APA-1
Revised 4/2018

TRANSMITTAL SHEET FOR
NOTICE OF INTENDED ACTION

Control 410 Department or Agency State Health Planning and Development Agency
Rule No. 410-1
Rule Title: Appendix, Annual Report for Ambulatory Surgery Centers
_____ New X Amend _____ Repeal _____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	NO
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	YES
Is there another, less restrictive method of regulation available that could adequately protect the public?	NO
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	NO
Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule?	N/A
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	YES
Does the proposed action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule?	NO

****

Does the proposed rule have an economic impact?	NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

****

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer Alva M. Lambert

Date July 19, 2018

(DATE FILED)
(STAMP)

APA-2

(Agency Name)
(Agency Division, if applicable)

NOTICE OF INTENDED ACTION

AGENCY NAME: **STATE HEALTH PLANNING AND DEVELOPMENT AGENCY (Certificate of Need Review Board, "CONRB")**

RULE NO. & TITLE: **410-1, Appendix, Annual Report for Ambulatory Surgery Centers**

INTENDED ACTION:

The State Health Planning and Development Agency (Certificate of Need Review Board) proposes to amend the above styled section of the Alabama Certificate of Need Program Rules and Regulations.

SUBSTANCE OF PROPOSED ACTION:

This proposed amendment amends Section VI., Patient Origin by Zip Code, method of reporting patient zip code of residence and the total number of cases treated by the provider, mandating that the data be submitted in a Microsoft Excel or CSV formatted file. Typographic errors are corrected on Page 1.

TIME, PLACE, MANNER OF PRESENTING VIEWS:

In response to this Proposed Rule, all interested persons are invited to submit data, views, comments/and or arguments, orally or in writing. Any and all such data, comments, arguments and/or requests to orally address the CONRB shall be made in writing on or before Wednesday, September 5, 2018.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:

On September 19, 2018, at 10:00 a.m., the CONRB shall conduct a public hearing in the State Capitol Auditorium, Room, 600 Dexter Avenue, Montgomery, Alabama 36104, at which time it shall consider the Proposed Rule, along with all written and oral submissions with respect to the Proposed Rule. Only those interested persons who have made timely written requests will be afforded the opportunity speak.

CONTACT PERSON AT AGENCY:

Karen McGuire, Executive Secretary
100 North Union Street
RSA Union, Suite 870
Montgomery, AL 36104
(334) 242-4103

Alva M. Lambert
(Signature of officer authorized to promulgate and adopt rules or his or her deputy)

Copies of the proposed changes are available for review at 100 North Union Street, RSA Union Building, Suite 870, Montgomery, Alabama. Phone (334) 242-4103 or visit the office Monday through Friday from 8:00 a.m. to 5:00 p.m., excluding State holidays. Proposed changes are also available on the Agency's website, www.shpda.alabama.gov / Announcements / Certificate of Need.

APA-7

TRANSMITTAL SHEET FOR
BUSINESS ECONOMIC IMPACT STATEMENT
(Section 41-22-5.1)

Control No. 410 Department/Agency State Health Planning and Development Agency

Rule No. 410-1

Rule Title: Appendix, Annual Report for Ambulatory Surgery Centers

_____ New __X__ Amend _____ Repeal _____ Adopt by Reference

Attached is a Business Economic Impact Statement filed pursuant to Section 41-22-5.1, Code of Alabama 1975.

Signature of Filing Officer Alva M. Lambert

Date July 19, 2018

(DATE FILED)
(STAMP)

ECONOMIC IMPACT STATEMENT
FOR APA RULE
(Section 41-22-23(f))

Control No. 410 Department or Agency State Health Planning and Development Agency

Rule No: 410-1

Rule Title: Appendix, Annual Report for Ambulatory Surgery Centers

_____ New __X__ Amend _____ Repeal _____ Adopt by Reference

__X__ This rule has no economic impact.

_____ This rule has an economic impact, as explained below:

1. NEED/EXPECTED BENEFIT OF RULE:

2. COSTS/BENEFITS OF RULE AND WHY RULE IS THE MOST EFFECTIVE, EFFICIENT, AND FEASIBLE MEANS FOR ALLOCATING RESOURCES AND ACHIEVING THE STATED PURPOSE:

3. EFFECT OF THIS RULE ON COMPETITION:

4. EFFECT OF THIS RULE ON COST-OF-LIVING AND DOING BUSINESS IN THE GEOGRAPHICAL AREA WHERE THE RULE IS TO BE IMPLEMENTED:

5. EFFECT OF THIS RULE ON EMPLOYMENT IN THE GEOGRAPHICAL AREA WHERE THE RULE IS TO BE IMPLEMENTED:

6. SOURCE OF REVENUE TO BE USED FOR IMPLEMENTING AND ENFORCING THIS RULE:

7. THE SHORT-TERM/LONG-TERM ECONOMIC IMPACT OF THIS RULE ON AFFECTED PERSONS, INCLUDING ANALYSIS OF PERSONS WHO WILL BEAR THE COSTS AND THOSE WHO WILL BENEFIT FROM THE RULE:

8. UNCERTAINTIES ASSOCIATED WITH THE ESTIMATED BENEFITS AND BURDENS OF THE RULE, INCLUDING QUALITATIVE/QUANTITATIVE BENEFITS AND BURDEN COMPARISON:

9. THE EFFECT OF THIS RULE ON THE ENVIRONMENT AND PUBLIC HEALTH:

10. DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE RULE IS NOT IMPLEMENTED:

****Additional pages may be used if needed.**

FORM ASC-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
bradford.williams@shpda.alabama.gov

20-- ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)

SHPDA ID NUMBER
FACILITY NAME

Mailing Address: _____ (STREET ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Physical Address: _____ (STREET ADDRESS) _____ (CITY) **AL** _____ (ZIP)

County of Location: _____

Facility Telephone: _____ (AREA CODE) & TELEPHONE NUMBER **Facility Fax:** _____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for 10/1/20-- ____, through 9/30/20-- ____; or for **partial** year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.***

We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS

A member of administration <u>MUST</u> also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and <u>must be separate from the preparer</u>.

PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS

FOR OFFICE USE ONLY

Facility Verified:	_____	Initial Scan:	_____	Completed:	_____
Entered:	_____	Final Scan:	_____	Audited:	_____

FORM ASC-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

I. OWNERSHIP

____ Corporation	____ Non-Profit	____ Partnership
____ Individual	____ Healthcare Authority	____ LLC
____ Joint Venture	____ Government	____ Other (specify)

_____

II. FACILITIES

A. Total number of operating rooms _____

B. Number of operating rooms for general anesthesia _____

C. Number of beds available for extended recovery (less than 24 hours) _____

D. Total number of operations (cases) _____

E. Total number of procedures performed _____

F. Is this facility a designated separate/organized outpatient surgical unit of a hospital? ____ YES ____ NO

G. Number of weekdays procedures are routinely performed _____

III. SERVICES PROVIDED

	Number of Operations (cases)	Number of Procedures
General Surgery		
Dentistry		
Dermatology		
Eye, Ear, Nose & Throat		
Gastroenterology		
Gynecology		
Neurosurgery		
Ophthalmology		
Orthopedic		
Pain Management		
Plastic Surgery		
Podiatry		
Urology		
Other (specify) _____		
TOTALS ***(note: these totals should equal the totals as reported in Section II)***		

FORM ASC-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

IV. PRINCIPAL SOURCE OF PAYMENT

	Number of Operations (cases)
Self Pay	
Workman's Compensation	
Medicare	
Medicaid	
Tricare	
Blue Cross	
Other Insurance Companies	
No Charge (charity & others)	
Health Maintenance Organization (HMO)	
All Kids	
Other (specify) _____	
TOTALS ***(NOTE: This total should equal the total reported in Section II)***	

V. PATIENT ADMISSION DEMOGRAPHICS

A. ADMISSIONS BY AGE AND GENDER *(entire reporting period)*

	MALE	FEMALE	TOTAL
18 & under			
19 – 34 years of age			
35 – 54 years of age			
55 – 64 years of age			
65 – 74 years of age			
75 – 84 years of age			
85 years and older			
TOTALS			*

**** This total should equal the total reported in Section V-B.***

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

B. ADMISSIONS BY RACE *(entire reporting period)*

	TOTAL
White/Caucasian	
Black/African American/Negro	
Hispanic/Spanish/Latino	
Asian	
American Indian/Alaskan Native	
Pacific Islander	
India	
Middle Eastern	
Other (please specify other race category):	
TOTALS	*

This total should equal the total reported in Section V-A.

FORM ASC-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

VI. PATIENT ORIGIN BY ZIP CODE (entire reporting period)

Please report, by zip code of residence, the total number of cases treated by this provider. (This total should equal the total reported in Section II-D). ~~Make additional copies of this page and attach as required.~~ This data shall be submitted as a Microsoft Excel (v. 2003 or later) or CSV formatted file, and shall be submitted at the same time as the remainder of this report. The annual report will not be deemed received by the Agency on behalf of the submitting provider unless and until both the PDF document containing the first four pages of the report and the Excel or CSV file containing the data for this section are received.

The submitted file should contain the column headers and data formatting shown in the example provided below:

Please submit only a 5-digit zip code, not the full 9-digit zip code if supplied. Also, please ensure that the Facility ID Number supplied in the first column and the Facility ID Number reported on Page 1 are the same, and are correct.

FacilityIDNumber	PatZipCode	NumberOfPatientCases
999-U9999	99999	9999

~~Zip Code of Residence~~	~~Total Number of Cases~~

Author: Alva M. Lambert
Statutory Authority: §§ 22-4-34 and -35, Code of Alabama, 1975.
History: New Rule. Filed: March 18, 2016; effective May 2, 2016. Filed: _____; effective _____.