

March 2012

HEALTH State Health Planning and Development: Amend Title 31 of the Official Code of Georgia Annotated, Relating to Health, so as to Provide for Extensive Revision of the Certificate of Need Program; Revise and Add Definitions; Revise the Declaration of Policy for State Health Planning; Revise the Composition and Duties of the Health Strategies Council; Revise the Duties of the Department of Community Health; Revise Provisions Relating to Requirements for Certificate of Need; Provide for Destination Cancer Hospitals; Allow for Set Times to Accept Applications for Capital Projects; Provide for the Establishment of

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Assistance for Purposes of Medicaid; Change Certain Provisions Relating to an Annual Report; Add, Revise, and Delete Certain Exemptions to the Certificate of Need Requirements; Authorize the Department of Community Health to Require Notice and its Certification That an Activity Is Exempt from the Certificate of Need Requirements; Provide for the Transfer of Certain Functions Relating to the State Health Plan to the Board of Community Health from the Health Strategies Council; Abolish the Health Planning Review Board; Transfer Pending Matters of the Health Planning Review Board to the Certificate of Need Appeal Panel; Revise a Provision Relating to Application of Review Procedures to Expenditures Under a Federal Law; Require Health Care Facilities and Other Entities to Submit Annual Reports to the Department of Community Health; Increase the Penalties for Untimely and Incomplete Reports; Transfer Licensing of Hospitals and Other Health Care Facilities from the Department of Human Resources to the Department of Community Health; Provide for Transition; Provide for Licensure Standards on a Clinical Service Level for Hospitals and Related

Institutions; Amend Various Other Titles of the
Official Code of Georgia Annotated so as Revise
Provisions for Purposes of Conformity; Provide for
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HEALTH

State Health Planning and Development: Amend Title 31 of the Official Code of Georgia Annotated, Relating to Health, so as to Provide for Extensive Revision of the Certificate of Need Program; Revise and Add Definitions; Revise the Declaration of Policy for State Health Planning; Revise the Composition and Duties of the Health Strategies Council; Revise the Duties of the Department of Community Health; Revise Provisions Relating to Requirements for Certificate of Need; Provide for Destination Cancer Hospitals; Allow for Set Times to Accept Applications for Capital Projects; Provide for the Establishment of Conditions for Approval of a Certificate of Need; Change Certain Provisions Relating to Perinatal Services; Provide for Certain Facilities to Divide; Change Certain Provisions Relating to Considerations; Provide for a Letter of Intent for Proposed New Clinical Health Services; Provide for Batching and Comparative Review of Applications for Clinical Health services; Revise Provisions Relating to Time Frames for Review of Applications; Provide for the Imposition of a Temporary Moratorium on the Issuance of Certificates of Need for New and Emerging Health Care Services; Reassign the Hearing Functions from the Health Planning Review Board to a Certificate of Need Appeal Panel; Revise Provisions Relating to Judicial Review of a Final Agency Decision; Add Grounds for Which a Certificate of Need May Be Revoked; Provide That a Portion of a Certificate of Need May Be Revoked Under Certain Circumstances; Increase the Penalties for Services Conducted Without a Required Certificate of Need; Provide for Investigating Authority of the Department; Provide That Applicants for Certificates of Need May Be Required to Participate as a Provider of Medical Assistance for Purposes of Medicaid; Change Certain Provisions Relating to an Annual Report; Add, Revise, and Delete Certain Exemptions to the Certificate of Need Requirements; Authorize the Department of Community Health to Require Notice and its Certification That an Activity Is Exempt from the Certificate of Need Requirements; Provide for the Transfer of Certain Functions Relating to the State Health Plan to the Board of Community Health from the Health Strategies Council; Abolish the Health Planning Review Board;

Transfer Pending Matters of the Health Planning Review Board to the Certificate of Need Appeal Panel; Revise a Provision Relating to Application of Review Procedures to Expenditures Under a Federal Law; Require Health Care Facilities and Other Entities to Submit Annual Reports to the Department of Community Health; Increase the Penalties for Untimely and Incomplete Reports; Transfer Licensing of Hospitals and Other Health Care Facilities from the Department of Human Resources to the Department of Community Health; Provide for Transition; Provide for Licensure Standards on a Clinical Service Level for Hospitals and Related Institutions; Amend Various Other Titles of the Official Code of Georgia Annotated so as to Revise Provisions for Purposes of Conformity; Provide for Related Matters; Provide for an Effective Date; Repeal Conflicting Laws; and for Other Purposes

CODE SECTIONS:

O.C.G.A. §§ 19-10A-2 (amended), 20-3-476 (amended), 20-3-513 (amended), 24-9-47 (amended), 24-10-70 (amended), 25-2-13 (amended), 31-1-1 (amended), 31-6-1 (amended), 31-6-2 (amended), 31-6-20 (amended), 31-6-21 (amended), 31-6-21.1 (amended), 31-6-40 (amended), 31-6-40.1 (amended), 31-6-40.2 (amended), 31-6-41 (amended), 31-6-42 (amended), 31-6-43 (amended), 31-6-44 (amended), 31-6-44.1 (amended), 31-6-45 (amended), 31-6-45.1 (amended), 31-6-45.2 (amended), 31-6-46 (amended), 31-6-47 (amended), 31-6-48 (amended), 31-6-49 (amended), 31-6-50 (amended), 31-6-70 (amended), 31-7-1 (amended), 31-7-2.1 (amended), 31-7-3 (amended), 31-7-4 (amended), 31-7-5 (amended), 31-7-9 (amended), 31-7-17 (new), 31-7-150 (amended), 31-7-155 (amended), 31-7-159 (new), 31-7-175 (amended), 31-7-250 (amended), 31-7-265 (new), 31-7-280

(amended), 31-7-282 (amended), 31-7-300 (amended), 31-7-308 (new), 31-7-354 (new), 31-7-400 (amended), 31-8-46 (amended), 31-11-81 (amended), 31-18-3 (amended), 31-20-1 (amended), 31-21-5 (amended), 31-33-2 (amended), 33-19-10 (amended), 36-42-3 (amended), 43-34-26.3 (amended), 44-14-470 (amended), 51-1-29.3 (amended), 51-2-5.1 (amended), 52-7-14 (amended)

BILL NUMBER:

SB 433

ACT NUMBER:

392

GEORGIA LAWS:

2008 Ga. Laws 392

SUMMARY:

The Act defines destination cancer hospital and includes this type of hospital within the definition of health care facility. A destination cancer hospital will not be required to apply for or obtain certificates of need for new institutional health services. The Act requires destination cancer hospitals to provide a minimum amount of uncompensated, charitable care to Georgia residents and provides for fines if less than 65% of its patients are not Georgia residents. The Act classifies general surgeons as a single specialty for purposes of the certificate of need process. The Act allows two closely related specialties to be classified as a single specialty practice. The Act provides for charity and indigent care obligations for ambulatory surgical centers. The Act facilitates joint venture ambulatory surgical centers between hospitals and doctors.

EFFECTIVE DATE: O.C.G.A. §§ 31-6-1, 31-6-2, 31-6-20, 31-6-21, 31-6-21.1, 31-6-40, 31-6-40.1, 31-6-40.2, 31-6-41, 31-6-42, 31-6-43, 31-6-44, 31-6-44.1, 31-6-45, 31-6-45.1, 31-6-45.2, 31-6-46, 31-6-47, 31-6-48, 31-6-49, 31-6-50, 31-6-70, July 1, 2008.

O.C.G.A. §§ 19-10A-2, 20-3-476, 20-3-513, 24-9-47, 24-10-70, 25-2-13, 31-1-1, 31-7-1, 31-7-2.1, 31-7-3, 31-7-4, 31-7-5, 31-7-9, 31-7-17, 31-7-150, 31-7-155, 31-7-159, 31-7-175, 31-7-250, 31-7-265, 31-7-280, 31-7-282, 31-7-300, 31-7-308, 31-7-354, 31-7-400, 31-8-46, 31-11-81, 31-18-3, 31-20-1, 31-21-5, 31-33-2, 33-19-10, 36-42-3, 43-34-26.3, 44-14-470, 51-1-29.3, 51-2-5.1, 52-7-14, July 1, 2009

History

Certificate of Need

Federal certificate of need (CON) legislation was introduced in the 1970s to deal with the unintended windfall doctors and hospitals received as a result of the implementation of Medicare and Medicaid.¹ Certain providers were reimbursed at cost or even cost plus 10%, which created the incentive to increase rates for services, resulting in skyrocketing costs for consumers.² Proponents of CON argued that the market demonstrated it could not regulate itself in this area and the government had to step in.³ Federal CON legislation, enacted in 1974, was repealed in 1982 due to its failure to contain the

1. Interview with Rep. Sharon Cooper, (R-41st), (Apr. 4, 2008) [hereinafter Cooper Interview]; Theodore McDowell, *The Medicare-Medicaid Anti-Fraud and Abuse Amendments: Their Impact on the Present Health Care System*, 36 EMORY L.J. 691, 699-702 (1987).

2. Cooper Interview, *supra* note 1; McDowell, *supra* note 1, at 701.

3. JOHN BARNES, WASHINGTON POLICY CENTER POLICY BRIEF, FAILURE OF GOVERNMENT CENTRAL PLANNING: WASHINGTON'S MEDICAL CERTIFICATE OF NEED PROGRAM, (2006), http://www.washingtonpolicy.org/Centers/healthcare/policybrief/06_barnes_constudy.html.

problem of rising costs.⁴ However, Georgia has kept its CON program active and has one of the most extensively regulated healthcare industries in the country.⁵

The CON statute has been tweaked over the years, but has not undergone a major revision since the early 1980s.⁶ The existing law has support from major interest groups including the Georgia Chamber of Commerce and the Georgia Hospital Association.⁷ Their argument is that the current statute should remain intact until there is evidence that the market can operate independently and still produce a quality healthcare system.⁸ By regulating the supply in the industry, CON laws also help to prevent the costs from being spread to the patients.⁹ Additionally, there is a fear that if the industry is not regulated hospitals would “cherry pick” services which have high profit margins, and services, like neo-natal care, that are needed but are less profitable, would disappear or become cost prohibitive.¹⁰

Opponents of CON also have strong supporters on their side including the Georgia Chapter of the American College of Surgeons and the Medical Association of Georgia.¹¹ One charge against CON laws is that by regulating the industry so tightly, they stifle innovation and prevent physicians from being able to practice in a manner they see fit.¹² Critics argue the rules are antiquated and

4. *Id.*

5. Andy Miller, *Pros and Cons of Healthcare Licenses; System Creates Patchwork*, ATLANTA J.-CONST., Aug. 24, 2001, at 10A.

6. See Cooper Interview, *supra* note 1.

7. Jim Galloway & Bob Kemper, *Chamber to Senate: Don't Pretend that Health Care in Georgia Obeys the Rules of the Market*, ATLANTA J.-CONST., Feb. 19, 2008, available at 2008 WLNR 3359971 (printing a letter from the Georgia Chamber of Commerce); C. Richard Dwozan, Chairman, Georgia Hospital Association, Remarks Prepared for the Study Commission on the Efficacy of Georgia's Certificate-of-Need System 4 (Aug. 8, 2005), http://dch.georgia.gov/vgn/images/portal/cit_1210/30/7/41941225Dick_Dwozan_Testimony.pdf (noting that “GHA’s membership is unanimous in its support of a strong CON Program in Georgia”).

8. Galloway, *supra* note 7.

9. Dwozan, *supra* note 7.

10. Miller, *supra* note 5.

11. FACS.org, American College of Surgeons Urges Georgia State Legislators to Amend CON Law, <http://www.facs.org/news/gaconlaw.html> (last visited June 8, 2008); MAG.org, Stop the CON, <http://www.mag.org/governmentrelations/certificate-of-need-0307.shtml> (last visited June 8, 2008).

12. MAG.org, Stop the CON, <http://www.mag.org/governmentrelations/certificate-of-need-0307.shtml> (last visited June 8, 2008); Cooper Interview, *supra* note 1 (noting the old law says that general surgery is not a single specialty and therefore they cannot open ambulatory surgery centers and hospitals could not be part owner of a joint venture ambulatory surgery center with a doctor that works with them).

overreaching, requiring a hospital to apply for a CON to build a bigger parking lot, for example.¹³ The process often prevents or slows the opening of facilities providing new treatment options.¹⁴ It also allows large, wealthy hospitals to challenge any CON application in order to obtain a monopoly in a given service area.¹⁵

Opponents have been actively attempting to reform, or even repeal, the CON statute for more than a decade.¹⁶ In 2005, the State Commission on the Efficacy of the Certificate of Need (hereinafter “the Commission”) was created to study and evaluate the effectiveness and efficiency of Georgia’s CON program.¹⁷ In late 2006, the Commission put out recommendations for change in the current law, and House Bill 568, written based on those recommendations and backed by the Governor, was introduced to the Legislature in early 2007.¹⁸ The Georgia Hospital Association immediately began lobbying against the bill and prevented the bill from coming to a vote in the House on Crossover Day.¹⁹ After HB 568 was recommitted at the end of the 2007 session, Senator Joseph Carter (R-13th) offered a floor amendment to HB 429 that made rules promulgated by the Health Strategies Council (hereinafter “the

13. Cooper Interview, *supra* note 1.

14. Susan Lancetti Meyers, *Health Care Rivalries Raise Debate over State Controls*, ATLANTA J.-CONST., Feb. 2, 2002, at 3F, available at 2002 WLNR 4650674 (noting that WellStar hospital in Cobb County was repeatedly sued by Piedmont Hospital and St. Joseph’s Hospital to prevent them from opening an open heart surgery center); Miller, *supra* note 5 (noting that “the state reviews, appeals and court fights in such CON matters can drag on for years”).

15. Cooper Interview, *supra* note 1 (noting that Northside Hospital challenged numerous other hospitals’ attempts to open obstetrics facilities, including a hospital in Cumming); Miller, *supra* note 5 (noting that St. Joseph’s hospital, across the street from Northside Hospital, cannot deliver babies); Susan Laccetti Meyers, *Taylor: Revamp Facility Certificate of Need Law*, ATLANTA J.-CONST., Feb. 8, 2002 at 4F, available at 2002 WLNR 4661231 (noting that a hospital in Macon, which “previously had the sole authority to perform [cardiac] procedures” instigated several appeals challenging a grant of certificate of need to a competing hospital. She quotes the former Lieutenant Governor, Mark Taylor, who stated that “the people of Macon really have been whipsawed with this issue.”).

16. Meyers, *supra* note 15 (noting that “the Legislature narrowly defeated an attempt to repeal Georgia’s certificate of need law in 1997.”).

17. Press Release, Georgia Department of Community Health, CON Commission Meets for Two-Day Retreat to Build Consensus on Issues Facing Committee (Nov. 28, 2006), http://dch.georgia.gov/vgn/images/portal/cit_1210/5/55/70156985CON_Commission_Retreat_Press_Release.pdf (last visited June 8, 2008).

18. Cooper Interview, *supra* note 1; Georgia General Assembly, HB 568, Bill Tracking., http://www.legis.state.ga.us/legis/2007_08/sum/hb568.htm; Travis Fain, *Certificate of Need Bill to Start Journey*, MACON TELEGRAPH, Feb. 23, 2007, available at 2007 WLNR 3511955.

19. Fain, *supra* note 18; Cooper Interview, *supra* note 1.

Council”) discretionary.²⁰ The Council previously had the power to make binding CON rules.²¹ The Council was entirely made up of hospital administrators and the rules reflected their support of strict CON enforcement.²² Once HB 429 passed, the Department of Community Health (DCH) began changing the rules to reflect a more moderate view of the CON requirements, and the hospitals lost a foothold in the argument.²³

Cancer Treatment Centers of America and Certificate of Need

Cancer Treatment Centers of America (CTCA) is a corporation that operates hospitals with a self-described innovative approach to cancer treatment, which is to provide all aspects of the treatment and recovery process including surgery, chemotherapy, nutrition and even spirituality.²⁴ Headquartered in Illinois, the CTCA has centers in Zion, IL, Philadelphia, PA, and Tulsa, OK, and is opening a center near Phoenix in 2009.²⁵

Neither Pennsylvania nor Arizona have certificate of need legislation.²⁶ The CTCA came head to head with certificate of need, however, in Washington.²⁷ CTCA filed an application for a CON to build a center near Seattle. The Washington Department of Health denied the grant based on the CTCA’s failure to meet any of the four criteria required for a CON: (1) need; (2) financial feasibility; (3) structure and process of care; and (4) cost containment.²⁸ CTCA then

20. HB 429 (SCSFA) (07 AM 33 0585), 2007 Ga. Gen. Assem.

21. See 1999 Ga. Laws 296, § 5, at 304 (codified at O.C.G.A. § 31-6-20(g)(1)–(2) (2006)); Cooper Interview, *supra* note 1.

22. Cooper Interview, *supra* note 1.

23. Cooper Interview, *supra* note 1 (noting that Hospitals began to feel the pressure – if they didn’t at least try to compromise they could lose a lot).

24. Cancerpatientsfirst.org, Georgia: Cancer Patients First Frequently Asked Questions, <http://www.cancerpatientsfirst.org/faq/> (last visited June 8, 2008) [hereinafter CTCA Frequently Asked Questions].

25. Cancercenter.com, Our Hospitals and Clinics, <http://www.cancercenter.com/cancer-hospitals.cfm> (last visited June 8, 2008) [Hereinafter Our Hospitals and Clinics].

26. National Conference on State Legislatures, Certificate of Need: State Health Laws and Programs, <http://www.ncsl.org/programs/health/cert-need.htm> (last visited May 2008).

27. Bruce Japsen, *Cancer Center on Track in Arizona*, CHI. TRIB. Aug. 2, 2007, at C3 (noting that “Georgia and Washington...have state regulations called certificates of need that have slowed Cancer Treatment Centers’ ability to expand . . .”).

28. WASH. ST. DEP’T OF HEALTH, DEPARTMENT OF HEALTH’S FINDINGS FOR THE CERTIFICATE OF NEED APPLICATION SUBMITTED ON BEHALF OF CANCER TREATMENT CENTERS OF AMERICA (CTCA)

requested an appeal from the Department that was denied.²⁹ Although CTCA currently operates a wellness clinic in Seattle, they were not allowed to open an expansive center like their facilities in Tulsa, Zion, and Philadelphia.³⁰

Even with the problems faced in Washington, CTCA has been pursuing a location in Georgia since 2006.³¹ Georgia's CON statute, while different from Washington's, still requires that CTCA show an unmet need in the region for the services it provides.³² In Georgia, CTCA would have to show need within metropolitan Atlanta to open in that area.³³ CTCA proponents, however, assert that CON requirements should not apply to them because the majority of their patients will come from out of state, and thus the requirement of showing need in the Atlanta area is irrelevant.³⁴ Additionally, the CTCA argues that in 2006, over 700 people from the Southeast visited or were treated at their other locations, which indicates the need for a regional hub.³⁵ The Georgia Department of Human Resources was not receptive, denying CTCA's CON request before the application was even filed.³⁶ Legislation was introduced in the 2007 Georgia General Assembly that would modify existing law to

PROPOSING TO ESTABLISH A NEW TWENTY-FOUR BED HOSPITAL LOCATED IN KENT, KING COUNTY 3-4, 12, 15, 19 (2005), available at <http://www.doh.wa.gov/hsqa/fsl/CertNeed/Docs/Decisions/Archive/Arch2005/05-05CancerTreat.pdf> [hereinafter WASH. DOH FINDINGS] (denying the certificate of need in part because "the CTCA is not providing a unique array of services").

29. Peter Neurath, *Patients See Hope but the State Says There's No Need*, 276 PUGET SOUND BUS. J. 1, 2 (2006), available at <http://seattle.bizjournals.com/seattle/stories/2006/05/15/focus1.html>.

30. See *Our Hospitals and Clinics*, *supra* note 25; Neurath, *supra* note 29.

31. *Cancer Center Bill Stirs Controversy*, ATHENS BANNER-HERALD (Feb. 12, 2007), available at http://onlineathens.com/stories/021207/news_20070212020.shtml.

32. Compare O.C.G.A. § 31-6-42 (2006) (Qualifications for Issue of Certificate), with WASH. REV. CODE § 70.38.115 (2007) (Certificates of Need-Procedures-Rules-Criteria for Review).

33. O.C.G.A. § 31-6-42(a)(2) (2006) (noting an application for a certificate of need must show "the population residing in the area served...has a need for such services").

34. CTCA Frequently Asked Questions, *supra* note 24 (noting that "[t]he CTCA hospital in Tulsa draws less than 28 percent of its patients from Oklahoma, and only 3.4 percent of its patients from Tulsa. The CTCA hospital in Zion, Ill. (an hour outside of Chicago) draws only 23% percent of its patients from Illinois - and less than 1% percent from Chicago. The new CTCA hospital in Philadelphia draws only 27% percent of patients from Pennsylvania, and a minuscule 3.4% percent from Philadelphia.").

35. *Id.*

36. Video Recording of Senate Proceedings, Feb. 27, 2008 at 1 hour, 31 min., 40 sec. (remarks by Sen. Tommy Williams (R-19th)), mms://mediam1.gpb.org/ga/leg/2008/ga-leg-senate-2_27_2008-10_08_pt1%20AM.wmv [hereinafter Senate Video].

provide that “acute cancer treatment hospitals” are exempt from certificate of need requirements.³⁷ The bill was introduced on January 26, 2007, referred to the Senate Health and Human Services Committee, and left there.³⁸

The legislation introduced in 2008 attempted to find a compromise and allow CTCA entry into Georgia.³⁹ The clamor for change from the Governor, the hospitals’ loss of power in the area of regulation, and CTCA’s push to enter the Georgia market created a “perfect storm” for reform in this area.⁴⁰

Bill Tracking of SB 433

Consideration and Passage by the Senate

Senators Tommie Williams (R-19th), Chip Rogers (R-21st), Eric Johnson (R-1st), Jeff Mullis (R-53rd), Dan Moody (R-56th) and Jack Hill (R-4th) sponsored SB 433. It was first read in the Senate on February 8, 2008. It was then referred to the Health and Human Services Committee.⁴¹ The bill as introduced by Senator Williams contained a discretionary fine provision if the percentage of out of state patients treated by CTCA fell below 65%. The Senate committee changed that provision to make the fine mandatory.⁴² The change in the fine was the result of Senator Williams trying to build a consensus on the bill.⁴³

The committee also attached a few sections that are not related to the CTCA’s quest for a certificate of need.⁴⁴ The committee proposed

37. SB 53, as introduced, 2007 Ga. Gen. Assm.

38. Georgia General Assembly, SB 53, Bill Tracking, http://www.legis.state.ga.us/legis/2007_08/sum/sb53.htm (last visited Nov. 18, 2008).

39. Compare SB 53, as introduced, 2007 Ga. Gen. Assm., with SB 433, as introduced, 2008 Ga. Gen. Assm.

40. Cooper Interview, *supra* note 1.

41. See Georgia General Assembly, SB 433, Bill Tracking, http://www.legis.ga.gov/legis/2007_08/sum/sb433.htm (last visited Nov. 18, 2008) [hereinafter SB 433 Bill Tracking].

42. Compare SB 433, as introduced, 2008 Ga. Gen. Assm., with SB 433 (SCS) (08 LC 33 2430S), 2008 Ga. Gen. Assm., at p. 3, lines 34–35.

43. Video Recording of House Special Committee on Certificate of Need Meeting, Mar. 18, 2008 at 2 min., 43 sec. (remarks by Sen. Tommie Williams (R-19th)), <http://media.legis.ga.gov/hav/08/comm/sccon/cert031808.wmv> [hereinafter SCON Meeting 3/18].

44. SB 433 (SCS) (08 LC 33 2430S), p. 4, ln. 4–16, p. 5, ln. 19–32, 2008 Ga. Gen. Assm.

that SB 433 be changed to include an amendment to Code section 31-6-41.⁴⁵ The law, prior to the passage of SB 433, stated that the “scope, location, cost, service area and person named in the application” limits the validity of a certificate of need for each facility and if the facility is transferred to a different person the factors listed above remain the same.⁴⁶ The proposed addition to SB 433, lines 12-16 on page 4 of the Senate committee substitute, would add a sentence to Code section 31-6-41 which would allow a “skilled nursing facility, intermediate care facility, or intermingle nursing facility” to split into two or more facilities without reference to the existing certificate of need.⁴⁷ Instead it would require the department to consider whether “the division is financially feasible and would be consistent with quality patient care” when allowing the split.⁴⁸ In addition to allowing those facilities to split, the committee also relaxed the requirements for those facilities to move locations within the same county, by allowing review of the application under general criteria rather than the more stringent service specific criteria.⁴⁹ The last change to the original bill made by the Senate committee adds a new paragraph to Code section 31-6-47(a), which would allow facilities that treat prisoners and that are operated by or on behalf of the Department of Corrections or the Department of Juvenile Justice to be exempt from certificate of need requirements.⁵⁰ The committee added these changes to SB 433 and voted to approve the bill on February 19, 2008.⁵¹

The bill was read for the second time in the Senate on February 20, 2008.⁵² On February 27, 2008 the bill was read for the third time and debated by the Senate.⁵³ During the floor debate, Senators Williams

45. *Id.* at p. 4, ln. 12–16.

46. O.C.G.A. § 31-6-41(a) (2006).

47. SB 433 (SCS) (08 LC 33 2430S), p. 4, ln. 12–16, 2008 Ga. Gen. Assem.

48. *Id.* at ln. 15–16.

49. *Id.* at p. 5, ln. 19–32 (requiring three additional elements be met in order to have review under the general criteria: (1) the facility has had prior certificate of need review, approval or exemption; (2) the new location is in the same county as the old location; and (3) the new facility is not qualified as an expanded service).

50. *Id.* at p. 5, ln. 34–35, p. 6, ln. 1–9.

51. SB 433 Bill Tracking, *supra* note 41.

52. *Id.*

53. *Id.*

and Senator Carter offered a floor amendment to SB 433.⁵⁴ The amendment removed from the bill all language regarding “skilled nursing facilities, intermediate care facilities and intermingled nursing facilities.”⁵⁵ Senator Williams remarked that the language was being removed based on the request of CTCA.⁵⁶ The amendment left the penalties for the CTCA as mandatory and the exemption from certificate of need for prison health care facilities intact.⁵⁷ SB 433 passed the Senate by a vote of 31 yeas to 23 nays.⁵⁸

Consideration and Passage by the House

SB 433 then moved to the House, and was read for the first time on February 28, 2008 and for a second time on February 29, 2008.⁵⁹ It was assigned to the Special Committee on Certificate of Need (SCCON).⁶⁰ Senator Williams introduced a substitute to SB 433 on March 18, 2008, which created a more comprehensive bill instituting broad CON revisions, beyond the cancer destination center.⁶¹ The House used SB 433 as a vehicle for comprehensive reform, which is why the substitute was so drastically different.⁶² After much debate and change, a substitute to SB 433 passed out of committee on March 31, 2008 by a unanimous vote.⁶³ It was read for a third time and passed by the House on April 4, 2008, by a vote of 138 to 17.⁶⁴ The Senate agreed to the substitute on April 4, 2008 by a vote of 44 to 6, and the Governor signed the Act on April 9, 2008.⁶⁵

54. Senate Video, *supra* note 36, at 1 hr., 12 min., 46 sec. (remarks by Sen. Tommie Williams (R-19th)).

55. See SB 433 (SCSFA) (08 AM 14 0853), 2008 Ga. Gen. Assem. (removing lines 4–16 on p. 4, 19–35 on p. 5 and line 1–9 on p. 6); SB 433 (08 SB433/CSFA/2), as passed Senate, 2008 Ga. Gen. Assem.

56. Senate Video, *supra* note 36, at 1 hr., 12 min., 46 sec. (remarks by Sen. Tommie Williams (R-19)).

57. SB 433 (SCSFA) (08 AM 14 0853), 2008 Ga. Gen. Assem.

58. Georgia Senate Voting Record, SB 433 (Feb. 27, 2008).

59. SB 433 Bill Tracking, *supra* note 41.

60. *Id.*

61. See SCCON Meeting 3/18, *supra* note 43 at 4 min., 59 sec. (remarks by Sen. Tommie Williams (R-19th)) (stating that getting the bill out of the House would require a more comprehensive bill).

62. Cooper Interview, *supra* note 1.

63. SB 433 Bill Tracking, *supra* note 41; Cooper Interview, *supra* note 1.

64. SB 433 Bill Tracking, *supra* note 41; Georgia House of Representatives Voting Record, SB 433 (April 4, 2008).

65. SB 433 Bill Tracking, *supra* note 41; Georgia Senate Voting Record, SB 433 (April 4, 2008).

The Act

The Act first amends Code section 31-6-1 to add “access to quality health care services” as an additional policy goal of this chapter.⁶⁶ It also moves the licensing function from the Department of Human Resources to the Department of Community Health.⁶⁷ The function was transferred so that “the same facility that approved your CON application will also approve your license.”⁶⁸ Throughout the bill, references to the Department of Human Resources are struck and replaced by “the department” (referring to the Department of Community Health).

Definitions

The Act makes some technical changes to words defined by the statute. “Certificate of Need Appeal Panel” refers to the panel created by amended Code section 31-6-44.⁶⁹ The Act moves the definition of a “new institutional health service” to Code section 31-6-40.⁷⁰ The definition of “operating room environment” is amended to mean “an environment which meets the minimum physical plant and operational standards” promulgated by the Department.⁷¹ It requires that the Department use the American Institute of Architects’ *Guidelines for Design and Construction of Health Care Facilities* when making those rules.⁷²

The Act also defines certain services and providers that receive individualized treatment in later parts of the Act. “Basic perinatal services” are defined to include care for all levels of pregnancy and childbirth, starting with community education on perinatal health through referrals for newborn care.⁷³ The Act adds a definition for a

66. O.C.G.A. § 31-6-1 (Supp. 2008).

67. *See generally* O.C.G.A. § 31-6-1(12) (Supp. 2008) (defining “department” as Department of Community Health); O.C.G.A. § 31-6-42 (Supp. 2008) (stating “[t]he department shall issue a certificate of need...”).

68. SCCON Meeting 3/18, *supra* note 43, at 10 min., 39 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

69. O.C.G.A. § 31-6-2(7) (Supp. 2008).

70. *Id.* § 31-6-40.

71. *Id.* § 31-6-2(27).

72. *Id.*

73. O.C.G.A. § 31-6-2(3) (Supp. 2008).

“continuing care retirement community,” although the label is slightly misleading, as discussed below.⁷⁴ The continuing care retirement community is a place that provides basic services, either in a residential setting or in a nursing home, but the definition is not limited to institutions providing care for elderly individuals.⁷⁵

A definition for a “destination cancer hospital” is included here, taking the proposed definition from the bill as passed in the Senate.⁷⁶ Destination cancer hospitals are also added to the definition of “health care facility” in Code section 31-6-2(17). Code section 31-6-2(15) defines “diagnostic imaging” to include MRI scans, CT scans, PET scans, and other “advanced imaging services as defined by the department by rule” but not “X-rays, fluoroscopy, or ultrasound services.”⁷⁷

The Act defines “rural county” to include a county with less than 35,000 people, and “urban county” as any county with more than 35,000 people.⁷⁸ The distinction was made because rural counties get certain exemptions in a different section of the law.⁷⁹ A definition for “specialty hospital” was added to include hospitals that primarily treat patients with cardiac or orthopedic conditions, “patients receiving a surgical procedure,” or “other specialized category of services defined by the department.”⁸⁰ “Destination cancer hospital” is defined separately by the Act, and is not included in the definition of specialty hospital.⁸¹

A substantial change in this section is the addition of a definition for a “joint venture ambulatory surgery center.”⁸² This definition allows a physician or group of physicians to team up with a hospital to open a single specialty freestanding ambulatory surgery center, which was previously not permitted.⁸³ The original committee substitute required that the doctor who was pairing with the hospital

74. *Id.* § 31-6-2(11).

75. *Id.*

76. *See* O.C.G.A. § 31-6-2(13) (Supp. 2008); SB 433, as passed, 2008 Ga. Gen. Assem.

77. O.C.G.A. § 31-6-2(15) (Supp. 2008).

78. *Id.* §§ 31-6-2(32), -2(38).

79. O.C.G.A. § 31-6-47(a)(10) (Supp. 2008); SCON Meeting 3/18, *supra* note 43, at 31 min., 07 sec., (Josh Belinfante giving an example of differential treatment).

80. O.C.G.A. § 31-6-2(35) (Supp. 2008).

81. *Id.* §§ 31-6-2(13), -2(35).

82. *Id.* § 31-6-2(23).

83. Cooper Interview, *supra* note 1; O.C.G.A. § 31-6-2(23) (Supp. 2008).

be completely unaffiliated with that hospital.⁸⁴ The committee removed that requirement, requiring only that the hospital own at least 30% and that the doctors own at least 30%.⁸⁵ However, the addition of the word “freestanding,” in the later committee substitute, makes clear that “even if the hospital owned 70% . . . [it] will be billing as an ambulatory surgery center not as a hospital.”⁸⁶

Code section 31-6-2(33) defines a single specialty ambulatory surgery center. It requires that the doctor or group of doctors performing the surgery be of one single specialty.⁸⁷ Additionally, this subsection specifically states that general surgery, a group practice including one or more physiatrists performing “services that are reasonably related to the surgical procedures performed in the center” and a group practice in orthopedics including certain plastic hand surgeons, are single specialties. The same specification is re-stated in Code section 31-6-2(23).⁸⁸ That amendment represents a compromise between the doctors and hospitals, and the goal was to encourage them to work together.⁸⁹ Before this Act, only doctors that practiced a single specialty (orthopedics, ophthalmologists, etc.) were allowed to open a center. General surgery was not considered a single specialty, which limited where and how general surgeons could practice.⁹⁰ Consequently, general surgeon associations encouraged young doctors to avoid Georgia because of this law.⁹¹ The law was originally put in place due to concerns from the hospitals that general surgeons would leave the hospitals en masse making the hospital unable to function.⁹² This Act reaches a compromise, giving the

84. Video Recoding of Special Committee on Certificate of Need Meeting, Mar. 31, 2008 at 3 min., 47 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor), <http://media.legis.ga.gov/hav/08/comm/sccon/cert033108.wmv> [hereinafter SCCON Meeting 3/31].

85. O.C.G.A. § 31-6-2(23) (Supp. 2008).

86. SCCON Meeting 3/31, *supra* note 84, at 4 min., 30 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor); O.C.G.A. § 31-6-2(23) (Supp. 2008).

87. O.C.G.A. § 31-6-2(33) (Supp. 2008).

88. *Id.* § 31-6-2(23); SCCON Meeting 3/18, *supra* note 43, at 46 min., 06 sec., (Josh Belinfante explaining the physiatrist classification was added in the expectation they would practice at neurosurgery or orthopedic centers; there are only a few plastic hand surgeons, and they practice in a way similar to orthopedists).

89. Cooper Interview, *supra* note 1; SCCON Meeting 3/18, *supra* note 43, at 53 min., 14 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

90. Cooper Interview, *supra* note 1.

91. *Id.*

92. *Id.*

general surgeons the ability to open these centers, but also giving the hospitals the ability to partner with any single specialty center and requiring that they have at least 30% ownership of any such center.⁹³

The Act also changes some definitions. A project is considered a “development” based on the amount of money the project costs and the goal of the project.⁹⁴ For construction, remodeling, or a capital expenditure the threshold amount, after which the project is considered a development, increased from \$900,000 to \$2,500,000.⁹⁵ For projects dealing with “orders, purchases, leases or acquisitions...of major medical equipment” the threshold was increased from \$500,000 to \$1,000,000.⁹⁶ The Act further adds that the million dollar threshold “shall not include build out costs...but shall include all functionally related equipment software, and any warranty and services contract costs”⁹⁷ The Act also changes the definition of “diagnostic, treatment, or rehabilitation center” to require a facility originally categorized under this section to be categorized as a hospital if it allows patients to stay more than 23 hours.⁹⁸ The definition of “person” was amended to include a partnership or limited liability company or any “entity that owns or controls, is owned or controlled by, or operates under common ownership or control with a person.”⁹⁹

Agency Structure

Article 2 of Chapter 6 is amended to further limit the Health Strategies Council’s power. HB 429 (2007) made the council discretionary, and this Act further changes the duties of the council, alters the number of people on the council, and changes what sectors are to be represented on the council.¹⁰⁰ A specific addition is that any

93. *Id.*

94. O.C.G.A. § 31-6-2(14) (Supp. 2008).

95. Compare 1991 Ga. Laws 1871, § 3, at 1872 (codified at O.C.G.A. § 31-6-2(7)(A)), with O.C.G.A. § 31-6-2(14)(A) (Supp. 2008).

96. Compare 1991 Ga. Laws 1871, § 3, at 1872 (codified at O.C.G.A. § 31-6-2(7)(B)), with O.C.G.A. § 31-6-2(14)(B) (Supp. 2008).

97. O.C.G.A. § 31-6-2(14)(B) (Supp. 2008).

98. *Id.* § 31-6-2(16).

99. *Id.* § 31-6-2(29).

100. See O.C.G.A. § 31-6-20(a) (Supp. 2008) (requiring that the private insurance industry, rural and urban hospitals, primary care physicians, specialty physicians, nursing homes, home health agencies,

doctor on the board must be currently practicing medicine.¹⁰¹ The term of the members of the old Health Strategies Council will terminate on June 30, 2008, with seven of the new members serving four year terms and six serving two year terms.¹⁰² The requirements for removal were debated, with the Commission recommending removal at the complete discretion of the Governor, and the SCCON committee requiring dismissal only for cause.¹⁰³ The bill lists three specific reasons—"inability or neglect to perform the duties required of members, incompetence or dishonest conduct"—or if a member, without an excuse, misses 50% or more of the meetings.¹⁰⁴

The Health Strategies Advisory Council's duties are reduced in Code section 31-6-20(g). The Act specifically describes the Council as an advisory body, and later notes that the Department of Community Health can "seek advice, at its discretion from the...Council."¹⁰⁵ It also removes from the Council the requirement of making an annual report to the General Assembly and the power to make rules, giving that power to the Department alone.¹⁰⁶ Specifically, the Act added Code section 31-6-21(b)(8) requiring the Department to create "need methodologies for new institutional health services and health facilities" and service-specific need criteria.¹⁰⁷ Any rules or regulations made by the department must be sent to the Legislature for approval prior to final adoption.¹⁰⁸ If the proposed new rules are not objected to by either the Senate or House Health and Human Services Committees within 30 days, they may be adopted by the Department.¹⁰⁹ Additionally, the Department must

women, disabled, elderly, mental health, indigent people, and business personnel be represented); SCCON Meeting 3/18, *supra* note 43, at 11 min., 55 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor) (noting that "[t]his law cleans it up and makes clear that the Health Advisory Council stays advisory").

101. O.C.G.A. § 31-6-20(a)(4)–(5) (Supp. 2008); SCCON Meeting 3/18, *supra* note 43, at 12 min., 21 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

102. O.C.G.A. § 31-6-20(a), (c) (Supp. 2008).

103. SCCON Meeting 3/18, *supra* note 43, at 13 min., 05 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

104. O.C.G.A. § 31-6-20(d) (Supp. 2008).

105. *Id.* §§ 31-6-20(g), -21(b)(3).

106. *See* O.C.G.A. § 31-6-21(b)(4) (Supp. 2008); 2005 Ga. Laws 333, § 24, (codified at O.C.G.A. § 31-6-20(h)).

107. O.C.G.A. § 31-6-21(b)(8) (Supp. 2008).

108. *Id.* § 31-6-21.1(b).

109. *Id.*

send an annual report to the Health and Human Services Committees of the House and Senate, including “information and updates relating to the state health plan and the certificate of need program” and any federal law issues.¹¹⁰

The Process to Obtain a Certificate of Need

The Act grandfathers in certain facilities which were exempt under previous law, allowing them to continue to give services without obtaining a CON.¹¹¹ To maintain the exemption, however, ambulatory surgery centers and places offering imaging services must meet certain requirements.¹¹² The major issue here is that many existing facilities are not required to offer indigent/Medicaid/PeachCare services.¹¹³ HB 568 phased in these requirements, but this bill gives these facilities two choices: (1) elect to provide that care at 2%; or (2) continue to operate without providing the services and be forced to provide it at 4% if the facility makes certain capital expenditures in the future.¹¹⁴ The goal is to eventually include all previously exempt facilities into this requirement, but on their terms—if a facility never chooses to expand, it will never be subject to these requirements.¹¹⁵

Certain existing ophthalmic ambulatory surgery centers are exempt from the indigent care provision because that kind of specialty has an overall exemption from the indigent care requirement.¹¹⁶ Penalties for non-compliance include monetary fines in the amount of the difference between the percentage committed and the percentage actually given, and possibly revocation.¹¹⁷ These facilities are also

110. *Id.* § 31-6-46.

111. *Id.* § 31-6-40(c)(1).

112. *Id.* § 31-6-40(c)(2) (requiring ambulatory surgery centers give the department notice of their exemption and provide annual reports).

113. SCCON Meeting 3/18, *supra* note 43, at 56 min., 39 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

114. SCCON Meeting 3/18, *supra* note 43, at 56 min., 49 sec.; O.C.G.A. § 31-6-40(c)(2)(C) (Supp. 2008).

115. SCCON Meeting 3/18, *supra* note 43, at 58 min., 29 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

116. O.C.G.A. § 31-6-40(c)(2) (Supp. 2008); SCCON Meeting 3/31, *supra* note 84, at 15 min., 06 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

117. SCCON Meeting 3/31, *supra* note 84, at 14 min., 40 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor) (Josh Belinfante noting the list of reasons for revocation was an

required to identify themselves to the department by January 1, 2009.¹¹⁸ If they do not, they will be fined up to \$500 per day for the first 30 days and \$1,000 per day thereafter.¹¹⁹ The Act, in Code section 31-6-41(a), also allows an “existing skilled nursing facility, intermediate care facility, or intermingled nursing facility” to split into more than one facility without receiving a certificate of need if “the department determines that the proposed division is financially feasible and would be consistent with quality patient care.”¹²⁰ This is the same language that was added in the Senate committee and removed by floor amendment before the Senate vote.¹²¹ The intent here was to allow large nursing homes to split into smaller care facilities as long as the number of beds is not increased.¹²²

The process to obtain a CON, located in Article 3 of Chapter 6, was completely overhauled. Creating or offering a new institutional health service generally requires a CON. The Act moves the definition of “new institutional health service” to Code section 31-6-40, but the definition itself did not change drastically.¹²³ The changes include raising the capital expenditure threshold from \$900,000 to \$2.5 million, so any capital expenditure over \$2,500,000 would be considered a new institutional health service requiring a CON.¹²⁴ HB 568 had set the cap at \$5 million, which many hospital groups did not see as a cap at all, and \$2.5 million is seen as a compromise.¹²⁵ That number is indexed to the “annual percentage of change in the composite index of construction material prices.”¹²⁶ The bill also increases the threshold for the purchase or lease of “diagnostic or therapeutic equipment” from \$500,000 to \$1 million, tying that

amendment to the original substitute, which just said the exemption could be revoked, in order to give the Department guidance); O.C.G.A. § 31-6-40(c) (Supp. 2008).

118. O.C.G.A. § 31-6-40(c)(2)(B) (Supp. 2008).

119. *Id.* § 31-6-70(e)(1).

120. *Id.* § 31-6-41(a).

121. Compare SB 433 (SCS) (08 AM 14 0853), p. 4, ln. 13–16, 2008 Ga. Gen. Assem. with O.C.G.A. § 31-6-41(a) (Supp. 2008).

122. Cooper Interview, *supra* note 1.

123. Compare 1991 Ga. Laws 1871, § 5, at 1873 (previously codified at O.C.G.A. § 31-6-2(14)), with O.C.G.A. § 31-6-40(a) (Supp. 2008).

124. Compare 1991 Ga. Laws 1871, § 5, at 1873 (previously codified at O.C.G.A. § 31-6-2(14)(B)), with O.C.G.A. § 31-6-40(a)(2) (Supp. 2008).

125. SCCON Meeting 3/18, *supra* note 43, at 27 min., 46 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

126. O.C.G.A. § 31-6-40(a)(2) (Supp. 2008).

number to the consumer price index.¹²⁷ Code section 31-6-40(e) allows the commissioner to institute a moratorium on granting CONs for new services.¹²⁸ This gives the department time to act to ensure proper regulation of technology that is new to Georgia.¹²⁹ It also allows facilities to apply for and receive expedited review of applications for new services or capital expenditures during times of emergency.¹³⁰

Code section 31-6-43 requires that prior to applying for a CON a facility must submit a letter of intent to the department.¹³¹ Once the application is submitted, the department considers numerous factors in deciding whether to grant or deny a CON and this Act adds three additional considerations.¹³² First, the service must meet certain quality standards, echoing back to the new policy goal added by the Act.¹³³ Second, the resources and personnel to operate the service must be obtainable.¹³⁴ Finally, the department must favor an application that agrees to provide an underrepresented service along with the service initially applied for.¹³⁵ Additionally, the Act exempts perinatal service providers applying to open a facility from consideration of the population of the area in a county if: (1) only one other facility doing the same service; and (2) there are three or less facilities providing the same service in adjacent counties.¹³⁶

The process of reviewing a CON application is altered by the Act. The department has 120 days to review the application, which can be extended to 150 days with written notice to the applicant if 120 days is not practicable.¹³⁷ The Act allows the department to implement batching cycles. The department would be able to review all the applications for any given service at one time, provided it reviews the

127. *Id.* § 31-6-40(a)(3).

128. *Id.* § 31-6-40(e).

129. SCCON Meeting 3/18, *supra* note 43, at 11 min., 08 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

130. O.C.G.A. § 31-6-43(k) (Supp. 2008).

131. *Id.* § 31-6-43(a).

132. *Id.* § 31-6-42(a)(15)-(17).

133. *Id.* § 31-6-42(a)(15).

134. *Id.* § 31-6-42(a)(16).

135. *Id.* § 31-6-42(a)(17).

136. O.C.G.A. § 31-6-42(b.2) (Supp. 2008).

137. *Id.* § 31-6-43(d).

service at least twice a year.¹³⁸ Under the old system, whoever applied first had the advantage throughout the entire procedure, and the intent was to eliminate that advantage.¹³⁹ A floor amendment re-inserted language specifying that no application, regardless of when it was submitted, will be considered as the first application in a batch.¹⁴⁰ Applications can be added to a batch if the “applications involve similar clinical health service projects in the same service area or overlapping service areas.”¹⁴¹ The original substitute mandated batching, but the Act allows the department to decide which applications to batch and which applications to consider individually.¹⁴² The rationale is that some applications, for example adding an operating room, are not as competitive and do not need to be reviewed all together.¹⁴³ If the department requires additional information the applicant has the ability to meet with the department and provide that information.¹⁴⁴ Opponents to the application also have the ability to meet and provide information supporting the denial of the CON.¹⁴⁵ The department then has 120 days to review the application or group of applications and notify the applicant, and has an additional seven days to make the decision public.¹⁴⁶

Destination Cancer Hospitals Specifically

Code section 31-6-40(d) deals specifically with the individualized process of CON licensing for destination cancer hospitals. That language was taken from the bill as it passed the Senate but some

138. *Id.* § 31-6-43(e), (f).

139. SCCON Meeting 3/18, *supra* note 43, at 15 min., 35 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

140. *See* O.C.G.A. § 31-6-43(f) (Supp. 2008); SB 433 (HCS) (08 LC 33 2657S), 2008 Ga. Gen. Assem., at p. 33, lines 9–18; SB 433 (HCSFA) (08 SB 433/HCSFA), 2008 Ga. Gen. Assem., at p. 1, lines 14–19.

141. O.C.G.A. § 31-6-43(f)(1) (Supp. 2008).

142. O.C.G.A. § 31-6-43(f) (Supp. 2008) (noting “the department may order the joinder of an application...); SCCON Meeting 3/31, *supra* note 84, at 35 min., 20 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

143. SCCON Meeting 3/31, *supra* note 84, at 35 min., 41 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

144. O.C.G.A. § 31-6-43(h) (Supp. 2008).

145. *Id.* (also noting that an opposing party must have attended “an opposition meeting” to challenge a decision of the department).

146. O.C.G.A. § 31-6-43(i) (Supp. 2008).

additional language was added to the bill.¹⁴⁷ The initial CON issued to a destination cancer hospital must list the number of beds and any new institutional health services it is allowed to operate.¹⁴⁸ A destination cancer hospital will not need to apply for a CON for any new services and any review of the services will be under rules created by the department specifically for destination cancer hospitals.¹⁴⁹ A change in the final Act, compared to the version of the bill that passed the Senate, is that the destination cancer hospital specific exemptions only apply if the “institutional health services relate[s] to the treatment of cancer patients,” or is otherwise required “to meet federal or state laws applicable to a hospital.”¹⁵⁰ If the department decides the service is not reasonably related to the treatment of cancer, it will apply the service specific rules to any review.¹⁵¹ This provision is directed towards CTCA, and was inserted to make sure that if its members are treating anything other than cancer, then their application is treated the same as any other hospital, limiting their ability to expand.¹⁵² Additionally, if the destination cancer hospital cannot prove that 65% of its patients in the prior two years were from out of state, any application for a new health service must be denied.¹⁵³

A requirement added by the substitute grants a CON to a destination cancer hospital only if it is located within 25 miles of “a commercial airport in this state with five or more runways.”¹⁵⁴ The intent of the law was to allow CTCA to open near Hartsfield-Jackson Atlanta International Airport, but the substitute as introduced did not contain the word “commercial” and Representative Houston (R-170th) pointed out that other airports in the state had more than 5 runways. To further lock CTCA into the metro-Atlanta area, “commercial” was added in committee and the radius was reduced

147. Compare SB 433 (08 SB433/CSFA/2), p. 2, ln. 5–32, as passed Senate, 2008 Ga. Gen. Assem. with O.C.G.A. § 31-6-40(d) (Supp. 2008).

148. O.C.G.A. § 31-6-40(d) (Supp. 2008).

149. *Id.*

150. Compare SB 433 (08 SB433/CSFA/2), p. 2, ln. 10–14, as passed Senate, 2008 Ga. Gen. Assem. with O.C.G.A. § 31-6-40(d) (Supp. 2008).

151. O.C.G.A. § 31-6-40(d) (Supp. 2008).

152. SCCON Meeting 3/31, *supra* note 84, at 16 min., 09 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

153. O.C.G.A. § 31-6-40(d) (Supp. 2008).

154. *Id.*

from 50 miles to 25 miles.¹⁵⁵ The substitute also added the requirement that a person can only have one CON for a destination cancer hospital. This limits CTCA, or any corporation, to one destination cancer hospital.¹⁵⁶ There can be more than one in the state, but not operated by the same person.¹⁵⁷ The substitute also states that after January 1, 2010, no CON application for destination cancer hospitals shall be reviewed.¹⁵⁸ The intent was to limit CTCA to one destination cancer hospital.¹⁵⁹

The original bill only required that destination cancer hospitals provide indigent care in the amount of 3% of their adjusted gross revenues, but Code section 31-6-40.1(c) mandates that plus an additional independent Medicaid commitment.¹⁶⁰ The goal was to make sure CTCA provided both kinds of care.¹⁶¹ The substitute also adds the penalty of partial or full revocation of the CON if the destination cancer hospital fails to meet these requirements.¹⁶²

The Act requires the destination cancer hospital, through a sworn statement of its CEO, prepare an annual report affirming it has met the 65% requirement, and the department has the ability to review books or records of the hospital.¹⁶³ The Act levies hefty fines on destination cancer hospitals that do not meet the 65% requirement of out-of-state patients.¹⁶⁴ The original Senate bill had a \$1 million

155. See SCCON Meeting 3/18, *supra* note 43, 1 hour, 2 min., 23 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor); Video Recording of Special Committee on Certificate of Need Meeting, March 19, 2008 at 1 hour, 13 min., 42 sec. (remarks by Rep. Houston (R-170th)), <http://media.legis.ga.gov/hav/08/comm/sscon/cert031908.wmv> [hereinafter SCCON Meeting 3/19]; SCCON Meeting 3/31, *supra* note 84, at 16 min., 58 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor); SB 433 (HCSFA) (08 SB 433/HCSFA), 2008 Ga. Gen. Assem.

156. SCCON Meeting 3/18, *supra* note 43, at 1 hour, 02 min., 17 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor) (noting the definition of person was expanded to include all corporate forms, and “only one person can have a CON for a destination cancer hospital”).

157. SCCON Meeting 3/18, *supra* note 43, at 1 hour, 02 min., 10 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

158. O.C.G.A. § 31-6-40(d) (Supp. 2008).

159. SCCON Meeting 3/18, *supra* note 43, at 1 hour, 02 min., 18 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

160. Compare O.C.G.A. § 31-6-40.1(c) (Supp. 2008) (adding the phrase “and provide care to Medicaid beneficiaries), with SB 433 (08 SB433/CSFA/2), as passed Senate, Ga. Gen. Assem., p.3, line 26.

161. SCCON Meeting 3/19, *supra* note 155, at 8 min., 34 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

162. O.C.G.A. § 31-6-40.1(c) (Supp. 2008).

163. *Id.* § 31-6-40.1(c.1)(3).

164. *Id.* § 31-6-40.1(c.1)(1).

dollar fine if the percentage was not met.¹⁶⁵ The original Senate committee substitute had the fine starting at \$1 million and increasing by \$1 million for each additional year the percentage was not met.¹⁶⁶ The Act requires a \$2 million dollar fine the first year, \$4 million the second, and \$6 million the third, with an additional \$8 million fine in the third year.¹⁶⁷ The fines were increased to create a larger incentive for the destination cancer hospital to meet its required numbers.¹⁶⁸ If the CON is revoked because of failure to meet the 65% requirement, the destination cancer hospital will be responsible for additional fines related to “operating without a [CON].”¹⁶⁹

Destination cancer hospitals have to apply for a CON, but the review of the application is specialized.¹⁷⁰ This is different and less contentious than the procedure proposed in HB 568, which would have not required destination cancer hospitals to obtain a CON at all. The requirements are that: (1) 65% of the hospital’s patients will come from out of state; (2) it will provide 3% indigent care and treat Medicaid patients; (3) it will conduct certain kinds of research; (4) it will be “reasonably financially and physically accessible”; (5) it will create a positive relationship with the existing medical community and participate in staffing developments; and (6) have less than a 10% negative impact on the hospitals in the area.¹⁷¹ Those factors were in both the bill as passed out of the Senate and the Act as finally passed.¹⁷² The Act additionally requires a destination cancer hospital to establish a transfer agreement with a nearby hospital.¹⁷³ The language of the original substitute read as “transfer agreement or affiliation agreement” but was changed because affiliation implies

165. SB 433 (08 SB433/CSFA/2), as passed Senate, 2008 Ga. Gen. Assem., p.3, lines 34–37.

166. SCCON Meeting 3/18, *supra* note 43, at 2 min., 57 sec. (remarks by Sen. Tommy Williams (R-19th)).

167. O.C.G.A. § 31-6-40.1(c.1)(1) (Supp. 2008) (noting that the money will be paid into the Indigent Care Trust Fund).

168. SCCON Meeting 3/18, *supra* note 43, at 3 min., 05 sec. (remarks by Sen. Tommy Williams (R-19th)).

169. O.C.G.A. § 31-6-40.1(c.1)(2) (Supp. 2008).

170. O.C.G.A. § 31-6-42(b.1) (Supp. 2008) (stating that factors in paragraphs 1, 2, 3, 7, 8, 10, 11 and 14 shall not apply, but all others will).

171. *Id.* § 31-6-42(b.1)(2) to -42(b.1)(7).

172. *See Id.*; SB 433 (08 SB433/CSFA/2), p.4, ln. 11–35, p.5, ln. 1–2, as passed Senate, 2008 Ga. Gen. Assem.

173. O.C.G.A. § 31-6-42(b.1)(6.1) (Supp. 2008).

liability, and it was not intended for the receiving hospital to be liable for the acts that occurred at the destination cancer hospital.¹⁷⁴

Appeals Process

The Act replaces the Health Planning Review Board with the Certificate of Need Appeal Panel, consisting of independent hearing officers, as the decision makers at the initial level of appeal from the department's decision to grant or deny a CON application.¹⁷⁵ The panel will have five members appointed by the Governor, all of whom are healthcare attorneys, instead of eleven, and the members will serve as hearing officers, unlike the members of the Health Planning Review Board which appointed attorneys to act as hearing officers.¹⁷⁶ The attorneys appointed to the panel must be "familiar with the health care industry" but cannot "have a financial interest in or represent or have any compensation arrangement with any health care facility," and further cannot be a "person required to register with the Secretary of State as a lobbyist or registered agent."¹⁷⁷ The switch was made because the Review Board was cumbersome and slow to act, and the use of the panel brings the review process under the Administrative Procedures Act.¹⁷⁸ The members are not compensated for their position as panel members but are compensated for their time acting as hearing officer.¹⁷⁹

Within thirty days of a decision by the department, the appealing party must file a request for a hearing with the panel, the panel will appoint one of their members as a hearing officer "on a random basis by the chairperson" within thirty days of the filing of that request and the hearing officer must contact the parties within fourteen days of

174. SCCON Meeting 3/31, *supra* note 84, at 37 min., 09 sec. (remarks by John Walraven, Speaker's Counsel).

175. O.C.G.A. § 31-6-44(a) (Supp. 2008); *Id.* § 31-6-49 (noting that "[a]ll matters of the Health Planning Review Board that are pending on June 30, 2008, shall automatically be transferred to the Certificate of Need Appeal Panel . . .").

176. O.C.G.A. §§ 31-6-44(b), (c) (Supp. 2008).

177. *Id.* § 31-6-44(b).

178. SCCON Meeting 3/18, *supra* note 43, at 17 min., 25 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

179. O.C.G.A. § 31-6-44(c) (Supp. 2008).

being appointed to schedule a hearing.¹⁸⁰ Once the hearing officer is appointed, no party may make contact with that officer or any other member of the panel regarding the decision being appealed.¹⁸¹ The Act requires a hearing to be held after 60 days but no later than 120 days from the first contact of the hearing officer.¹⁸²

The hearing officer's review is *de novo* and the appealing party bears the burden of proof.¹⁸³ New evidence can be admitted if the party entering the evidence can show it "was not reasonably available to the party presenting the evidence at the time of the department's review."¹⁸⁴ This rule is more flexible than the old one, but also prevents the parties from purposely holding back evidence.¹⁸⁵ If new evidence is presented, the hearing officer can remand the case and have the department review the new evidence and reconsider the decision if necessary.¹⁸⁶ The decision of the hearing officer is reported in writing to the chairperson of the panel, who gives the decision to the commissioner of the department.¹⁸⁷ If the hearing officer's decision is not objected to within 30 days by filing an objection with the commissioner, it becomes the final decision of the department upon the sixty-first day following the date of the decision.¹⁸⁸

A decision of the panel may be appealed to the commissioner within 30 days.¹⁸⁹ Under old law, review of the hearing officer's decision was done by the Health Planning Review Board.¹⁹⁰ This Act allows review by the commissioner of the department, who has authority to review and reject or modify certain aspects of the

180. *Id.* §§ 31-6-44 (c), (d) (if the appeal is filed by a competing facility, then they must pay certain fees upfront).

181. *Id.* § 31-6-44(h).

182. *Id.* § 31-6-44(d).

183. *Id.* § 31-6-44(f).

184. *Id.* §§ 31-6-44(f)-(g) (specifically preventing an applicant from giving evidence of a new study that is "responsive to the general need consideration or service-specific need formula" if the result is substantially different from prior studies and the different results were available before the department made its decision).

185. SCON Meeting 3/18, *supra* note 43, at 20 min., 22 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

186. O.C.G.A. § 31-6-44(g) (Supp. 2008).

187. *Id.* § 31-6-44(i).

188. *Id.* § 31-6-44(j).

189. *Id.* § 31-6-44(i).

190. 1994 Ga. Laws 684, § 3, at 690-91 (codified at O.C.G.A. § 31-6-44(h)).

decision.¹⁹¹ Conclusions of law may be overturned if there is error, but conclusions of fact can only be overturned if they “were not based upon any competent substantial evidence,” or if “the proceedings on which the findings were based did not comply with the essential requirements of law.”¹⁹² The intent was to limit the commissioner’s ability to overturn a hearing officer’s decision.¹⁹³ The decision of the commissioner (or of the hearing officer if not appealed) becomes the official position of the department, and an unsatisfied party is entitled to judicial review.¹⁹⁴

Judicial reversal or modification of the decision is only permitted if the “substantial rights of the appellant have been prejudiced because of procedures followed by the department” or the findings are unconstitutional; outside the scope of the departments’ authority; unlawful; there is inadequate evidence to support such a finding; or arbitrary or reflect an abuse of discretion.¹⁹⁵ The court has 120 days (absent a continuance) to hear the appeal or the department’s position is affirmed.¹⁹⁶ Cases have sat pending in the Superior Courts for months or even years and this is intended to make the appeals process more streamlined and efficient.¹⁹⁷

The Act creates a substantial fee shifting scheme. If “the appeal filed by any party of a decision of the department lacks substantial justification and was undertaken primarily for the purpose of delay or harassment” awarding attorney’s fees and costs is appropriate.¹⁹⁸ An amendment to the original substitute, proposed in the committee, used the word “solely” instead of “primarily.”¹⁹⁹ During a SCCON debate, the point was raised that “solely” is a very hard standard to

191. O.C.G.A. § 31-6-44(k)(1) (Supp. 2008).

192. *Id.*

193. SCCON Meeting 3/18, *supra* note 43, at 21 min., 01 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

194. O.C.G.A. §§ 31-6-44(m), -44.1(a) (Supp. 2008).

195. *Id.* § 31-6-44.1(a).

196. *Id.* § 31-6-44.1(b).

197. SCCON Meeting 3/18, *supra* note 43, at 23 min., 22 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

198. O.C.G.A. § 31-6-44(l) (Supp. 2008).

199. SCCON Meeting 3/31, *supra* note 84, at 1 hour, 19 min., 20 sec. (remarks by John Walraven, Speaker’s Counsel).

meet, and the word was changed to “primarily” to deter parties thinking about engaging in frivolous litigation.²⁰⁰

Fee shifting is only appropriate if the decision of the department is upheld throughout the entire appeals process.²⁰¹ The commissioner may grant attorneys fees but the superior court judge must award attorney’s fees to the responding party if that party prevails, except when the department is not required to pay fees.²⁰² The initial substitute mandated the grant of attorney’s fees if the standard was proven at either level. However, the day of the committee vote, the Speaker of the House, Glenn Richardson (R-19th), introduced an amendment to make all fee awards discretionary. The argument against softening the provision was that the mandatory fees were the teeth of the law and discretionary awards of attorney’s fees would not sufficiently deter frivolous litigation.²⁰³ The Speaker, through his attorney, John Walraven, argued that in some cases there are truly justiciable claims that need to be appealed and the deciding body should have the discretion to not award fees in those situations.²⁰⁴

The committee voted six to three to change the mandatory provision to discretionary at the commissioner’s level, but voted to keep it at the judicial level.²⁰⁵ However, fees will not be assessed against the department or against parties bringing certain claims about the department’s authority or jurisdiction.²⁰⁶

Revocation and Exemption from Certificate of Need Requirements

Code section 31-6-45 was amended to allow whole or partial revocation of a CON, and added five additional reasons for

200. SCCON Meeting 3/31, *supra* note 84, at 1 hour, 21 min., 13 sec. (remarks by Rep. Sharon Cooper (R-41st) and Josh Belinfante, Deputy Executive Counsel to the Governor).

201. SCCON Meeting 3/18, *supra* note 43, at 21 min., 33 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

202. O.C.G.A. § 31-6-44.1(c), (Supp. 2008).

203. SCCON Meeting 3/31, *supra* note 84, at 1 hour, 33 min., 03 sec. (remarks by Rep. Allen Peake (R-137th)); *Id.* at 1 hour, 37 min., 55 sec. (remarks by Rep. Billy Mitchell (D-88th)).

204. *Id.* at 1 hour, 31 min., 50 sec. (remarks by John Walraven, Speaker’s Counsel). House Speaker Glenn Richardson is a Georgia State University College of Law alum, the editors are proud to note.

205. *Id.* at 1 hour, 35 min., 09 sec.; *Id.* at 1 hour, 46 min., 26 sec.

206. O.C.G.A. §§ 31-6-44(n), -44.1(c) (Supp. 2008).

revocation.²⁰⁷ Revocation can also occur if a person receives a CON but fails to build or supply the service for which the CON was issued “in a timely manner.”²⁰⁸ The Act increased the fines for a facility operating without a CON. The original fine was \$5,000 per day, but based on the recommendation of the commission, the amount was increased to \$10,000 per day, after the first month of fines (at \$5,000 per day), and \$25,000 each day, after the second month.²⁰⁹ The Act specifically allows the department to revoke a facility’s CON if it fails to meet the requirement to “participate as a provider of medical assistance for Medicaid purposes.”²¹⁰ To enforce the provisions of the section and determine whether to move for revocation, the department has the ability to investigate any facility operating with a CON, requiring document and record production.²¹¹ The committee amended this section to require the department to provide the party with reasonable notice of the request to produce.²¹²

The list of facilities exempted from CON was significantly amended. The Act first exempts “religious, nonmedical health care institutions,” as defined by federal law.²¹³ A facility in an urban county, providing diagnostic imaging services and holding a current letter of non-reviewability, can spend up to \$870,000 to replace equipment without having to apply for a CON.²¹⁴ If a facility is repairing damage, caused by a natural disaster, for example, no CON is needed.²¹⁵ Any money spent on non-clinical projects is exempt.²¹⁶ This was specifically included to deal with prior situations where

207. O.C.G.A. § 31-6-45 (Supp. 2008) (adding the following: (3) “[r]epeated failure to pay fines...”; (4) “[f]ailure to maintain minimum quality of care standards...”; (5) “[f]ailure to participate as a provider of medical assistance for Medicaid purposes...”; (6) “failure to submit a timely or complete report...”; and (7) “[f]ailure of a destination cancer hospital to meet an annual patient based composed of a minimum of 65% of patients who reside outside this state...”).

208. *Id.* § 31-6-45(a.1).

209. *Id.* § 31-6-45(c).

210. O.C.G.A. §§ 31-6-45.2(a)–(b) (Supp. 2008).

211. *Id.* § 31-6-45(e).

212. SCCON Meeting 3/31, *supra* note 84, at 25 min., 20 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

213. O.C.G.A. § 31-6-47(a)(5) (Supp. 2008).

214. *Id.* § 31-6-47(a)(10).

215. *Id.* § 31-6-47(a)(10.1); SCCON Meeting 3/31, *supra* note 84, at 26 min., 50 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

216. O.C.G.A. § 31-6-47(a)(16) (Supp. 2008) (specifically mentioning “parking lots, parking decks...computer systems, software...medical office buildings; and state mental health facilities”).

hospitals had to apply for a CON to replace carpeting or expand their parking garage.²¹⁷ Continuing care facilities are exempted subject to certain requirements.²¹⁸ An example of a continuing care facility is a complex that has independent living, assisted living, and a nursing home.²¹⁹ The nursing homes in this group were not allowed to take patients from outside their chain of facilities but had to be fully staffed to obtain a CON.²²⁰ Often, moving people from assisted living to the nursing home took six to eight years.²²¹ The Act allows the nursing home of the group to be exempt from the CON requirement and let outside people into the nursing home for the first five years.²²²

The next exemption added by the Act applies to “single specialty ambulatory surgery center[s].”²²³ To be exempt, the center must: (1) not exceed \$2,500,000 in “capital expenditures associated with [its] construction, development or other establishment”; and (2) be “the only single specialty ambulatory surgical center in the county owned by the group practice and has two or fewer operating rooms.”²²⁴ The county restriction was added to prevent physicians from essentially opening a hospital by owning five ambulatory surgery centers in a row.²²⁵ The center must also have a hospital affiliation agreement, provide care to Medicaid beneficiaries, and provide annual reports in accordance with Code section 31-6-70.²²⁶ Moreover, by giving centers that need more than two operating rooms the option to acquire them pursuant to the normal CON process, the law permits more flexibility.²²⁷

217. SCCON Meeting 3/19, *supra* note 155, at 1 hour, 13 min., 02 sec. (remarks by Rep. Penny Houston (R-170th)).

218. O.C.G.A. § 31-6-47(a)(17) (Supp. 2008).

219. Cooper Interview, *supra* note 1.

220. *Id.*

221. *Id.*

222. O.C.G.A. § 31-6-47(a)(17) (Supp. 2008) (noting that the percentage of outside people allowed phases out; the “facility may utilize not more than 50% of its licensed beds for patients who are not residents” in the first year, 40% of bed capacity for new patients in year 2, 30% in year 3, etc, with the maximum at any one time being 50% total occupied beds).

223. *Id.* § 31-6-47(a)(18) (applying to physician owned centers only).

224. *Id.* § 31-6-47(a)(18)(A).

225. SCCON Meeting 3/18, *supra* note 43, at 49 min., 00 sec (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

226. O.C.G.A. §§ 31-6-47(a)(18)(B)–(D) (Supp. 2008).

227. SCCON Meeting 3/18, *supra* note 43, at 48 min., 44 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

The next requirement an ambulatory surgery center must meet to be exempt, similar to destination cancer hospitals, is that the center must have a hospital affiliation or transfer agreement with a local hospital.²²⁸ The rule also requires that if a hospital denies a transfer/affiliation agreement, the denial must be reasonable.²²⁹ The final requirement deals with the center's provision of indigent care. If a center provides Medicaid and PeachCare, it must "provide[] uncompensated indigent and charity care in an amount equal to or greater than 2% of its adjusted gross revenue."²³⁰ Centers that do not participate in Medicaid or PeachCare remain exempt only if they provide 4% or more indigent care.²³¹ The numbers are fixed to provide uniformity for all centers.²³² Ophthalmology centers are exempt from the indigent care requirement.²³³ Code section 31-6-47(18) also states that failure to pay fines imposed for repeated noncompliance—in the amount of the difference between the indigent service pledged and indigent service provided—or repeated failure to report the required information could result in revocation of the exemption.²³⁴

The Act next creates an exemption for "joint venture ambulatory surgery centers." Unlike physician owned centers, joint venture centers must not exceed \$5 million in construction, development or other establishment costs to qualify them for an exemption.²³⁵ The cap was increased from the threshold for physician owned centers to encourage doctors and hospitals to team up.²³⁶ The joint ventures also have the 2% or 4% indigent care requirement. In the original

228. O.C.G.A. § 31-6-47(a)(18)(B) (Supp. 2008).

229. *Id.*

230. *Id.* § 31-6-41 (a)(18)(C)(i).

231. *Id.* § 31-6-41 (a)(18)(C)(ii).

232. SCCON Meeting 3/18, *supra* note 43, at 51 min., 10 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

233. O.C.G.A. § 31-6-47(a)(18)(C)(ii) (Supp. 2008); SCCON Meeting 3/18, *supra* note 43, at 52 min., 08 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor) (noting that ophthalmologists are exempted from this requirement because they mainly have self pay or Medicare patients, they would almost always be required to pay the fine and could then be subject to exemption revocation).

234. O.C.G.A. § 31-6-47(18) (Supp. 2008).

235. Compare O.C.G.A. § 31-6-47(a)(18)(A)(i) (Supp. 2008), with O.C.G.A. § 31-6-47(a)(19)(A) (Supp. 2008).

236. SCCON Meeting 3/18, *supra* note 43, at 53 min., 13sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

substitute, the percentage was the same as hospitals—at 3%—but it was changed to make it consistent with the physician owned centers.²³⁷ The rules about revocation for non-compliance are the same as for physician owned centers.²³⁸

Imaging centers that are forced to expand due to increased need are exempt if they can show that: (1) it was open before January 1, 2008; (2) are owned by a hospital or physicians, at least 80% of whom are certified in radiology; (3) the center provides three or more different kinds of diagnostic imaging services; (4) “accepts all patients regardless of ability to pay”; and (5) at least matches the amount of indigent care provided by the nearest general acute care hospital.²³⁹ The Act also exempts “diagnostic cardiac catheterization [if performed] in a hospital setting on patients 15 years of age and older.”²⁴⁰ Therapeutic cardiac catheterization services are exempt if the hospital meets the criteria to participate in the C-PORT research study.²⁴¹ An additional exemption excludes “infirmaries or facilities operated by, on behalf or, or under contract with the Department of Corrections or the Department of Juvenile Justice for the sole and exclusive purpose of providing health care services . . . to prisoners within a penal institution, penitentiary, prison, detention center, or other secure correctional institution.”²⁴² The Act also allows certain facilities to relocate, as long as they do not add new services, without obtaining a CON.²⁴³ This was implemented because many existing facilities, especially nursing homes, are so old that building a new facility would be more cost effective than remodeling the existing

237. SCCON Meeting 3/31, *supra* note 84, at 27 min., 50 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

238. O.C.G.A. § 31-6-47(a)(19)(B)–(C) (Supp. 2008).

239. *Id.* §§ 31-6-47(a)(20)(A)–(E).

240. *Id.* § 31-6-47(a)(21).

241. *See id.* § 31-6-47(a)(22) (C-PORT is the Atlantic Cardiovascular Patient Outcomes Research Team); SCCON Meeting 3/31, *supra* note 84, at 29 min., 51 sec., (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor) (The original substitute only exempted hospitals that were actually in the study, but the Act includes all eligible hospitals because some hospitals that applied for the study were rejected based on conditions out of their control); *see also* O.C.G.A. § 31-7-3 (Supp. 2008) (requiring that once the study is completed new rules must be made and any hospitals previously exempt must “apply for a permit to continue providing therapeutic cardiac catheterization services once the department promulgates the rules.”).

242. O.C.G.A. § 31-6-47(a)(23) (Supp. 2008).

243. *Id.* § 31-6-47(a)(24) (listing “skilled nursing facility or intermediate care facility within the same county, any other health care facility in a rural county within the same county, and any other health care facility in an urban county within a three-mile radius of the existing facility”).

facility.²⁴⁴ Finally, facilities “devoted to the provision of treatment and rehabilitative care” of traumatic brain injuries are exempt from CON requirements with the understanding that there will be strict licensing procedures in place.²⁴⁵

The Act requires that any facility implementing an exempt service notify the department in advance.²⁴⁶ Opposition to the exemption will be heard and rulings can be appealed pursuant to the procedures stated above.²⁴⁷ Code section 31-6-70 requires that all facilities requiring a CON, and all “ambulatory surgical centers and imaging centers, whether or not exempt from obtaining a certificate of need under this chapter” file an annual report with the department. If this information is not filed, the department has the authority to revoke the CON for that facility.²⁴⁸

Switching the Licensing Function

The Act transfers licensing functions from the Department of Human Resources (DHR) to the Department of Community Health (DCH).²⁴⁹ Code section 31-1-1 defines “board,” “commissioner,” and “department” to refer to the DHR, and the Act amends this section by noting reference to the DHR is appropriate “except as specifically provided otherwise.”²⁵⁰ The Act then changes the definition of “department” to refer to the DCH in Code sections dealing with the regulation of hospitals,²⁵¹ home health agencies,²⁵² data collection in

244. Cooper Interview, *supra* note 1.

245. O.C.G.A. § 31-6-47(a)(25) (Supp. 2008); SCCON Meeting 3/18, *supra* note 43, at 44 min., 32 sec. (remarks by Josh Belinfante, Deputy Executive Counsel to the Governor).

246. O.C.G.A. § 31-6-47.1 (Supp. 2008).

247. *Id.*

248. *Id.* §§ 31-6-70(a), (e)(2).

249. SB 433, as passed, 2008 Ga. Gen. Assem.

250. O.C.G.A. § 31-1-1 (Supp. 2008).

251. *Id.* § 31-7-1. The change in this Code section caused changes in Code section 24-10-70, dealing with producing medical records for evidence in legal proceedings, Code section 31-7-5 dealing with exemptions from permit requirements for physicians, Code section 31-7-9(a), dealing with physician reporting requirements, Code section 31-33-2(1)(a) dealing with providing copies of health records to patients and third parties and Code section 51-1-29.3(a)(3), dealing with immunity for physicians who authorizes the installation of external defibrillators. However, none of these Code sections were affected substantively.

252. O.C.G.A. § 31-7-150 (Supp. 2008).

the healthcare field,²⁵³ private home care providers,²⁵⁴ and personal home healthcare facilities power to license and conduct employee record checks.²⁵⁵

The Act switches the licensing function to the DCH in the definition of medical facilities,²⁵⁶ hospitals,²⁵⁷ birthing centers,²⁵⁸ projects,²⁵⁹ and emergency medical providers.²⁶⁰ The Act also switches the licensing function in relation to State Medical Education Board scholarships,²⁶¹ loan programs for osteopathic medicine,²⁶² disclosure of confidential AIDS information,²⁶³ cremation,²⁶⁴ corporations contracting with hospitals,²⁶⁵ fire regulation,²⁶⁶ and reporting certain traumatic brain and spinal cord injuries.²⁶⁷

The Act amends Code section 31-7-175, dealing with Georgia Hospice Law, to require that any standards or rules promulgated by the DHR under this section be comprehensive. The Act also includes “freestanding imaging center” in the definition of “institution” in Code section 31-7-1. It also expands the definition of “medical facility” in Code section 31-7-9, dealing with reporting requirements, to include “freestanding imaging center” and “destination cancer hospital or specialty hospital.”²⁶⁸

The Act also makes substantive changes in relation to the powers and duties of the DCH. Code section 31-7-354, newly created by the Act, gives the DCH authority to promulgate rules and regulations in

253. *Id.* § 31-7-280.

254. *Id.* § 31-7-300.

255. *Id.* § 31-7-250.

256. *Id.* § 52-7-14(c)(4)(A) (in the context of watercraft accidents and collisions); *id.* § 19-10A-2 (as applied to the Safe Place for Newborns Act).

257. O.C.G.A. § 31-20-1 (Supp. 2008) (in the context of hospitals authorized to perform sterilization procedures); *id.* 51-2-5.1(a)(2) (relating to the “relationship between hospital and health care provider as a prerequisite to liability”); *id.* § 31-7-400(8) (in the statute dealing with hospital acquisitions); *id.* § 44-14-470(a)(1) (relating to creating liens for injured parties).

258. *Id.* § 43-34-26.3(a)(2) (Supp. 2008) (detailing procedures registered nurses are authorized to perform).

259. *Id.* § 36-42-3(6) (relating to municipal regulation of downtown development authorities).

260. O.C.G.A. § 31-11-81 (Supp. 2008) (relating to the provision of emergency services).

261. *Id.* § 20-3-513.

262. *Id.* § 20-3-476.

263. *Id.* § 24-9-47.

264. *Id.* § 31-21-5(a).

265. *Id.* § 33-19-10.

266. O.C.G.A. § 25-2-13 (Supp. 2008).

267. *Id.* § 31-18-3 (also replacing the word ‘disability’ with the word injury).

268. *Id.* § 31-7-9(a).

relation to nursing home employee record checks, and Code section 31-8-46 gives the DCH power to suspend or revoke a hospital's license for a violation of unrelated Code sections.²⁶⁹ The Act also requires the DCH to promulgate quality standards for clinical services provided by hospitals, and empowers the DCH to grant permits for clinical services—and revoke those permits if the quality standards are not met.²⁷⁰

Code section 31-7-3(a) addresses the ongoing Atlantic Cardiovascular Patient Outcomes Research Team Study (C-Port Study).²⁷¹ The Act requires that once the study is complete, DCH will promulgate rules stating the quality of care required for cardiac catheterization.²⁷² Any hospital that participated in the study, although exempt from certificate of need requirements, must apply for a permit under this section to continue providing cardiac catheterization.²⁷³

The Act inserted Code section 31-7-308 in the article regulating private home care providers.²⁷⁴ Subsection (a) transfers the licensing and regulating power over private home care providers from the DHR to the DCH.²⁷⁵ Subsection (b) requires the DCH to comply with all pre-existing “rules, regulations, policies, procedures, and administrative orders,” and also requires DCH to accept all “rights, privileges, entitlements, obligations, and duties of the DHR.”²⁷⁶ Subsection (c) states any pre-existing rights, privileges, or duties will not be diminished and will continue to exist after the transfer.²⁷⁷ Subsection (d) outlines the status of employees after the transfer.²⁷⁸ The Act adds additional sections throughout the Code similar to Code section 31-7-308, but in the context of “facility licensing and employee records checks for personal care homes,”²⁷⁹ “licensure and

269. *Id.* § 31-8-46.

270. *Id.* §§ 31-7-2.1, -3(a), -4.

271. O.C.G.A. § 31-7-3(a) (Supp. 2008).

272. *Id.*

273. *Id.*

274. O.C.G.A. § 31-7-308 (Supp. 2008) (located in Article 13 entitled Private Home Care Providers).

275. *Id.* § 31-7-308(a).

276. *Id.* § 31-7-308(b).

277. *Id.* § 31-7-308(c).

278. *Id.* § 31-7-308(d).

279. O.C.G.A. § 31-7-265 (Supp. 2008).

regulation of home health agencies,”²⁸⁰ and “the licensure and regulation of hospitals and related institutions.”²⁸¹

Analysis

The Debate Over the Need for Certificate of Need Laws

The Continuation of Certificate of Need Laws Throughout the United States

The Federal Health Planning Resources Development Act of 1974 required all states to implement procedures for state health planning agencies to control costs associated with building and purchasing equipment for healthcare facilities.²⁸² Although Congress repealed the act and its funding in 1987, as of February 2008, thirty-six states, including Georgia, maintained certificate of need programs, which were initially enacted to control costs and prevent duplication of healthcare services.²⁸³

States face a variety of issues in controlling healthcare costs: the growth of healthcare facilities, the most cost-effective way to provide new healthcare services, creating new facilities based on population growth, adding new facilities in the right geographical areas, ensuring the availability of nurses and other healthcare personnel to adequately staff new facilities, addressing concerns about the financial health of hospitals who will carry a greater debt load from new construction, and increasingly cutthroat competition among healthcare providers.²⁸⁴ Certificate of need regulations attempt to control healthcare price inflation by limiting the expansion of healthcare facilities and healthcare technology and not allowing for the creation

280. *Id.* § 31-7-159.

281. *Id.* § 31-7-17.

282. Richard Cauchi et al., National Conference of State Legislatures, Certificate of Need: State Health Laws and Programs (May 8, 2008), <http://www.ncsl.org/programs/health/cert-need.htm#resources>.

283. *Id.*

284. Jodie Snyder, *Valley Hospital Boom Under way: Where, How to Staff Are Challenges*, ARIZ. REP., May 1, 2005, available at <http://www.azcentral.com/arizonarepublic/news/articles/0501hospitals01.html>

of excess capacity, which would, in turn, require patients to pay more to cover the facility's higher fixed costs.²⁸⁵

Regulation advocates favoring controlled healthcare facility growth through certificate of need laws disagree with those who are in favor of free-market competition.²⁸⁶ Research linking an absence of certificate of need programs to higher mortality in patients post-surgery supports arguments in favor of the certificate of need regulations.²⁸⁷ Both employers and full-service hospitals argue that unregulated hospital expansion leads to overcapacity, higher costs, and increased financial pressure on large public hospitals that must continue to provide vital but unprofitable services, while losing revenue-generating business to specialty hospitals.²⁸⁸ This financial pressure could endanger a large, public hospital's ability to provide care for the local citizens.²⁸⁹

On the other side of the debate, for-profit hospitals argue that exemptions within certificate of need programs, or simply repealing CON statutes, prevent existing, local hospitals from continuing their

285. Cauchi et al., *supra* note 282.

286. See Snyder, *supra* note 284; see also Cauchi et al., *supra* note 282 (chart of both CON Supporters' Views and CON Opponents' Views).

287. Mary S. Vaughan-Sarrazin et al., *Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation*, 288 J. AM. MED. ASS'N 1859 (Oct. 16, 2002).

288. See Bernard Wysocki, Jr., *Regulation or Competition? States Battle Over How to Get Reasonable, Quality Health Care*, WALL ST. J., May 7, 2002, at A4; see also Mark Gaffney & Martin Zimmerman, *Opinions Commentary, An Old-Fashioned Way to Control Costs: Well-Run Certificate of Need Programs Can Help Rein in Rising Healthcare Spending*, MOD. HEALTHCARE, Nov. 11, 2002, at 32 (discussing controlling costs and the "medical arms race"). But see *Physician-Owned Specialty Hospitals: Hearing Before the S. Comm. on Health*, 109th Cong. (2005) (statement of James Grant, American Surgical Hospital Association):

Based on a longitudinal study of general hospital profit margins in markets with and without specialty hospitals, we find that profit margins of general hospitals have not been affected by the entry of specialty hospitals. Consistent with economic theory, the models consistently showed that the most important predictor of general hospital profitability was the extent of competition from other general hospitals in the same market area. . . . Contrary to the conjecture that entry by specialty hospitals erodes the overall operating profits of general hospitals, general hospitals residing in markets with at least one specialty hospital have higher profit margins than those that do not compete with specialty hospitals.

These findings are also consistent with economic theory, which suggests that firms will enter markets in which extant profit margins are comparatively higher.

289. See Wysocki, *supra* note 288.

monopolies over a state's healthcare services.²⁹⁰ Both the Federal Trade Commission and Department of Justice recommend that states reevaluate whether existing certificate of need programs best serve their residents: "[T]he FTC and DOJ believe that such programs are not successful in containing health care costs, and they pose serious anticompetitive risks that usually outweigh their purported economic benefits"²⁹¹ Hospitals that are seeking to expand argue that additional facilities are warranted due to growing waitlists for surgeries and patients who travel farther from home to seek care.²⁹²

The Continuation of Certificate of Need Laws in Georgia

The debate over the continuing existence of certificate of need laws has occurred nationally as well as in Georgia.²⁹³

The Georgia Chamber of Commerce generally supported the more stringent certificate of need law as it existed prior to the passage of SB 433.²⁹⁴ The Georgia Chamber of Commerce is concerned about the rise in health care costs for its members, who are also paying more to insure their employees.²⁹⁵ George Israel, President and CEO of the Georgia Chamber of Commerce, stated that while the organization generally favors free enterprise and competition, it is not in favor of letting free market forces work in the healthcare arena due to reductions in reimbursement for Medicaid and Medicare and hospitals' increased costs for indigent care.²⁹⁶ Mr. Israel is concerned

290. *Id.*

291. Press Release, Federal Trade Comm'n, FTC and DOJ Issue Report on Competition and Health Care: Report Reviews the Role of Competition, Provides Recommendations to Improve the Balance Between Competition and Regulation in Health Care (July 23, 2004), available at <http://www.ftc.gov/opa/2004/07/healthcarerpt.shtm>; see also Jim Wooten, Opinion, *The Real Need? Healthy Competition*, ATLANTA J.-CONST., Mar. 18, 2008, available at <http://www.ajc.com/news/content/opinion/stories/2008/03/18/tuwooten0318.html?> (stating that Georgia's certificate of need law is "a relic that protects monopolies and tempts the creation of 'an illegal cartel among the hospitals,' a phrase drawn from an 11th U.S. Circuit Court of Appeals decision in 1991").

292. See Wysocki, *supra* note 288.

293. See *infra* notes 294–304 and accompanying text.

294. Telephone Interview with George M. Israel, III, President & CEO, Georgia Chamber of Commerce (Apr. 24, 2008) [hereinafter Israel Interview].

295. *Id.*; see also Gaffney and Zimmerman, *supra* note 288 ("Unions fear that escalating health costs . . . mean that there are fewer funds for wages and other employee benefits. . . . [B]usinesses and unions do not want to eliminate CON – one of the most important cost-containment tools available.").

296. Israel Interview, *supra* note 294.

because hospitals providing services through emergency rooms and general facilities are in the red; in fact, three years ago, there were more than ninety hospitals in the red.²⁹⁷ Atlanta's twenty-five largest hospitals spent almost \$485 million in uncompensated, indigent care for uninsured patients in 2005, a 12% increase from the previous year.²⁹⁸ Chambers of commerce throughout Georgia are concerned about the future health of the hospitals in their areas and what will happen to the communities clustered around those hospitals if those local hospitals are endangered by weaker certificate of need regulations.²⁹⁹ Mr. Israel stated that the Georgia Chamber may have supported SB 433 and letting the free market work if Medicare and Medicaid were fully funded, so that insured patients were not subsidizing indigent care, emergency room care, Medicare, and Medicaid.³⁰⁰

On the other side of the issue, the Medical Association of Georgia would have preferred that SB 433 remove certificate of need regulation in Georgia completely.³⁰¹ Brian Looby, Associate General Counsel for the Medical Association of Georgia, argued that "CON hinders competition in healthcare markets" and noted that most consumers are unaware of the effect of CON laws on healthcare costs.³⁰² However, in the end, the Medical Association supported SB 433.³⁰³ Dr. Jack Chapman, President of the Medical Association of Georgia, "thought that it was a good compromise for everyone involved to be able to move forward and get more toward an open market from where we are today" and that patients will benefit from more choices.³⁰⁴

297. *Id.*

298. Douglas Sams, *Hospitals Compete for Indigent Funds*, ATLANTA BUS. CHRON., May 18, 2007, available at <http://atlanta.bizjournals.com/atlanta/stories/2007/05/21/story9.html>.

299. Israel Interview, *supra* note 294.

300. *Id.*

301. Telephone Interview with Brian Looby, Associate General Counsel, Medical Association of Georgia (Apr. 23, 2008) [hereinafter Looby Interview].

302. *Id.*

303. Telephone Interview with Jack Chapman, M.D., President, Medical Association of Georgia (Apr. 23, 2008) [hereinafter Chapman Interview].

304. *Id.*

Provision in SB 433 for Cancer Treatment Centers of America

Cancer Treatment Centers of America (CTCA) aggressively lobbied the Georgia legislature to create an exception for destination cancer hospitals from its certificate of need program.³⁰⁵ CTCA currently has four centers throughout the United States: Philadelphia, Pennsylvania; Seattle, Washington; Tulsa, Oklahoma; and Zion, Illinois.³⁰⁶ Pennsylvania is the only state in which CTCA has a clinic that currently does not have a certificate of need program.³⁰⁷ Certificate of need programs in other states have prevented and delayed the creation of new cancer treatment facilities.³⁰⁸ CTCA will open a new facility near Phoenix, Arizona, in early 2009.³⁰⁹ Although Arizona does not have a certificate of need program, it has struggled with the same healthcare facility expansion problems that plague all states, including Georgia.³¹⁰

The Georgia Chamber of Commerce counts eighty of the state's hospitals and health care facilities as members, and opposes the loophole that SB 433 creates for destination cancer hospitals.³¹¹ Georgia Chamber of Commerce President George M. Israel stated, "Georgia's existing cancer treatment facilities provide outstanding, first-class service to our state and region—in fact, to the nation—and they have invested millions and millions in the very same technologies as CTCA. . . . It is only fair and equitable that all new entrants to this area be subjected to the same procedures as their predecessors."³¹²

Although twenty-three senators voted against SB 433 on February 27, 2008, only those in favor of the bill took the floor, and their statements echo the concerns of legislators from other states that have

305. Andrea Jones, 'Destination Cancer Hospital' Gets Senate Approval, ATLANTA J.-CONST., Feb. 27, 2008, available at http://www.ajc.com/news/content/metro/atlanta/stories/2008/02/27/legcancer_0227.html.

306. Our Hospitals and Clinics, *supra* note 25.

307. Cauchi et al., *supra* note 282.

308. See, e.g., WASH. DOH FINDINGS, *supra* note 28.

309. Our Hospitals and Clinics, *supra* note 25.

310. Snyder, *supra* note 284; see also Wysocki, *supra* note 288.

311. GeorgiaChamber.com, Hot Legislative Issues (Healthcare), <http://www.gachamber.com/Hot-Issues.65.0.html?&category=42> (last visited June 9, 2008).

312. Mike King, *Our Opinion: Special Treatment for One Hospital*, ATLANTA J.-CONST., Feb. 27, 2008, available at <http://www.ajc.com/opinion/content/opinion/stories/2008/02/27/cancered0227.html>.

struggled with certificate of need programs.³¹³ Senate Majority Leader Tommie Williams addressed concerns that creating a loophole for destination cancer hospitals would be financially detrimental to existing Georgia hospitals:

[SB 433] modifies the CON application process to let a company that is a regional, of a regional nature, in other words they never could qualify under current CON because they can't meet that population base. Their population base is from out of state. Although they would see, and they went as far to guarantee so that other hospitals would not worry about them taking their business, that they would see sixty-five percent from out of state and would put a million dollar fine on themselves to do that.³¹⁴

Senator Ross Tolleson's (R-20th) statements reflect the emotion surrounding this controversial issue, and illustrate that certificate of need restrictions can be a very personal issue to legislators:

As you punch that button, don't think about money; don't think about politics; don't think about whether you're coming back; don't think about whether you're under attack by whatever you vote. But I'd ask you out of respect for people that I've seen come and go close to me, and that you've probably seen come and go close to you. I'd ask out of respect for them that you think about the people that are dying now of cancer and just give them the opportunity to make that decision themselves.³¹⁵

Senator Vincent Fort (D-39th) voted against SB 433 because Grady Hospital is in his district, and he was concerned about the possibility of resources being taken away from it.³¹⁶ Senator Fort believes that CTCA may be able to cherry pick wealthy patients to

313. See *Lawmakers 2008* (GPTV broadcast, Feb. 27, 2008), available at <http://www.gpb.org/lawmakers/2008/02/27>; Georgia Senate Voting Record, *supra* note 58.

314. Senate Video, *supra* note 36.

315. Senate Video, *supra* note 36, at 1 hr., 46 min., 10 sec. (remarks by Sen. Ross Tolleson (R-20th)); see also Jones, *supra* note 305 ("Sen. Ross Tolleson broke down at the podium as he talked about his sister's painful death from cancer. He urged his fellow senators to vote to approve the bill.").

316. Telephone Interview with Sen. Vincent Fort (D-39th) (Apr. 23, 2008) [hereinafter Fort Interview].

the detriment of hospitals like Grady.³¹⁷ The Senator also noted that the issues and policy became secondary due to CTCA's extensive lobbying effort.³¹⁸ CTCA employed six lobbyists to work the Georgia Senate and House of Representatives and gave more than \$73,000 in campaign contributions to members of the General Assembly.³¹⁹

The Georgia Chamber of Commerce was one of the opponents to the provision for CTCA's new facility in Georgia due to concerns that CTCA is offering a service already being provided by other Georgia hospitals.³²⁰ George Israel also noted that the fifty bed restriction placed on CTCA may be misleading because many patients will only stay in the facility for a few days, and others will only receive outpatient services; the facility will still be able to treat a large number of patients.³²¹ Leo Reichert, representing the Georgia Alliance of Community Hospitals, commented that CTCA was not applying for a certificate of need, but "[w]hat they seek is effectively a guarantee that if they come in and file an application, the department will stamp yes on it, and they can build. Respectfully, we don't believe that there is a justification to give this out-of-state company any benefit under the CON laws that's not available to Georgia's hospitals."³²²

Jason Bring, a partner in the health law practice at Arnall Golden Gregory in Atlanta, noted that the provisions relating to CTCA may face legal challenges under the Georgia Constitution, which contains a provision against special legislation on behalf of one entity.³²³

317. *Id.* See also Sams, *supra* note 298 ("[Grady] teeters on the edge of a financial cliff, losing \$3 million a month. It is projected to go broke by the end of the year unless the state or additional Georgia counties give the hospital a major infusion of cash.") and Shaila Dewan & Kevin Sack, *A Safety-Net Hospital Falls into Financial Crisis*, N.Y. TIMES, Jan. 8, 2008, available at <http://www.nytimes.com/2008/01/08/us/08grady.html> ("[B]ecause in Atlanta, as in most other cities, better-financed private and nonprofit hospitals are able to market their services and high-tech equipment to patients with good insurance coverage, including those on Medicare, leaving Grady with little but those it was intended to help: the under-insured and those without insurance at all.").

318. Fort Interview, *supra* note 316.

319. Editorial, *Senate Bill Would Help Erode Georgia's Health-Care System*, MACON TELEGRAPH, Feb. 28, 2008, at A, available at 2008 WLNR 3856258 [hereinafter Editorial].

320. Israel Interview, *supra* note 294.

321. *Id.*

322. SCCON Meeting 3/19, *supra* note 155, at 38 min., 5 sec. (remarks by Leo Reichert, Georgia Alliance of Community Hospitals).

323. GA. CONST. art III, § 6, para. 4; Telephone Interview with Jason Bring, Partner, Arnall Golden Gregory, J.D. Georgia State University School of Law 1998 (Apr. 24, 2008) [hereinafter Bring Interview].

Although SB 433 does not expressly name CTCA, “everyone knew that is what it is for.”³²⁴

Provisions in SB 433 for Recognizing General Surgeons as a Single Specialty

Professor Randall Hughes, with the health law department at Georgia State University’s College of Law, noted that both doctors and the Department of Community Health focused a lot of attention on how general surgeons were classified for the purposes of obtaining a certificate of need.³²⁵ Previously, general surgeons did not meet the definition of “single specialty” due to the breadth of their practice.³²⁶ SB 433 allows general surgeons to now meet the qualifications for owning a single practice, because single specialty ambulatory surgical centers fall under a certificate of need exemption, as long as the capital expenditures are below a specified threshold.³²⁷ Dr. Jack Chapman, President of the Medical Association of Georgia, is very happy that SB 433 recognizes general surgery as a single specialty.³²⁸

Hospitals are concerned that this provision will allow one more class of doctors to cherry pick patients by directing paying patients to their ambulatory surgery centers and nonpaying patients to the hospitals.³²⁹ Professor Hughes noted that this concern is partially answered by provisions that require facilities obtaining a single specialty certificate of need exemption to provide an indigent care commitment based on their gross adjusted revenue.³³⁰ Temple Sellers, Vice President of Legal Services for the Georgia Hospital Association, voiced her concerns about the general surgery exemption in SB 433 and the “types of provisions that just ultimately result in more services being provided outside of the hospital setting

324. Bring Interview, *supra* note 323.

325. Telephone Interview with Randall Hughes, Professor in the Health Law Department of Georgia State University’s College of Law (Apr. 23, 2008) [hereinafter Hughes Interview].

326. O.C.G.A. § 31-6-47(a)(18)(A)(i) (Supp. 2008); Hughes Interview, *supra* note 325.

327. *Id.*

328. Chapman Interview, *supra* note 303.

329. See Hughes Interview, *supra* note 325; see also Editorial, *supra* note 319, (explaining problems caused by cherry-picking patients: “Paying customers help defray the costs of those who cannot pay. Eliminate that revenue stream, bit by bit, and before long, hospitals all over the state will be in the same fiscal shape as Atlanta’s Grady Hospital.”).

330. O.C.G.A. § 31-6-47(a)(18)(C)(i) (Supp. 2008); Hughes Interview, *supra* note 325.

that are profitable services as hospitals struggle to be able to meet the needs of many patients that just don't have the means of paying for those services."³³¹ Leo Reichert, representing the Georgia Alliance of Community Hospitals, also noted that the new general surgery centers will take insured patients away from hospitals.³³²

Provisions in SB 433 for Ambulatory Surgical Centers

The provision in SB 433 relating to ambulatory surgery centers must be looked at in the context of federal anti-kickback laws, in addition to the Stark Law, which prohibit a party who owns an interest in an entity that bills Medicare from referring patients to the entity.³³³ There are two important exceptions to the Stark Law: if the party owns an interest in a whole hospital or if the party owns an interest in an ambulatory surgical center.³³⁴ Dr. Jack Chapman, President of the Medical Association of Georgia, believes that ambulatory surgical centers are a less costly, more efficient form of healthcare, and patients like these types of facilities.³³⁵ He stated that SB 433 leaves an important issue concerning ambulatory surgical centers unresolved: the only patients who can use a doctor's ambulatory surgical center are ones from his own practice.³³⁶ Solo practitioners and doctors who are not a part of the group cannot use the facility.³³⁷ This has a greater impact on ophthalmologists like Dr. Chapman, because it is difficult for them to get time in hospital operating rooms.³³⁸

331. SCCON Meeting 3/19, *supra* note 155, at 22 min., 42 sec. (remarks by Temple Sellers, Vice President of Legal Services, Georgia Hospital Association).

332. SCCON Meeting 3/19, *supra* note 155, at 37 min., 10 sec. (remarks by Leo Reichert, Georgia Alliance of Community Hospitals).

333. Hughes Interview, *supra* note 325. Congress enacted the Stark Law to address the conflict of interest problems that arise when physicians refer patients to facilities in which the physician has a financial interest. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6204, 103 Stat. 2106, 2236-43 (1989); See Jo-Ellyn Sakowitz Klein, *The Stark Laws: Conquering Physician Conflicts of Interest?*, 87 GEO. L.J. 499, 510-14 (1998) (discussing the purpose and provisions of the Stark Laws).

334. 42 U.S.C.A. § 1395nn(d)(3) (Supp. 2008) (listing an exception to the prohibition on physician referrals for physicians who have an ownership in the recommended hospital); 42 C.F.R. § 411.351 (2007) (excluding ambulatory surgical centers from the definition of designated health services which are regulated by the Medicare program); Hughes Interview, *supra* note 325.

335. Chapman Interview, *supra* note 303.

336. Chapman Interview, *supra* note 303; 42 U.S.C.A. § 1395nn(b)(2) (Supp. 2008).

337. *Id.*

338. Looby Interview, *supra* note 301.

Dr. Chapman also thinks SB 433 strikes a good balance by increasing the capital expenditure threshold for certificate of need exemption to \$2,500,000, with an alternative provision that does not contain a threshold but limits the facility's size to two operating rooms.³³⁹ However, the Medical Association of Georgia would have preferred to eliminate the capital expenditure threshold completely for single specialty ambulatory surgery centers.³⁴⁰

Provisions in SB 433 for Joint Ventures Between Hospitals and Physicians

Professor Hughes noted that hospitals have had two reactions to doctors establishing their own ambulatory surgery centers.³⁴¹ Some hospitals fought hard to prevent these facilities, perhaps through disciplinary actions or removing the doctors from the hospitals' medical staff.³⁴² However, some hospitals are interested in entering into joint venture ambulatory surgical centers with doctors.³⁴³

Hospitals benefit from joint ventures with doctors by receiving a portion of the profits, and the doctors benefit through capital contributions from the hospitals.³⁴⁴ SB 433 facilitates joint ventures, in the future, between doctors and hospitals in Georgia.³⁴⁵ Jason Bring, a partner in the health law practice at Arnall Golden Gregory, believes that this provision may ameliorate tensions between doctors and hospitals and force them to work together.³⁴⁶ Stan Jones, a partner at Nelson Mullins Riley & Scarborough, LLP, represents hospitals and is also happy with the provision allowing joint ventures between doctors and hospitals.³⁴⁷

However, hospitals may be hurt by this provision if they do not enter a joint venture or if they are impacted financially by the

339. O.C.G.A. 31-6-47(a)(18) (Supp. 2008); Chapman Interview, *supra* note 303.

340. Chapman Interview, *supra* note 303.

341. Hughes Interview, *supra* note 325.

342. Hughes Interview, *supra* note 325.

343. Hughes Interview, *supra* note 325.

344. Hughes Interview, *supra* note 325.

345. Hughes Interview, *supra* note 325.

346. Bring Interview, *supra* note 323.

347. Telephone Interview with Stanley S. Jones, Partner, Nelson Mullins (Apr. 21, 2008).

continued development of ambulatory surgery centers that may cherry pick patients.³⁴⁸

Mr. Bring also expressed concerns about the possibility of physician-owned surgery centers operating under the joint venture category when in fact they are not.³⁴⁹ Small, rural hospitals could be controlled by an out-of-town physicians' group with significant financing and be run as an ambulatory surgery center under the guise of operating as a hospital.³⁵⁰

Provisions in SB 433 Increasing Capital Expenditure Provisions

Professor Hughes noted that costs associated with obtaining a CON can be a large percentage of the budget for smaller projects.³⁵¹ Healthcare facilities will benefit from the provision increasing the threshold to \$2,500,000 for capital expenditures, which require a certificate of need.³⁵² Healthcare facilities will also benefit from the provision that makes non-medical capital expenditures, like expenses related to building a parking lot, exempt from the CON process.³⁵³

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348. Bring Interview, *supra* note 323.

349. *Id.*

350. *Id.*

351. Hughes Interview, *supra* note 325.

352. O.C.G.A. 31-6-40(a)(1) (Supp. 2008).

353. O.C.G.A. 31-6-47(a)(16) (Supp. 2008); Hughes Interview, *supra* note 325.

