STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
100 NORTH UNION STREET, SUITE 870
MONTGOMERY, ALABAMA 36104
June 30, 2006

NOTICE

TO: Recipients of the Alabama State Health Plan 2004-2007

FROM: Alva M. Lambert
Executive Director

SUBJECT: Amendment for End Stage Renal Disease Services §410-2-3-.05 and Inpatient Physical Rehabilitation §410-2-4-.08

The Statewide Health Coordinating Council (SHCC) at the June 15, 2006 meeting approved these amendments. Governor Bob Riley approved the amendments on June 27, 2006. Please substitute pages 37, 38, 39, 40, 41, 42, 43, 44 and pages 148, 148A, 149 and 150 in the Alabama State Health Plan 2004-2007.

Attachments: as stated

AML:jl

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410-2-3-.05 **End Stage Renal Disease Services**

(1) Discussion. Prior to the 1972 enactment of Section 299 i of Public Law 92-603, End Stage Renal Disease services were provided almost exclusively for the general population in the Jefferson County area. Financing was derived from a number of sources, some with unpredictable reliability. Since the advent of Section 299 i, and its stable source of reimbursement, the supply of End Stage Renal Disease services in the state has dramatically increased. The supply of these services now dictates that a specific need determination is needed to guide the future development of these units.

(a) Those who suffer with End Stage Renal Disease have inadequate function to support life. Individuals with end-stage disease must rely in kidney dialysis or peritoneal dialysis to survive. End Stage Renal Disease may be caused by a number of problems including diabetes, sickle cell disease, hypertension and congenital renal disease (polycystic kidney disease).

(b) In 1991 the Legislature declared that it was in the best interest of the state and its residents for kidney disease treatment centers to be established and operated throughout the state so that any patient needing such treatment would be able to utilize a hemodialysis unit located within a reasonable distance of their home. § 22-21-278 Code of Alabama, 1975 allows kidney disease treatment centers with ten stations or less to operate in 63 of 67 counties without Certificate of Need approval. Centers in Jefferson, Madison, Mobile and Montgomery counties are required to receive certificate of need approval for any dialysis stations.

(c) On June 11, 2003, the Alabama Legislature passed legislation that the Alabama Department of Public Safety provide to the Alabama Organ Center (AOC) the names of all individuals who have indicated their intent to become organ donors on their license. Approximately 1,114,000 names will be added to the Legacy Organ and Tissue Donor Registry. When a potential organ donor is referred to the AOC, that information will be checked against the registry to see if the patient is listed. The information will be presented to the patient's next of kin.

(d) Other states with registries have noted increases in donation. This is the goal for Alabama.

(2) Planning Policies

(a) The determination of need for additional hemodialysis stations will be based on the utilization of present in-center hemodialysis stations (capacity at the time of application as utilized by census at the time of application) and any anticipated increases of census.

1. In calculating the present capacity, "Isolation Stations" (stations reserved for Hepatitis-B positive patients) and stations used for home hemodialysis training will be removed from the total number of stations at the facility. No further reduction of station

count will be made for down-time, transients, or back-up of home patients, since provision is made for these in the Optimal Utilization Criterion.

2. Present Capacity is defined as two shifts per day, six days per week, based on the fact that most patients require three dialysis treatments per week. Third shift ("evening dialysis") will not be considered in calculating capacity since patient demand for this shift is erratic and unpredictable.

3. Optimal Utilization is defined as 80% of present capacity, thus making provision for cost-effective use of services and orderly growth, as well as reserving some capacity for downtime, transients, and back up of home patients. Optimal capacity is, therefore, 9.6 dialysis treatments per station per week (.80 x 12 dialysis treatments/station/week = 9.6 dialysis treatments/station/week).

4. Maximum Optimal Capacity is defined as the number of patients that can receive treatment under optimal capacity on a three dialysis treatment per week schedule.

EXAMPLE:

Total Stations		20
Dialysis Treatments/Station/Week	x	12
Capacity		240 Available Dialysis Treatments/Week
Optimal Utilization	x	.80
Optimal Capacity		192 Available Dialysis Treatments/Week
Patient Usage	÷	3 Dialysis Treatments/Week
Maximum Optimal Census		64 Patients

(b) Projection of census will be submitted in a yearly fashion for the three years subsequent to the date of application. Note that much of the first year will be consumed by the application process (both state and federal), construction or renovation and licensure process. Calculations of anticipated census are to be based on:

1. Present In-Center Hepatitis-Negative Hemodialysis Patients.

(i) Other patients treated by the facility in the home settings [(Home Hemodialysis, Continuous Ambulatory Peritoneal Dialysis (CAPD), Continuous Cyclic Peritoneal Dialysis (CCPD)], will be excluded; Hepatitis-B positive patients will be excluded unless the application specifically addresses the need for Hepatitis-B positive stations;

(ii) Note that if more than one End Stage Renal Disease facility exists within the defined service area, all present dialysis stations and present patients in all End Stage Renal Disease facilities must be considered in developing a demonstration of need.

2. New End Stage Renal Disease patient projections shall be based on:

(i) The total population of the county in which the stations are to be located plus any contiguous county that does not have a dialysis center.

(ii) Incidence Rate: The definition of incidence rate is the rate at which new events occur in a population. The formula to determine incidence rate is as follows: The numerator is the number of new events occurring in a defined period; the denominator is the population at risk of experiencing the event during this period. Applicant will use the 2004 state average of 400/million/year or the sum of 734/million non white population/year plus 258/million white population/year within the service area. In 2004 there were 1844 new patients.

(iii) Note that if more than one End Stage Renal Disease facility exists within the service area, the historical distribution of patients between the facilities will be used in determining the number of new patients who will seek services at the applying facility.

(iv) Loss Rate:

(I) Death: 24.8% of the sum of the in-center census at the start of each new year plus new patients during the year.

(II) Transplantation: 4.5% of the sum of the in-center census at the start of each new year plus new patients.

(III) Home Training: 9.6% of new patients.

I. Incidence Rate: statewide average of 2004 400/million/year, or 734/million non white population/year plus 258/million white population/year.

II. Loss Rate:

Death: 24.8% of initial census plus new patients.

Transplant: 4.5% of initial census plus new patients.

Home Training: 9.6% of new patients.

EXAMPLE:

In-Center Census Start of Year:	100 Patients
New Patients During Year:	50 Patients
	150
Less: 24.8% Death	36
Less: 4.5% Transplant	7
Less: 9.6% Home Training	5
In-Center Census, Year End	102

Note: Figures for incidence rates and loss rates were obtained from the 2004 Network 8, Inc. Annual Report http://www.esrdnetwork8.org.

3. A kidney transplant is a surgical procedure by which a healthy kidney is removed from one person and implanted in the ESRD patient. Transplantation is, ideally, a one-time procedure; if the donated kidney functions properly, the patient can live a relatively normal life. There is only one transplant center operating in Alabama. The University of Alabama Hospital located in Birmingham is one of the largest kidney transplant centers in the country with 331 transplants in 2002. The number of patients waiting for transplants is 1,975.

4. A free-standing licensed pediatric facility shall have the ability to make application directly to the Certificate of Need Review Board for the purpose of adding dialysis stations serving pediatric patients, provided it can clearly demonstrate that the need cannot be met by existing ESRD facilities.

Due to the frequency of facilities changing, ownerships, name, locations, and numbers of stations a listing of dialysis facilities will no longer be published in the *Alabama State Health Plan.* State Health Planning and Development Agency (SHPDA) Data Division staff will provide an up-to-date listing of dialysis facilities to requesters as needed.

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: §22-21-260(4), Code of Alabama, 1975.
History: Effective: November 22, 2004
Amended: Filed: June 30, 2006; Effective: August 4, 2006

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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 and inventory of inpatient rehabilitation facilities will be addressed.

(3) Need Determination. The Statewide Health Coordinating Council (SHCC) has determined that there is a need for 12 rehabilitation beds per 100,000 population for each region (see Table I).

(4) Planning Policies

(a) Planning Policy

Regional occupancy for the most recent reporting year should be at least 75% before the SHCC gives consideration to 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) Accessibility-Distribution. Inpatient Rehabilitation services appear to be well distributed in the most populous regions of Alabama, with the exception of Region V, the largest of the seven planning regions. The SHCC, through the adjustment process in August of 2005, recognized the need for 5 additional rehabilitation beds to be located in Houston County. Future consideration should be given to locating a unit in Dallas County to serve the western counties of Region V.

INPATIENT REHABILITATION BED REGIONS

REGION I

Lauderdale
Limestone
Madison
Jackson
Colbert
Franklin
Lawrence
Morgan
Marshall

REGION II

Lamar
Fayette
Pickens
Tuscaloosa
Sumter
Greene
Hale
Bibb

REGION III

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

REGION IV

DeKalb
Etowah
Cherokee
Calhoun
Cleburne
Clay
Randolph

REGION V

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

REGION VI

Choctaw
Washington
Mobile
Baldwin
Escambia
Conecuh
Monroe
Clarke

REGION VII

Covington
Coffee
Dale
Geneva
Houston
Barbour
Henry

TABLE I

INPATIENT PHYSICAL REHABILITATION
PROJECTION OF BED NEED
(Based on 12 Beds Per 100,000 Population)

Region	Population (2006)	Beds Needed	Beds Existing	CON Issued	Net Need (Excess)
I	851,208	102	70	20	12
II	292,599	35	42	0	(7)
III	1,327,358	159	268	0	(109)
IV	368,285	44	0	40	4
V	825,755	99	87	31	(19)
VI	718,313	86	75	0	11
VII	299,847	36	34	12	(10)

TABLE II

REHABILITATION BEDS AUTHORIZED

COUNTY	FACILITY	TYPE LICENSE	BEDS	OCCUPANCY (2002)
Baldwin	Mercy Medical, A Corporation	REH	25	65.6%
Etowah	HealthSouth Rehabilitation Hospital of Gadsden	REH	40	*
Houston	HealthSouth Rehabilitation Hospital	REH	34	95.5%
Jefferson	Baptist Medical Center Montclair	GEN	17	72.2%
	Bessemer Carraway Medical Center	GEN	31	51.1%
	Carraway Methodist Medical Center	GEN	17	84.0%
	HealthSouth Lakeshore Rehabilitation Hospital	REH	100	90.6%
	Medical Center East	GEN	20	80.8%
	University of Alabama Hospital	GEN	78	50.0%
Madison	Huntsville Hospital	GEN	20	45.5%
	HealthSouth Rehabilitation Hospital of North Alabama	REH	50	99.0%
Mobile	Mobile Infirmary	REH	50	66.3%
Montgomery	HealthSouth Rehabilitation Hospital of Montgomery	REH	80	96.4%
Tuscaloosa	Northport Hospital DCH	REH	50	74.2%
	Totals		600	

Utilization Source: Annual Report for Hospitals & Related Facilities (Form BHD-134-A)

* Facility opened in October 2003 no occupancy data available.

CON 2014-H issued August 2, 2002 to HealthSouth Regional Rehabilitation Hospital for construction and operation of a 38 bed rehabilitation hospital in Phenix City, Russell County. Seven of these beds would be relocated from Montgomery County.

CON 2072-H issued October 29, 2003 to Andalusia Regional Hospital for the construction and operation of a patient wing to house 12 rehabilitation beds in Andalusia, Covington County.

Author: Statewide Health Coordinating Council (SHCC).
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