critical Access Hospital or a general acute care hospital to an REH

shall file a Request for Determination of Reviewability with SHPDA to ensure that no part of their proposed conversion is reviewable under Certificate of Need law.

(c) Any REH seeking to convert back to either a Critical Access Hospital or a general acute care hospital shall require a Certificate of Need to add inpatient beds to its existing outpatient services. For the limited purpose of this conversion, need shall be presumed for that facility to add up to the total number of general acute care beds it possessed Certificate of Need authority to operate as of the date of its conversion to an REH. This presumed need shall exist only for that provider and only for the location at which the REH was operated. Need shall not be presumed for that provider at any other location in the planning area, nor shall it be presumed for any other type of specialized bed defined elsewhere in this plan. Further, need shall not be presumed for any other provider seeking to establish a new facility in the same planning area. This need shall be presumed for a period of time not to exceed eight (8) years following the conversion of the facility to an REH through the issuance of a license by the Alabama Department of Public Health.

(11) Birthing Centers

(a) In addition to other applicable criteria, any entity proposing to establish a birthing center must demonstrate, through substantial evidence, that their project will meet all of the requirements for licensure under Ala. Admin. Code r. 420-5-13, which is incorporated herein by reference.

(b) Any entity seeking to establish a birthing center that does not offer any services that would require the entity to be licensed by the Alabama Department of Public Health as a hospital or as an ambulatory surgery center may file a Request for Determination of Reviewability with SHPDA in order to determine if a Certificate of Need is required to establish the facility.

(c) Any entity seeking to establish a birthing center that offers services that would require the entity to be licensed by the Alabama Department of Public Health as a hospital or as an ambulatory surgery center shall constitute a new institutional health service requiring a Certificate of Need under Alabama law. An applicant seeking to establish a birthing center, in this instance, shall not be required to show a need for acute hospital beds or for additional ambulatory surgery center operating rooms, but shall instead provide substantial evidence in its application to demonstrate to the Certificate of Need Review Board that the proposed facility is necessary to the health and welfare of the citizens of the proposed planning area. Specifically, data related to maternal and infant mortality, distances between

the proposed location and existing acute care hospitals providing obstetric and maternity care, the policy regarding the types of patients who will be treated versus the types of patients that would automatically be referred to an acute care facility, and copies of transfer agreements regarding the care of high-risk patients and/or patients requiring care above and beyond that available at the proposed facility between the proposed facility and existing acute care providers should all be included as part of the application to create a new birthing center. The grant of a Certificate of Need for the establishment of a birthing center shall not constitute authority for the creation of new acute care beds, other ambulatory surgical services, or any other service requiring a Certificate of Need.

(d) The SHCC is aware that there is currently ongoing litigation between representatives seeking to establish birthing centers and the Alabama Department of Public Health regarding licensure rules for these facilities. Once a final decision is issued in this ongoing litigation, the SHCC will review and revise this section as appropriate based on the ruling issued by the courts.

For a listing of Acute Care, Long Term Acute Care, or Critical Access Hospitals or the most current statistical need projections in Alabama contact the Data Division as follows:

MAILING ADDRESS STREET ADDRESS
(U.S. Postal Service) (Commercial Carrier)
PO BOX 303025 100 NORTH UNION STREET, SUITE 870
MONTGOMERY, AL 36130-3025 MONTGOMERY, AL 36104

TELEPHONE: FAX:
(334) 242-4103 (334) 242-4113

EMAIL: WEBSITE:
data.submit@shpda.alabama.gov http://www.shpda.alabama.gov

Appendix A

LTACH Regional County Listings

REGION I	**REGION V**	**REGION VII**
Colbert	Fayette	Baldwin
Franklin	Greene	Choctaw
Lauderdale	Hale	Clarke
Lawrence	Lamar	Conecuh
	Pickens	Escambia

Sumter

Tuscaloosa

REGION II

Jackson

Limestone

Madison

Marshall

Morgan

REGION III

Bibb

Blount

Cullman

Jefferson

Marion

Saint Clair

Shelby

Talladega

Walker

Winston

REGION IV

Calhoun

Cherokee

Clay

Cleburne

REGION VI

Autauga

Bullock

Butler

Chambers

Chilton

Coosa

Crenshaw

Dallas

Elmore

Lee

Lowndes

Macon

Marengo

Montgomery

Perry

Pike

Russell

Tallapoosa

Wilcox

Mobile

Monroe

Washington

REGION VIII

Barbour

Coffee

Covington

Dale

Geneva

Henry

Houston

DeKalb

Etowah

Randolph
Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective May 18, 1993. **Amended:** June 19, 1996; effective July 25, 1996. **Amended:** Filed August 1, 1996; effective September 5, 1996. **Amended:** Filed August 14, 1996; effective September 18, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.03 Nursing Homes.

(1) Definition. A Nursing Home is a business entity engaged in providing housing, meals and care to sick or disabled individuals who require medical care, nursing care, or rehabilitative services on a daily or more frequent basis. Hospital swing beds are included in Section 410-2-4-.09.

(2) Analysis of Existing Facilities

(a) As of October 2019, there were 232 licensed nursing homes, excluding state owned and operated facilities, totaling 27,383 beds operating in the state of Alabama. Average occupancy for the 228 facilities was approximately84.8% for Fiscal Year 2018. Currently, there are approximately 32.9 beds per one thousand persons age 65 and older.

(b) Approximately 84.6 % of nursing home beds in Alabama are occupied by persons age 65 and older. This aged population represents 16.5% of the state's total population and is projected to increase during the coming years.

(c) Nursing homes provide various levels of care for those needing their services. These include:

1. Short-term post hospital care (PAC) for those who require specialized rehabilitation after their acute care hospital episodes. Most of these PAC admissions return home.

2. Long term care for those with complex chronic conditions requiring care and supervision unavailable in a home setting through available supports and services.

3. Palliative care for hospice patients unable to remain in a home environment.

4. Memory care in a secured environment for those with complex chronic conditions requiring care and supervision unavailable in a home setting through available supports and services and suffering from Alzheimer’s disease and other forms of dementia.

(3) Long Term Supports and Services

(a) Efforts should be made to maintain an optimum quality of life for long term care residents in their home for as long as possible. The types and amounts of services needed for long term care residents vary. In order to enhance opportunities for residents needing long term care services, which would allow them to remain in their homes for as long as possible, the health care and social needs of these residents should be evaluated by an independent multidisciplinary team prior to

nursing home admission. This team should also evaluate the ability of resources within the local community to meet the needs of these residents.

(b) To foster the ability of Medicaid beneficiaries needing long term care and supports to remain and thrive in their homes, the Alabama Medicaid Agency implemented a home and community-based services (HCBS) program. After consultation with consumers, consumer advocates, and a wide range of health care providers, Medicaid has further enhanced the HCBS program by developing and implementing the integrated care network (ICN) program. The ICN program focuses on bringing medical case management to the home and community-based services (HCBS) population to permit better medical risk assessment of those in the HCBS program which promotes their ability to thrive at home. The ICN also case manages Medicaid beneficiaries in nursing facilities through the existing minimum data set (or MDS) assessments, which includes a return to home assessment. Individuals who might otherwise require admission to a nursing home are now able to remain in their homes because of the home and community-based services provided through this program. Currently, there are nearly 8,200 residents whose long term care needs can be met through the program.

(4) Financing

(a) The Alabama Medicaid program was started in 1970, and as a result, the nursing home industry grew rapidly during the 70s. Since the 1980 adoption of a more restrictive bed need methodology, the number of beds added have tapered off considerably. Also, with the containment of health care costs as a primary concern, a moratorium on additional nursing home beds was established in August of 1984, and lifted in June of 1989, and was reinstituted in 2005. Medicaid patients account for 53.7% of patient days, private pay patients 20.7%, and Medicare 14.5% as of FY 2018.

(5) Availability

(a) The 232 licensed nursing homes located in Alabama are generally geographically well distributed and are accessible to the majority of the elderly population within thirty (30) minutes normal driving time. Every Alabama county has a least one nursing home.

(6) Continuity

(a) Discussion

1. Nursing homes should provide care appropriate to resident needs. To ensure that comprehensive services are available and to ensure residents are at a proper level

of care, nursing homes should provide, or should have agreements with other health care providers to provide, a broad range of care. When providing these services, or a part of any agreement to provide these services, transfer of residents and support service should be provided as necessary.

(b) Planning Policy. The rendering of complementary long term care services, such as home health care adult day care, senior citizen nutrition programs, hospice, etc., to long term care recipients should be fostered and encouraged. In areas where such services are sufficiently developed, health care facilities should be encouraged to have agreements that increase the availability of such services to residents. In areas where such services are not sufficiently available, facilities should be encouraged to develop and offer such services. The Alabama Department of Public Health, Bureau of Provider Standards, is encouraged to make the appropriate changes to the licensure requirements.

(7) Quality

(a) Quality care is an obligation of all nursing homes operating in Alabama. Each facility must meet standards of care as established by the federal government (Medicare and Medicaid Requirements of Participation) and the Alabama State Board of Health Rules and Regulations. The Bureau of Provider Standards of the Alabama Department of Public Health is responsible for determining compliance. Additionally, the Quality Improvement Organization (QIO) includes some nursing homes in its review.

(8) Nursing Home Bed Need Methodology

(a) Purpose. The purpose of this nursing home bed need methodology is to identify, by county, the number of nursing home beds needed to assure the continued availability, accessibility, and affordability of quality nursing home care for residents of Alabama.

(b) General. Formulation of this bed need methodology was accomplished by a committee of the Statewide Health Coordinating Council (SHCC). The committee which provided its recommendations to the SHCC, was composed of providers and consumers of health care. Only the SHCC, with the Governor's final approval, can make changes to this methodology except that the SHPDA staff shall annually update bed need projections and inventories to reflect more current population and utilization statistics. Adjustments are addressed in paragraph (e).

(c) Basic Methodology. Considering the availability of more home and community-based services for the elderly in Alabama,

there should be a minimum of 40 beds per 1,000 population 65 and older for each county.

1. The beds need formula is as follows:

(40 beds per thousand) x (population 65 and older) =Projected Bed Need

2. Due to budgetary limitations of the Alabama Medicaid Agency, additional nursing home beds cannot be funded by Medicaid funds; therefore, applications for additional nursing home beds to be funded by Medicaid should not be approved. Based upon the funding shortage, projects for additional nursing home beds would not be financially feasible. Until further action by the Statewide Health Coordinating Council, there shall be no need for additional skilled nursing beds in the State of Alabama.

(d) Planning Policies

1. The county's annual occupancy for the most recent reporting year should be at least 97% before additional nursing home beds are approved.

2. Conversion of existing hospital beds to nursing home beds should be given priority over new construction when the conversion is significantly less costly and the existing structure can be adapted economically to meet licensure and certification requirements. The conversion shall result in a decrease in the facility’s licensed acute care beds equal to or greater than the number of beds to be converted.

3. Bed need projections will be based on a three year planning horizon.

4. Planning will be on a county-wide basis.

5. Subject to SHCC adjustments, no beds will be added in any county where that county's projected ratio exceeds 40 beds per 1,000 population age 65 and older.

6. No new free standing nursing home should be constructed having less than fifty (50) beds.

7. ICF/ IID facilities, state and privately owned, will not be included in the application of the SHCC adopted nursing home bed need methodology.

8. When any nursing home facility relinquishes its license to operate, either voluntarily or involuntarily other than by a Certificate of Need approved transfer, or by obtaining title by a foreclosure as specified in the

opinion rendered by the Alabama Attorney General, November 17, 1980, the need for the facility and its resources will automatically be eliminated from the facilities portion of the State Health Plan. The new bed need requirement in the county where the facility was located will be that number which will bring the county ratio up to 40 beds per 1,000 population 65 and older.

(e) Adjustments. The bed need, as determined by the methodology, is subject to adjustments by the SHCC. The nursing home bed need may be adjusted by the SHCC if an applicant can prove that the identified needs of a targeted population are not being met by existing nursing homes in the county of the targeted population.

For a listing of Nursing Homes or the most current statistical need projections in Alabama contact the Data Division as follows:

MAILING ADDRESS	STREET ADDRESS
(U.S.Postal Service)	(Commercial Carrier)
PO BOX 303025	100 N. UNION STREET SUITE 870
MONTGOMERY, AL 36130-3025	MONTGOMERY, AL 36104
TELEPHONE:	FAX:
(334) 242-4103	(334) 242-4113
EMAIL:	WEBSITE:
data.submit@shpda.alabama.gov	http://www.shpda.alabama.gov

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective March 8, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Amended:** Filed August 14, 2012; effective September 18, 2012. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.04 **Limited Care Facilities – Specialty Care Assisted Living Facilities**.

(1) Definition. Specialty Care Assisted Living Facilities ("SCALFs") are intermediate care facilities which provide residents with increased care and/or supervision designed to address the residents' special needs due to the onset of dementia, Alzheimer's disease or similar cognitive impairment in addition to assistance with normal daily activities including, but not limited to, restriction of egress for residents where appropriate and necessary to protect the resident and which require a license from the Alabama Department of Public Health as a Specialty Care Assisted Living Facility pursuant to Ala. Admin. Code r 420-5-20, et seq.

(2) Specialty Care Assisted Living Facility Bed Need Methodology

(a) Purpose. The purpose of this specialty care assisted living facility bed need methodology is to identify, by county, the number of beds needed to assure the continued availability, accessibility, and affordability of quality care for residents of Alabama.

(b) General. Only the SHCC, with the Governor's final approval, can make changes to this methodology except that the SHPDA staff shall annually update bed need projections and inventories to reflect more current population and utilization statistics. Adjustments are addressed in paragraph (e).

(c) Basic Methodology. Considering the availability of more home and community-based services for the elderly in Alabama, there should be a minimum of six (6) beds per 1,000 population age 65 and older for each county.

The bed need formula is as follows:

(6 beds per thousand) x (population age 65 and older/1,000) = Projected Bed Need

(d) Planning Policies

1. Projects to develop specialty care assisted living facilities or units in areas where there exist medically underserved, low income, or minority populations should be given priority over projects not being developed in these critical areas when the project to develop specialty care assisted living facilities in areas where there exists medically underserved, low income or minority populations is not more costly to develop than other like projects.

2. Bed need projections will be based on a three-year planning horizon.

3. Planning will be on a countywide basis.

4. Subject to SHCC adjustments, no beds will be added in any county where that county's projected ratio exceeds six (6) beds per 1,000 population age 65 and older, except in the case of any county meeting the conditions delineated in sections (d) 6 – 8 below.

5. When any specialty care assisted living facility relinquishes its license to operate, either voluntarily or involuntarily other than by a Certificate of Need approved transfer, or by obtaining title by a foreclosure as specified in the opinion rendered by the Alabama Attorney General, November 17, 1980, the beds authorized for use at that facility shall be returned to inventory. The new bed need requirement in the county where the facility was located will be that number which will bring the county ratio up to six (6) beds per 1,000 population age 65 and older, except in the case of any county meeting the conditions delineated in sections (d) 6 – 8 below.

6. Applicants for adjustments have provided evidence to the SHCC that certain counties in the state have a patient base drawn from multiple additional counties for several reasons, including but not limited to: the location of other family members; the difficulties in constructing and operating a financially viable SCALF in rural areas; the location of other medical providers; and the creation of multi-level senior living developments allowing for "aging in place." The SHCC recognizes that an alternative means of assessing need for certain counties is necessary. Any county with a projected population, age 65 and older, of 20,000 or more qualifies for an alternative need projection which shall account for both the projected need and the existing CON authorized bed capacity of that county, and all counties contiguous to that county. The sum of the authorized bed capacity of the target county and all contiguous counties shall be subtracted from the sum of the projected need for the target county and all contiguous counties. This projected net need shall be compared to the projected net need determined under the methodology in section (2)(c) above. The larger of the two projected net need values shall be the need for the target county and shall be reflected on any Statistical Update published by SHPDA.

7. Additional need may be shown in situations involving a sustained high occupancy rate either for a county or for a single facility. An applicant may apply for additional beds, and thus the establishment of need above and beyond the standard methodology utilizing one of the following two policies. Once additional beds have been applied for

under one of the policies, that applicant shall not qualify to apply for additional beds under either of these policies unless and until the established time limits listed below have passed. All CON authorized SCALF beds shall be included in consideration of occupancy rate and bed need.

(i) If the occupancy rate for a county is greater than 92% utilizing the census data in the most recent full year "Annual Report(s) for Specialty Care Assisted Living Facilities (Form SCALF-1)" published by or filed with SHPDA, an additional need of the greater of either ten percent (10%) of the current total CON Authorized bed capacity of that county or sixteen (16) total beds may be approved for either the creation of a new facility or for the expansion of existing facilities within that county. However, due to the priority of providing the most cost-effective health care services available, a new facility created under this policy shall only be allowed through the conversion of existing beds at an Assisted Living Facility currently in possession of a regular, non-probationary license from the Alabama Department of Public Health. Once additional need has been shown under this policy, no new need shall be shown in that county based upon this rule for twenty-four (24) months following issuance of the initial CON, to allow for the impact of those beds in that county to be analyzed. Should the initial applicant for beds in a county not apply for the total number of beds allowed to be created under this rule, the remaining beds are available to be applied for by other providers in the county meeting the conditions listed in this rule.

(ii) If the occupancy rate for a single facility is greater than 92% utilizing the census data in the last two (2) most recent full year "Annual report(s) for Specialty Care Assisted Living Facilities (Form SCALF-1)" published by or filed with SHPDA, irrespective of the total occupancy rate of the county over that time period, up to sixteen (16) additional beds may be approved for the expansion of that facility only. Once additional beds have been approved under this policy, no new beds shall be approved for that facility for twenty-four (24) months following issuance of the CON to allow for the impact of those beds at that facility to be analyzed.

8. No application for the establishment of a new, freestanding SCALF shall be approved for fewer than sixteen (16) beds, to allow for the financial feasibility and viability of a project. Need may be adjusted by the

Agency for any county currently showing a need of more than zero (0) but fewer than sixteen (16) total beds to a total need of sixteen (16) new beds, but only in the consideration of an application for the construction of a new facility in that county. Need shall not be adjusted in consideration of an application involving the expansion of a currently authorized and licensed SCALF or for the conversion of beds at an existing Assisted Living Facility.

9. Any CON Application filed by a licensed SCALF shall not be deemed complete until, and unless:

(i) The applicant has submitted all survey information requested by SHPDA prior to the application date; and

(ii) The SHPDA Executive Director determines that the survey information is complete.

10. No licensed SCALF filing an intervention notice or statement in opposition in any CON proceeding may cite or otherwise seek consideration by SHPDA of such facility's utilization data until, and unless:

(i) The intervenor or opponent has submitted all survey information requested by SHPDA prior to the application date; and

(ii) The SHPDA Executive Director determines that the survey information is complete.

(e) Adjustments. The bed need, as determined by the methodology, is subject to adjustments by the SHCC. The specialty care assisted living facility bed need may need to be adjusted by the SHCC if an applicant can prove that the identified needs of a targeted population are not being met by existing specialty care assisted living facilities in the county of the targeted population.

(f) Notwithstanding the foregoing, any application for Certificate of Need for specialty care assisted living facility beds for which a proper letter of intent was duly filed with SHPDA prior to the adoption of the bed need methodology shall not be bound by this bed need methodology.

(g) The determination of need for specialty care assisted living facility beds shall not be linked to the number of existing assisted living beds in the county.

(h) In order to determine if this methodology and related planning policies accurately reflect the need for SCALF beds in the state, the SHCC requires additional information to

determine the county of residence prior to admission to each SCALF. The SHCC requests that the Health Care Information and Data Advisory Council add a section to the "Annual Report for Specialty Care Assisted Living Facilities (Form SCALF-1)" reporting the county of residence for patients admitted to each SCALF. After the Annual Report is modified by the Health Care Information and Data Advisory Council, the SHCC shall use the information collected to review this methodology at the end of the third mandatory reporting period to determine if additional revisions to this methodology are required to better reflect both the existing utilization of SCALF services and the potential need for additional SCALF beds.

For a listing of Specialty Care Assisted Living Facilities or the most current statistical need projections in Alabama contact the Data Division as follows:

MAILING ADDRESS
(U. S. Postal Services)
PO BOX 303025
MONTGOMERY, AL 36130-3025

STREET ADDRESS
Commercial Carrier)
100 NORTH UNION STREET SUITE 870
MONTGOMERY, AL 36104

TELEPHONE:
(334) 242-4103

FAX:
(334) 242-4113

EMAIL:
data.submit@shpda.alabama.gov

WEBSITE:
http://www.shpda.alabama.gov

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: New Rule: Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed January 16, 2001; effective February 20, 2001. **Amended:** Filed July 29, 2003; effective September 2, 2003. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended:** Filed August 18, 2012, effective September 18, 2012. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.05 Assisted Living Facilities.

(1) Definition. Assisted living facilities provide, or offer to provide, any combination of residence, health supervision, and personal care to three (3) or more individuals in need of assistance with daily living activities.

(2) Existing Assisted Living Facilities. As of September 2019 there were 194 licensed assisted living facilities totaling 7,253 beds operating in the state of Alabama, or approximately 8.7 beds per 1,000 persons age 65 and older. Assisted living is available in Alabama on a private-pay basis only.

(3) Availability. The 194 licensed assisted living facilities are concentrated in the more populated counties. Three (3) counties contain 35% of the assisted living beds and ten (10) counties contain 65% of the assisted living beds. Forty-eight (48) of the sixty-seven (67) counties have assisted living facilities and nineteen (19) counties have no assisted living facilities.

(4) Continuity

(a) Discussion. Assisted living facilities should provide assistance appropriate to resident needs. To ensure that comprehensive services are available and to be certain residents are at a proper level of care, assisted living facilities should provide, or should have agreements with health care providers to provide, a broad range of care. When providing these services, transfer of residents and support services should be provided as necessary.

(b) Self-Help Program. Assisted living providers will be encouraged to provide a level of assistance that would help and encourage the residents to be self-sufficient for as long as possible before requiring a change to a more dependent home.

(5) Quality. Quality assistance is an obligation of all assisted living facilities operating in Alabama. Each facility must meet standards established by the Alabama Department of Public Health (see paragraph 4 above). The Bureau of Health Provider Standards of the Alabama Department of Public Health is responsible for determining compliance.

A current listing of licensed Assisted Living Facilities in Alabama may be found on the Alabama Department of Public Health's website, www.alabamapublichealth.gov.
Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective October 29, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended:** Filed August 18, 2012, effective September 18, 2012. **Amended (SHP Year**

Only): Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.06 Adult Day Care Programs.

(1) Definition. Adult day care programs may be identified as structured, comprehensive programs designed to offer lower cost alternatives to institutionalization for newly or chronically disabled adults who cannot stay alone during the day, but who do not need 24-hour inpatient care. Designed to promote maximum independence, participants usually attend on a scheduled basis. Services may include nursing, counseling, social services, restorative services, medical and health care monitoring, exercise sessions, field trips, recreational activities, physical, occupational and speech therapies, medication administration, well balanced meals, and transportation to and from the facility. Adult day care can provide the respite family members require to sustain healthy relationships while caring for their elderly loved one at home. Adult day care programs provide services to one or more adults not related by blood or marriage to the owner and/or administrator.

(2) Analysis of Existing Adult Day Care Programs. Adult day care programs are not currently licensed by any department of the state of Alabama. As a consequence, it is extremely difficult to ascertain the actual number of such programs within Alabama. However, Adult Day Care Centers are approved through the Alabama Department of Human Resources, the Alabama Department of Senior Services and the Alabama Medicaid Agency. The Alabama Department of Mental Health also uses adult day care.

(3) Adult Day Care Programs as Alternatives to Nursing Home Admission

(a) Efforts should be made to maintain an optimum quality of life for individuals who require extended or long-term care. The types and amounts of services needed for these individuals vary. In order to enhance opportunities for individuals needing extended or long-term care services, the needs of these individuals should be evaluated prior to admission to any extended care or long-term care program, including nursing homes, assisted living homes, and adult day care programs.

(b) In an effort to encourage the development and utilization of alternatives to nursing home and assisted living (domiciliary) care, adult day care programs and services for the elderly should be utilized to the greatest extent possible. It is the intent to provide for the establishment of additional adult day care programs in order that: (i) the elderly will be given the opportunity to remain with their families and in their communities rather than being placed in nursing homes or state institutions; (ii) families, particularly those with one or more members working outside of the home, may keep their elderly parents and relatives with them instead of having to place them in impersonal institutions; and (iii) the state of Alabama can deal more

effectively and economically with the needs of its elderly citizens.

(4) Financing. Historically, all adult day care programs have been private pay with some assistance coming from public and community sources.

(5) Availability. Adult day care programs are concentrated in the more populated counties. Many counties have no adult day care programs.

(6) Continuity

(a) Discussion. Adult day care programs should provide care appropriate to the needs of their participants. To ensure that comprehensive services are available and that certain participants receive a proper level of care, adult day care programs should provide, or should have agreements with other health care providers to provide, a broad range of care. When providing these services, transportation and support services for participants should be provided as necessary.

(b) Self-Help Program. Adult day care program providers should be encouraged to provide a level of care that will help maintain and improve function and encourage participants to be as independent as they can for as long as possible before the condition of such participants requires a change to a more dependent level of care.

(7) Quality. Quality care is an obligation of all adult day care programs operating in Alabama. Each program should comply with applicable state and local building regulations, and zoning, fire, and health codes and ordinances. In addition, each program must comply with all requirements of its funding sources, including requirements with respect to a Medicaid Waiver, if applicable.

(8) Promotion of Adult Day Care Programs. The alternate special affordable care offered by adult day care programs should be publicized by responsible agencies using some or all of the following:

(a) Public Service Announcements

(b) Physicians (provide literature)

(c) Hospitals (discharge planners)

(d) Nursing Homes

(e) The Alabama Commission on Aging

(f) The American Association of Retired Persons

(g) Community Service Agencies/Projects

(h) Religious Organizations

(i) The Alabama Department of Human Resources

(j) The Alabama Department of Senior Services

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: **New Rule:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.07 Home Health.

(1) Definitions

(a) Home Health Agency. A home health agency is an organization that is primarily engaged in providing skilled nursing services and other therapeutic services. Services are provided on an intermittent basis. Each visit must be less than four hours in duration. Any visit made to or procedures performed on a patient at their home must only be made upon a physician's written order. Home health providers shall provide at least the following services, including, but not limited to, skilled nursing care, personal care, physical therapy, speech therapy, medical social services, and medical supplies services.

(b) Home Health Care. Home health care is that component of a continuum of comprehensive health care whereby intermittent health services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining or restoring health, or of maximizing the level of independence, while minimizing the effects of disability and illness, including terminal illness. Services appropriate to the needs of the individual patient and family are planned, coordinated, and made available by providers organized for the delivery of home health care through the use of employed staff, contractual arrangements, or a combination of employed staff and contractual arrangements. There is no licensure requirement for home health agencies in Alabama.

(c) Home Health Services. Home health services are made available based upon patient care needs as determined by an objective patient assessment administered by a multidisciplinary team or a single health professional. Centralized professional coordination and case management are included. These services are provided under a plan of treatment certified by a physician that may include, but are not limited to, appropriate service components, such as medical, nursing, social work, respiratory therapy, physical therapy, occupational therapy, speech therapy, nutrition, homemaker home health aide service, and provision of medical equipment and supplies.

(d) Section 22-21-265, Code of Alabama, 1975, allows an existing home health agency to accept referrals from a county which is contiguous to a county in which the agency holds CON authority. Additional restrictions are provided in statute.

(2) Inventory of Existing Resources. The State Health Planning and Development Agency annually compiles several home health agency reports and identifies counties which are in need of an additional provider. A current listing of home health agencies is located at http://www.shpda.alabama.gov or http://www.adph.org.

(3) Availability. Home health visits are scheduled on an intermittent basis and must be available seven days a week at such times as may be ordered by referring physicians. While availability must include provision for weekend and evening services, emergency services are not within the scope or purpose of home health providers.

(4) Accessibility

(a) Home health services must be obtainable by the general public in every county in the state.

(b) Because physicians and other referral sources are sometimes unfamiliar with the total scope of services offered by home health providers, patients' accessibility is also limited by failure to refer appropriately to home health services. Every agency should provide an active community information program to educate consumers and professionals to the availability, nature, and extent of home health services.

(c) Services are provided in patients' homes, and accessibility to services is not dependent upon physical or geographic accessibility to the home health provider's offices. The essential characteristics are location of home health visiting staff in proximity to patients' places of residence and accessibility of the provider to patients, physicians, and other referral sources.

(5) Acceptability and Continuity

(a) Acceptability is the willingness of consumers, physicians, discharge planners, and others to use home health services as a distinct component of the health care continuum.

(b) Continuity reflects a case management approach that allows patient entry into the health care continuum at the point that ensures delivery of appropriate services. Home health care provides a balanced program of clinical and social services and may serve as a transitional level of care between inpatient treatment and infrequent physician office visits. Home health also extends certain intensive, specialized treatments into the home setting.

(c) Planning Guides and Policies

1. Planning Guide. Home health providers shall maintain referral contacts with appropriate community providers of health and social services to facilitate continuity of care and to coordinate services not provided directly by the home health provider.

2. Planning Policy. Home health providers must furnish discharge-planning services for all patients.

(6) Quality

(a) Quality is that characteristic which reflects professionally appropriate and technically adequate patient services.

(b) The state home health industry, through development of ethical standards and a peer review process, can foster provision of quality home health care services. Each provider must establish mechanisms for quality assurance, including procedures for resolving concerns identified by patients, physicians, families or others involved in patient referral or patient care.

(c) Planning Policies

1. Planning Policy. The county is the geographic unit for need determination, based upon population.

2. Planning Policy – (New Providers). When a new provider is approved for a county, that provider will have eighteen (18) months from the date the Certificate of Need is issued to meet the identified need in the county before a new provider may apply for a Certificate of Need to serve a county.

3. Planning Policy – Favorable Consideration. Home health agencies that achieve or agree to achieve Charity Care plus Self Pay at the statewide average percent for all home health providers shall be given favorable CON consideration over home health applicants that do not achieve the statewide average for Charity Care plus Self Pay, but not less than one percent (1%). The latest published SHPDA data report HH-11 shall be used to determine the assets to governmental and non-profit organizations at the individual county level to be considered. See section 410-2-2-.06 for the definition of charity care.

4. Planning Policy – CON Intervention/Opposition

(i) Any CON application filed by a health care facility shall not be deemed complete until, and unless:

(I) The applicant has submitted all survey information requested by SHPDA prior to the application date; and

(ii) The SHPDA Executive Director determines that the survey information is substantially complete.

5. No Home Health Agency or Hospice Agency filing an intervention notice or statement in opposition in any CON proceeding may cite or otherwise seek consideration by SHPDA of such facility's utilization data until, and unless:

(i) the intervenor or opponent has submitted all survey information requested by SHPDA prior to the application date; and

(ii) the SHPDA Executive Director determines that the survey information is substantially complete.

(7) Home Health Need Methodology

(a) Purpose. The purpose of this home health need methodology is to identify, by county, the number of home health agencies needed to assure the continued availability, accessibility, and affordability of quality home health care for residents of Alabama.

(b) Basic Methodology. In order to perform the calculations for this methodology, population data from the Center for Business and Economic Research (CBER) is utilized. All time frames are based on the year of the latest reported data.

(c) Methodology Terms. The following methodology terms are defined for determining Home Health need by County.

1. Target Year (TY). The Target Year (TY) as used in this methodology refers to the most recent year of utilization data approved by the Health Care Information and Data Advisory Council and published by

SHPDA Numeric references following "TY" (-1, +1, etc.) refer to a specific number of years before or after the Target Year for either data or population projections.

This methodology shall be based on a three (3) year planning horizon, meaning that the need shall be projected three years ahead of the most recently published home health data, and this methodology shall also use a weighted average of the three (3) most recent sets of annual reports published by SHPDA to determine need.

2. Persons Served (PS). Persons Served (PS) is defined as the number of patients receiving Home Health services during a reporting year.

3. Population. The ratio of persons served is divided into two (2) cohorts for determination of need as follows:

(i) Patients aged 65 and older (P65O)

(ii) Patients aged 64 and under (P64U)

4. Persons Served by County by Year (PSCY). The ratio of persons served by county by year (PSCY) is determined as follows:

PSCY TY+3 = [PS TY x 0.75 x (P65O TY+3 / P65O TY)] + [PS TY x 0.25 x (P64U TY+3 / P64U TY)]

PSCY TY+2 = [PS TY-1 x 0.75 x (P65O TY+2 / P65O TY-1)] + [PS TY-1 x 0.25 x (P64U TY+2 / P64U TY-1)]

PSCY TY+1 = [PS TY-2 x 0.75 x (P65O TY+1 / P65O TY-2)] + [PS TY-2 x 0.25 x (P64U TY+1 / P64U TY-2)]

5. Average Projected Persons Served per 1,000 Population per Year (APPS). The average projected persons served per 1,000 population per year (APPS) is determined as follows:

APPS TY+3 = [(SUM PSCY TY+3 x 0.75)/(Statewide TY+3 P65O/ 1,000)] + [(SUM PSCY TY+3 x 0.25)/(Statewide TY+3 P64U/ 1,000)]

APPS TY+2 = [(SUM PSCY TY+2 x 0.75)/(Statewide TY+2 P65O/ 1,000)] + [(SUM PSCY TY+2 x 0.25)/(Statewide TY+2 P64U/ 1,000)]

APPS TY+1 = [(SUM PSCY TY+1 x 0.75)/(Statewide TY+1 P65O/ 1,000)] + [(SUM PSCY TY+1 x 0.25)/(Statewide TY+1 P64U/ 1,000)]

6. Statewide Average Comparative Value (SACV). The Statewide Average Comparative Value (SACV) is determined as follows:

SACV = [((APPS TY+3 x 3) + (APPS TY+2 x 2) + APPS TY+1)/6)] x 0.85

7. Projected Total Persons Served per 1,000 Population by County (PJPS). The Projected Total Persons Served per 1,000 Population by County, three (3) years into the future (PJPS), is determined as follows:

PJPS = [(PSCY TY+3 x 0.75)/(P65O TY+3/1,000)] + [(PSCY TY+3 x 0.25)/(P64U TY+3/1,000)]

8. Additional Persons Projected to Need Service to meet SACV Value by County (APNS). The Additional Persons Projected to Need Service to meet SACV value by County,

three (3) years into the future (APNS), is determined as follows:

APNS = (SACV – PJPS)/[(0.75 x (1,000/P65O TY+3)) + (0.25 x (1,000/P64U TY+3))]

(d) Need. Need, by County, based upon the above calculations, will be determined as follows:

If APNS ≥ 100, need for one (1) additional home health provider is shown in that county

If APNS ≤ 99, no need is shown for any additional home health providers in that county.

(e) Application Approval Limits. No more than one (1) application may be approved in any county showing a need for additional home health services during any approval cycle as defined by the Statewide Health Coordinating Council, or as implemented by SHPDA.

(f) SHPDA Review and Analysis of Utilization Data

During the effective time period of this Plan, SHPDA shall review and analyze existing utilization data to determine if the county should continue to be the planning area for Home Health services in the future or if a regional approach to planning for new Home Health services would be a more accurate means to determine need.

As part of such review, SHPDA shall also determine if a move to a regional planning model would present a detrimental impact on the delivery of services to patients and whether it would present a detrimental impact on existing providers.

Such review and analysis shall be made available to existing Home Health providers in the state, who shall be given an opportunity to provide testimony or written input to the SHCC based on upon the results.

(8) Criteria for Plan Adjustments

(a) The need, as determined by the methodology, is subject to adjustment by the SHCC as provided in Ala. Admin Code 410-2-5-.04, and the additional, specific criteria set forth below. An applicant seeking an adjustment has the burden of demonstrating extraordinary circumstances that result in the identified needs of a target population not being met by existing Home Health Providers, and not able to be met in a timely fashion through application of the methodology, based on each of the following:

1. Evidence that affected residents do not have access to necessary health services that can be met through application of the methodology. Accessibility refers to an individual's ability to make use of available health resources. Problems which might affect access to care include persons living in a county in which no Home Health provider has an existing office, lack of health manpower in certain counties, and individuals being without financial resources to obtain access to care;

2. Evidence of unique, area specific circumstances demonstrating that a plan adjustment would result in health care services being rendered in a more cost-effective manner. The SHCC, by adopting the need methodology herein, has determined that services in excess of those computed to be necessary are not cost-effective. Therefore, a party seeking a plan adjustment would have a high burden in establishing such circumstances; and

3. Evidence that a plan adjustment would result in improvements in the quality of health care delivered to residents in the proposed county.

(b) Applicants seeking an adjustment shall address, and the SHCC shall consider, the potential detrimental financial impact upon existing health care providers in the proposed county.

For a listing of Home Health Agencies or the most current statistical need projections in Alabama please contact the Data Division as follows:

MAILING ADDRESS
(U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025

STREET ADDRESS
(Commercial Carrier)
100 NORTH UNION STREET SUITE 870
MONTGOMERY AL 36104

TELEPHONE:
(334) 242-4103

FAX:
(334) 242-4113

E-Mail:
data.submit@shpda.alabama.gov

Website:
http://www.shpda.alabama.gov

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective 8, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Amended:** Filed January 8, 1997; effective February 12, 1997. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Repealed and New Rule:** Filed December 12, 2006; effective January 16, 2008. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Amended:** Filed February 10, 2015; effective March 17, 2015. **Repealed and New Rule:** Published March 31, 2020;

effective May 15, 2020. **Repealed and New Rule**: Published April 30, 2024; effective June 14, 2024.

410-2-4-.08 Inpatient Physical Rehabilitation.

(1) Definition. Inpatient physical rehabilitation services are those designed to be provided on an integrated basis by a multidisciplinary rehabilitation team to restore the disabled individual to the highest physical usefulness of which he is capable. These services may be provided in a distinct part unit of a hospital, as defined in the Medicare and Medicaid Guidelines, or in a free-standing rehabilitation hospital.

(2) General. Rehabilitation can be viewed as the third phase of the medical care continuum, with the first being the prevention of illness, the second, the actual treatment of disease, and the third, rehabilitation or a constructive system of treatment designed to enable individuals to attain their highest degree of functioning. In many cases, all three phases can occur simultaneously. For the purposes of this section of the State Health Plan, only the need for and inventory of inpatient rehabilitation beds will be addressed.

(3) Need Determination. The Statewide Health Coordinating Council (SHCC) has determined that there is a need for 15 rehabilitation beds per 100,000 population for each region.

(4) Planning Policies

(a) Planning Policy. Regional occupancy for the most recent reporting year should be at least seventy-five percent (75%) before the SHCC considers any requests for plan adjustments for additional bed capacity.

(b) Planning Policy. Conversion of existing hospital beds to rehabilitation beds should be given priority consideration over new construction when the conversion is significantly less costly, and the existing structure can meet licensure and certification requirements.

(5) Bed Availability Assurance

(a) Over the last three (3) years, on behalf of the SHCC, SHPDA has collected additional data from hospitals with Certificate of Need (CON) authority to operate inpatient rehabilitation beds and from skilled nursing facilities providing inpatient rehabilitation care. This data was collected specifically to review and analyze certain claims made before the SHCC by both groups related to the acuity levels of patients treated in each type of facility. This review and analysis was also to take into account the fact that certain patients can only be treated in one specific type of facility, while others can be treated in either based in large part on the patient’s diagnosis.

(b) SHPDA, working under the instruction of the Health Care Information and Data Advisory Council, and in cooperation with the Alabama Hospital Association (AlaHA) and the Alabama Nursing Home Association (ANHA), amended the annual reports for both facility types to collect additional data on the provision of inpatient rehabilitation services similar in nature to information submitted to the Centers for Medicare and Medicaid Services (CMS) for reimbursement. This data was collected for each of the last three (3) reporting years. SHPDA has reviewed and analyzed the data submitted and has reported the results of that analysis to the SHCC. This bed availability rule is the result of the analysis and recommendation provided to the SHCC by SHPDA, with additional comment and testimony from AlaHA, ANHA, and other interested parties.

(c)An inpatient rehabilitation facility (IRF), or an inpatient rehabilitation unit of an existing acute care hospital, shall qualify to add additional beds above and beyond any need projections shown in this plan should all of the following conditions be met. If any single condition is not met, any application filed to expand under this provision shall be deemed inconsistent with this Plan and shall be removed from the review cycle. For the purposes of this rule, all CON authorized inpatient rehabilitation beds shall be counted in the determination of the provider's occupancy rate.

1. The occupancy rate of the applicant shall have been a minimum of 80% for each of the two (2) most recent annual reporting periods as defined by SHPDA;

2. The acuity rate, a value derived by SHPDA using the same formulas and rules used by CMS to determine compliance with the "60% Rule", with the noted exception of those related to BMI (Body Mass Index), shall have been a minimum of 60% for each of the two (2) most recent annual reporting periods as defined by SHPDA; and

3. The average of the occupancy rate and the acuity rate shall be a minimum of 80% for each of the two (2) most recent annual reporting periods as defined by SHPDA.

4. For (i) through (iii) above, the condition defined shall need to have been met for each reporting period separately, and not as a combination of the two reporting periods together.

(d) Should all of the conditions listed in (c) above be met, the applicant may seek to add either 10% of their existing CON authorized bed capacity or up to 10 beds, whichever is greater. Any inpatient physical rehabilitation beds granted under this section shall only be added at or upon the existing campus of the applicant facility and cannot be sold or

transferred to another provider or location. The only exception to this rule is in the case of an IRF or acute care hospital with an inpatient rehabilitation unit applying for a Certificate of Need to relocate or otherwise create a replacement facility that is consistent with all other parts of this Plan. Furthermore, once beds are granted to a facility under this Bed Availability Assurance policy, no additional beds may be granted to that facility utilizing this policy for a minimum of two (2) years following initial ADPH licensure of those beds to allow for the impact of the addition of those beds to be shown.

(e) The provisions of Bed Availability Assurance shall not become effective until the first statistical update is published for inpatient rehabilitation beds following the effective date of this plan. Furthermore, the provisions of Bed Availability Assurance shall not apply in a region where need is shown for inpatient rehabilitation beds according to the methodology defined in (3) above

(6) The SHCC requires that the Data Council maintain any changes made to the Annual Reports filed by hospitals necessary to capture the data used by Medicare Administrative Contractors to determine presumptive compliance with the inpatient rehabilitation facility compliance threshold requirement, also known as the "60% Rule", including the diagnosis, comorbidities and impairment for each patient. The SHCC requires that the Data Council maintain any changes made to the Annual Reports filed by nursing homes to include comparable patient origin level data to allow for comparison between hospital and nursing home providers. The data supplied should continue to allow for an analysis of current utilization in such a manner as to reflect all inpatient rehabilitative services being offered, regardless of location or facility type, and should therefore be collected from both hospitals and nursing homes. The data collected should not only provide information related to occupancy rate but should also provide information related to the acuity of patients treated at each facility and should, as closely as possible, collect data that is similar in both type and format to allow for as accurate a comparison as possible, while representing as many patients receiving inpatient rehabilitation services as possible. The data collected by SHPDA shall allow for the Agency to produce an analysis of patients served in a manner consistent with the formulas and rules used by CMS to determine compliance with the "60% Rule", with the noted exception of the collection of data related to a patient's BMI (Body Mass Index), which has not been and will continue to not be collected by SHPDA. Further, this data should allow SHPDA to confirm the contention of an applicant for additional beds under section (5) above that they meet each of the individual conditions required to allow for the grant of additional beds under that section.

(a) Any IRF or acute care hospital that does not substantially comply with any data request made on behalf of SHPDA related to this section shall not be allowed to apply for additional beds under the provisions set forth in paragraph (5) above. Any such application shall be deemed to be inconsistent with this Plan.

(b) Any IRF, acute care hospital or nursing home that does not substantially comply with any data request on behalf of SHPDA related to this section shall not be allowed to oppose any application filed on behalf of an IRF or an acute care hospital for additional beds under the provisions set forth in paragraph (5) above.

(c) Such barriers to an application for a Certificate of Need, or inability to intervene or oppose an application for a Certificate of Need, shall be applied in a manner consistent with the provisions set forth in Ala. Admin Code r. 410-1-3-.11.

For a listing of inpatient rehabilitation facilities or the most current statistical need projections in Alabama you may contact the Data Division as follows:

MAILING ADDRESS
(U.S. Postal Service)
PO BOX 303025
MONTGOMERY, AL 36130-3025

STREET ADDRESS
(Commercial Carrier)
100 N. UNION STREET SUITE 870
MONTGOMERY, AL 36104

TELEPHONE:
(334) 242-4103

FAX:
(334) 242-4113

EMAIL:
data.submit@shpda.alabama.gov

WEBSITE:
http://www.shpda.alabama.gov

INPATIENT REHABILITATION BED REGIONS

REGION I	**REGION IV**	**REGION VI**
Lauderdale	DeKalb	Choctaw
Limestone	Etowah	Washington
Madison	Cherokee	Mobile
Jackson	Calhoun	Baldwin
Colbert	Cleburne	Escambia
Franklin	Clay	Conecuh
Lawrence	Randolph	Monroe
Morgan		Clarke
Marshall		
REGION II	**REGION V**	**REGION VII**
Lamar	Perry	Covington
Fayette	Marengo	Coffee

Pickens
Tuscaloosa
Sumter
Greene
Hale
Bibb

REGION III
Marion
Winston
Cullman
Blount
Walker
Jefferson
Shelby
Chilton
Coosa
Talladega
St. Clair

Wilcox
Dallas
Autauga
Lowndes
Butler
Crenshaw
Pike
Montgomery
Elmore
Macon
Bullock
Lee
Russell
Tallapoosa
Chambers

Dale
Geneva
Houston
Barbour
Henry

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective March 11, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended:** Filed June 30, 2006; effective August 4, 2006. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Amended:** Published June 30, 2020; effective August 14, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.09 Swing Beds.

(1) Definition. A swing bed is a licensed hospital bed that can be used for either a hospital or skilled nursing home patient. A swing bed program is authorized in Alabama to include hospitals that meet the criteria as specified in Federal laws and regulations. In accordance with the appropriate directive and this State Health Plan, a swing bed hospital must meet the following requirements:

(a) must meet the federal requirements addressing the facility size, location, and utilization factors;

(b) must have a valid provider agreement under Medicare;

(c) must meet the discharge planning and social services standards applicable to participating skilled nursing facilities;

(d) must not have a waiver for 24-hour nursing coverage;

(e) must be granted a Certificate of Need by the State Health Planning and Development Agency to provide skilled nursing facility services;

(f) any provider seeking to offer swing beds as a new service is limited to an initial allotment of ten (10) beds;

(g) Subject to the procedure provided in paragraph (2) below, each participating hospital is limited to twenty-five (25) swing beds;

(h) the average length of stay for swing bed patients must not exceed 30 days;

(i) beds authorized as swing beds will remain licensed as general hospital beds and be included in the general acute care inventory and bed need methodology;

(j) critical access hospitals shall be given special consideration in any application for a Certificate of Need for swing beds.

(2) A participating hospital may apply for additional swing beds if it can demonstrate an average occupancy rate for its existing swing beds greater than eighty percent (80%) for the most recent twelve (12) month period. That hospital may apply for no more than five (5) additional swing beds in any given twelve (12) month period, and its application cannot result in a total number of swing beds exceeding the maximum number set forth in paragraph (1) (g) above.

(3) Any hospital certified and operating as a Critical Access Hospital which is located in a county in which only one Nursing Home is licensed and providing service is not required to meet the occupancy rates in paragraph (2) but must adhere to all other requirements set forth in this section in order to apply for additional swing beds.

For a listing of hospitals with CON authorized swing beds contact the Data Division as follows:

MAILING ADDRESS	STREET ADDRESS
(U. S. Postal Service)	(Commercial Carrier)
PO BOX 303025	100 NORTH UNION STREET, SUITE 870
MONTGOMERY, AL 36130-3025	MONTGOMERY, AL 36104
TELEPHONE:	FAX:
(334) 242-4103	(334) 242-4113
EMAIL:	WEBSITE:
data.submit@shpda.alabama.gov	http://www.shpda.alabama.gov

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective May 18, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.10 Psychiatric Care.

(1) Background

(a) In the early 1990s, the Alabama Department of Mental Health and Mental Retardation developed a psychiatric bed need methodology that provided for an inventory of 37.1 beds per 100,000 population. Originally, the methodology was calculated using regions; however, in 2003 it was changed to reflect a statewide need methodology. Although the statewide need methodology was helpful in the early years to ensure access to care, it resulted in an uneven distribution of psychiatric beds, with higher concentrations of beds in some regions and shortages of psychiatric beds in other regions of the state.

(b) Over time, the number of psychiatric beds, both private beds and state beds, has declined. States have transitioned funding for mental health services from institutional care to community-based services, as state budgets have been cut and as more is known about the benefits of providing care in a non-institutional, community setting. Alabama mirrors these national trends, as it has closed three state facilities and downsized from 4,000 beds in 2009 to approximately 1,600 beds in 2017. In some areas, community-based services include crisis stabilization and access to timely follow-up care. In other areas, community resources may be limited, and those with psychiatric emergencies often present to a general acute care hospital emergency room for care; some of the more severely mentally ill remain for extended periods of time in private psychiatric facilities, waiting on a state bed to become available.

(2) Methodology

(a) Discussion. The Statewide Health Coordinating Council (SHCC) developed a proposal for a new methodology based on the increasing need for psych beds and a better distribution of those beds. Approved by the full SHCC, the purpose of this inpatient psychiatric services need methodology is to identify, by region and by bed type, the number of inpatient psychiatric beds needed to ensure the continued availability, accessibility, and affordability of quality inpatient psychiatric care for residents of Alabama. Only the SHCC, with the Governor's approval, can make changes to this methodology. The State Health Planning and Development Agency (SHPDA) staff shall annually update statistical information to reflect more current utilization through the Hospital Annual Survey.

(b) Bed Need Determined by Region and by Category of Bed. The new methodology is based upon the regional needs of the state as opposed to a statewide need methodology. It also addresses need based on the category of patients served in the beds being used; the bed categories include: 1. Child/Adolescent;

2. Adult; and 3. Geriatric. Calculation of beds needed will be based on utilization of those beds by category and by region as reported annually in the Hospital Annual Report. The Hospital Annual Report must be amended to accomplish the purposes of this new methodology. This new methodology will become effective after the certification by the Healthcare Information and Data Advisory Council of the first new Hospital Annual Report following the passage of this amendment. All providers will report their licensed beds, operating beds and patient days by inpatient psychiatric category each year via the new Hospital Annual Report. Operating beds may be the same as or fewer than the total number of licensed psychiatric beds. Providers with unrestricted psychiatric beds obtained prior to the effective date of this new methodology shall be allowed to change the categories of their beds during the first two reporting periods. The bed allocation by category reported on the third Hospital Annual Report following the passage of this amendment shall be considered final for operating beds. Thereafter, any permanent change to a different inpatient psychiatric bed category for an existing operating bed or beds will require the approval of a new CON. This requirement will not apply to licensed beds not currently in use; however, once beds are put into use, the provider will have to declare the category(ies) of the beds.

After this methodology becomes effective, applicants for new inpatient psychiatric beds will be required to select a category (Child/Adolescent, Adult, Geriatric) for which they are seeking inpatient psychiatric beds. Applicants may apply for more than one inpatient psychiatric category if a need is shown. See Section (3)(c), below regarding new beds.

Note: This new methodology is intended for planning purposes. The declaration of psychiatric beds by category on the Hospital Annual Report is not intended to preclude providers from using their psychiatric beds as necessary to address seasonal needs and surge situations. If a hospital determines that it needs to permanently change its psychiatric bed allocation, a new CON will be required. This new methodology, however, does not apply to pediatric specialty hospital providers, and is not intended: to preclude pediatric specialty hospital providers from using their pediatric specialty beds to provide pediatric psychiatric services, as necessary; to require such providers to report or declare via the SHPDA Hospital Annual Report their pediatric specialty beds used for pediatric psychiatric services as psychiatric beds, with related patient days, by inpatient category; or require such providers to obtain a CON for any new or additional use of their pediatric specialty beds for the provision of any pediatric specialty services, including pediatric psychiatric services.

(3) Planning Policies

(a) Planning on a Regional Basis. Planning will be on a regional basis. Please see attached listing for the counties in each region as designated by the SHCC.

(b) Planning Policies for applicants.

1. An applicant for an inpatient psychiatric bed must be either: 1) an established and licensed hospital provider that has been operational for at least twelve (12) months; or, 2) a new inpatient psychiatric hospital seeking a minimum of at least twenty (20) inpatient psychiatric beds. (Specialty, Free-Standing Psychiatric Hospitals must have at least twenty (20) inpatient beds pursuant to Rule 420-5-7-.03 Classification of Hospitals, found in Chapter 420-5-7 of the Alabama Department of Public Health Administrative Code.)

2. An applicant for inpatient psychiatric beds in a particular category must demonstrate the ability to comply with state law.

3. In Certificate of Need decisions concerning psychiatric services, the extent to which an applicant proposes to serve all patients in an area should be considered. The problem of indigent care should be addressed by Certificate of Need applicants.

(c) Applying for Additional beds. Applicants may apply for new psychiatric beds using one of the following occupancy need determinations:

1. Regional occupancy calculation.

Any region that shows an occupancy rate of 75 percent (75%) or greater in any one of the three (3) bed categories shall be eligible for additional beds in that category. The number of additional beds needed shall be calculated by dividing the average daily census for the region by the desired occupancy rate of 70 percent (70%) and then subtracting from this number the current beds in operation. Information for this calculation shall be obtained from the most recent Hospital Annual Report as compiled by SHPDA. Beds granted under the regional methodology shall be deemed part of the official regional bed inventory at time of issuance. See formula below:

To calculate regional occupancy:

Total patient days/(Beds operating x days in Reporting Period)

To calculate beds needed to get the region to 70 percent (70%) occupancy:

(i) (Total patient days/days in Reporting Period)/.70

= total beds needed for the region to have a 70 percent (70%) occupancy rate.

(ii) To calculate additional beds needed for the region:

Total beds needed to reach 70 percent (70%) occupancy rate minus current beds in operation.

The total patient days and the beds in operation used for the calculations shall come from the information reported to SHPDA through the most recent Hospital Annual Report.

The following is an example of how the regional methodology would be calculated if a single region had 25,000 adult patient days and 90 adult beds:

To calculate the regional occupancy:

25,000 adult days/(90 beds operating x days in Reporting Period) = 76% regional occupancy

To calculate beds needed to have a 70%t occupancy:

(25,000 adult days/days in Reporting Period)/.70 = 98 total beds needed for that occupancy level

Beds needed (98) minus current beds (90) = 8 additional adult beds needed for the region.

2. Individual Provider Occupancy Calculation.

If the average occupancy rate for a single facility within a region is 80 percent (80%) or greater for a continuous period of twelve (12) months in any of the three (3) bed categories, as calculated by the SHPDA using data reported on the most recent Hospital Annual Report, that facility may apply for up to 10 percent (10%) of its current bed capacity or six (6) beds, whichever is greater. An individual facility may demonstrate a need based on occupancy irrespective of the total occupancy for the region in that bed category. Information for this calculation shall be obtained from the most recent Hospital Annual Report as compiled by SHPDA.

Any beds obtained through the Individual Provider Occupancy Calculation shall not be included in the regional bed calculation for a period of three years after the beds are brought into service. After this three-year period the beds shall be included in the

regional count. Any provider obtaining beds through this provision shall not be eligible to use the 10 percent rule for 24 months from the date the CON is granted.

(4) Plan Adjustments. The psychiatric bed need for each region as determined by the methodology is subject to adjustments by the SHCC. The psychiatric bed need may be adjusted by the SHCC if an applicant can prove that the identified needs of a target population are not being met by the current bed need methodology.

For a listing of Hospitals providing inpatient psychiatric services or the most current statistical need projections in Alabama contact the Data Division as follows:

MAILING ADDRESS
(U. S. Postal Service)
PO BOX 303025
MONTGOMERY, AL 36130-3025

STREET ADDRESS
(Commercial Carrier)
100 N. UNION STREET SUITE 870
MONTGOMERY, AL 36104

TELEPHONE:
(334) 242-4103

FAX:
(334) 242-4113

EMAIL:
data.submit@shpda.alabama.gov

WEBSITE:
http://www.shpda.alabama.gov

Appendix A

Psychiatric Care Regions

North Central Region
Blount
Calhoun
Cherokee
Chilton
Clay
Cleburne
Coosa
DeKalb
Etowah
Jefferson
Randolph
Shelby
St. Clair
Talladega
Tallapoosa
Walker

Southeast Region
Autauga
Barbour
Bullock
Butler

North Region
Colbert
Cullman
Franklin
Jackson
Lauderdale
Lawrence
Limestone
Madison
Marshall
Morgan

Southwest Region
Baldwin
Clarke
Conecuh
Escambia
Mobile
Monroe
Washington

West Region

Chambers
Coffee
Covington
Crenshaw
Dale
Dallas
Elmore
Geneva
Henry
Houston
Lee
Lowndes
Macon
Montgomery
Pike
Russell
Wilcox
Bibb
Choctaw
Fayette
Greene
Hale
Lamar
Marengo
Marion
Perry
Pickens
Sumter
Tuscaloosa
Winston

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §§22-21-260(13), (15).
History: Effective April 23, 1991. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. Amended (SHP Year Only): Filed December 2, 2014; effective January 6, 2015. **Amended:** Filed June 21, 2018; effective August 5, 2018. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.11 Substance Use.

(1) Discussion

(a) The National Household Survey on Drug Abuse (NHSDA) estimated 22.2 million Americans age twelve (12) or older in 2012 were classified with dependence on or use of either alcohol or illicit drugs, a figure significantly higher than in 2000 – about 14.5 million. Most of these persons (14.9 million) were dependent on or used alcohol only. Another 2.8 million were dependent on or used both alcohol and illicit drugs, while 4.5 million were dependent on or used illicit drugs but not alcohol. Persons age eighteen (18) to twenty-five (25) had the highest rates of alcohol dependence or use (14.8%). (Source: www.samhsa.gov)

(b) There are more deaths and disabilities each year in the United States from Substance use than from any other cause. One-quarter of all emergency room visits, one-third of all suicides, and more than one half of all homicides and incidents of domestic violence are alcohol-related. (Source: www.ncadd.org)

(c) Alcohol and drug use costs the American economy an estimated $276 billion per year in lost productivity, health care expenditures, crime, motor vehicle crashes and other conditions. (Source: www.ncadd.org)

(2) Background

(a) Substance use services for treating individuals with substance use disorders or those who misuse substances is provided through an array of private and public providers throughout the state. The array of services ranges from inpatient medical detoxification services to residential treatment services to a variety of outpatient types of services including various affiliated support groups.

(b) In the past few years the technology for treating individuals with dependence and use problems has changed rather dramatically from a traditional inpatient/residential mode to outpatient treatment. This has occurred for a variety of reasons including financial considerations. These phenomena can be verified through analysis of current utilization of both inpatient and residential services.

(3) Methodology

(a) The Alabama Department of Mental Health (DMH) has developed a substance use bed need methodology, which is based upon a formula utilized in other states, commonly referred to as the “Mardin Formula”. This prevalence base formula was selected in lieu of utilization-based formulas due to the lack

of comprehensive statistical information on the current utilization of residential treatment centers. Calculation of needed beds is performed as follows:

(b) Step 1: Multiply the population ages 10-17 by 19%, which is the proportion assumed to have problems with chemical dependency;

(c) Step 2: Multiply the population ages 18 and over by 7%, which is the proportion assumed to have problems with chemical dependency;

(d) Step 3: Multiply the sum of steps 1 and 2 by 12%, which is the proportion who will seek treatment annually;

(e) Step 4: Multiply the product in step 3 by 60% which is the proportion of those seeking treatment who will require detoxification services for 3 days. Calculate total number of patient days;

(f) Step 5: Multiply those receiving detoxification services by 50%, which is the proportion who will need residential treatment for 10 days. Calculate total number of patient days;

(g) Step 6: Add the patient days in steps 4 and 5 to arrive at total patient days;

(h) Step 7: Divide by 365 to determine average daily census (ADC);

(i) Step 8: Divide by 80% occupancy to arrive at total needed beds;

(j) Step 9: Subtract existing public beds to arrive at total private bed need;

(k) Step 10: Subtract existing private beds to determine need or excess.

The Statewide Health Coordinating Council (SHCC) is aware that the Alabama Department of Mental Health (ADMH) currently utilizes multiple different classifications for residential and inpatient substance use treatment beds, differentiated based on the level, type and amount of medical care provided in each classification. It is the position of the SHCC that an accurate definition of substance use treatment beds for the purposes of health planning is required in order to be able to provide a more appropriate set of planning policies for these facilities moving forward. Therefore, the State Health Planning and Development Agency (SHPDA) is hereby directed to work with ADMH along with any interested parties to create a formal definition of substance use treatment beds, based on the classifications already utilized by ADMH, to determine which types of these beds would require a

Certificate of Need under current law. SHPDA shall, within one (1) year of the effective date of this plan, provide to the SHCC a definition of a substance use treatment bed that would require a Certificate of Need under current law as well as a proposed amendment to this section reflecting that definition. SHPDA is further directed to analyze the existing planning methodology established in this section utilizing the proposed definitions defined above to determine whether the methodology should be amended to more accurately and appropriately determine need for these providers in the state.

For a listing of Substance Use Treatment Centers or the most current statistical need projections in Alabama contact the Data Division as follows:

MAILING ADDRESS (U. S. Postal Service) PO BOX 303025 MONTGOMERY, AL 36130-3025	STREET ADDRESS (Commercial Carrier) 100 N. UNION STREET SUITE 870 MONTGOMERY, AL 36104
TELEPHONE: (334) 242-4103	FAX: (334) 2424-4113
EMAIL: data.submit@shpda.alabama.gov	WEBSITE: http://www.shpda.alabama.gov

(4) Methadone Treatment

(a) Definition. Methadone is an opioid agonist medication used to treat heroin and other opiate addiction. Methadone reduces the craving for heroin and other opiates by blocking receptor sites that are affected by heroin and other opiates.

(b) Background

1. Prior to June 1991 Alabama operated two methadone clinics in Birmingham and in Mobile, both of which were operated through a DMH contract. These clinics are part of the UAB Mental Health Center and the Mobile Mental Health Center. The average number of clients served in any given month never exceeded 380 of which fewer than 5% were clients from out of state.

2. As of April 2015, Alabama has twenty-two (22) certified methadone treatment programs.

(c) Recommendations

1. A methadone treatment program should provide adequate medical, counseling, vocational, educational, mental health assessment, and social services to patients enrolled in the opioid treatment program with the goal of

the individual becoming free of opioid dependency, with oversight by the Alabama Department of Mental Health.

2. The Methadone Advisory Committee suggests the following information be submitted with Certificate of Need applications:

(i) The number of arrests for the previous year regarding the sale and possession of opioids by county for the area to be served.

(ii) Data from the Medical Examiner regarding all deaths related to overdose from opioids by county for the area to be served during the previous year.

(iii) Data from all hospital emergency rooms regarding the number of persons diagnosed and treated for an overdose of opioids by county for the area to be served.

(iv) The number of clients within specific geographic areas who, out of necessity, must travel in excess of 50 miles round-trip for narcotic treatment services.

(v) The name and number of existing narcotic treatment programs within 50 miles of the proposed site.

(vi) Number of persons to be served by the proposed program and the daily dosing fee.

(vii) Applicant shall submit evidence of the ability to comply with all applicable rules and regulations of designated governing authorities.

(d) Need

1. Basic Methodology

(i) The purpose of this need methodology is to identify, by region, need for additional treatment facilities to ensure the continued availability, accessibility, and affordability of quality opioid replacement treatment services for residents of Alabama.

(ii) A multi-county region shall be the planning area for methadone treatment facilities. A listing of the counties in each region is attached as part of this section. These were derived from the regions used by the Alabama Department of Mental Health (ADMH), Division of Mental Health and Substance Abuse Services.

(iii) The Center for Business and Economic Research, University of Alabama, (CBER) population data shall be used in any determination of need for methadone treatment facilities in Alabama.

(iv) Data from the National Survey on Drug Use and Health (NSDUH) shall be used in the calculation of national rates of dependency on heroin or prescription pain relievers in Alabama.

(v) Data from ADMH shall be used in the determination of the number of current patients seen by each clinic within a region. ADMH shall supply, on an annual basis, an Annual Report to SHPDA with rates of prevalence, service utilization and epidemiological data to assist with implementation of the methodology and publication of statistical updates to this plan.

(vi) For each region, need shall be calculated using the following methodology:

(I) For each county in the region, list the population, ages 18 and over, as reported by CBER, for the year matching the year for which need is being projected.

(II) Using NSDUH data for the same time period, determine the rate of dependency on heroin and prescription pain relievers nationally.

(III) For each county in the region, multiply the population from step (I) above by the dependency rate in step (II) above to determine the projected number of residents in that county addicted to heroin or prescription pain relievers.

(IV) Multiply the estimate from step (III) above by 20% (0.2) to determine the projected number of residents of that county likely to seek Medication Assisted Therapy for opioid dependency.

(V) Add the county totals determined in step (IV) above to determine the regional totals.

(VI) Using data supplied by ADMH, determine the current census of each treatment center in the region on the last day of the year matching the year of population and NSDUH dependency data used in step (I) and step (II) respectively.

(VII) Add the facility census totals determined in step (VI) above to determine regional totals.

(VIII) If the number of residents projected to seek treatment in a region as determined in step (V) is greater than the current census of all treatment centers in the region as determined in step (VII) by more than 10%, a need shall be shown for a new methadone treatment facility in that region.

(IX) Only one methadone treatment facility may be approved in any region showing a need under this methodology during any application cycle, defined here as the period of time between the date of publication of one statistical update and the date of publication of a successive update.

(X) Upon the issuance of a Certificate of Need for a new methadone treatment facility in a region, no additional CONs shall be issued for the development of a new methadone treatment facility in that region for a period of eighteen (18) months to allow for the impact of a new provider in the region to be shown and reflected in the next statistical update.

2. The provisions of subsection 1 above shall not prohibit the grant of a Certificate of Need for the relocation and replacement of an existing methadone treatment facility within the same planning region.

3. All methadone clinic applications shall be site specific. No CON shall be granted for a new methadone treatment facility to be located within fifty (50) linear miles of an existing methadone treatment facility.

(e) Adjustments. Need for additional methadone treatment facilities, as determined in subsection 1 above, is subject to adjustment by the SHCC as provided below. The SHCC may adjust the need for a new methadone treatment facility only upon demonstration of one or more of the following conditions listed in 1 through 3 below. Applicants seeking an adjustment under this section shall include, as part of the application, supporting documentation from ADMH.

1. The opioid-related arrest or death rate in the region exceeds the national average, and there are no methadone treatment facilities within fifty (50) miles of the county for which the proposed adjustment applies.

2. Hospital emergency room admissions for opioid-overdose related conditions in the region exceed the national

average, and there are no methadone treatment facilities within fifty (50) miles of the county for which the proposed adjustment applies.

3. Admissions to drug-free programs specifically treating opioid dependency in the region exceed the national average, and there are no methadone treatment facilities within fifty (50) miles of the county for which the proposed adjustment applies.

(f) Preference for Indigent Patients. In considering CON applications filed under this section, whether pursuant to the regular need methodology or an adjustment, preference shall be given to those applicants demonstrating the most comprehensive plan for treating patients regardless of their ability to pay.

Methadone Treatment Facility Regional County Listings

Region I	**Region II**	**Region III**	**Region IV**
Cherokee	Bibb	Autauga	Baldwin
Colbert	Blount	Bullock	Barbour
Cullman	Calhoun	Chambers	Butler
DeKalb	Chilton	Choctaw	Clarke
Etowah	Clay	Dallas	Coffee
Fayette	Cleburne	Elmore	Conecuh
Franklin	Coosa	Greene	Covington
Jackson	Jefferson	Hale	Crenshaw
Lamar	Pickens	Lee	Dale
Lauderdale	Randolph	Lowndes	Escambia
Lawrence	Shelby	Macon	Geneva
Limestone	St. Clair	Marengo	Henry
Madison	Talladega	Montgomery	Houston
Marion	Tuscaloosa	Perry	Mobile
Marshall		Pike	Monroe
Morgan		Russell	Washington

Walker	Sumter
Winston	Tallapoosa
	Wilcox

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective April 23, 1991. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended:** Filed August 16, 2012, effective September 20, 2012. **Amended:** Filed November 20, 2013; effective December 25, 2013. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Amended:** Filed September 9, 2015; effective October 14, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.12 Ambulatory Surgery.

(1) Discussion. An evolution in the provision of surgical care provided in ambulatory surgery centers has taken place. As a result of cost containment measures and advances in medical technology, many surgical procedures which previously required inpatient care (both before and after the procedures) are now done on an outpatient basis.

(2) Definitions. For the purposes of this section, the following definitions shall be used:

(a) Ambulatory Surgery Center (ASC) – a health care facility, licensed by the Alabama Department of Public Health, with the primary purpose of providing medically necessary or elective surgical care on an outpatient basis and in which the patient stays less than 24 hours. Excluded from this definition are the offices of private physicians and dentists, including those organized as professional corporations, professional associations, partnerships, or individuals in sole proprietorship. Also excluded from this definition are health care facilities licensed as hospitals.

(b) Hospital-owned Ambulatory Surgery Center (HASC) – a facility either owned and operated exclusively by an existing acute care hospital or where the hospital holds majority ownership in conjunction with other entities and which is operated as a separately licensed entity distinct from the hospital, containing operating rooms which are solely and exclusively used for the provision of outpatient surgical services that, due to licensure, practice standards or other reasons, are not performed in a physician’s office or in an office-based lab (OBL).

(c) Hospital Surgical Department (HSD) – operating rooms specifically designated by a hospital for performing surgical procedures, on an inpatient, outpatient, or “mixed-use” basis.

(d) Multi-Specialty Ambulatory Surgery Center (MASC) – an ASC established for the provision of outpatient surgical procedures in a variety of specialties. MASCs allow for physicians from multiple disciplines to perform surgical procedures in a centralized location that, due to licensure, practice standards or other reasons, are not performed in a physician’s office or in an office-based lab (OBL).

(e) Operating Room – rooms used for the performance of surgical procedures requiring one or more incisions and which must comply with licensure standards for an operating room. Operating Rooms are not to include procedure rooms.

(f) Procedure Room – rooms designated for the performance of special procedures that do not require a restricted environment and are not considered to be operating rooms.

(g) Single-Specialty Ambulatory Surgery Center (SASC) – an ASC established for the provision of outpatient surgical procedures of a single specialty only. SASCs allow for surgical procedures to be performed that, due to licensure, practice standards or other reasons, are not performed in a physician's office or in an office-based lab (OBL).

(3) **Purpose**

(a) The purpose of this need methodology is to identify the number of Ambulatory Surgery Center operating rooms needed at least three (3) years into the future to assure the continued availability of quality ambulatory surgical care for the residents of the state of Alabama. Such number, as identified later in this section, shall be the basis for statewide health planning and certificate of need approval, except:

1. In circumstances that pose a threat to public health, and/or

2. When the SHCC makes an adjustment based on criteria specified later in this section

(4) **Planning Policies.** For the purposes of this section, the following planning policies shall apply regarding the provision of ambulatory surgical services:

(a) The methodology in (5) below shall not apply to the expansion of an existing HSD, nor shall it apply to any hospital seeking to establish an outpatient surgical department internal to the existing hospital.

(b) The methodology in (5) below shall not apply to any hospital seeking to convert up to four (4) of its existing operating rooms in a HSD for use in the creation of a HASC, provided that said conversion does not seek to add any additional operating rooms to its existing complement as reported to SHPDA on the Annual Report for Hospitals and Related Facilities for the most recent reporting period. However, the methodology in (5) below shall apply if the applicant seeks to add additional rooms to its existing complement, as reported, as a part of any conversion. Any application to create a new HASC through the conversion of existing HSD rooms shall only be allowed in the same county in which the HSD is currently located. Once a Certificate of Need is issued related to the conversion of the operating rooms in a HSD to a HASC, those rooms will be counted as a part of the CON authorized inventory for the purposes of future statistical updates to this plan. Once CONs are issued for the

conversion of the maximum number of operating rooms allowed to be converted through the use of this policy, that hospital shall not qualify to apply to convert additional operating rooms through the use of this policy for a minimum of twenty-four (24) months following the licensure by the Alabama Department of Public Health of all facilities created by that applicant through this policy to allow for the impact of any new ASC created through this policy to be shown.

1. Any ORs converted using this policy shall be removed from the hospital inventory upon licensure of any ASC established through this policy by ADPH. These converted ORs shall not be reopened by the hospital after licensure of the ASC created under this policy unless and until additional action is taken by the hospital, either through the granting of a CON or a determination by SHPDA that the reopening of said converted ORs is not reviewable under CON law.

2. Furthermore, any applicant seeking to establish a HASC through the use of this provision shall affirm, as a part of their application, that the hospital shall maintain majority ownership of the HASC for a minimum of five (5) years following its initial licensure to ensure financial viability for the project.

(c) The methodology in (5) below shall apply to any hospital seeking to construct and/or operate a HASC that is not to be created through the conversion of operating rooms in an existing HSD.

(d) An HASC created through these planning policies shall be considered a MASC once established, and the methodology in (5) below shall apply to any existing HASC seeking to expand through the addition of new operating rooms.

(e) The methodology in (5) below shall not apply to any applicant seeking to establish a new SASC consisting of no more than four (4) operating rooms. The methodology in (5) below shall apply, however, to any operating rooms beyond the four (4) allowed under this policy. Applicants seeking to establish a new SASC consisting of no more than four (4) operating rooms shall need to provide, as part of their application, evidence that the SASC is needed in the service area. Once a Certificate of Need is issued related to the establishment of a SASC, those rooms will be counted as a part of the CON authorized inventory for the purposes of future statistical updates to this plan.

(f) The methodology in (5) below shall not apply to any applicant seeking to convert an existing SASC into either a MASC or a SASC of a different specialty without adding additional operating rooms, but shall apply to any applicant

seeking to establish a new MASC, to expand an existing MASC, or to an applicant seeking to convert an existing SASC into a MASC that also seeks to add additional operating rooms. Any provider seeking to convert an SASC either to a MASC or to a SASC of a different specialty shall still be required to file for a CON even if the applicant does not seek to add additional operating rooms to its existing CON authorized capacity.

(g) Irrespective of (a)-(f) above, any applicant seeking to offer any service listed elsewhere in this plan which contains its own statistical need methodology or planning policies shall be required to adhere to the need criteria of that section in addition to the need criteria established in this section.

(h) An application for a Certificate of Need for an ambulatory surgical center that is exempt from the methodology in (5) below shall remain subject to the remaining criteria set forth in Alabama's Certificate of Need laws and regulations.

(i) While reviewing any application for the construction of a new Ambulatory Surgery Center, the Certificate of Need Review Board shall consider the physical location of the proposed new ASC in relation to any existing health care facilities in the same planning area to determine whether the proposed new location would create a detrimental impact upon existing providers that might negatively impact the provision of care to existing patients.

(j) The methodology in (5) below shall not apply to any applicant seeking to create or add procedure rooms to an existing facility or to create an ambulatory surgery center that only consists of procedure rooms. Any applicant seeking to create or add procedure rooms shall, in the alternative, provide as a part of any application evidence that the additional rooms are necessary for the delivery of quality outpatient surgical care to patients.

(5) Methodology

(a) The county shall be the planning area for the determination of need for additional outpatient surgery rooms in Ambulatory Surgery Centers.

(b) For the purposes of this methodology, only those ORs utilized and patient cases treated in Ambulatory Surgery Centers shall be used. ORs utilized and patient cases treated at any other location shall not be included as a part of this methodology.

(c) No application for the establishment of a new MASC shall be approved for fewer than four (4) operating rooms to allow

for the financial feasibility and viability of a project. Need may be adjusted, therefore, by the Agency for any county currently showing need of more than zero (0) but fewer than four (4) operating rooms to a total of four (4) operating rooms, but only in the consideration of an application for the construction of a new facility in that county, and in situations in which no MASC currently exists in that county. Need shall not be adjusted in consideration of an application involving the expansion of an existing MASC or SASC, nor shall it be adjusted in consideration of an application involving the creation of a new MASC in a county wherein a MASC already exists.

(d) For the purposes of this methodology, the following values will be used to perform the necessary calculations: Average Time of Outpatient Surgery – 1.5 hours; Average Hours of Operation – 8 hours/day 5 days/week, 50 weeks/year; Maximum Cases per OR in one year – 1,350.

(e) In counties in which an existing CON Authorized ASC already exists, need shall be shown for additional Ambulatory Surgery Center operating rooms should the average number of cases per room in the county projected three (3) years from the most recent reported year and considering the growth of population of that county over the three (3) year planning horizon exceed 70% of the maximum, or 945 operations/room/ year. Should a need for additional operating rooms be determined, the need shall be the total number of operating rooms required to decrease the average number of cases per room in the county to 70%, or 945 cases/room/year.

(f) In counties in which an existing CON Authorized ASC does not exist, need shall be shown for Ambulatory Surgery Center operating rooms based upon the projected number of cases for residents of that county in ASC's located elsewhere and the growth in population of that county over a three year planning horizon. The total number of operating rooms shown to be needed will be that number required to sustain a utilization rate of 70%, or 945 cases/room/year.

(g) Need for new operating rooms/suites shall be determined using the following formula:

$$\text{County Net OR need} = \left(\frac{\left(\frac{(Y1 * 3) + (Y2 * 2) + Y3}{6} \right) * \left(\frac{P3}{P1} \right)}{945} \right) - \text{Existing County ORs}$$

*For counties with existing ASCs:

Y1 = total operations, ASCs in county, current reporting year

Y2 = total operations, ASCs in county, current reporting year – 1

Y3 = total operations, ASCs in county, current reporting year – 2

*For counties without existing ASCs:

Y1 = total operations, county residents in ASCs, current reporting year

Y2 = total operations, county residents in ASCs, current reporting year – 1

Y3 = total operations, county residents in ASCs, current reporting year – 2

P1 = current reporting year's population as projected by CBER[1]

P3 = population 3 years from current reporting year as projected by CBER

** Due to the impact of COVID-19 on the delivery of ambulatory surgical services, the SHCC, in consultation with the Health Care Information and Data Advisory Council, has determined that data from the 2020 reporting period shall NOT be utilized in the determination of need for additional ASC operating rooms. SHPDA is hereby directed to omit FY2020 data, if necessary, and utilize FY2019 data in its place.

Once a CON is issued for the provision of ASC services in a county in which an ASC did not previously exist, or should all ASCs in a county cease to operate AND lose CON authority, the appropriate methodology shall be applied on the next issued statistical update.

(h) The current need for additional operating rooms/suites can be found as a statistical update to this section

(i) Additional need may be shown in situations involving a sustained high utilization rate for a single facility in a county. An applicant may apply for additional ORs, and thus the establishment of need above and beyond the standard methodology, utilizing one of the following two policies. A provider obtaining a Certificate of Need under either of the two following policies may not submit another application under either such policy for a period of twenty-four (24) months following the date the additional ORs are licensed/ become operationalized to allow for the impact of those additional ORs to be shown.

1. If the utilization rate for an ASC is greater than 80% for each of the two (2) most recent "Annual Report(s) for Ambulatory Surgery Centers" published by or filed with SHPDA, an additional need of the greater of either ten percent (10%) of the current total CON authorized OR capacity of that provider, or four (4) total ORs may be approved for the expansion of that facility, irrespective of the total utilization rate of ASC ORs of the county over that time period.

2. If an ASC is seeking to add the services of additional surgeons treating cases in a service line not currently offered at that ASC, an additional need of the greater of either ten percent (10%) of the current total CON authorized OR capacity of that provider, or four (4) total ORs, may be approved for the expansion of that facility, irrespective of the total utilization rate of ASC ORs of the county over that time period. However, these additional ORs may be added ONLY if the projected number of additional cases to be treated in this new service line for the first two (2) years following implementation of the service would cause the utilization rate of the existing ORs at that facility to increase to 80% or higher according to the calculations used to determine utilization rate as defined above.

As a part of any application seeking to expand based upon this specific policy, additional information shall be submitted showing both the current volume of cases treated by the additional surgeons currently at any other surgery locations for the previous two (2) years along with the current volume of cases treated by the ASC seeking expansion for the previous two (2) years AND the projected number of cases to be treated at the ASC for the first two (2) years following implementation of the new service line. No application shall be accepted under this policy in which the underlying utilization data for the previous two (2) years OR the projected number of cases for the first two (2) years following implementation of the new service does not support a projected utilization rate of the existing ORs at that ASC of 80% or greater for the first two (2) years following implementation of the new service line.

(j) Any ASC or Hospital that does not substantially comply with any data request made on behalf of SHPDA shall not be allowed to apply for a Certificate of Need under any provision in this section of the Plan, nor shall they be allowed to intervene in or oppose any application filed on behalf of another ASC or Hospital under any provision in this section of the Plan. Such barriers to an application for a Certificate of Need, or inability to intervene or oppose an application for a Certificate of Need, shall be applied in a manner consistent

with the provisions set forth in Ala. Admin. Code r. 410-1-3-.11.

(k) The SHCC finds that a minimum of three (3) years is needed to evaluate the effectiveness of the need methodology in this section. To facilitate such review:

1. On the date this new methodology becomes effective, SHPDA shall memorialize the total number of ambulatory surgery centers, including both single- and multi-specialty, and the total number of outpatient surgery rooms including all hospitals, HASCs, SASCs, and MASCs for future use. This memorialization shall also be used by SHPDA to establish and maintain the CON authorized OR capacity for each ambulatory surgery center currently licensed and operational, as well as all CON projects still active and under development, which will establish the existing state inventory of CON authorized ORs for the purposes of this methodology moving forward.

2. SHPDA shall consult with the Health Care Information and Data Advisory Council to make such amendments to the existing Annual Report for Ambulatory Surgery Centers as needed to more accurately determine the utilization of ASCs as defined by the methodology in this section. The SHCC specifically requests that any amendments to the existing Annual Report for Ambulatory Surgery Centers include the collection of additional information related to the amount of available time for all operating rooms at a facility and the total amount of surgical time (including any necessary preparatory or clean-up) the operating rooms at a facility are in use, as well as a specific breakdown of cases treated in operating rooms versus cases treated in procedure rooms.

3. SHPDA shall compile and summarize the information for the three-year period defined above, and shall provide a report to the SHCC showing the growth or decline in outpatient surgery rooms, HASCs, SASCs, and MASCs and in the total number of outpatient surgeries/procedures performed in these locations. SHPDA shall identify potential causes for such changes including population and demographic changes. Such information shall also be distributed to any interested parties, which shall be given an opportunity to provide testimony or written input to the SHCC regarding the impact of the methodology.

4. As part of the analysis of the impact of this new methodology, SHPDA shall review the number of cases in which patients travel outside of their county of residence to receive services. This information shall be used by SHPDA to provide to the SHCC information allowing

for future discussions related to both the ability for an HASC to be created in a contiguous county of an existing hospital and whether the county is the appropriate planning area for ASCs. Furthermore, SHPDA shall specifically review the information collected regarding the total time available for surgeries in operating rooms and the total time the operating rooms are in use to determine if this would be a more accurate mechanism to determine need for additional operating rooms under the utilization exemption defined in (5)(i) above. Such information shall also be distributed to any interested parties, which shall be given an opportunity to provide testimony or written input to the SHCC regarding this analysis as part of those discussions.

5. Following receipt of such input, SHCC shall review the methodology to consider any needed changes.

(6) Criteria for Plan Adjustments

(a) The need, as determined by the methodology, is subject to adjustment by the SHCC as provided in Ala. Admin Code 410-2-5-.04, and the additional, specific criteria set forth below. An applicant seeking an adjustment has the burden of demonstrating extraordinary circumstances that result in the identified needs of a target population not being met by existing ambulatory surgery providers, and not able to be met in a timely fashion through application of the methodology, based on each of the following:

1. Evidence that affected residents do not have access to necessary health services that can be met through application of the methodology. Accessibility refers to an individual's ability to make use of available health resources. Problems which might affect access to care include persons living more than thirty (30) minutes travel time from a facility providing ambulatory surgical services, lack of health manpower in certain counties, and individuals being without financial resources to obtain access to care;

2. Evidence of unique, area specific circumstances demonstrating that a plan adjustment would result in health care services being rendered in a more cost-effective manner. The SHCC, by adopting the need methodology herein, has determined that services in excess of the number computed to be needed are not cost-effective. Therefore, a party seeking a plan adjustment would have a high burden in establishing such circumstances; and

3. Evidence that a plan adjustment would result in improvements in the quality of health care delivered to residents in the proposed county.

(b) Applicants seeking an adjustment shall address, and the SHCC shall consider, the potential detrimental financial impact on existing health care facilities in the proposed county.

(7) Inventory of Existing Resources. For a listing of Ambulatory Surgery Centers contact the Data Division as follows:

MAILING ADDRESS	**STREET ADDRESS**
(U. S. Postal Service)	(Commercial Carrier)
PO BOX 303025	100 NORTH UNION STREET, SUITE 870
MONTGOMERY, AL 36130-3025	MONTGOMERY, AL 36104
TELEPHONE:	FAX:
(334) 242-4103	334) 242-4113
EMAIL:	WEBSITE:
data.submit@shpda.alabama.gov	http://www.shpda.alabama.gov

---

[1] Centers for Business and Economic Research, University of Alabama

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: **New Rule:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.13 Renovations.

(1) Renovation is defined as a project for modernization, improvement, alteration and/or upgrading of an existing physical plant and/or equipment. Renovation does not include the modernization or construction of a non-clinical building, parking facility, or any other non-institutional health services capital item on the existing campus of a health care facility, provided that construction or modernization does not allow the health care facility to provide new institutional health services subject to review and not previously provided on a regular basis.

(2) Planning Policies

(a) The applicant must demonstrate that the proposed renovation is the most cost effective or otherwise most appropriate alternative to provide patients with needed health care services and/or facility improvements.

(b) The applicant must provide evidence that the proposed square footage, construction cost per square foot, and cost of fixed equipment is appropriate and reasonable for the types and volumes of patients to be served.

(c) The applicant must demonstrate how the disruption of normal operations will be minimized during the period of construction.

(3) Needs Assessment.

(a) For the renovation of a health care facility an applicant must submit significant evidence of need for the project. Evidence of need for the project should include, but is not limited to, one or more of the following:

1. The service being provided by the applicant requires additional space or the facility requires renovation to meet minimum licensure and certification requirements.

2. There are operating problems which can best be corrected by renovation of the existing facility.

3. The renovation will correct deficiencies that place the health and safety of patients and/or employees at significant risk.

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: New Rule: Filed May 14, 1997; effective June 18, 1997. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.14 Replacements.

(1) Replacement is defined as a project for the erection, construction, creation or other acquisition of a physical plant or facility where the proposed new structure will replace an existing structure and will be located in the same planning area and market area. Replacement does not include the modernization or construction of a non-clinical building, parking facility, or any other non-institutional health services capital item on the existing campus of a health care facility, provided that construction or modernization does not allow the health care facility to provide new institutional health services subject to review and not previously provided on a regular basis.

(2) Planning Policies

(a) The applicant must demonstrate that the proposed replacement is the most cost effective or otherwise most appropriate alternative to provide patients with needed health care services and/or facility improvements.

(b) The applicant must provide evidence that the proposed square footage, construction cost per square foot, and cost of fixed equipment is appropriate and reasonable for the types and volumes of patients to be served.

(c) The applicant for the proposed replacement must be the same as the owner of the facility to be replaced.

(3) Needs Assessment

(a) For replacement of a health care facility an applicant must submit significant evidence of need for the project. Evidence of need for the project should include, but is not limited to, one or more of the following:

1. The existing structure requires replacement to meet minimum licensure and certification requirements.

2. There are operating problems, which can best be corrected by replacement of the existing facility.

3. The replacement of the existing structure will correct deficiencies that place the health and safety of patients and/or employees at significant risk.

(b) For replacement of hospitals, the occupancy rate for the most recent annual reporting period should have been at least 60%. If this occupancy level was not met, the hospital should agree to a reduction in bed capacity that will increase its occupancy rate to 60 percent. For example, if a 90-bed hospital had an average daily census (ADC) of 45 patients, its occupancy rate was 50%. (The ADC of 45 patients divided by 90

beds equals 50 percent). To determine a new bed capacity that would increase the hospital's occupancy rate to 60%, divide the ADC of 45 patients by 0.60 (a fraction of a bed should be rounded upward to the next whole bed). The hospital's new capacity should be 75 beds, a 15 bed reduction to its original capacity of 90 beds.

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: New Rule: Filed May 14, 1997; effective June 18, 1997. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.15 Inpatient Hospice Services.

(1) Discussion

(a) Hospice care is a choice made to enhance end of life. Hospice focuses on caring and comfort for patients and not curative care. In most cases, care is provided in the patient's place of residence.

(b) It is the intent of this section to address health planning concerns relating to hospice services provided on an inpatient basis. For coverage of hospice services provided primarily in the patient's place of residence, please see Section 410-2-3-.10.

(c) A hospice program is required by federal statutes as a Condition of Participation for hospice care (Title 42- Public Health; Chapter IV – CMS, Department of Health and Human Services; Part 418 – Hospice care; Section 418.98 or successors) and state statutes and regulations (Alabama State Board of Health, Department of Public Health; Administrative Code, Chapter 420-5-17; Section 420-5-17-.01 or successors) to provide general inpatient level of care and inpatient respite level of care as two of the four levels of hospice care. As per the Medicare Condition of Participation (418.108), the total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed twenty percent (20%) of the total number of hospice days consumed in total by this group of beneficiaries.

(d) A hospice program per federal statute must provide the inpatient levels of care that meets the conditions of participation specified. The approved locations for inpatient hospice care are a hospital, a skilled nursing facility ("SNF"), or an inpatient hospice facility.

(e) A hospice program may provide the inpatient levels of care in a freestanding inpatient facility/unit which the hospice program owns and manages; through beds owned by either a hospital or a skilled nursing facility ("SNF") but leased and managed by a hospice program; or through contracted arrangements with another hospice program's inpatient facility/unit.

(2) Definitions

(a) All definitions included in Section 410-2-3-.10 are incorporated herein by reference.

(b) Inpatient hospice facility. An "Inpatient Hospice Facility" is defined as a freestanding hospice facility or a designated unit, floor or specific number of beds located in a

skilled nursing facility or hospital leased or under the management of a hospice services provider.

(c) General Inpatient Level of Care. The general inpatient ("GIP") level of hospice care is intended for short term acute care for pain control and symptomatic management. It is not intended for long term care, residential or rehabilitation.

(d) Inpatient Respite Level of Care. The inpatient respite level of care is limited per Medicare and Medicaid to a maximum of five (5) days per episode for the purpose of family respite.

(3) Availability and Accessibility

(a) Hospice services must be obtainable by all of the residents of the State of Alabama.

(b) Physicians and other referral sources may be unfamiliar with the total scope of services offered by hospice; accessibility may be limited due to lack of awareness. Every provider should provide an active community informational program to educate consumers and professionals to the availability, nature, and extent of their hospice services provided.

(c) In order for a SNF to provide the inpatient levels of care for hospice patients, the SNF must meet the standards specified by CMS regarding items such as required staffing of facilities.

(d) Hospice agencies are limited in establishing contracts with hospitals for the inpatient levels of care. This is due to (a) the increased number of hospice providers that request contracts from the same hospitals in the same service areas; and (b) the reimbursement hospitals receive from the hospice providers for the hospice inpatient levels of care.

(4) Inventory

(a) The establishment of an inpatient hospice facility does not eliminate the need for contractual arrangements with hospitals or SNF for inpatient levels of care. If the inpatient hospice facility is at full capacity and a hospice patient is eligible for/requires inpatient care, the hospice remains responsible to provide that level of care at a contracted facility.

(5) Quality

(a) Quality is that characteristic which reflects professionally and technically appropriate patient services. Each provider must establish mechanisms for quality assurance,

including procedures for resolving concerns identified by patients, physicians, family members, or others in patient care or referral. Providers should also develop internal quality assurance and grievance procedures.

(b) Providers are encouraged to achieve a utilization level which promotes the most cost effective service delivery.

(c) Hospice programs are required to meet the most stringent or exceed the current Medicare Hospice Conditions of Participation, as adopted by CMS, and codified in the Code of Federal Regulations, along with State Licensure Regulations of the Department of Public Health.

(6) Inpatient Hospice Facility Need Methodology

(a) Purpose. The purpose of this inpatient hospice services need methodology is to identify, by region, the number of inpatient hospice beds needed to assure the continued availability, accessibility, and affordability of quality of care for residents of Alabama.

(b) General. Formulation of this methodology was accomplished by a committee of the Statewide Health Coordinating Council (SHCC). The committee, which provided its recommendations to the SHCC, was composed of providers and consumers of health care, and received input from hospice providers and other affected parties. Only the SHCC, with the Governor’s final approval, can make changes to this methodology, except that SHPDA staff shall annually update statistical information to reflect more current population and utilization. Adjustments are addressed in paragraph (e) below.

(c) Basic Methodology

1. The purpose of this need methodology is to identify, by region, the number of inpatient hospice beds needed to assure the continued availability, accessibility, and affordability of quality hospice care for residents of Alabama.

2. The need methodology shall be calculated by aggregating the reported average daily censuses (ADC) for all licensed hospices in the designated Region, as reported annually to SHPDA, and multiplying that aggregate regional ADC by 3%. The resulting figure shall be the regional need.

3. Any increase in regional need shall be limited to no more than five percent (5%) per year with the sole exclusion of any need determined under Planning Policy 7 of this section.

(d) Planning Policies

1. Planning will be on a regional basis. The attached listing defines the regional descriptions designated by the SHCC.

2. An applicant for an inpatient hospice facility must be an established and licensed hospice provider and operational for at least thirty-six (36) months in Alabama.

3. An applicant for an inpatient hospice facility must demonstrate the ability to comply with Medicare/Medicaid regulations.

4. An applicant for an inpatient hospice facility must demonstrate that existing inpatient hospice beds in the region cannot meet the community demand for inpatient hospice services.

5. An applicant for an inpatient hospice facility must demonstrate that sharing arrangements with existing facilities have been studied and implemented when possible.

6. An applicant for an inpatient hospice facility may provide supplemental evidence in support of its application from other data reported by licensed hospices on an annual basis to the State of Alabama or the Federal Government.

7. Additional need may be shown in situations involving a sustained high occupancy rate either for a region or for a single facility. An applicant may apply for additional beds, and thus the establishment of need above and beyond the standard methodology, utilizing one of the following two policies. Once additional beds have been applied for under one of the policies, that applicant shall not qualify to apply for additional beds under either of these policies unless and until the established time limits listed below have passed. All CON Authorized Inpatient Hospice beds shall be included in consideration of occupancy rate and bed need.

(i) If the total combined occupancy rate for all CON Authorized Inpatient Hospice facilities in a region is above 90% as calculated by SHPDA using data reported on the most recent full year "Annual Report for Hospice Providers (Form HPCE-4)" published by or filed with SHPDA, an additional need of the greater of five percent (5%) of the current total CON Authorized bed capacity of that region or five (5) total beds may be approved for the expansion of an

existing facility within that region. Once additional bed need has been shown under this policy, no new need shall be shown in that region based upon this rule for twenty-four (24) months following issuance of the initial CON to allow for the impact of those beds in that region to be analyzed. Should the initial applicant for beds in a region not apply for the total number of beds allowed under this rule, the remaining beds would then be available to be applied for by other providers in the region meeting the conditions listed in this rule.

(ii) If the occupancy rate for a single facility within a region is greater than 90% as calculated by SHPDA using data reported on the most recent full year "Annual Report for Hospice Providers (Form HPCE-4)" published by or filed with SHPDA, irrespective of the total occupancy rate for all CON Authorized Inpatient Hospice facilities in that region, up to five (5) additional beds may be approved within that region for the expansion of that facility only. Once additional beds have been approved under this policy, no new beds shall be approved for that facility for twenty-four (24) months following issuance of the CON to allow for the impact of those beds at that facility to be analyzed.

8. No application for the establishment of a new, freestanding Inpatient Hospice facility shall be approved for fewer than ten (10) beds to allow for the financial feasibility and viability of a project. Need may be modified by the Agency for any county currently showing a need of more than zero (0) but fewer than ten (10) total beds to a total need of ten (10) new beds, but only in the consideration of an application for the construction of a new, freestanding facility in a region in which no freestanding Inpatient Hospice currently exists. Need shall not be adjusted in consideration of an application involving the expansion of a CON Authorized Inpatient Provider, nor shall need be adjusted according to this rule in any region wherein a CON Authorized freestanding Inpatient Hospice facility already exists.

(e) Adjustments. The need for inpatient hospice beds, as determined by the methodology, is subject to adjustments by the SHCC. The SHCC may adjust the need for inpatient hospice beds in a region if an applicant documents the existence of at least one of the following conditions:

1. Absence of available inpatient beds for a hospice certified for Medicaid and Medicare in the proposed region, and evidence that the applicant will provide

Medicaid and Medicare-certified hospice services in the region; or

2. Absence of services by a hospice in the proposed region that serves patients regardless of the patient's ability to pay, and evidence that the applicant will provide services for patients regardless of ability to pay.

3. A community need for additional inpatient hospice services greater than those supported by the numerical methodology.

(7) Inpatient Hospice Regions. The attached "Inpatient Hospice Regional County Listing" is hereby adopted as an Appendix "A" to Section 410-2-4-.15.

For a listing of Inpatient Hospice Facilities or the most current statistical need projections in Alabama contact the Data Division as follows:

MAILING ADDRESS
(U. S. Postal Service)
PO BOX 303025
MONTGOMERY, AL 36130-3025

STREET ADDRESS
(Commercial Carrier)
100 NORTH UNION STREET, SUITE 870
MONTGOMERY, AL 36104

TELEPHONE:
(334) 242-4103

FAX:
(334) 242-4113

EMAIL:
data.submit@shpda.alabama.gov

WEBSITE:
http://www.shpda.alabama.gov

Appendix A

Inpatient Hospice Regional County Listings

REGION 1	**REGION 5**	**REGION 9**	**REGION 12**
Colbert	Jefferson	Chambers	Lee
Franklin		Clay	Macon
Lauderdale		Randolph	Russell
Marion	**REGION 6**	Talladega	
	Calhoun	Tallapoosa	
	Cherokee		**REGION 13**
REGION 2	Cleburne		Baldwin
Jackson	Saint Clair	**REGION 10**	Mobile

Limestone
Madison

REGION 3
Cullman
Lawrence
Morgan
Walker
Winston

REGION 4
Blount
DeKalb
Etowah
Marshall

REGION 7
Bibb
Fayette
Greene
Hale
Lamar
Pickens
Tuscaloosa

REGION 8
Chilton
Coosa
Shelby

Choctaw
Dallas
Marengo
Perry
Sumter
Wilcox

REGION 11
Autauga
Bullock
Butler
Crenshaw
Elmore
Lowndes
Montgomery
Pike

Washington

REGION 14
Clarke
Conecuh
Covington
Escambia
Monroe

REGION 15
Barbour
Coffee
Dale
Geneva
Henry
Houston

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: New Rule: Filed February 1, 2010; effective March 8, 2010. **Amended:** Filed January 24, 2012; effective February 28, 2012. **Amended:** Filed November 2, 2012; effective December 7, 2012. **Amended:** Filed December 2, 2014; effective January 6, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.

410-2-4-.16 Freestanding Emergency Departments (FEDs).

A "Freestanding Emergency Department" or "FED" is a new institutional health service requiring a Certificate of Need under Alabama law. In addition to other applicable criteria, all proposed FEDs must demonstrate, through substantial evidence, that their project will meet all the requirements for licensure under Ala. Admin. Code r 420-5-9, which is incorporated herein by reference.
Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §§22-21-260(13), (15).
History: New Rule: Filed June 5, 2015; effective July 10, 2015. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024.