

PROPOSED REVISIONS WITH DEPARTMENT RECOMMENDATIONS
Draft of 2014-2015 South Carolina Health Plan

Chapter III - Acute Care Hospitals
Pediatric Long Term Acute Care Hospitals

Explanation of Proposed Revision

As drafted the Standard currently reads:

"Should a hospital lease general beds to another entity to create a Pediatric Long-Term Acute Care Hospital, that hospital shall be entitled to regain these beds once the lease is terminated No entity other than the hospital that initially leased the general acute beds (or its successor) to the Pediatric Long-Term Acute Care Hospital shall be entitled to obtain the rights to the general beds upon termination of the lease."

The proponent of this proposed revision stated that an unnamed client is concerned that this provision may set up a scenario in which the hospital could terminate the lease, dispossess the provider, and ultimately take over operation of the facility. The proposed revision would add language to the Standard to protect the Pediatric LTACH applicant in this scenario.

Proposed Revision (Not Recommended)

"Upon termination of the lease of general hospital beds, the Pediatric Long Term Acute Care Hospital is authorized to continue to operate the same number of Pediatric Long Term Acute Care Hospital beds in another suitable location within the same service area. A Certificate of Need application is required only for the capital expenditure for such relocation if it exceeds the applicable threshold The Pediatric Long Term Acute Care Hospital would inform DHEC prior to the relocation and upon completion of the relocation of the service to a new location within the service area."

Chapter IV - Psychiatric Services

Explanation of Proposed Revision

In the existing State Health Plan (SHP) a general acute care hospital may apply for up to 20 beds to establish an economical unit if the SHP shows a bed need in a service area. It also allows hospitals with existing psychiatric beds to apply for up to 20 additional psychiatric beds, beyond those shown as needed in the SHP, if the hospital's occupancy rate exceeds 70%.

An allowance for general acute care hospitals to add beds based upon individual occupancy will likely reduce the bed need in that Service Area reflected in the State Health Plan, thus reducing the opportunity for freestanding psychiatric facilities to add beds. To redress this imbalance, the aforementioned provision to add beds based in individual occupancy should be extended to

freestanding psychiatric facilities. Such a provision will make additional beds available to alleviate overcrowding in hospital emergency rooms.

Summary of recommended changes:

1. Clarify that only one CON-approved project per planning region can add up to 20 beds if the region's actual bed need in the SHP is 20 or less.
2. The language that allows hospitals to add psychiatric beds if the individual facility's occupancy level is greater than 70% should state that the allowance extends to freestanding psychiatric facilities as well as general hospitals.

Proposed Revision (Recommended)

Chapter IV under subheading Certificate of Need Standards:

2. The bed need methodology takes the greater of actual utilization of the facilities in the service area or 75% of the statewide average beds per 1,000 population to project need. For service areas without existing psychiatric units and related utilization data, the statewide average beds per 1,000 population was used in the projection.
3. Should the service area show a need for additional beds, a general acute care hospital may be approved for the maximum of the actual projected bed need or up to 20 additional beds ("20 Bed Rule") to establish an economical unit ("Unit"). ~~Other hospitals are limited to applying for the maximum of the projected bed need. However~~ An applicant seeking more beds than are projected may not use such beds for establishment of a specialty psychiatric unit. Any beds sought in excess of the projected bed need in the service area must be used for the provision of adult psychiatric services in order to address the growing number of psychiatric patients being held in hospital emergency departments. ~~If a hospital already has licensed psychiatric beds they must have been used at a minimum of 70% occupancy rate for the most current year prior to applying for additional beds beyond those shown as needed in the Plan unless the applicant meets the above criteria. Finally, only one general acute care hospital per service area may be approved for additional beds beyond the projected bed need. To allow multiple hospitals to apply for up to 20 additional beds beyond the projected need would result in an unacceptable level of beds in the service area and adversely impact existing providers.~~
4. An existing general acute care hospital or freestanding psychiatric facility that already has licensed psychiatric beds may apply for additional beds beyond the need demonstrated in the Plan. However, prior to applying for additional beds beyond the need demonstrated in the Plan, the facility must demonstrate that it has maintained a minimum 70% occupancy rate as demonstrated by its most recent Joint Annual Report ("JAR"). The Department shall not approve an application for more beds than are shown as needed in the Plan unless the applicant meets this 70% occupancy rate criteria.

- ~~3. Any existing general acute care hospital with licensed and authorized adult psychiatric beds may apply to the Department's CON Program for permission to establish an economical unit ("Unit") of up to twenty (20) additional beds in areas without a calculated bed need upon a showing of a 70% occupancy rate for its existing psychiatric beds in the preceding Joint Annual Report (JAR). Use of this Unit is limited to provision of adult psychiatric services in order to address the growing number of psychiatric patients being held in hospital emergency departments, as set forth above. Hospitals who apply for beds pursuant to this procedure must satisfy all the other Certificate of Need Standards and the Relative Importance of Project Review Criteria set forth in this chapter.~~
- ~~4. For service areas without existing psychiatric units and related utilization data, the statewide average beds per 1,000 population was used in the projections.~~
5. Priority should be given to excess general hospital beds that can be economically cost effectively converted for use as a specialized psychiatric unit over the construction of new beds, if such beds will be accessible to the target population.

Proposed Revision (Not Recommended)

State Mental Health Facilities:

Any beds which are converted from existing general hospital acute care beds or any beds which are added for Crisis Stabilization services as described in (a) and/or (b) above will be included in the psychiatric bed need calculations for the Plan.

Chapter V - Rehabilitation Facilities

Explanation of Proposed Revision

- The State's current inpatient rehab bed need methodology projects need based on either the greater of the actual utilization of the facilities in the service area or the statewide average number of beds per 1,000 population to project need.
- Current methodology does not take into account the variation in concentrations of elderly populations throughout the state. This is a significant omission as the elderly account for more than 65% of all inpatient rehab patient days.
 - As a result, the current methodology prescribes too many beds in areas with smaller elderly populations and too few beds in areas with larger elderly populations.
- South Carolina's total elderly population is growing twice as fast as the general population, but is concentrated in certain geographic regions. From 2000 to 2010, South Carolina's elderly population grew over 30%, twice that of the State's general population.

- Basing rehab bed need on the elderly population will enable the State to:
 - Improve rehab access to underserved areas with large elderly populations; and
 - Ensure that, going forward, rehab bed supply is scaled appropriately as the State's population continues to age at an accelerated rate.
- By accounting for trends in the State's elderly population, the revised methodology suggests a need of 223 beds (72 more than the current plan) and highlights key geographies of unmet need, especially in the southern part of the State.

Proposed Revision (Recommended) - See chart on following page:

The revised methodology suggests a need of 223 beds (~70 more than the current plan) and highlights key geographies in the southern part of the State

Reliant-Proposed Rehab Bed Need Methodology

SERVICE AREA	2013 ≥ 65 POP ¹	2020 ≥ 65 POP ¹	EXISTING BEDS ²	PROJ ADC ³	OCCUP FACTOR	BED NEED		+/-	BED NEED (SW)	+/-	NEED	Current SHP Bed Need Method ⁴
						USE	NEED					
Anderson, Oconee	45,701	54,670	60	50	0.70	71	11	11	55	-5	11	11
Greenville, Pickens	79,205	94,653	72	49	0.70	70	-2	23	95	23	23	21
Cherokee, Spartanburg, Union 3	52,898	59,263	46	11	0.70	16	-30	14	60	14	14	10
Chester, Lancaster, York	47,126	61,825	50	47	0.70	67	17	12	62	12	17	17
Abbeville, Edgefield, Greenwood, Laurens, McCormick, Saluda	35,441	39,395	42	30	0.70	43	1	-2	40	-2	1	1
Fairfield, Lexington, Newberry, Richland	85,103	101,305	96	68	0.70	97	1	6	102	6	6	19
Chesterfield, Darlington, Dillon, Florence, Marion, Marlboro, Williamsburg	54,458	60,882	130	65	0.70	93	-37	-69	61	-69	-37	-37
Clarendon, Kershaw, Lee, Sumter	33,045	37,982	0	0	0.70	0	0	38	38	38	38	32
Georgetown, Horry	65,585	88,908	43	37	0.70	53	10	46	89	46	46	14
Aiken, Allendale, Bamberg, Barnwell, Calhoun, Oconee	50,867	58,653	24	15	0.70	21	-3	35	59	35	35	22
Beaufort, Hampton, Jasper 4	44,475	63,184	24	8	0.70	11	-13	40	64	40	40	11
Berkeley, Charleston, Colleton, Dorchester	89,658	109,911	101	91	0.70	130	29	10	111	10	29	29
Total	683,563	830,631	688	470		672	-16	148	836	148	223	151

Beds per 1000 ≥ 65 POP 1.006

³ Bed count reflects newly opened Spartanburg Rehabilitation Institute which did not report 2013 JARs.
⁴ Bed count reflects Pace which had not implemented its CON during the reporting period.

Chapter VI - Alcohol And Drug Abuse Facilities

Proposed Revision (Recommended)

Inpatient Treatment Facilities under the Certificate of Need Standards:

1. Need projections are calculated by service area. Because patients in need of alcohol and/or drug abuse treatment frequently require psychiatric treatment services as well, the inpatient treatment service areas mirror the psychiatric service areas (e.g., Anderson/Oconee, Greenville/Pickens, etc.) to facilitate planning in a manner that recognizes the comorbidity this patient population.
2. The bed need methodology takes the greater of the actual utilization of the facilities in the service area or the statewide beds per 1,000 population to project need.
3. For service areas without existing psychiatric units and related utilization data, the state use rate was used in the projections.
4. Because a minimum of 20 beds is needed for an inpatient program, a 20 bed unit may be approved in a Service Area that does not have any existing beds provided the applicant can document the need.
54. Inpatient treatment facilities are physically distinct from freestanding detoxification centers. Applicants may not combine the bed need for freestanding detoxification with the bed need for inpatient treatment in order to generate a higher bed need for an inpatient facility. There are no prohibitions against an inpatient facility providing detoxification services to its clients as needed, but the bed need projections refer to two distinct treatment modes that cannot be commingled.
6. The establishment of regional treatment center that serves more than a single service area may be proposed in order to improve access to care for patients in service areas that do not currently have such services available. Such a proposed center would be allowed to combine the bed need for a service area shows a need for additional beds. The applicant must document with patient origin data the historical utilization of the residents in the service area that is to be combined, or why it is in the best interest of these residents for their projected bed need to be used to form a regional treatment facility.
75. It is frequently impossible for facility to totally predict or control short-term deviation in the number of patients with mixed psychiatric/addictive etiology their illnesses. Therefore, in the case of facilities with licensed beds for both psychiatric and substance abuse treatment, the department will allow deviations of up to 25% of the total number

of license beds as swing beds to accommodate patients having diagnoses of both psychiatric and substance abuse disorders.

86. Services are accessible within sixty (60) minutes travel time for the majority of residents of the state.

97. Current utilization and population growth are factored into the methodology for determining the need for additional beds.

108. The benefits of improved accessibility will be equally weighed with the adverse effects of duplication in evaluating Certificate of Need applications for this service.

Narcotic Treatment Programs

Proposed Revision (Recommended)

Index XIII-30 -List of existing Narcotic Treatment Programs:

LAAM has not been produced in the US since 2003 due to the identification of cardiac related risks. It has not be used in treatment in over a decade. Its reference here should be considered for removal entirely.

Proposed Revision (Not Recommended)

"An additional treatment program can only be approved in counties where an existing program exists if the applicant is able to document that the existing program has a sufficient waiting list for admission that would justify the need for an additional program. **Wait lists are defined as the point at which a narcotic treatment program has met its capacity and can no longer accept new patients until treatment slots become available.**"

Proposed Revision (Not Recommended)

"The benefit of improved accessibility may outweigh the adverse effects of the duplication of existing services." NTPs are medical programs; good quality of care and patient safety and stability are paramount importance. In light of this we feel that this sentence should be changed to read, "The benefit of improved accessibility does not outweigh the adverse effects of the duplication of this existing service."

Chapter VII - Residential Treatment Facilities for Children and Adults

Explanation of Proposed Revision

In July 2014, changes to the South Carolina Medicaid Program allowed for placement of children into PRTF's without an affiliation with a state child placing agency. This modification substantially increased the occupancy rates of South Carolina's PRTF's. These resulting high

occupancy rates have forced children requiring services to be seen in the emergency rooms and acute psychiatric hospitals, further delaying needed treatment. State child placing agencies such as the Department of Social Services, the Department of Mental Health, and Juvenile Justice are also impacted by the high occupancy rates, as they must wait for an open PRTF bed for placement of children in their care.

Proposed Revision (Recommended)

3. An existing facility that can demonstrate a 70% or greater occupancy rate for the most recent year prior can apply to add up to 5 additional beds, regardless of whether there is a bed need in the region.
4. ~~3.~~ For a new facility, the applicant must document where they are currently being served, to include the expected shift in patient volume from existing providers. For the expansion of an existing facility, the applicant must provide patient origin information on the current facility.
5. ~~4.~~ The applicant must document the potential impact that the proposed new PRTF or expansion will have upon the existing service providers and referral patterns.
6. ~~5.~~ The applicant must provide a written commitment that the facility will provide services for indigent and charity patients at a percentage that is comparable to other health care facilities in the service area.
7. ~~6.~~ The applicant agrees to provide utilization data on the operation of the facility to the Department.

Chapter IX - Megavoltage Radiotherapy & Radiosurgery

Explanation of Proposed Revision (Recommended)

Recommendation that the title of this chapter be changed to “Radiation Oncology” to better reflect how these services are now referenced.

Explanation of Proposed Revision (Recommended)

Relevant Definitions should be updated for accuracy as follows:

Stereotactic Radiosurgery (SRS): The statement “A special frame is attached to the patient’s skull. The frame is used to aim high-dose radiation beams directly at the tumor inside the patient’s head” is not accurate. Some systems, such as the CyberKnife, are frameless. No HALOs are needed for treatment. Staff recommends removing the statement.

Types of Radiation Equipment should be updated for accuracy as follows:

Particle Beam (Therapy): The statement “Unlike other equipment forms, some particle beams can only penetrate a short distance into tissue. Therefore, they are often used to treat cancers located on the surface of or just below the skin” is not accurate. This sentence only pertains to electrons. Protons are heavy particles that are able to treat at great depth in a patient. Staff recommends correcting the statement as follows:

~~Particle beams use heavy charged subatomic particles to deliver radiation to the tumor. Unlike the other equipment forms, some particle beams can only penetrate a short distance into tissue. Therefore, they are often used to treat cancers located on the surface of or just below the skin. There are only a few facilities that operate particle beam (or cyclotron) units, which can be used to treat brain cancers and fractionated to treat other cancers. Most tumors could be cured with a sufficiently high dose of radiation; however, such a treatment is ineffective due to collateral damage to healthy tissue. Particle therapy can lessen the damage to healthy tissue by tailoring the particle (either a proton particle or a heavier carbon particle) dose to the tumor. Unfortunately, this promising treatment option is not readily available.~~

Linear Accelerator (X-Ray or LINAC)

Minimal equipment requirements for linear accelerator include:

4. Capability to provide appropriate dose distribution information for external beam treatment, ~~and brachytherapy.~~ (Staff recommends the term brachytherapy be removed.)

Explanation of Proposed Revision (Not Recommended)

In order for an applicant to establish or expand radiotherapy services, the capacity of existing units must be considered. Although, varying capacity levels have been identified based on the capability of the linear accelerator, the inventory of such specialized units has been removed from the Draft Plan. As a result, an applicant would be unable to accurately address the capacity of existing units without the identification of specialized units.

Recommendation that the capacity of existing units be included in the Plan.

Explanation of Proposed Revision (Not Recommended)

Recommendation that the equipment mentioned in Chapter IX be inventoried in Chapter XIII by facility.

Chapter XI - Outpatient Facilities Ambulatory Surgical Facilities

Proposed Revision (Recommended)

Standard 10. In the last sentence the reference is made to interpreting Standard 8. It should also include "and 9."

Proposed Revision (Not Recommended)

CON Standards Suggest the following rewrites:

Standard 1. The county in which the proposed facility is to be located is to be the regional inventory listing. The ASF inventory will be listed by regional area and then by county.

Standard 2. This is a petty point but physicians/surgeons needs to used. Most physicians are prevented by Stark from investing in ASFs. Only GIs who own and operate endoscopy centers are physicians. Most licensed MD owning ASFs or staffing them are surgeons or anesthesiologists.

Standard 6. Applicant must document impact on existing service providers. Applicants must use publicly available data sources. The source of data is critical and publicly available need to be the standard. Data should not come from an applicant phone survey, private insurance plan, or trade association only. DHEC requires population data be public data the same standard should apply here.

Project Review Criteria

Ten criteria are at least five too many. The Department needs to select five. I suggest the following: Compliance with Health Plan, community need documentation, financial feasibility, adverse impact on existing providers, and staffing resources or quality indicator. Others can certainly be included by an applicant but the Department needs not to get bogged down in justifying the priority listing of ten criteria. Keep it simple. This works for all the services in the Health Plan.