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## Care and Protection of Indigent and Elderly Patients SB 24

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## HEALTH

***Care and Protection of Indigent and Elderly Patients: Amend Chapter 8 of Title 31 of the Official Code of Georgia Annotated, Relating to Care and Protection of Indigent and Elderly Patients, so as to Enact the “Hospital Medicaid Financing Program Act;” Authorize the Department of Community Health to Assess One or More Provider Payments on Hospitals for the Purpose of Obtaining Federal Financial Participation for Medicaid; Provide for Definitions; Provide for Rules and Regulations; Provide for One or More Segregated Accounts within the Indigent Care Trust Fund; Provide for the Use of Funds; Provide for Repeal unless Reauthorized; Provide for Related Matters; Provide for Effective Dates; Repeal Conflicting Laws; and for Other Purposes***

CODE SECTION:	O.C.G.A. § 31-8-179 (amended)
BILL NUMBER:	SB 24
ACT NUMBER:	1
GEORGIA LAWS:	2013 Ga. Laws 1
SUMMARY:	The Act authorizes the Department of Community Health (DCH) to assess a provider payment on all Georgia hospitals to obtain federal matching funds for Medicaid patients. Popularly known as the “bed tax,” the Act continues legislation set to expire in 2012. This Act ensures Georgia’s ability to receive federal matching dollars through June 30, 2017, unless reauthorized by the General Assembly before then. The Act is intended to avoid the detrimental impact on healthcare access and local economies that could potentially result from non-participation.
EFFECTIVE DATE:	July 1, 2013

*History*

First enacted under Governor Sonny Perdue, the Provider Payment Agreement Act imposed a net patient revenue tax of 1.45% on Georgia hospitals.<sup>1</sup> Representative Kevin Levitas introduced House Bill (HB) 1055 during the 2010 session for the purpose of giving the state access to federal matching funds which replenish the state's Medicaid budget and provide reimbursements to hospitals. In 2011, the State of Georgia collected \$215 million in Medicaid provider fees from Georgia hospitals.<sup>2</sup> The Act defined net patient revenue to include the total gross patient revenue of a hospital less charity and indigent care.<sup>3</sup> Further, HB 1055 defined hospitals to include nursing homes and other healthcare facilities, but exclude statutorily-defined "critical access hospitals."<sup>4</sup> The Act was set to expire by its own terms on June 30, 2013.<sup>5</sup> Just as the General Assembly approved HB 1055, several other states passed or were considering similar measures better known as "hospital" or "bed" taxes.<sup>6</sup> By the time the General Assembly convened in 2013, forty-nine of fifty states had passed their own versions of a bed tax.<sup>7</sup>

In 2013, Governor Deal's floor leaders in the General Assembly introduced Senate Bill (SB) 24 to revise and extend the bed tax program before it expired.<sup>8</sup> The Hospital Medicaid Financing Program Act authorizes the Department of Community Health

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1. O.C.G.A. § 31-8-179 (2010) (repealed 2013).

2. Carrie Teegardin & Misty Williams, 'Bed Tax' A Windfall For Some Hospitals, A Big Loser For Others, ATLANTA J.-CONST., Nov. 19, 2012, available at [http://www.ajc.com/news/news/bed-tax-a-windfall-for-some-hospitals-a-big-loser-/nS9hH/](http://www.ajc.com/news/news/bed-tax-a-windfall-for-some-hospitals-a-big-loser-for-some-hospitals-a-big-loser-/nS9hH/); Ouch! Georgia General Assembly Enacts 1.45% "Hospital Tax", SUTHERLAND ASBILL & BRENNAN LLP, May 17, 2010, available at <http://www.lexology.com/library/detail.aspx?g=dc67d6e5-5f14-498c-8548-929cb43d4861>.

3. O.C.G.A. § 31-8-179.1(3) (repealed 2013).

4. O.C.G.A. § 31-8-179.1(2) (2010); see also O.C.G.A. § 37-3-1 (2013) (defining critical access hospitals).

5. O.C.G.A. § 31-8-179.8 (2010).

6. E.g., Colorado (HB 1293 in 2009), Maine (HB 1351 in 2004), Ohio (HB 1 in 2009), Oregon (HB 2116 in 2009), and Wisconsin (SB 62 in 2009).

7. Video Recording of House Governmental Affairs Committee, Jan. 29, 2013 at 8 min., 42 sec. (remarks by Sen. Charlie Bethel (R-54th)), [http://media.legis.ga.gov/hav/13\\_14/2013/committees/govAffairs/govAffairs012913EDITED.wmv](http://media.legis.ga.gov/hav/13_14/2013/committees/govAffairs/govAffairs012913EDITED.wmv) [hereinafter House Committee Video]. Alaska is the only state that does not participate in a similar program. *Id.*

8. Jim Galloway, *Gov. Nathan Deal's Solution to the 'Hospital Bed Tax' Debate*, ATLANTA J.-CONST., Jan. 14, 2013, <http://blogs.ajc.com/political-insider-jim-galloway/2013/01/14/gov-nathan-deal-s-solution-to-the-hospital-bed-tax-debate>.

(DCH) to assess a fee on hospitals based on their net patient revenue.<sup>9</sup> Now in its second year, the program is needed to avoid losses totaling \$700 million for low-income Georgians.<sup>10</sup> Without the fee, hospitals would face as much as a 50% cut in Medicaid reimbursement, forcing many facilities to close.<sup>11</sup> In addition to reducing access to healthcare, this would mean lost jobs in communities that are already hard-hit by the recession. Among the hardest hit would be hospitals in rural areas and those with larger percentages of Medicaid patients.<sup>12</sup> Because closing rural hospitals would drive more Medicaid patients to seek healthcare in urban areas, SB 24 held broad support from hospital alliances across the state.<sup>13</sup> Led by Governor Deal's delegation in the Georgia House and Senate, SB 24 passed quickly through both chambers of the General Assembly. Those voting against passage expressed concern that the fee was just another tax on Georgians or that the bill was steamrolled through the Senate during the first week of the legislative session.<sup>14</sup>

Under the current legislation, DCH charges Georgia hospitals a 1.45% fee on net patient revenue.<sup>15</sup> Although the General Assembly delegates this function to DCH, the amount is controlled by the

9. O.C.G.A. § 31-8-179.2 (Supp. 2013).

10. Ewa Kochanska, *Deal's 'Hospital Bed Tax' Alternative Passes Senate*, THE EXAMINER, Jan. 18, 2013, <http://www.examiner.com/article/deal-s-hospital-bed-tax-alternative-passes-senate>.

11. House Committee Video, *supra* note 7, at 24 min., 55 sec. (remarks by David Tatum, Children's Healthcare of Atlanta); *see also id.* at 36 min., 12 sec. (remarks by Julie Wendom, Georgia Alliance of Community Hospitals). Ms. Wendom is the Vice President of the Georgia Alliance of Community Hospitals which represents non-profit hospitals. *Id.* She claimed that should SB 24 not pass, hospitals' reimbursement for treating Medicaid patients would decrease from 85 to 90 cents for each dollar spent to approximately 65 cents. *Id.* Others estimated even lower rates, including 59 cents on the dollar. *See* Video Recording of House Proceedings, Feb. 1, 2013 at 55 min., 26 sec. (remarks by Rep. Terry England (R-116th)), <http://www.gpb.org/lawmakers/2013/day-9> [hereinafter House Video].

12. *See* House Committee Video, *supra* note 7, at 28 min., 12 sec. (remarks by Jimmy Lewis, HomeTown Health, LLC). Mr. Lewis estimated that had SB 24 not passed, approximately twenty-seven rural hospitals would close due to their inability to receive funding through the Medicaid program. *Id.* Accordingly, healthcare access would be disrupted for 450,000 Georgians across the state. *Id.*

13. Misty Williams, *New Medicaid Debate: Hospital 'Bed Tax' Renewal*, ATLANTA J.-CONST., Jan. 8, 2013, <http://www.ajc.com/news/news/new-medicare-debate-hospital-bed-tax-renewal/nTp8y> ("Georgia hospitals have agreed among themselves to support the extension of a special fee that bolsters the state's massive Medicaid program.").

14. Dave Williams, *Hospital 'Bed Tax' Clears Georgia Senate*, ATLANTA BUS. CHRON., Jan. 17, 2013, <http://www.bizjournals.com/atlanta/news/2013/01/17/hospital-bed-tax-clears-georgia-senate.html?page=all> (Senate Minority Whip Vincent Fort (D-39th) claimed there were a number of alternatives to SB 24 available. One such choice was an increase in the tobacco tax.).

15. O.C.G.A. § 31-8-179.3 (repealed 2013).

General Assembly.<sup>16</sup> This allows the State to tap into approximately \$450 million in federal matching dollars targeted towards low-income patients.<sup>17</sup> Over the past decade, Georgia experienced a large population growth, particularly of those needing assistance to afford medical services.<sup>18</sup> With Medicaid costs rising, Georgia and other “red states” opted out of the federal Affordable Care Act, also known as “Obamacare.”<sup>19</sup> This created the perfect storm for Georgia: skyrocketing Medicaid costs, a rising population, and ever-decreasing federal funding. The population growth and corresponding demand for healthcare services affect larger hospitals like Grady in downtown Atlanta, as well as those in rural areas like Murray Medical Center in Chatsworth.<sup>20</sup> Hospital and healthcare system representatives from both urban and rural facilities testified during Georgia House Committee hearings on SB 24 and voiced support for the bill despite the fact that their respective hospital might be adversely affected by its passage.<sup>21</sup> Overall, Georgia healthcare providers urged state lawmakers to take action in the 2013 legislative session. The Governor’s Senate delegation introduced SB 24 as one of the first bills the General Assembly considered in 2013.

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16. O.C.G.A. § 31-8-179.2(a.1) (Supp. 2013) (“The General Assembly shall have the authority to override any provider payment assessed by the board . . .”).

17. Aaron Gould Sheinin & Misty Williams, *‘Bed Tax’ Clears Final Legislative Hurdle*, ATLANTA J.-CONST., Feb. 1, 2013, <http://www.ajc.com/news/news/state-regional-govt-politics/bed-tax-clears-final-hurdle/nWDHT>.

18. Governor Nathan Deal, *DEAL: Georgia’s Budget Can’t Take Obamacare*, THE WASH. TIMES, Aug. 30, 2012, available at <http://www.washingtontimes.com/news/2012/aug/30/georgias-budget-cant-take-obamacare/> (Governor Deal stated: “Here in Georgia—a million miles from Washington’s printing press—we are constitutionally bound to balance the budget.”).

19. *Id.*

20. For example, approximately 30% of Grady Hospital’s patients are Georgians on Medicaid and another 30% are uninsured. See House Committee Video, *supra* note 7, at 38 min., 48 sec. (remarks by Matthew Hicks, Grady Health System). Mr. Hicks estimated that should SB 24 not pass, the hospital would lose \$36 million in revenue. *Id.*

21. See generally House Committee Video, *supra* note 7.

*Bill Tracking of SB 24**Consideration and Passage by the Senate*

Senators Charlie Bethel (R-54th), Rick Jeffares (R-17th), and Bill Jackson (R-24th) sponsored SB 24 in the Senate.<sup>22</sup> After the bill was first read on January 14, 2013, Lieutenant Governor Casey Cagle (R) referred the legislation to the Senate Regulated Industries and Utilities Committee, which favorably reported a Committee substitute on January 16, 2013.<sup>23</sup>

The Senate Committee substitute contained several substantive changes from the bill as introduced. First, the substitute authorized DCH to assess “one or more” provider payments and to provide for “one or more” segregated accounts within the Indigent Care Trust Fund.<sup>24</sup> The Committee substitute also compelled the Board of Community Health (the “Board”) to adopt a rule when establishing and assessing a provider payment on hospitals, or a “subclass of hospitals.”<sup>25</sup> Moreover, the Committee removed a provision that required a uniform application of the percentage assessed on all hospitals.<sup>26</sup>

The Committee substitute mandated that the Board cease to impose any provider payment if DCH: 1) reduces Medicaid payment rates to hospitals as are in effect on June 30, 2012, 2) reduces the factors utilized in developing the Fiscal Year 2013 capitated rates for Medicaid managed care organizations, 3) alters any payment methodology, administrative rule, or payment policy as are in effect on June 30, 2012, or 4) creates any new methodology, rule, or policy that has the effect of reducing Medicaid payments to hospitals.<sup>27</sup> The substitute also authorized the General Assembly to override any provider payment assessed by the Board.<sup>28</sup> The General Assembly

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22. SB 24, as introduced, 2013 Ga. Gen. Assem.

23. *Id.*; State of Georgia Final Composite Status Sheet, SB 24, May 9, 2013.

24. SB 24 (SCS), p. 1, ln. 3–6, 2013 Ga. Gen. Assem.

25. SB 24 (SCS), § 1, p. 2, ln. 35–36, 2013 Ga. Gen. Assem.

26. *Compare* SB 24 (SCS), § 1, p. 2, ln. 37–40, 2013 Ga. Gen. Assem., *with* SB 24, as introduced, § 1, p. 2, ln. 39–41, 2013 Ga. Gen. Assem. (“If any such provider payment is established and assessed, the percentage shall be assessed uniformly upon all hospitals and shall be calculated at an amount to achieve the purposes of this article.”).

27. SB 24 (SCS), § 1, p. 2, ln. 45–50, 2013 Ga. Gen. Assem.

28. *Id.* § 1, p. 2, ln. 51–53, 2013 Ga. Gen. Assem.

was also given the authority to appropriate any funds deposited into a segregated account under the statute.<sup>29</sup>

The Committee substitute deleted a provision that required DCH to notify a hospital if it underpaid a provider payment and a requirement that the payment be due within thirty days of the Department's notice.<sup>30</sup> Finally, the substitute altered the repeal date of the statute from June 30, 2018 to June 30, 2017, "unless reauthorized by the General Assembly prior to that date."<sup>31</sup>

The Senate Committee substitute was read a second time on January 16, 2013, and a third time on January 17, 2013.<sup>32</sup> Senators Jason Carter (D-42nd), John Albers (R-56th), Steve Thompson (D-33rd), Tommie Williams (R-19th), and Bill Cowsert (R-46th) offered an amendment on the floor.<sup>33</sup> The amendment, which stated "the aggregate amount of any fees established and assessed pursuant to this subsection shall not exceed 1.45 percent of the net patient revenue of the hospital" passed the Senate by a vote of 46 to 5.<sup>34</sup> Subsequently, Senators Jack Hill (R-4th), David Shafer (R-48th), Ronnie Chance (R-16th), and Judson Hill (R-32nd) offered an amendment to the amendment that stated the amount of fees established and assessed shall "not exceed those percentages of net patient revenues set forth in the General Appropriations Act."<sup>35</sup> The Senate adopted the amendment to the amendment without objection.<sup>36</sup>

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29. *Id.* § 1, p. 3, ln. 65–66, 2013 Ga. Gen. Assem.

30. *Compare* SB 24 (SCS), § 1, p. 3, ln. 77–79, 2013 Ga. Gen. Assem., *with* SB 24, as introduced, § 1, p. 3, ln. 69–71, 2013 Ga. Gen. Assem. ("In the event the department determines that a hospital has underpaid the provider payment, the department shall notify the hospital of the balance of the provider payment that is due. Such balance shall be due within 30 days of the department's notice.").

31. *Compare* SB 24 (SCS), § 1, p. 4, ln. 106–07, 2013 Ga. Gen. Assem., *with* SB 24, as introduced, § 1, p. 4, ln. 100–01, 2013 Ga. Gen. Assem.

32. State of Georgia Final Composite Status Sheet, SB 24, May 9, 2013.

33. *Compare* SB 24 (SCSFA), § 1, p. 2, ln. 40–42, 2013 Ga. Gen. Assem., *with* SB 24 (SCS), § 1, p.2, ln. 40–42, 2013 Ga. Gen. Assem.

34. *Id.*; Georgia Senate Voting Record, SB 24 (Jan. 17, 2013).

35. *Compare* SB 24 (SCSFA), § 1, p. 2, ln. 40–42, 2013 Ga. Gen. Assem., *with* SB 24, as passed Senate, § 1, p.2, ln. 41–43, 2013 Ga. Gen. Assem.

36. *Id.* As enacted, the Act reads: "The aggregate amount of any fees established and assessed pursuant to this subsection shall not exceed those percentages of net patient revenues set forth in the General Appropriations Act." *See* O.C.G.A. § 31-8-179.2(a) (Supp. 2013).

On January 17, 2013, the Senate passed the Committee substitute, as amended, by a vote of 46 to 9 and transmitted the bill to the House of Representatives.<sup>37</sup>

*Consideration and Passage by the House*

Representative Matt Hatchett (R-150th) sponsored SB 24 in the House, and the bill was first read on January 28, 2013.<sup>38</sup> After the bill was read for the second time on January 29, 2013, Speaker of the House David Ralston (R-7th) assigned the legislation to the House Committee on Governmental Affairs.<sup>39</sup> The Committee favorably reported the bill on January 30, 2013.<sup>40</sup> The House read the bill for the third time on February 1, 2013, and on the same day passed the bill by a vote of 147 to 18.<sup>41</sup>

*Signing Into Law by the Governor*

The Senate transmitted SB 24 to the Governor on February 11, 2013. Governor Deal signed SB 24 into law on February 13, 2013.<sup>42</sup>

*The Act*

The Act amends Title 31 of the Official Code of Georgia Annotated<sup>43</sup> for the purpose of continuing the assessment of provider payments on hospitals, thereby ensuring federal financial participation in the state's Medicaid program.<sup>44</sup> Section 31-8-179 states the constitutional authority for the legislation and entitles it the "Hospital Medicaid Financing Program Act."<sup>45</sup> Section 31-8-179.1 defines the entities affected by the Act as well as "provider payment."<sup>46</sup>

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37. Georgia Senate Voting Record, SB 24 (Jan. 17, 2013).

38. State of Georgia Final Composite Status Sheet, SB 24, May 9, 2013.

39. *Id.*

40. *Id.*

41. *Id.*; Georgia House of Representatives Voting Record, SB 24 (Feb. 1, 2013).

42. State of Georgia Final Composite Status Sheet, SB 24, May 9, 2013.

43. O.C.G.A. § 31-8-179 (Supp. 2013).

44. *Id.*

45. *Id.*

46. O.C.G.A. § 31-8-179.1 (Supp. 2013).



Code section 31-8-179.2 authorizes the Board to establish and assess provider payments, by board rule, on hospitals or a subclass of hospitals.<sup>47</sup> The section further provides that any payment assessed must not exceed the necessary amount to obtain federal financial participation allowable under Title XIX of the federal Social Security Act.<sup>48</sup> The Act limits the amount of any fees assessed to the percentage of net patient revenues established in the General Appropriations Act.<sup>49</sup> Moreover, this section requires the Board to discontinue any provider payment under certain conditions which include assessments that are or become ineligible for federal matching funds and any state modification to Medicaid payment rates to hospitals as are in effect on June 30, 2012.<sup>50</sup> The General Assembly also has the authority to override any provider payment assessed by the Board.<sup>51</sup> Finally, subsection (b) allows the Board to promulgate rules and regulations to carry out the Act.<sup>52</sup>

Code section 31-8-179.3 requires funds collected from any provider payment to be deposited into a segregated account for each payment program within the Indigent Care Trust Fund.<sup>53</sup> This section allows the General Assembly to appropriate all funds deposited but only for the purpose of “obtaining federal financial participation for medical assistance payments to providers on behalf of Medicaid recipients.”<sup>54</sup> A hospital must maintain and preserve any records for seven years that are necessary to determine the amount for which it is liable under the Act.<sup>55</sup> Subsection (d) authorizes DCH to impose a penalty of up to six percent on any hospital that fails to satisfy a provider payment within the time required.<sup>56</sup> The Department must also withhold “an amount equal to the provider payment and penalty owed from any medical assistance payment due such hospital under the Medicaid program.”<sup>57</sup> Additionally, the state may collect a

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47. O.C.G.A. § 31-8-179.2(a) (Supp. 2013).

48. O.C.G.A. § 31-8-179.2(a)(1) (Supp. 2013).

49. O.C.G.A. § 31-8-179.2(a) (Supp. 2013).

50. O.C.G.A. § 31-8-179.2(a)(1)–(2) (Supp. 2013).

51. O.C.G.A. § 31-8-179.2(a.1) (Supp. 2013).

52. O.C.G.A. § 31-8-179.2(b) (Supp. 2013).

53. O.C.G.A. § 31-8-179.3(a) (Supp. 2013).

54. O.C.G.A. § 31-8-179.3(a) and (b) (Supp. 2013).

55. O.C.G.A. § 31-8-179.3(c) (Supp. 2013).

56. O.C.G.A. § 31-8-179.3(d) (Supp. 2013).

57. *Id.*

provider payment by a civil action, a tax lien, or any other enforcement means available.<sup>58</sup>

Section 31-8-179.4 empowers the General Assembly to appropriate all revenues raised through the provider payment program, as state funds, to DCH provided such funds are used for the purpose of obtaining federal financial participation in the Medicaid program.<sup>59</sup> Appropriations from an account to the Department may not lapse to the general fund at the end of any fiscal year.<sup>60</sup>

Pursuant to Code section 31-8-179.5, the Georgia Medical Assistance Act of 1977 continues to apply to DCH unless its provisions are inconsistent with the Act.<sup>61</sup> Finally, section 31-8-179.6 automatically repeals the Act on June 30, 2017 unless it is reauthorized by the General Assembly prior to that date.<sup>62</sup>

### *Analysis*

#### *Constitutionality of SB 24*

The House and Senate floor debates on SB 24 included questions about its validity under Georgia's Constitution. Specifically, some members considered SB 24 as a revenue measure.<sup>63</sup> Georgia's Constitution requires all bills that raise revenue or appropriate money "originate in the House of Representatives."<sup>64</sup> The bill's sponsors characterized SB 24 as an "authority bill," not a revenue measure.<sup>65</sup> Other supporters reminded the Assembly that SB 24 is simply a continuance of HB 1115, which was the predecessor hospital "bed tax" legislation originating in the House and scheduled to sunset on June 30, 2013.<sup>66</sup>

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58. *Id.*

59. O.C.G.A. § 31-8-179.4(a) and (b) (Supp. 2013).

60. O.C.G.A. § 31-8-179.4(c) (Supp. 2013).

61. O.C.G.A. § 31-8-179.5 (Supp. 2013).

62. O.C.G.A. § 31-8-179.6 (Supp. 2013).

63. Video Recording of Senate Proceedings, Jan. 17, 2013 at 43 min., 14 sec. (remarks by Sen. David Lucas (D-26th)), <http://gpb.org/lawmakers/2013/day-4> [hereinafter Senate Video].

64. GA. CONST. art. III, § 5, para. 2.

65. Andy Miller, *Bid to Avert Fee Battle Galvanizes Capitol*, GA. HEALTH NEWS, Jan. 15, 2013, <http://www.georgiahealthnews.com/2013/01/bid-avert-fee-battle-galvanizes-capitol/>.

66. House Video, *supra* note 11, at 49 min., 10 sec. (remarks by Rep. Matt Hatchett (R-150th)).

Despite opposing characterizations of SB 24 in the floor debates, there have yet to be any legal challenges to SB 24's constitutionality brought in Georgia courts. This fact underscores the widespread support for SB 24 in both legislative chambers and recognition that failure to pass SB 24 would further exacerbate Georgia's widening Medicaid deficit. Another reason might be that Georgia courts, beginning in the 1930s, consistently upheld the constitutionality of so-called "revenue acts" as long as both chambers agreed and the Governor signed the bill into law.<sup>67</sup> This despite the fact that some measures originated in the Senate or as a joint resolution, as was the case in *Grizzard v. State Revenue Commission*.<sup>68</sup>

*Grizzard* involved a challenge to a joint resolution requiring the Georgia State Revenue Commission to sell a list of all Georgia automobile owners when paid a fee.<sup>69</sup> Citizens challenged the resolution's constitutionality under article III, section 7 of the Georgia Constitution; namely, that a joint resolution to raise revenue did not originate in the House and, therefore, the resolution was unconstitutional.<sup>70</sup> The Georgia Supreme Court disagreed.<sup>71</sup> Although the resolution was a revenue measure, the Court recognized the joint resolution was first introduced in the House, and thereby satisfied article, III, section 7 of the Georgia Constitution.<sup>72</sup> Similarly, a court would likely find SB 24 constitutional because the original "bed tax" measure in fact originated in the House under HB 1115. The reason the Governor's floor leaders brought SB 24 was to continue HB 1115 beyond a sunset date set by its own terms.

In a more recent case, *Collins v. Woodham*, a plaintiff challenged the constitutionality of the Child Abuse and Neglect Prevention Act, a portion of which increased the marriage license fee.<sup>73</sup> Mr. Woodham, who inquired about the cost of a marriage license, successfully argued at the trial-court level that the Act effectively

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67. See generally *Collins v. Woodham*, 257 Ga. 643, 362 S.E.2d 61 (1987); *State v. State Toll Bridge Auth.*, 210 Ga. 690, 82 S.E.2d 626 (1954); *McLucas v. State Bridge Bldg. Auth.*, 210 Ga. 1, 77 S.E.2d 531 (1953); *Grizzard v. State Revenue Comm'n*, 177 Ga. 845, 171 S.E. 765 (1933).

68. *Grizzard*, 177 Ga. at 845, 171 S.E. at 766-67.

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

73. *Collins v. Woodham*, 257 Ga. 643, 362 S.E.2d 61, 62 (1987).

raised revenue but was not first introduced in the House of Representatives.<sup>74</sup> Like in *Grizzard*, the Georgia Supreme Court disagreed and overturned the trial court.<sup>75</sup> The Court noted the Act was signed by the President of the Senate, the Speaker of the House, and the Governor, and was further deposited with the Secretary of State.<sup>76</sup> Achieving these approvals meant the Act held the status of an “enrolled act.”<sup>77</sup> A duly enrolled act, properly authenticated by the presiding officers of both chambers and approved by the Governor, is conclusively presumed to have met constitutional requirements.<sup>78</sup>

*Collins* demonstrates the Georgia judiciary’s deference to the constitutional validity of acts gaining all necessary approvals to become law. Even despite procedural technicalities, such as a bill’s precise origin, *Grizzard* and *Collins* suggest that as long as all the steps were followed for a bill to become an “enrolled act,” Georgia courts will generally not interfere by entertaining a constitutional challenge to an act based on its origin.<sup>79</sup> The same would likely hold true for SB 24 because the bill ultimately passed through all necessary steps to become an “enrolled act.” Furthermore, SB 24 is arguably not a revenue bill governed by article III, section 7<sup>80</sup> of the Georgia Constitution because the provider fee is only assessed to obtain matching monies from the federal government. This means the assessed fees are more than refunded back to the hospitals serving Medicaid patients.

Because of the deference Georgia courts generally show in favor of upholding the constitutionality of enrolled acts, SB 24 would very likely survive a challenge under Georgia’s Constitution.

### *Separation of Powers Argument*

Members of the General Assembly also raised a separation of powers concern questioning whether the legislature can

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74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.* (quoting *Atl. Coast Line R. Co. v. State*, 135 Ga. 545, 545, 69 S.E. 725, 725 (1910)).

78. *Id.* (accord *Capitol Distrib. Co. v. Redwine*, 206 Ga. 477, 477, 57 S.E.2d 578, 579 (1950)).

79. *Grizzard*, 177 Ga. at 847, 171 S.E. at 765; *Collins*, 257 Ga. at 644, 362 S.E.2d at 62–63.

80. The current provision for revenue origination in the Georgia Constitution is found in GA. CONST. art. III, § 5, para. 2.

constitutionally delegate authority to DCH to set the provider payment rate.<sup>81</sup> Defenders of SB 24 countered that the Act is constitutional but provided little legal support aside from citing the Georgia Administrative Procedure Act as adequate oversight of the agency and noting that no legal challenges have been made since 2003 when the agency first assumed authority to promulgate rules and set the fees for nursing homes.<sup>82</sup> The Georgia Constitution and case law interpreting the balance of power between the General Assembly and state administrative agencies, however, seem to support the argument that this delegation of authority to DCH is constitutional.

### *Other Georgia Constitutional Provisions*

The Georgia Constitution vests all legislative powers in the General Assembly.<sup>83</sup> Further, it explicitly requires the separation of powers between the executive, legislative, and judicial branches of government.<sup>84</sup> But one specifically enumerated legislative power states the General Assembly may provide for:

The participation by the state and political subdivisions and instrumentalities of the state in federal programs and the compliance with laws relating thereto, including but not limited to the powers, which may be exercised to the extent and in the manner necessary to effect such participation and compliance, to tax, to expend public money, to condemn property, and to zone property.<sup>85</sup>

This provision allows the legislature to use DCH as a conduit to comply with the federal Medicaid program. Although the ability to “tax” remains within the legislature’s purview, supporters of SB 24

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81. Senate Video, *supra* note 63, at 8 min., 56 sec. (remarks by Sen. Vincent Fort (D-39th)); House Video, *supra* note 11, at 1 hr., 12 min., 26 sec. (remarks by Rep. Brian Thomas (D-100th)).

82. House Video, *supra* note 11, at 1 hr., 4 min., 09 sec. (remarks by Rep. Edward Lindsey (R-54th)); *Id.* at 1 hr., 21 min., 43 sec. (remarks by Rep. Larry O’Neal (R-146th)).

83. GA. CONST. art. III, § 1, para. 1.

84. GA. CONST. art. I, § 2, para. 3.

85. GA. CONST. art. III, § 6, para. 2.

argue that the provider payment is not a tax.<sup>86</sup> The definition of “provider payment” contains no reference to a tax and means only “a payment assessed by the department pursuant to this article for the privilege of operating a hospital.”<sup>87</sup> Additionally, advocates point to the provision of the Act that demands any payments assessed be placed into the constitutionally protected Indigent Trust Fund Account.<sup>88</sup> These funds are then appropriated by the General Assembly according to its constitutional mandate to expend public money.<sup>89</sup> The Act also limits the aggregate amount of any fee assessed to the percentages of net patient revenues set forth in the General Appropriations Act.<sup>90</sup> And the Georgia Constitution requires the General Assembly to pass the General Appropriations Act each year.<sup>91</sup> Thus, the Act’s supporters believe the delegation to DCH to merely set the payment rate at which hospitals will be assessed fully complies with the state’s constitutional requirements of separation of powers and fulfills the legislature’s role in the process.

#### *Georgia Administrative Procedure Act*

SB 24 supporters also argue the Georgia Administrative Procedure Act (APA) is another check on agency authority and provides additional oversight by the General Assembly.<sup>92</sup> SB 24 explicitly allows the General Assembly to override any provider payment assessed by DCH according to the procedures contained in the APA.<sup>93</sup> The APA requires a state agency to provide thirty-days notice to the General Assembly prior to implementing a rule.<sup>94</sup> That notice is then assigned to the standing committees of the House and Senate with jurisdiction over the agency.<sup>95</sup> If a standing committee files an objection to the proposed rule, and the agency then adopts the rule,

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86. Senate Video, *supra* note 63, at 7 min., 21 sec. (remarks by Sen. Charlie Bethel (R-54th)).

87. GA. CONST. art. III, § 9, para. 6; O.C.G.A. § 31-8-179.1(4) (Supp. 2013).

88. O.C.G.A. § 31-8-179.3(a) (Supp. 2013).

89. *Id.*

90. O.C.G.A. § 31-8-179.2(a) (Supp. 2013).

91. GA. CONST. art. III, § 9, para. 2.

92. House Video, *supra* note 11, at 1 hr., 4 min., 09 sec. (remarks by Rep. Edward Lindsey (R-54th)).

93. O.C.G.A. § 31-8-179.2(a.1) (Supp. 2013).

94. O.C.G.A. § 50-13-4(e) (Supp. 2013).

95. *Id.*

the General Assembly may consider adopting a resolution to override the rule within the first thirty legislative days of the next session.<sup>96</sup> If the General Assembly adopts a resolution by two-thirds of voting members of both chambers, then the rule is void even without the Governor's signature.<sup>97</sup> If the resolution is adopted by less than a two-thirds majority, the Governor may still sign the resolution which would void the rule.<sup>98</sup>

The APA also allows a standing committee to “stay” a rule until the next legislative session if two-thirds of the committee, after a public hearing, vote to object to the proposed rule.<sup>99</sup> The General Assembly may then vote to override the proposed rule during the next legislative session according to the same procedures had the committee not voted to stay the proposed rule.<sup>100</sup> If the legislature does not adopt a resolution to override the proposed rule prior to the thirtieth legislative day, the rule goes into effect.<sup>101</sup>

### *Georgia Precedent Supports Delegation*

Georgia courts have historically upheld legislative delegation to state agencies.<sup>102</sup> One of the first Georgia cases challenging an agency's authority to issue rules and regulations pursuant to a duly adopted law involved the setting of payment rates applied by the Georgia Railroad Commission to private rail companies.<sup>103</sup> In *Georgia Railroad v. Smith*, the Georgia Supreme Court upheld legislation that created the Georgia Railroad Commission along with the agency's authority to set railway rates for passengers and freight.<sup>104</sup> A constitutional provision required the legislature to regulate the rates, but the Court held that passing a law creating the commission to actually regulate the railways did not violate the

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96. O.C.G.A. § 50-13-4(f)(1) (Supp. 2013).

97. *Id.*

98. *Id.*

99. O.C.G.A. § 50-13-4(f)(2) (Supp. 2013).

100. *Id.*

101. *Id.*

102. For a historical discussion of Georgia courts' approval of the General Assembly's delegation to state agencies, see generally David E. Shipley, *The Status of Administrative Agencies Under the Georgia Constitution*, 40 GA. L. REV. 1109, 1111–33 (2006).

103. *Ga. R.R. v. Smith*, 70 Ga. 694, 696 (1883).

104. *Id.* at 697–99.

separation of powers.<sup>105</sup> All that was required of the legislature was to “pass laws to accomplish the ends in view. When this was done, its duty had been discharged.”<sup>106</sup> Interestingly, the Court also cited the need for flexibility in responding to issues related to Georgia railways, which is similar to concerns raised by supporters of SB 24 in the wake of massive budget shortfalls, particularly those caused by the federal expansion of Medicaid.<sup>107</sup>

In a more recent case, the Georgia Supreme Court rejected a challenge to DCH’s authority to issue rules related to the state’s certificate of need statutes.<sup>108</sup> A regulated hospital specifically claimed the APA’s application to the underlying rules amounted to “legislative acquiescence” thus violating separation of powers.<sup>109</sup> The Court restated the rule that “it has long been recognized that the General Assembly is empowered to enact laws of general application and then delegate to administrative officers or agencies the authority to make rules and regulations necessary to effectuate such laws.”<sup>110</sup> It then held that rules and regulations adopted by DCH to implement the statute were not laws and therefore did not mix legislative and executive functions.<sup>111</sup> There is a difference, the Court noted, between the constitutional requirements of enactment, presentment, and bicameralism for laws and agency-issued regulations.<sup>112</sup> Merely because the standing committees of the General Assembly, after given the statutorily prescribed notice under the APA, remain silent

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105. *Id.* at 699 (“The difference between the power to pass a law and the power to adopt rules and regulations to carry into effect a law already passed, is apparent and strikingly great, and this we understand to be the distinction recognized by all the courts as the true rule in determining whether or not in such cases a legislative power is granted. The former would be unconstitutional, whilst the latter would not.”).

106. *Id.* at 698.

107. *Id.* at 698–99. *See also* House Video, *supra* note 11, at 49 min., 10 sec. (remarks by Rep. Matt Hatchett (R-150th)).

108. *Albany Surgical, P.C. v. Ga. Dept. of Comm. Health*, 278 Ga. 366, 367–68, 602 S.E.2d 648, 650–51 (2004).

109. *Id.* at 367.

110. *Id.* at 368 (quoting *Dept. of Transp. v. Del-Cook Timber Co.*, 248 Ga. 734, 737, 285 S.E.2d 913, 916 (1982)).

111. *Id.* at 368. In a footnote, the Court stated “[s]ome overlap of functions between the three branches of government is inevitable and to be expected. After all, the three branches serve but one government. Thus, the separation of powers doctrine does not, and cannot, mean a complete separation in all respects.” *Id.* at 368 n.5 (citing *Ga. Dept. of Human Res. v. Word*, 265 Ga. 461, 463, 458 S.E.2d 110, 113 (1995)).

112. *Id.* at 368.



as to a proposed rule, this silence does not convert the rule into a law.<sup>113</sup> Thus, agency rules and regulations, if consistent with the authorizing statute, do not require the legislature's affirmative approval under the APA or the Georgia Constitution.<sup>114</sup>

The Georgia Supreme Court remains deferential to the legislature's delegation of authority to state agencies. Although SB 24 supporters cited sufficient oversight under the APA and continuing a practice already implemented for nursing homes as constitutional support, they likely stand on solid ground. The State Supreme Court has long upheld this type of delegation to state agencies, and one of its first rulings on the issue specifically related to rates applied to private actors. Moreover, the APA was recently upheld as a constitutionally sufficient oversight mechanism, and the Court again reiterated that agencies may be entrusted to implement a statute.

#### *The Hospital Bed Tax in Other States*

Senator Charlie Bethel (R-54th) commented that forty-nine of fifty states enacted some form of the Hospital Bed Tax.<sup>115</sup> Many states face increasing Medicaid budget shortfalls and see the Bed Tax as the only way to preserve coverage for indigent patients. But the impact varies between states, as does the legislation which enables them to tap into federal matching dollars. This section first describes the federal-state partnership that delivers healthcare services under the Medicaid program, and then explores the implementation differences between Georgia and Colorado.

#### *The Federal Social Security Act—Medicaid Program*

Medicaid is a federal-state partnership program intended to provide healthcare coverage to low-income patients. Title XIX of the Federal Social Security Act establishes the program as well as the U.S. Department of Health and Human Services. Beneath this umbrella, the Centers for Medicare and Medicaid Services manage

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113. *Id.*

114. *Albany Surgical*, 278 Ga. at 368, 602 S.E.2d at 651.

115. House Committee Video, *supra* note 7, at 8 min., 41 sec. (remarks by Sen. Charlie Bethel (R-54th)).

the federal portion of the program. At the state level, a separate public agency or department manages the state program. In Georgia, this department is part of the executive branch and is called DCH. DCH oversees Georgia's state-run Medicaid programs, including nursing homes. Georgia residents seeking Medicaid coverage must meet federally-mandated eligibility requirements, which are determined by income, family size, and other factors.<sup>116</sup>

Under the federal guidelines, each state must submit a plan to the Center for Medicare and Medicaid Services and agree to the terms of the federal plan.<sup>117</sup> States receive the federal portion of Medicaid on a reimbursement basis. Reimbursements are based off an annually-published Federal Medical Assistance Percentages table, which determines matching funds for each participating state program. Federal Medicaid laws allow states to impose healthcare fees or "provider taxes."<sup>118</sup> These fees may be used to access matching funds from the federal Medicaid program. Federal law prohibits assessing fees directly against indigent patients or healthcare insurers, but allows, for example, assessing fees based on a hospital's total patient revenue.

Many states experience budget shortfalls in their Medicaid programs because of the widening gap between federal reimbursement rates and hospital costs to provide indigent healthcare services. This cost-to-reimbursement gap was the genesis of the hospital provider fee, better known as the "bed tax." The idea is simple: charge hospitals fees to increase the amount of money flowing into a state's Medicaid program in order to access additional federal matching dollars to offset costs. Although simple in concept, the implementation details vary substantially between states. For example, states must determine who sets the fee and the amount charged. This question is complicated by state-law issues of legislative delegation of power. Colorado provides a good example in contrast to Georgia's approach to solve the same problem.

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116. *See generally* O.C.G.A. § 31-8-179 (2010).

117. The federal Medicaid laws have three basic program requirements: (1) the fees must be *broad-based*, meaning they are applied to all providers in the jurisdiction; (2) the fees must be *uniform*, meaning the same amount is charged to all the providers; and (3) the fee structure may not violate the hold-harmless provision of the law, meaning states may not create a mechanism to ensure providers that pay fees are repaid for all or a portion of the fees they were charged. 42 C.F.R. § 433.68(f) (2008).

118. 42 C.F.R. § 433.68(a) (2008).

*Colorado*

Passed in 2009, Colorado's Health Care Affordability Act took aim at that state's growing Medicaid healthcare deficit.<sup>119</sup> The Act was part of Colorado's comprehensive healthcare reform, which expanded healthcare coverage for Coloradans and sought to reduce costs of uncompensated healthcare.<sup>120</sup> The Act allowed Colorado's Department of Healthcare Policy and Financing to implement a hospital provider fee program and assess fees on all licensed hospitals in the state.<sup>121</sup> Colorado's Medicaid Hospital Provider Fee Program offset \$50 million of Colorado's general fund Medicaid expenditures.<sup>122</sup>

A similarity between Georgia and Colorado's provider fee program is that both allow an executive department to establish the amount of the fee subject to certain rules and oversight from the General Assembly. The Colorado Act states that the fee will be "established by rule of the state board but shall not exceed the federal limit for such fees."<sup>123</sup> The current federal limit is six percent.<sup>124</sup> Likewise, the Georgia Act allows the board flexibility to "establish and assess, by board rule, one or more provider payments on hospitals . . . as defined by the board."<sup>125</sup> Both Acts require compliance with federal law when imposing a provider fee and permit flexibility for the respective boards to reduce or eliminate provider fees in response to changes made to Title XIX of the Federal Social Security Act.

Both the Georgia and Colorado General Assemblies are in regular session for only a portion of the year. Georgia's regular session lasts forty legislative days each year, while the Colorado general session is 120 days. In Georgia, SB 24's sponsors were concerned about the General Assembly's ability to respond to changes in federal law

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119. Colorado Department of Health Care Policy & Financing, *Colorado Health Care Affordability Act*, Sept. 2010, <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251655280877&ssbinary=true>.

120. *Id.*

121. *Id.*

122. *Id.*

123. COLO. REV. STAT. § 25.5-4-402.3(b) (2009).

124. 42 C.F.R. § 433.68(f)(3)(i)(A) (2008).

125. O.C.G.A. § 31-8-179.2 (Supp. 2013).

which may occur outside of the relatively short legislative session. Georgia's answer was to empower DCH to manage the fee structure within the statutory bounds established by the General Assembly. Some legislators expressed concern that the Assembly was improperly delegating legislative responsibility, but the statutory language places several restrictions on DCH's ability to change the fee structure. Also, Code section 38-8-179(a.1) preserved the General Assembly's authority to "override any provider payment assessed by the board" if necessary.<sup>126</sup>

Colorado implemented a different oversight approach for their program. The Colorado Act created a hospital provider fee Oversight and Advisory Board.<sup>127</sup> The Advisory Board consists of thirteen members appointed by the Governor and approved by the Senate. The provider fees are "assessed pursuant to the rules adopted by the state board[.]"<sup>128</sup> But the state board is required to "[c]onsider recommendations"<sup>129</sup> of the advisory board and cannot increase the fees "above the amount recommended by the advisory board[.]"<sup>130</sup> Georgia has tighter restrictions in its statute; for example, requiring assessments not exceed percentages of net patient revenue established in the General Appropriations Act.<sup>131</sup> The Georgia General Assembly also expressly authorized the Board to "discontinue any provider payment assessed pursuant to this article."<sup>132</sup> Further, Code section 31-8-179.2(a) enumerates conditions where the Georgia board must cease fee assessments,<sup>133</sup> highlighting the importance the Assembly placed in DCH's ability to respond when the Assembly is not in session.

Georgia and Colorado similarly segregate provider fee funds from the state's general fund. Georgia's provider fees are deposited and invested as part of the Indigent Care Trust Fund, created under a separate Code section.<sup>134</sup> Colorado's statute provides that all hospital

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126. O.C.G.A. § 31-8-179.2(a.1) (Supp. 2013).

127. COLO. REV. STAT. § 25.5-4-402.3(6) (2009).

128. COLO. REV. STAT. § 25.5-4-402.3(3)(b) (2009).

129. COLO. REV. STAT. § 25.5-4-402.3(3)(b.1) (2009).

130. COLO. REV. STAT. § 25.5-4-402.3(3)(b.II) (2009).

131. O.C.G.A. § 31-8-179.2(a) (Supp. 2013).

132. *Id.*

133. O.C.G.A. § 31-8-179.2(a)(1-2) (Supp. 2013).

134. The Indigent Care Trust Fund was created pursuant to O.C.G.A. § 31-8-152 (2010).

fees must be credited to the “hospital provider fee cash fund.”<sup>135</sup> Furthermore, any unexpended funds remaining at the end of a fiscal year do not “roll over” into Colorado’s general fund.<sup>136</sup> Likewise, Georgia restricts hospital provider fees held in the Indigent Care Trust Fund from lapsing into the general fund. In fact, Georgia’s statutory language seems more protective of these funds, claiming the fees are held “for the sole purpose of obtaining federal financial participation” and declaring any appropriation for a different purpose as void.<sup>137</sup>

Georgia and Colorado’s bed tax programs are representative of the ones adopted by most states. Recognizing massive state budget shortfalls—Medicaid as one of the largest deficit contributors—states implement hospital bed taxes to lighten the load with federal money. With minor variations on program oversight and provider fee fund management, the states’ statutory implementations largely perform the same function: obtain as much federal matching funds as possible to offset the rising costs of state indigent healthcare.

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135. COLO. REV. STAT. § 25.5-4-402.3(4) (2009).

136. COLO. REV. STAT. § 25.5-4-402.3(4)(c) (2009).

137. O.C.G.A. § 31-8-179.4(a) (Supp. 2013).