The House Special Committee on Access to Quality Health Care offers the following substitute to HB 198:

A BILL TO BE ENTITLED
AN ACT

To amend Title 31 of the Official Code of Georgia Annotated, relating to health, so as to eliminate certificate of need requirements for all health care facilities except certain long-term care facilities and services; to provide for a special health care services license for other health care facilities and services; to provide for definitions; to provide for requirements; to provide for exceptions; to provide for applications; to provide for notice and timely objections; to require the provision of indigent and charity care and Medicaid services; to provide for revocation; to require annual reports; to provide for rules and regulations; to provide for transition and grandfather provisions; to provide for the posting of certain documents on hospital websites; to prohibit certain actions relating to medical use rights; to revise provisions relating to the sale or lease of a hospital by a hospital authority; to provide for the investment of funds by certain hospital authorities; to amend Code Section 50-18-70 of the Official Code of Georgia Annotated, relating to legislative intent and definitions relative to open records laws, so as to revise definitions; to amend Code Section 48-7-29.20 of the Official Code of Georgia Annotated, relating to tax credits for contributions to rural hospital organizations, so as to revise provisions relating to the rural hospital tax credit program; to amend other provisions in various titles of the Official Code of Georgia Annotated for purposes of conformity; to provide for related matters; to provide for effective dates; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

PART I

SECTION 1-1.

Title 31 of the Official Code of Georgia Annotated, relating to health, is amended by revising Chapter 6, relating to state health planning and development, as follows:

″CHAPTER 6

ARTICLE 1

31-6-1.

The policy of this state and the purposes of this chapter are to ensure access to quality ~~health~~ long-term care services and to ensure that long-term health care services and facilities are developed in an orderly and economical manner and are made available to all citizens and that only those long-term health care services found to be in the public interest shall be provided in this state. To achieve such public policy and purposes, it is essential that appropriate health planning activities be undertaken and implemented and that a system of mandatory review of new institutional health services be provided. Long-term health ~~Health~~ care services and facilities should be provided in a manner that avoids unnecessary duplication of services, that is cost effective, that provides quality health care services, and that is compatible with the long-term health care needs of the various areas and populations of the state.

31-6-2.

As used in this chapter, the term:

~~(1) 'Ambulatory surgical center or obstetrical facility' means a public or private facility, not a part of a hospital, which provides surgical or obstetrical treatment performed under general or regional anesthesia in an operating room environment to patients not requiring hospitalization.~~

~~(2)~~(1) 'Application' means a written request for a certificate of need made to the department, containing such documentation and information as the department may require.

~~(3) 'Basic perinatal services' means providing basic inpatient care for pregnant women and newborns without complications; managing perinatal emergencies; consulting with and referring to specialty and subspecialty hospitals; identifying high-risk pregnancies; providing follow-up care for new mothers and infants; and providing public/community education on perinatal health.~~

~~(4)~~(2) 'Bed capacity' means space used exclusively for inpatient care, including space designed or remodeled for inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the department, except that single beds in single rooms shall be counted even if the room contains inadequate square footage.

~~(5)~~(3) 'Board' means the Board of Community Health.

~~(6)~~(4) 'Certificate of need' means an official determination by the department, evidenced by certification issued pursuant to an application, that the action proposed in the application satisfies and complies with the criteria contained in this chapter and rules promulgated pursuant hereto.

~~(7)~~(5) 'Certificate of Need Appeal Panel' or 'appeal panel' means the panel of independent hearing officers created pursuant to Code Section 31-6-44 to conduct appeal hearings.

~~(8)~~(6) 'Clinical health services' means diagnostic, treatment, or rehabilitative services provided in a health care facility, or parts of the physical plant where such services are located in a health care facility, and includes~~, but is not limited to, the following: radiology and diagnostic imaging, such as magnetic resonance imaging and positron emission tomography; radiation therapy; biliary lithotripsy; surgery; intensive care; coronary care; pediatrics; gynecology; obstetrics; general medical care; medical/surgical care;~~ inpatient nursing care, whether intermediate, skilled, or extended care~~; cardiac catheterization; open-heart surgery; inpatient rehabilitation; and alcohol, drug abuse, and mental health services~~.

~~(9)~~(7) 'Commissioner' means the commissioner of community health.

~~(10) 'Consumer' means a person who is not employed by any health care facility or provider and who has no financial or fiduciary interest in any health care facility or provider.~~

~~(11)~~(8) 'Continuing care retirement community' means an organization, whether operated for profit or not, whose owner or operator undertakes to provide shelter, food, and either nursing care or personal services, whether such nursing care or personal services are provided in the facility or in another setting, and other services, as designated by agreement, to an individual not related by consanguinity or affinity to such owner or operator providing such care pursuant to an agreement for a fixed or variable fee, or for any other remuneration of any type, whether fixed or variable, for the period of care, payable in a lump sum or lump sum and monthly maintenance charges or in installments. Agreements to provide continuing care include agreements to provide care for any duration, including agreements that are terminable by either party.

~~(12)~~(9) 'Department' means the Department of Community Health established under Chapter 2 of this title.

~~(13) 'Destination cancer hospital' means an institution with a licensed bed capacity of 50 or less which provides diagnostic, therapeutic, treatment, and rehabilitative care services to cancer inpatients and outpatients, by or under the supervision of physicians, and whose proposed annual patient base is composed of a minimum of 65 percent of patients who reside outside of the State of Georgia.~~

~~(14)~~(10) 'Develop,' with reference to a project, means~~:~~

~~(A) Constructing~~ constructing, remodeling, installing, or proceeding with a project, or any part of a project, or a capital expenditure project, the cost estimate for which exceeds ~~$2.5 million; or~~ $3,068,601.00. The dollar amount specified in this paragraph shall be adjusted annually by an amount calculated by the department to reflect inflation, which may be calculated by multiplying such dollar amount, as adjusted for the preceding year, by the annual percentage of change in the composite index of construction material prices, or its successor or appropriate replacement index, if any, published by the United States Department of Commerce for the preceding calendar year, commencing on July 1, 2019, and on each anniversary thereafter of the publication of the index. The department shall immediately institute rule-making procedures to adopt such adjusted dollar amounts. In calculating the dollar amount of a proposed project for purposes of this paragraph, the costs of all items subject to review by this chapter and items not subject to review by this chapter associated with and simultaneously developed or proposed with the project shall be counted; provided, however, that

~~(B) The expenditure or commitment of funds exceeding $1 million for orders, purchases, leases, or acquisitions through other comparable arrangements of major medical equipment; provided, however, that this shall not include build-out costs, as defined by the department, but shall include all functionally related equipment, software, and any warranty and services contract costs for the first five years.~~

~~Notwithstanding subparagraphs (A) and (B) of this paragraph,~~ the expenditure or commitment or incurring an obligation for the expenditure of funds to develop certificate of need applications, studies, reports, schematics, preliminary plans and specifications, or working drawings or to acquire, develop, or prepare sites shall not be considered to be the developing of a project.

~~(15) 'Diagnostic imaging' means magnetic resonance imaging, computed tomography (CT) scanning, positron emission tomography (PET) scanning, positron emission tomography/computed tomography, and other advanced imaging services as defined by the department by rule, but such term shall not include X-rays, fluoroscopy, or ultrasound services.~~

~~(16) 'Diagnostic, treatment, or rehabilitation center' means any professional or business undertaking, whether for profit or not for profit, which offers or proposes to offer any clinical health service in a setting which is not part of a hospital; provided, however, that any such diagnostic, treatment, or rehabilitation center that offers or proposes to offer surgery in an operating room environment and to allow patients to remain more than 23 hours shall be considered a hospital for purposes of this chapter.~~

~~(17)~~(11) 'Health care facility' means ~~hospitals; destination cancer hospitals; other special care units, including but not limited to podiatric facilities;~~ skilled nursing facilities; intermediate care facilities; personal care homes; ~~ambulatory surgical centers or obstetrical facilities; health maintenance organizations;~~ and home health agencies~~; and diagnostic, treatment, or rehabilitation centers, but only to the extent paragraph (3) or (7), or both paragraphs (3) and (7), of subsection (a) of Code Section 31-6-40 are applicable thereto~~.

~~(18) 'Health maintenance organization' means a public or private organization organized under the laws of this state which:~~

~~(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physicians' services, hospitalization, laboratory, X-ray, emergency and preventive services, and out-of-area coverage;~~

~~(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and~~

~~(C) Provides physicians' services primarily:~~

~~(i) Directly through physicians who are either employees or partners of such organization; or~~

~~(ii) Through arrangements with individual physicians organized on a group practice or individual practice basis.~~

~~(19) 'Health Strategies Council' or 'council' means the body created by this chapter to advise the department.~~

~~(20)~~(12) 'Home health agency' means a public agency or private organization, or a subdivision of such an agency or organization, which is primarily engaged in providing to individuals who are under a written plan of care of a physician, on a visiting basis in the places of residence used as such individuals' homes, part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse, and one or more of the following services:

(A) Physical therapy;

(B) Occupational therapy;

(C) Speech therapy;

(D) Medical social services under the direction of a physician; or

(E) Part-time or intermittent services of a home health aide.

~~(21) 'Hospital' means an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or~~

~~rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term includes public, private, psychiatric, rehabilitative, geriatric, osteopathic, micro-hospitals, and other specialty hospitals.~~

~~(22)~~(13) 'Intermediate care facility' means an institution which provides, on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide but who, because of their mental or physical condition, require health related care and services beyond the provision of room and board.

~~(23) 'Joint venture ambulatory surgical center' means a freestanding ambulatory surgical center that is jointly owned by a hospital in the same county as the center or a hospital in a contiguous county if there is no hospital in the same county as the center and a single group of physicians practicing in the center and that provides surgery in a single specialty as defined by the department; provided, however, that general surgery, a group practice which includes one or more physiatrists who perform services that are reasonably related to the surgical procedures performed in the center, and a group practice in orthopedics which includes plastic hand surgeons with a certificate of added qualifications in Surgery of the Hand from the American Board of Plastic and Reconstructive Surgery shall be considered a single specialty. The ownership interest of the hospital shall be no less than 30 percent and the collective ownership of the physicians or group of physicians shall be no less than 30 percent.~~

~~(23.1) 'Micro-hospital' means a hospital in a rural county which has at least two and not more than seven inpatient beds and which provides emergency services seven days per week and 24 hours per day.~~

~~(24) 'New and emerging health care service' means a health care service or utilization of medical equipment which has been developed and has become acceptable or available for implementation or use but which has not yet been addressed under the rules and regulations promulgated by the department pursuant to this chapter.~~

~~(25)~~(14) 'Nonclinical health services' means services or functions provided or performed by a health care facility, and the parts of the physical plant where they are located in a health care facility that are not diagnostic, therapeutic, or rehabilitative services to patients and are not clinical health services defined in this chapter.

~~(26)~~(15) 'Offer' means that the health care facility is open for the acceptance of patients or performance of services and has qualified personnel, equipment, and supplies necessary to provide specified clinical health services.

~~(27) 'Operating room environment' means an environment which meets the minimum physical plant and operational standards specified in the rules of the department which shall consider and use the design and construction specifications as set forth in the~~

~~*Guidelines for Design and Construction of Health Care Facilities* published by the American Institute of Architects.~~

~~(28) 'Pediatric cardiac catheterization' means the performance of angiographic, physiologic, and, as appropriate, therapeutic cardiac catheterization on children 14 years of age or younger.~~

~~(29)~~(16) 'Person' means any individual, trust or estate, partnership, limited liability company or partnership, corporation (including associations, joint-stock companies, and insurance companies), state, political subdivision, hospital authority, or instrumentality (including a municipal corporation) of a state as defined in the laws of this state. This term shall include all related parties, including individuals, business corporations, general partnerships, limited partnerships, limited liability companies, limited liability partnerships, joint ventures, nonprofit corporations, or any other for profit or not for profit entity that owns or controls, is owned or controlled by, or operates under common ownership or control with a person.

~~(30)~~(17) 'Personal care home' means a residential facility that is certified as a provider of medical assistance for Medicaid purposes pursuant to Article 7 of Chapter 4 of Title 49 having at least 25 beds and providing, for compensation, protective care and oversight of ambulatory, nonrelated persons who need a monitored environment but who do not have injuries or disabilities which require chronic or convalescent care, including medical, nursing, or intermediate care. Personal care homes include those facilities which monitor daily residents' functioning and location, have the capability for crisis intervention, and provide supervision in areas of nutrition, medication, and provision of transient medical care. Such term does not include:

(A) Old age residences which are devoted to independent living units with kitchen facilities in which residents have the option of preparing and serving some or all of their own meals; or

(B) Boarding facilities which do not provide personal care.

~~(31)~~(18) 'Project' means a proposal to take an action for which a certificate of need is required under this chapter. A project or proposed project may refer to the proposal from its earliest planning stages up through the point at which the new institutional health service is offered.

~~(32) 'Rural county' means a county having a population of less than 50,000 according to the United States decennial census of 2010 or any future such census.~~

~~(33) 'Single specialty ambulatory surgical center' means an ambulatory surgical center where surgery is performed in the offices of an individual private physician or single group practice of private physicians if such surgery is performed in a facility that is owned, operated, and utilized by such physicians who also are of a single specialty;~~

~~provided, however, that general surgery, a group practice which includes one or more physiatrists who perform services that are reasonably related to the surgical procedures performed in the center, and a group practice in orthopedics which includes plastic hand surgeons with a certificate of added qualifications in Surgery of the Hand from the American Board of Plastic and Reconstructive Surgery shall be considered a single specialty.~~

~~(34)~~(19) 'Skilled nursing facility' means a public or private institution or a distinct part of an institution which is primarily engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

~~(35) 'Specialty hospital' means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following: patients with a cardiac condition, patients with an orthopedic condition, patients receiving a surgical procedure, or patients receiving any other specialized category of services defined by the department. A 'specialty hospital' does not include a destination cancer hospital.~~

~~(36)~~(20) 'State health plan' means a comprehensive program based on recommendations by ~~the Health Strategies Council and~~ the board, approved by the Governor, and implemented by the State of Georgia for the purpose of providing adequate long-term health care services and facilities throughout the state.

~~(37)~~(21) 'Uncompensated indigent or charity care' means the dollar amount of 'net uncompensated indigent or charity care after direct and indirect (all) compensation' as defined by, and calculated in accordance with, the department's Hospital Financial Survey and related instructions.

~~(38) 'Urban county' means a county having a population equal to or greater than 50,000 according to the United States decennial census of 2010 or any future such census.~~

ARTICLE 2

31-6-20.

Reserved.

31-6-21.

(a) The Department of Community Health, established under Chapter 2 of this title, is authorized to administer the certificate of need program established under this chapter and, within the appropriations made available to the department by the General Assembly of Georgia and consistently with the laws of the State of Georgia, a state health plan adopted

by the board. The department shall provide, by rule, for procedures to administer its functions until otherwise provided by the board.

(b) The functions of the department shall be:

(1) To conduct the health planning activities of the state and to implement those parts of the state health plan which relate to the government of the state;

(2) To prepare and revise a draft state health plan;

~~(3) To seek advice, at its discretion, from the Health Strategies Council in the performance by the department of its functions pursuant to this chapter;~~

~~(4)~~(3) To adopt, promulgate, and implement rules and regulations sufficient to administer the provisions of this chapter including the certificate of need program;

~~(5)~~(4) To define, by rule, the form, content, schedules, and procedures for submission of applications for certificates of need and periodic reports;

~~(6)~~(5) To establish time periods and procedures consistent with this chapter to hold hearings and to obtain the viewpoints of interested persons prior to issuance or denial of a certificate of need;

~~(7)~~(6) To provide, by rule, for such fees as may be necessary to cover the costs of hearing officers, preparing the record for appeals before such hearing officers and the Certificate of Need Appeal Panel of the decisions of the department, and other related administrative costs, which costs may include reasonable sharing between the department and the parties to appeal hearings;

~~(8)~~(7) To establish, by rule, need methodologies for new institutional health services and health facilities. In developing such need methodologies, the department shall, at a minimum, consider the demographic characteristics of the population, the health status of the population, service use patterns, standards and trends, financial and geographic accessibility, and market economics. The department shall establish service-specific need methodologies and criteria for ~~at least~~ the following clinical health services: ~~short stay hospital beds, adult therapeutic cardiac catheterization, adult open heart surgery, pediatric cardiac catheterization and open heart surgery, Level II and III perinatal services, freestanding birthing centers, psychiatric and substance abuse inpatient programs,~~ skilled nursing and intermediate care facilities, home health agencies, and continuing care retirement community sheltered facilities;

~~(9)~~(8) To provide, by rule, for a reasonable and equitable fee schedule for certificate of need applications;

~~(10)~~(9) To grant, deny, or revoke a certificate of need as applied for or as amended; and

~~(11)~~(10) To perform powers and functions delegated by the Governor, which delegation may include the powers to carry out the duties and powers which have been delegated to

the department under Section 1122 of the federal Social Security Act of 1935, as amended.

31-6-21.1.

(a) Rules of the department shall be adopted, promulgated, and implemented as provided in this Code section and in Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act,' except that the department shall not be required to comply with subsections (c) through (g) of Code Section 50-13-4.

(b) The department shall transmit three copies of the notice provided for in paragraph (1) of subsection (a) of Code Section 50-13-4 to the legislative counsel. The copies shall be transmitted at least 30 days prior to that department's intended action. Within five days after receipt of the copies, if possible, the legislative counsel shall furnish the presiding officer of each house with a copy of the notice and mail a copy of the notice to each member of the Senate Health and Human Services Committee ~~of the Senate~~ and each member of the House Committee on Health and Human Services ~~Committee of the House of Representatives~~. Each such rule and any part thereof shall be subject to the making of an objection by either such committee within 30 days of transmission of the rule to the members of such committee. Any rule or part thereof to which no objection is made by both such committees may become adopted by the department at the end of such 30 day period. The department may not adopt any such rule or part thereof which has been changed since having been submitted to those committees unless:

(1) That change is to correct only typographical errors;

(2) That change is approved in writing by both committees and that approval expressly exempts that change from being subject to the public notice and hearing requirements of subsection (a) of Code Section 50-13-4;

(3) That change is approved in writing by both committees and is again subject to the public notice and hearing requirements of subsection (a) of Code Section 50-13-4; or

(4) That change is again subject to the public notice and hearing requirements of subsection (a) of Code Section 50-13-4 and the change is submitted and again subject to committee objection as provided in this subsection.

Nothing in this subsection shall prohibit the department from adopting any rule or part thereof without adopting all of the rules submitted to the committees if the rule or part so adopted has not been changed since having been submitted to the committees and objection thereto was not made by both committees.

(c) Any rule or part thereof to which an objection is made by both committees within the 30 day objection period under subsection (b) of this Code section shall not be adopted by the department and shall be invalid if so adopted. A rule or part thereof thus prohibited

from being adopted shall be deemed to have been withdrawn by the department unless the department, within the first 15 days of the next regular session of the General Assembly, transmits written notification to each member of the objecting committees that the department does not intend to withdraw that rule or part thereof but intends to adopt the specified rule or part effective the day following adjournment sine die of that regular session. A resolution objecting to such intended adoption may be introduced in either branch of the General Assembly after the fifteenth day but before the thirtieth day of the session in which occurs the notification of intent not to withdraw a rule or part thereof. In the event the resolution is adopted by the branch of the General Assembly in which the resolution was introduced, it shall be immediately transmitted to the other branch of the General Assembly. It shall be the duty of the presiding officer of the other branch to have that branch, within five days after receipt of the resolution, consider the resolution for purposes of objecting to the intended adoption of the rule or part thereof. Upon such resolution being adopted by two-thirds of the vote of each branch of the General Assembly, the rule or part thereof objected to in that resolution shall be disapproved and not adopted by the department. If the resolution is adopted by a majority but by less than two-thirds of the vote of each such branch, the resolution shall be submitted to the Governor for his or her approval or veto. In the event of a veto, or if no resolution is introduced objecting to the rule, or if the resolution introduced is not approved by at least a majority of the vote of each such branch, the rule shall automatically become adopted the day following adjournment sine die of that regular session. In the event of the Governor's approval of the resolution, the rule shall be disapproved and not adopted by the department.

(d) Any rule or part thereof which is objected to by only one committee under subsection (b) of this Code section and which is adopted by the department may be considered by the branch of the General Assembly whose committee objected to its adoption by the introduction of a resolution for the purpose of overriding the rule at any time within the first 30 days of the next regular session of the General Assembly. It shall be the duty of the department in adopting a proposed rule over such objection so to notify the chairpersons of the Senate Health and Human Services Committee ~~of the Senate~~ and the House Committee on Health and Human Services ~~Committee of the House~~ within ten days after the adoption of the rule. In the event the resolution is adopted by such branch of the General Assembly, it shall be immediately transmitted to the other branch of the General Assembly. It shall be the duty of the presiding officer of the other branch of the General Assembly to have such branch, within five days after the receipt of the resolution, consider the resolution for the purpose of overriding the rule. In the event the resolution is adopted by two-thirds of the votes of each branch of the General Assembly, the rule shall be void on the day after the adoption of the resolution by the second branch of the General

Assembly. In the event the resolution is ratified by a majority but by less than two-thirds of the votes of either branch, the resolution shall be submitted to the Governor for his or her approval or veto. In the event of a veto, the rule shall remain in effect. In the event of the Governor's approval, the rule shall be void on the day after the date of approval.

(e) Except for emergency rules, no rule or part thereof adopted by the department after April 3, 1985, shall be valid unless adopted in compliance with subsections (b), (c), and (d) of this Code section and subsection (a) of Code Section 50-13-4.

(f) Emergency rules shall not be subject to the requirements of subsection (b), (c), or (d) of this Code section but shall be subject to the requirements of subsection (b) of Code Section 50-13-4. Upon the first expiration of any department emergency rules, ~~where~~ when those emergency rules are intended to cover matters which had been dealt with by the department's nonemergency rules but such nonemergency rules have been objected to by both legislative committees under this Code section, the emergency rules concerning those matters may not again be adopted except for one 120 day period. No emergency rule or part thereof which is adopted by the department shall be valid unless adopted in compliance with this subsection.

(g) Any proceeding to contest any rule on the ground of noncompliance with this Code section must be commenced within two years from the effective date of the rule.

(h) For purposes of this Code section, 'rules' shall mean rules and regulations.

(i) The state health plan or the rules establishing considerations, standards, or similar criteria for the grant or denial of a certificate of need pursuant to Code Section 31-6-42 shall not apply to any application for a certificate of need as to which, prior to the effective date of such plan or rules, respectively, the evidence has been closed following a full evidentiary hearing before a hearing officer.

(j) This Code section shall apply only to rules adopted pursuant to this chapter.

31-6-40.

(a) On and after July 1, 2008, any new institutional health service shall be required to obtain a certificate of need pursuant to this chapter. New institutional health services include:

(1) The construction, development, or other establishment of a new health care facility;

~~(2) Any expenditure by or on behalf of a health care facility in excess of $2.5 million which, under generally accepted accounting principles consistently applied, is a capital expenditure, except expenditures for acquisition of an existing health care facility not owned or operated by or on behalf of a political subdivision of this state, or any combination of such political subdivisions, or by or on behalf of a hospital authority, as defined in Article 4 of Chapter 7 of this title, or certificate of need owned by such facility~~

~~in connection with its acquisition. The dollar amounts specified in this paragraph and in subparagraph (A) of paragraph (14) of Code Section 31-6-2 shall be adjusted annually by an amount calculated by multiplying such dollar amounts (as adjusted for the preceding year) by the annual percentage of change in the composite index of construction material prices, or its successor or appropriate replacement index, if any, published by the United States Department of Commerce for the preceding calendar year, commencing on July 1, 2009, and on each anniversary thereafter of publication of the index. The department shall immediately institute rule-making procedures to adopt such adjusted dollar amounts. In calculating the dollar amounts of a proposed project for purposes of this paragraph and subparagraph (A) of paragraph (14) of Code Section 31-6-2, the costs of all items subject to review by this chapter and items not subject to review by this chapter associated with and simultaneously developed or proposed with the project shall be counted, except for the expenditure or commitment of or incurring an obligation for the expenditure of funds to develop certificate of need applications, studies, reports, schematics, preliminary plans and specifications or working drawings, or to acquire sites;~~

~~(3) The purchase or lease by or on behalf of a health care facility or a diagnostic, treatment, or rehabilitation center of diagnostic or therapeutic equipment with a value in excess of $1 million; provided, however, that diagnostic or other imaging services that are not offered in a hospital or in the offices of an individual private physician or single group practice of physicians exclusively for use on patients of that physician or group practice shall be deemed to be a new institutional health service regardless of the cost of equipment; and provided, further, that this shall not include build out costs, as defined by the department, but shall include all functionally related equipment, software, and any warranty and services contract costs for the first five years. The acquisition of one or more items of functionally related diagnostic or therapeutic equipment shall be considered as one project. The dollar amount specified in this paragraph, in subparagraph (B) of paragraph (14) of Code Section 31-6-2, and in paragraph (10) of subsection (a) of Code Section 31-6-47 shall be adjusted annually by an amount calculated by multiplying such dollar amounts (as adjusted for the preceding year) by the annual percentage of change in the consumer price index, or its successor or appropriate replacement index, if any, published by the United States Department of Labor for the preceding calendar year, commencing on July 1, 2010;~~

~~(4)~~(2) Any increase in the bed capacity of a health care facility ~~except as provided in Code Section 31-6-47~~; and

~~(5)~~(3) Clinical health services which are offered in or through a health care facility, which were not offered on a regular basis in or through such health care facility within the 12 month period prior to the time such services would be offered~~;~~.

~~(6) Any conversion or upgrading of any general acute care hospital to a specialty hospital or of a facility such that it is converted from a type of facility not covered by this chapter to any of the types of health care facilities which are covered by this chapter; and~~

~~(7) Clinical health services which are offered in or through a diagnostic, treatment, or rehabilitation center which were not offered on a regular basis in or through that center within the 12 month period prior to the time such services would be offered, but only if the clinical health services are any of the following:~~

~~(A) Radiation therapy;~~

~~(B) Biliary lithotripsy;~~

~~(C) Surgery in an operating room environment, including but not limited to ambulatory surgery; and~~

~~(D) Cardiac catheterization.~~

(b) Any person proposing to develop or offer a new institutional health service or health care facility shall, before commencing such activity, submit a letter of intent and an application to the department and obtain a certificate of need in the manner provided in this chapter unless such activity is excluded from the scope of this chapter.

(c)~~(1)~~ Any person who had a valid exemption granted or approved by the former Health Planning Agency or the department prior to July 1, 2008, shall not be required to obtain a certificate of need in order to continue to offer those previously offered services.

~~(2) Any facility offering ambulatory surgery pursuant to the exclusion designated on June 30, 2008, as division (14)(G)(iii) of Code Section 31-6-2; any diagnostic, treatment, or rehabilitation center offering diagnostic imaging or other imaging services in operation and exempt prior to July 1, 2008; or any facility operating pursuant to a letter of nonreviewability and offering diagnostic imaging services prior to July 1, 2008, shall:~~

~~(A) Provide notice to the department of the name, ownership, location, single specialty, and services provided in the exempt facility;~~

~~(B) Beginning on January 1, 2009, provide annual reports in the same manner and in accordance with Code Section 31-6-70; and~~

~~(C)(i) Provide care to Medicaid beneficiaries and, if the facility provides medical care and treatment to children, to PeachCare for Kids beneficiaries and provide uncompensated indigent and charity care in an amount equal to or greater than 2 percent of its adjusted gross revenue; or~~

~~(ii) If the facility is not a participant in Medicaid or the PeachCare for Kids Program, provide uncompensated care for Medicaid beneficiaries and, if the facility provides~~

~~medical care and treatment to children, for PeachCare for Kids beneficiaries, uncompensated indigent and charity care, or both in an amount equal to or greater than 4 percent of its adjusted gross revenue if it:~~

~~(I) Makes a capital expenditure associated with the construction, development, expansion, or other establishment of a clinical health service or the acquisition or replacement of diagnostic or therapeutic equipment with a value in excess of $800,000.00 over a two-year period;~~

~~(II) Builds a new operating room; or~~

~~(III) Chooses to relocate in accordance with Code Section 31-6-47.~~

~~Noncompliance with any condition of this paragraph shall result in a monetary penalty in the amount of the difference between the services which the center is required to provide and the amount actually provided and may be subject to revocation of its exemption status by the department for repeated failure to pay any fees or moneys due to the department or for repeated failure to produce data as required by Code Section 31-6-70 after notice to the exemption holder and a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act.' The dollar amount specified in this paragraph shall be adjusted annually by an amount calculated by multiplying such dollar amount (as adjusted for the preceding year) by the annual percentage of change in the consumer price index, or its successor or appropriate replacement index, if any, published by the United States Department of Labor for the preceding calendar year, commencing on July 1, 2009. In calculating the dollar amounts of a proposed project for the purposes of this paragraph, the costs of all items subject to review by this chapter and items not subject to review by this chapter associated with and simultaneously developed or proposed with the project shall be counted, except for the expenditure or commitment of or incurring an obligation for the expenditure of funds to develop certificate of need applications, studies, reports, schematics, preliminary plans and specifications or working drawings, or to acquire sites. Subparagraph (C) of this paragraph shall not apply to facilities offering ophthalmic ambulatory surgery pursuant to the exclusion designated on June 30, 2008, as division (14)(G)(iii) of Code Section 31-6-2 that are owned by physicians in the practice of ophthalmology.~~

~~(d) A certificate of need issued to a destination cancer hospital shall authorize the beds and all new institutional health services of such destination cancer hospital. As used in this subsection, the term 'new institutional health service' shall have the same meaning provided for in subsection (a) of this Code section. A certificate of need shall only be issued to a destination cancer hospital that locates itself and all affiliated facilities within 25 miles of a commercial airport in this state with five or more runways. Such destination cancer hospital shall not be required to apply for or obtain additional certificates of need for new~~

~~institutional health services related to the treatment of cancer patients, and such new institutional health services related to the treatment of cancer patients offered by the destination cancer hospital shall not be reviewed under any service-specific need methodology or rules except for those promulgated by the department for destination cancer hospitals. After commencing operations, in order to add an additional new institutional health service, a destination cancer hospital shall apply for and obtain an additional certificate of need under the applicable statutory provisions and any rules promulgated by the department for destination cancer hospitals, and such applications shall only be granted if the patient base of such destination cancer hospital is composed of at least 65 percent of out-of-state patients for two consecutive years. The department may apply rules for a destination cancer hospital only for those services that the department determines are to be used by the destination cancer hospital in connection with the treatment of cancer. In no case shall destination cancer hospital specific rules be used in the case of an application for open heart surgery, perinatal services, cardiac catheterization, and other services deemed by the department to be not reasonably related to the diagnosis and treatment of cancer; provided, however, that the department shall apply the destination cancer hospital specific rules if a destination cancer hospital applies for services and equipment required for it to meet federal or state laws applicable to a hospital. If such destination cancer hospital cannot show a patient base of a minimum of 65 percent from outside of this state, then its application for any new institutional health service shall be evaluated under the specific statutes and rules applicable to that particular service. If such destination cancer hospital applies for a certificate of need to add an additional new institutional health service before commencing operations or completing two consecutive years of operation, such applicant may rely on historical data from its affiliated entities, as set forth in paragraph (2) of subsection (b.1) of Code Section 31-6-42. Because destination cancer hospitals provide services primarily to out-of-state residents, the number of beds, services, and equipment destination cancer hospitals use shall not be counted as part of the department's inventory when determining the need for those items by other providers. No person shall be issued more than one certificate of need for a destination cancer hospital. Nothing in this Code section shall in any way require a destination cancer hospital to obtain a certificate of need for any purpose that is otherwise exempt from the certificate of need requirement. Beginning January 1, 2010, the department shall not accept any application for a certificate of need for a new destination cancer hospital; provided, however, all other provisions regarding the upgrading, replacing, or purchasing of diagnostic or therapeutic equipment shall be applicable to an existing destination cancer hospital.~~

~~(e) The commissioner shall be authorized, with the approval of the board, to place a temporary moratorium of up to six months on the issuance of certificates of need for new~~

~~and emerging health care services. Any such moratorium placed shall be for the purpose of promulgating rules and regulations regarding such new and emerging health care services. A moratorium may be extended one time for an additional three months if circumstances warrant, as approved by the board. In the event that final rules and regulations are not promulgated within the time period allowed by the moratorium, any applications received by the department for a new and emerging health care service shall be reviewed under existing general statutes and regulations relating to certificates of need.~~

31-6-40.1.

(a) Any person who acquires a health care facility by stock or asset purchase, merger, consolidation, or other lawful means shall notify the department of such acquisition, the date thereof, and the name and address of the acquiring person. Such notification shall be made in writing to the department within 45 days following the acquisition and the acquiring person may be fined by the department in the amount of $500.00 for each day that such notification is late. Such fine shall be paid into the state treasury.

(b) The department may limit the time periods during which it will accept applications for the following health care facilities:

(1) Skilled nursing facilities;

(2) Intermediate care facilities; and

(3) Home health agencies,

to only such times after the department has determined there is an unmet need for such facilities. The department shall make a determination as to whether or not there is an unmet need for each type of facility at least every six months and shall notify those requesting such notification of that determination.

(b.1) The department may establish, by rule, set times during the year in which applications for capital projects exceeding the threshold ~~amounts~~ amount in paragraph (10) of Code Section 31-6-2 shall be accepted.~~:~~

~~(1) Paragraph (14) of Code Section 31-6-2; and~~

~~(2) Paragraph (2) or (3) of subsection (a) of Code Section 31-6-40~~

~~shall be accepted.~~

(c) The department may require that any applicant for a certificate of need agree to provide a specified amount of clinical health services to indigent patients as a condition for the grant of a certificate of need~~; provided, however, that each facility granted a certificate of need by the department as a destination cancer hospital shall be required to provide uncompensated indigent or charity care for residents of Georgia which meets or exceeds 3 percent of such destination cancer hospital's adjusted gross revenues and provide care to Medicaid beneficiaries~~. A grantee or successor in interest of a certificate of need or an

authorization to operate under this chapter which violates such an agreement or violates any conditions imposed by the department relating to such services, whether made before or after July 1, 2008, shall be liable to the department for a monetary penalty in the amount of the difference between the amount of services so agreed to be provided and the amount actually provided and may be subject to revocation of its certificate of need, in whole or in part, by the department pursuant to Code Section 31-6-45. Any penalty so recovered shall be paid into the state treasury.

~~(c.1)(1) A destination cancer hospital that does not meet an annual patient base composed of a minimum of 65 percent of patients who reside outside this state in a calendar year shall be fined $2 million for the first year of noncompliance, $4 million for the second consecutive year of noncompliance, and $6 million for the third consecutive year of noncompliance. Such fine amount shall reset to $2 million after any year of compliance. In the event that a destination cancer hospital does not meet an annual patient base composed of a minimum of 65 percent of patients who reside outside this state for three calendar years in any five-year period, such hospital shall be fined an additional amount of $8 million. It is the intent of the General Assembly that all revenues collected from any such fines shall be dedicated and deposited by the department into the Indigent Care Trust Fund created pursuant to Code Section 31-8-152.~~

~~(2) In the event a certificate of need for a destination cancer hospital is revoked pursuant to this subsection, such hospital shall be subject to fines pursuant to subsection (c) of Code Section 31-6-45 for operating without a certificate of need.~~

~~(3) In addition to the annual report required pursuant to Code Section 31-6-70, a destination cancer hospital shall submit an annual statement, in accordance with timeframes and a format specified by the department, affirming that the hospital has met an annual patient base composed of a minimum of 65 percent of patients who reside outside this state. The chief executive officer of the destination cancer hospital shall certify under penalties of perjury that the statement as prepared accurately reflects the composition of the annual patient base. The department shall have the authority to inspect any books, records, papers, or other information pursuant to subsection (e) of Code Section 31-6-45 of the destination cancer hospital to confirm the information provided on such statement or any other information required of the destination cancer hospital. Nothing in this paragraph shall be construed to require the release of any information which would violate the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191.~~

(d) Penalties authorized under this Code section shall be subject to the same notices and hearing for the levy of fines under Code Section 31-6-45.

~~31-6-40.2.~~

~~(a) As used in this Code section only, the term:~~

~~(1) 'Certificate of need application' means an application for a certificate of need filed with the department, any amendments thereto, and any other written material relating to the application and filed by the applicant with the department.~~

~~(2) 'First three years of operation' means the first three consecutive 12 month periods beginning on the first day of a new perinatal service's first full calendar month of operation.~~

~~(3) 'First year of operation' means the first consecutive 12 month period beginning on the first day of a new perinatal service's first full calendar month of operation.~~

~~(4) 'New perinatal service' means a perinatal service whose first year of operation ends after April 6, 1992.~~

~~(5) 'Perinatal service' means obstetric and neonatal services relating to managing high-risk pregnancies, care for moderately ill newborns, care for all maternal and fetal complications either on site or by referral, and operation of neonatal intensive care units equipped to treat critically ill newborns; provided however, this shall not include basic perinatal services as defined in Code Section 31-6-2.~~

~~(6) 'Year' means one of the three consecutive 12 month periods in a new perinatal service's first 36 months of operation.~~

~~(b)(1) A new perinatal service shall provide uncompensated indigent or charity care in an amount which meets or exceeds the department's established minimum at the time the department issued the certificate of need approval for such service for each of the service's first three years of operation; provided, however, that if the certificate of need application under which a new perinatal service was approved included a commitment that uncompensated indigent or charity care would be provided in an amount greater than the established minimum for any time period described in the certificate of need application that falls completely within such new perinatal service's first three years of operation, such new perinatal service shall provide indigent or charity care in an amount which meets or exceeds the amount committed in the certificate of need application for each time period described in the certificate of need application that falls completely within the service's first three years of operation.~~

~~(2) The department shall revoke the certificate of need and authority to operate of a new perinatal service if after notice to the grantee of the certificate or such grantee's successors, and after opportunity for a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act,' the department determines that such new perinatal service has failed to provide indigent or charity care in accordance with the requirements of paragraph (1) of this subsection and such failure is determined by the~~

~~department to be for reasons substantially within the perinatal service provider's control. The department shall provide the requisite notice, conduct the fair hearing, if requested, and render its determination within 90 days after the end of the first year, or, if applicable, the first time period described in paragraph (1) of this subsection during which the new perinatal service fails to provide indigent or charity care in accordance with the requirements of paragraph (1) of this subsection. Revocation shall be effective 30 days after the date of the determination by the department that the requirements of paragraph (1) of this subsection have not been met.~~

~~(c)(1) A new perinatal service shall achieve the standard number of births specified in the state health plan in effect at the time of the issuance of the certificate of need approval by the department in at least one year during its first three years of operation.~~

~~(2) The department shall revoke the certificate of need and authority to operate of a new perinatal service if after notice to the grantee of the certificate of need or such grantee's successors, and after opportunity for a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act,' the department determines that such new perinatal service has failed to comply with the applicable requirements of paragraph (1) of this subsection and such failure is determined by the department to be for reasons substantially within the perinatal service provider's control. The department shall provide the requisite notice, conduct the fair hearing, if requested, and render its determination within 90 days after the end of the new perinatal service's first three years of operation. Revocation shall be effective 30 days after the date of the determination by the department that the requirements of this paragraph or paragraph (1) of this subsection have not been met.~~

~~(d) Nothing contained in this Code section shall limit the department's authority to regulate perinatal services in ways or for time periods not addressed by the provisions of this Code section.~~

31-6-41.

(a) A certificate of need shall be valid only for the defined scope, location, cost, service area, and person named in an application, as it may be amended, and as such scope, location, service area, cost, and person are approved by the department, unless such certificate of need owned by an existing health care facility is transferred to a person who acquires such existing facility. In such case, the certificate of need shall be valid for the person who acquires such a facility and for the scope, location, cost, and service area approved by the department. However, in reviewing an application to relocate all or a portion of an existing skilled nursing facility, intermediate care facility, or intermingled nursing facility, the department may allow such facility to divide into two or more such

facilities if the department determines that the proposed division is financially feasible and would be consistent with quality patient care.

(b) A certificate of need shall be valid and effective for a period of 12 months after it is issued, or such greater period of time as may be specified by the department at the time the certificate of need is issued. Within the effective period after the grant of a certificate of need, the applicant of a proposed project shall fulfill reasonable performance and scheduling requirements specified by the department, by rule, to assure reasonable progress toward timely completion of a project.

(c) By rule, the department may provide for extension of the effective period of a certificate of need when an applicant, by petition, makes a good faith showing that the conditions to be specified according to subsection (b) of this Code section will be performed within the extended period and that the reasons for the extension are beyond the control of the applicant.

31-6-42.

(a) The written findings of fact and decision, with respect to the department's grant or denial of a certificate of need, shall be based on the applicable considerations specified in this Code section and reasonable rules promulgated by the department interpretive thereof. The department shall issue a certificate of need to each applicant whose application is consistent with the following considerations and such rules deemed applicable to a project, except as specified in subsection (f) of Code Section 31-6-43:

(1) The proposed new institutional health services are reasonably consistent with the relevant general goals and objectives of the state health plan;

(2) The population residing in the area served, or to be served, by the new institutional health service has a need for such services;

(3) Existing alternatives for providing services in the service area the same as the new institutional health service proposed are neither currently available, implemented, similarly utilized, nor capable of providing a less costly alternative, or no certificate of need to provide such alternative services has been issued by the department and is currently valid;

(4) The project can be adequately financed and is, in the immediate and long term, financially feasible;

(5) The effects of new institutional health service on ~~payors~~ payers for health services, including governmental ~~payors~~ payers, are not unreasonable;

(6) The costs and methods of a proposed construction project, including the costs and methods of energy provision and conservation, are reasonable and adequate for quality health care;

(7) The new institutional health service proposed is reasonably financially and physically accessible to the residents of the proposed service area;

(8) The proposed new institutional health service has a positive relationship to the existing health care delivery system in the service area;

(9) The proposed new institutional health service encourages more efficient utilization of the health care facility proposing such service;

(10) The proposed new institutional health service provides, or would provide, a substantial portion of its services to individuals not residing in its defined service area or the adjacent service area;

(11) The proposed new institutional health service conducts biomedical or behavioral research projects or new service development which is designed to meet a national, regional, or state-wide need;

(12) The proposed new institutional health service meets the clinical needs of health professional training programs which request assistance;

(13) The proposed new institutional health service fosters improvements or innovations in the financing or delivery of health services, promotes health care quality assurance or cost effectiveness, or fosters competition that is shown to result in lower patient costs without a loss of the quality of care;

(14) ~~The proposed new institutional health service fosters the special needs and circumstances of health maintenance organizations;~~ Reserved.

(15) The proposed new institutional health service meets the department's minimum quality standards, including, but not limited to, standards relating to accreditation, minimum volumes, quality improvements, assurance practices, and utilization review procedures;

(16) The proposed new institutional health service can obtain the necessary resources, including health care personnel and management personnel; and

(17) The proposed new institutional health service is an underrepresented health service, as determined annually by the department. The department shall, by rule, provide for an advantage to equally qualified applicants that agree to provide an underrepresented service in addition to the services for which the application was originally submitted.

~~(b) In the case of applications for the development or offering of a new institutional health service or health care facility for osteopathic medicine, the need for such service or facility shall be determined on the basis of the need and availability in the community for osteopathic services and facilities in addition to the considerations in subsection (a) of this Code section. Nothing in this chapter shall, however, be construed as otherwise recognizing any distinction between allopathic and osteopathic medicine.~~

~~(b.1) In the case of applications for the construction, development, or establishment of a destination cancer hospital, the applicable considerations as to the need for such service shall not include paragraphs (1), (2), (3), (7), (8), (10), (11), and (14) of subsection (a) of this Code section but shall include:~~

~~(1) Paragraphs (4), (5), (6), (9), (12), (13), (15), (16), and (17) of subsection (a) of this Code section;~~

~~(2) That the proposed new destination cancer hospital can demonstrate, based on historical data from the applicant or its affiliated entities, that its annual patient base shall be composed of a minimum of 65 percent of patients who reside outside of the State of Georgia;~~

~~(3) That the proposed new destination cancer hospital states its intent to provide uncompensated indigent or charity care which shall meet or exceed 3 percent of its adjusted gross revenues and provide care to Medicaid beneficiaries;~~

~~(4) That the proposed new destination cancer hospital shall conduct biomedical or behavioral research projects or service development which is designed to meet a national or regional need;~~

~~(5) That the proposed new destination cancer hospital shall be reasonably financially and physically accessible;~~

~~(6) That the proposed new destination cancer hospital shall have a positive relationship to the existing health care delivery system on a regional basis;~~

~~(6.1) That the proposed new destination cancer hospital shall enter into a hospital transfer agreement with one or more hospitals within a reasonable distance from the destination cancer hospital or the medical staff at the destination cancer hospital has admitting privileges or other acceptable documented arrangements with such hospital or hospitals to ensure the necessary backup for the destination cancer hospital for medical complications. The destination cancer hospital shall have the capability to transfer a patient immediately to a hospital within a reasonable distance from the destination cancer hospital with adequate emergency room services. Hospitals shall not unreasonably deny a transfer agreement with the destination cancer hospital. In the event that a destination cancer hospital and another hospital cannot agree to the terms of a transfer agreement as required by this paragraph, the department shall mediate between such parties for a period of no more than 45 days. If an agreement is still not reached within such 45 day period, the parties shall enter into binding arbitration conducted by the department;~~

~~(7) That an applicant for a new destination cancer hospital shall document in its application that the new facility is not predicted to be detrimental to existing hospitals within the planning area. Such demonstration shall be made by providing an analysis in such application that compares current and projected changes in market share and payor~~

~~mix for such applicant and such existing hospitals within the planning area. Impact on an existing hospital shall be determined to be adverse if, based on the utilization projected by the applicant, such existing hospital would have a total decrease of 10 percent or more in its average annual utilization, as measured by patient days for the two most recent and available preceding calendar years of data; and~~

~~(8) That the destination cancer hospital shall express its intent to participate in medical staffing work force development activities.~~

~~(b.2) In the case of applications for basic perinatal services in counties where:~~

~~(1) Only one civilian health care facility or health system is currently providing basic perinatal services; and~~

~~(2) There are not at least three different health care facilities in a contiguous county providing basic perinatal services,~~

~~the department shall not apply the consideration contained in paragraph (2) of subsection (a) of this Code section.~~

~~(c) If the denial of an application for a certificate of need for a new institutional health service proposed to be offered or developed by a:~~

~~(1) Minority administered hospital facility serving a socially and economically disadvantaged minority population in an urban setting; or~~

~~(2) Minority administered hospital facility utilized for the training of minority medical practitioners~~

~~would adversely impact upon the facility and population served by said facility, the special needs of such hospital facility and the population served by said facility for the new institutional health service shall be given extraordinary consideration by the department in making its determination of need as required by this Code section. The department shall have the authority to vary or modify strict adherence to the provisions of this chapter and the rules enacted pursuant hereto in considering the special needs of such facility and its population served and to avoid an adverse impact on the facility and the population served thereby. For purposes of this subsection, the term 'minority administered hospital facility' means a hospital controlled or operated by a governing body or administrative staff composed predominantly of members of a minority race.~~

~~(d)~~(b) For the purposes of the considerations contained in this Code section and in the department's applicable rules, relevant data which were unavailable or omitted when the state health plan or rules were prepared or revised may be considered in the evaluation of a project.

~~(e)~~(c) The department shall specify in its written findings of fact and decision which of the considerations contained in this Code section and the department's applicable rules are

applicable to an application and its reasoning as to and evidentiary support for its evaluation of each such applicable consideration and rule.

31-6-43.

(a) At least 30 days prior to submitting an application for a certificate of need for clinical health services, a person shall submit a letter of intent to the department. The department shall provide by rule a process for submitting letters of intent and a mechanism by which applications may be filed to compete with and be reviewed comparatively with proposals described in submitted letters of intent.

(b) Each application for a certificate of need shall be reviewed by the department and within ten working days after the date of its receipt a determination shall be made as to whether the application complies with the rules governing the preparation and submission of applications. If the application complies with the rules governing the preparation and submission of applications, the department shall declare the application complete for review, shall accept and date the application, and shall notify the applicant of the timetable for its review. The department shall also notify a newspaper of general circulation in the county in which the project shall be developed that the application has been deemed complete. The department shall also notify the appropriate regional commission and the chief elected official of the county and municipal governments, if any, in whose boundaries the proposed project will be located that the application is complete for review. If the application does not comply with the rules governing the preparation and submission of applications, the department shall notify the applicant in writing and provide a list of all deficiencies. The applicant shall be afforded an opportunity to correct such deficiencies, and upon such correction, the application shall then be declared complete for review within ten days of the correction of such deficiencies, and notice given to a newspaper of general circulation in the county in which the project shall be developed that the application has been so declared. The department shall also notify the appropriate regional commission and the chief elected official of the county and municipal governments, if any, in whose boundaries the proposed project will be located that the application is complete for review or when in the determination of the department a significant amendment is filed.

(c) The department shall specify by rule the time within which an applicant may amend its application. The department may request an applicant to make amendments. The department decision shall be made on an application as amended, if at all, by the applicant.

(d) There shall be a time limit of 120 days for review of a project, beginning on the day the department declares the application complete for review or in the case of applications joined for comparative review, beginning on the day the department declares the final application complete. The department may adopt rules for determining when it is not

practicable to complete a review in 120 days and may extend the review period upon written notice to the applicant but only for an extended period of not longer than an additional 30 days. The department shall adopt rules governing the submission of additional information by the applicant and for opposing an application.

(e) To allow the opportunity for comparative review of applications, the department may provide by rule for applications for a certificate of need to be submitted on a timetable or batching cycle basis no less often than two times per calendar year for each clinical health service. Applications for services, facilities, or expenditures for which there is no specified batching cycle may be filed at any time.

(f) The department may order the joinder of an application which is determined to be complete by the department for comparative review with one or more subsequently filed applications declared complete for review during the same batching cycle when:

(1) The first and subsequent applications involve similar clinical health service projects in the same service area or overlapping service areas; and

(2) The subsequent applications are filed and are declared complete for review within 30 days of the date the first application was declared complete for review.

Following joinder of the first application with subsequent applications, none of the subsequent applications so joined may be considered as a first application for the purposes of future joinder. The department shall notify the applicant to whose application a joinder is ordered and all other applicants previously joined to such application of the fact of each joinder pursuant to this subsection. In the event one or more applications have been joined pursuant to this subsection, the time limits for department action for all of the applicants shall run from the latest date that any one of the joined applications was declared complete for review. In the event of the consideration of one or more applications joined pursuant to this subsection, the department may award no certificate of need or one or more certificates of need to the ~~application or applications~~ applicant or applicants, if any, which are consistent with the considerations contained in Code Section 31-6-42, the department's applicable rules, and the award of which will best satisfy the purposes of this chapter.

(g) The department shall review the application and all written information submitted by the applicant in support of the application and all information submitted in opposition to the application to determine the extent to which the proposed project is consistent with the applicable considerations stated in Code Section 31-6-42 and in the department's applicable rules. During the course of the review, the department staff may request additional information from the applicant as deemed appropriate. Pursuant to rules adopted by the department, a public hearing on applications covered by those regulations may be held prior to the date of the department's decision thereon. Such rules shall provide that when good cause has been shown, a public hearing shall be held by the department. Any

interested person may submit information to the department concerning an application, and an applicant shall be entitled to notice of and to respond to any such submission.

(h) The department shall provide the applicant an opportunity to meet with the department to discuss the application and to provide an opportunity to submit additional information. Such additional information shall be submitted within the time limits adopted by the department. The department shall also provide an opportunity for any party that is opposed to an application to meet with the department and to provide additional information to the department. In order for an opposing party to have standing to appeal an adverse decision pursuant to Code Section 31-6-44, such party must attend and participate in an opposition meeting.

(i) Unless extended by the department for an additional period of up to 30 days pursuant to subsection (d) of this Code section, the department shall, no later than 120 days after an application is determined to be complete for review, or, in the event of joined applications, 120 days after the last application is declared complete for review, provide written notification to an applicant of the department's decision to issue or to deny issuance of a certificate of need for the proposed project. Such notice shall contain the department's written findings of fact and decision as to each applicable consideration or rule and a detailed statement of the reasons and evidentiary support for issuing or denying a certificate of need for the action proposed by each applicant. The department shall also mail such notification to the appropriate regional commission and the chief elected official of the county and municipal governments, if any, in whose boundaries the proposed project will be located. In the event such decision is to issue a certificate of need, the certificate of need shall be effective on the day of the decision unless the decision is appealed to the Certificate of Need Appeal Panel in accordance with this chapter. Within seven days of the decision, the department shall publish notice of its decision to grant or deny an application in the same manner as it publishes notice of the filing of an application.

(j) Should the department fail to provide written notification of the decision within the time limitations set forth in this Code section, an application shall be deemed to have been approved as of the one hundred twenty-first day following notice from the department that an application, or the last of any applications joined pursuant to subsection (f) of this Code section, is declared 'complete for review.'

(k) Notwithstanding other provisions of this article, when the Governor has declared a state of emergency in a region of the state, existing health care facilities in the affected region may seek emergency approval from the department to make expenditures in excess of the capital expenditure threshold or to offer services that may otherwise require a certificate of need. The department shall give special expedited consideration to such requests and may authorize such requests for good cause. Once the state of emergency has

been lifted, any services offered by an affected health care facility under this subsection shall cease to be offered until such time as the health care facility that received the emergency authorization has requested and received a certificate of need. For purposes of this subsection, 'good cause' means that authorization of the request shall directly resolve a situation posing an immediate threat to the health and safety of the public. The department shall establish, by rule, procedures whereby requirements for the process of review and issuance of a certificate of need may be modified and expedited as a result of emergency situations.

31-6-44.

(a) Effective July 1, 2008, there is created the Certificate of Need Appeal Panel, which shall be an agency separate and apart from the department and shall consist of a panel of independent hearing officers. The purpose of the appeal panel shall be to serve as a panel of independent hearing officers to review the department's initial decision to grant or deny a certificate of need application. The Health Planning Review Board which existed on June 30, 2008, shall cease to exist after that date and the Certificate of Need Appeal Panel shall be constituted effective July 1, 2008, pursuant to this Code section. The terms of all members of the Health Planning Review Board serving as such on June 30, 2008, shall automatically terminate on such date.

(b) On and after July 1, 2008, the appeal panel shall be composed of five members appointed by the Governor for a term of up to four years each. The Governor shall appoint to the appeal panel attorneys who practice law in this state and who are familiar with the health care industry but who do not have a financial interest in or represent or have any compensation arrangement with any health care facility. Each member of the appeal panel shall be an active member of the State Bar of Georgia in good standing, and each attorney shall have maintained such active status for the five years immediately preceding such person's appointment. The Governor shall name from among such members a chairperson and a vice chairperson of the appeal panel. The vice chairperson shall have the same authority as the chairperson; provided, however, the vice chairperson shall not exercise such authority unless expressly delegated by the chairperson or in the event the chairperson becomes incapacitated, as determined by the Governor. Vacancies on the appeal panel caused by resignation, death, or any other cause shall be filled for the unexpired term in the same manner as the original appointment. No person required to register with the Secretary of State as a lobbyist or registered agent shall be eligible for appointment by the Governor to the appeal panel.

(c) The appeal panel shall promulgate reasonable rules for its operation and rules of procedure for the conduct of initial administrative appeal hearings held by the appointed

hearing officers, including an appropriate fee schedule for filing such appeals. Members of the appeal panel shall serve as hearing officers for appeals that are assigned to them on a random basis by the chairperson of the appeal panel. The members of the appeal panel shall receive no salary but shall be reimbursed for their expenses in attending meetings and for transportation costs as authorized by Code Section 45-7-21, which provides for compensation and allowances of certain state officials; provided, however, that the chairperson and vice chairperson of the appeal panel shall also be compensated for their services rendered to the appeal panel outside of attendance at an appeal panel meeting, such as for time spent assigning hearing officers, the amount of which compensation shall be determined according to regulations of the Department of Administrative Services. Appeal panel members shall receive compensation for the administration of the cases assigned to them, including prehearing, hearing, and posthearing work, in an amount determined to be appropriate and reasonable by the Department of Administrative Services. Such compensation to the members of the appeal panel shall be made by the Department of Administrative Services.

(d) Any applicant for a project, any competing applicant in the same batching cycle, any competing health care facility that has notified the department prior to its decision that such facility is opposed to the application before the department, or any county or municipal government in whose boundaries the proposed project will be located who is aggrieved by a decision of the department shall have the right to an initial administrative appeal hearing before an appeal panel hearing officer or to intervene in such hearing. Such request for hearing or intervention shall be filed with the chairperson of the appeal panel within 30 days of the date of the decision made pursuant to Code Section 31-6-43. In the event an appeal is filed by a competing applicant, or any competing health care facility, or any county or municipal government, the appeal shall be accompanied by payment of such fee as is established by the appeal panel. In the event an appeal is requested, the chairperson of the appeal panel shall appoint a hearing officer for each such hearing within 30 days after the date the appeal is received. Within 14 days after the appointment of the hearing officer, such hearing officer shall confer with the parties and set the date or dates for the hearing, provided that no hearing shall be scheduled less than 60 days nor more than 120 days after the filing of the request for a hearing, unless the applicant consents or, in the case of competing applicants, all applicants consent to an extension of this time period to a specified date. Unless the applicant consents or, in the case of competing applicants, all applicants consent to an extension of said 120 day period, any hearing officer who regularly fails to commence a hearing within the required time period shall not be eligible for continued service as a hearing officer for the purposes of this Code section. The hearing officer shall have the authority to dispose of all motions made by any party before

the issuance of the hearing officer's decision and shall make such rulings as may be required for the conduct of the hearing.

(e) In fulfilling the functions and duties of this chapter, the hearing officer shall act, and the hearing shall be conducted as a full evidentiary hearing, in accordance with Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act,' relating to contested cases, except as otherwise specified in this Code section. Subject to the provisions of Article 4 of Chapter 18 of Title 50, all files, working papers, studies, notes, and other writings or information used by the department in making its decision shall be public records and available to the parties, and the hearing officer may permit each party to exercise such reasonable rights of prehearing discovery of such information used by the parties as will expedite the hearing.

(f) In addition to evidence submitted to the department, a party may present any additional relevant evidence to the appeal panel hearing officer reviewing the decision of the department if the evidence was not reasonably available to the party presenting the evidence at the time of the department's review. The burden of proof as to whether the evidence was reasonably available shall be on the party attempting to introduce the new evidence. The issue for the decision by the hearing officer shall be whether, and the hearing officer shall order the issuance of a certificate of need if, in the hearing officer's judgment, the application is consistent with the considerations as set forth in Code Section 31-6-42 and the department's rules, as the hearing officer deems such considerations and rules applicable to the review of the project. The appeal hearing conducted by the appeal panel hearing officer shall be a de novo review of the decision of the department. The hearing officer shall also consider:

(1) Whether the department committed prejudicial procedural error in its consideration of the application;

(2) Whether the appeal lacks substantial justification; and

(3) Whether such appeal was undertaken primarily for the purpose of delay or harassment.

The burden of proof shall be on the appellant. Appellants or applicants shall proceed first with their cases before the hearing officer in the order determined by the hearing officer, and the department, if a party, shall proceed last. In the event of a consolidated hearing on applications which were joined for comparative review pursuant to subsection (f) of Code Section 31-6-43, the hearing officer shall have the same powers specified for the department in subsection (f) of Code Section 31-6-43 to order the issuance of no certificate of need or one or more certificates of need.

(g) All evidence shall be presented at the initial administrative appeal hearing conducted by the appointed hearing officer. A party or intervenor may present any relevant evidence

on all issues raised by the hearing officer or any party to the hearing or revealed during discovery and shall not be limited to evidence or information presented to the department prior to its decision, except that an applicant may not present a new need study or analysis responsive to the general need consideration or service-specific need formula as provided in the applicable rules that is substantially different from any such study or analysis submitted to the department prior to its decision and that could have reasonably been available for submission. The hearing officer may consider the latest data available, including updates of studies previously submitted, in deciding whether an application is consistent with the applicable considerations or rules. The hearing officer shall consider the applicable considerations and rules in effect on the date the appeal is filed, even if the provisions of those considerations or rules were changed after the department's decision. The hearing officer may remand a matter to the department if the hearing officer determines that it would be beneficial for the department to consider new data, studies, or analyses that were not available before the decision or changes to the provisions of the applicable considerations or rules made after the department's decision. The hearing officer shall establish the time deadlines for completion of the remand and shall retain jurisdiction of the matter throughout the completion of the remand.

(h) After the issuance of a decision by the department pursuant to Code Section 31-6-43, no party to an appeal hearing, nor any person on behalf of such party, including the department, shall make any ex parte contact with the appeal panel hearing officer appointed to conduct the appeal hearing, any other member of the appeal panel, or the commissioner in regard to a decision under appeal.

(i) Within 30 days after the conclusion of the hearing, the hearing officer shall make written findings of fact and conclusions of law as to each consideration as set forth in Code Section 31-6-42 and the department's rules, including a detailed statement of the reasons for the decision of the hearing officer. If any party has alleged that an appeal lacks substantial justification or was undertaken primarily for the purpose of delay or harassment, the decision of the hearing officer shall make findings of fact addressing the merits of the allegation. The hearing officer shall file such decision with the chairperson of the appeal panel who shall serve such decision upon all parties, and shall transmit the administrative record to the commissioner. Any party, including the department, which disputes any finding of fact or conclusion of law rendered by the hearing officer in such hearing officer's decision and which wishes to appeal that decision may appeal to the commissioner and shall file its specific objections with the commissioner or his or her designee within 30 days of the date of the hearing officer's decision pursuant to rules adopted by the department.

(j) The decision of the appeal panel hearing officer will become the final decision of the department upon the sixty-first day following the date of the decision unless an objection

thereto is filed with the commissioner within the time limit established in subsection (i) of this Code section.

(k)(1) In the event an appeal of the hearing officer's decision is filed, the commissioner may adopt the hearing officer's order as the final order of the department or the commissioner may reject or modify the conclusions of law over which the department has substantive jurisdiction and the interpretation of administrative rules over which it has substantive jurisdiction. By rejecting or modifying such conclusion of law or interpretation of administrative rule, the department must state with particularity its reasons for rejecting or modifying such conclusion of law or interpretation of administrative rule and must make a finding that its substituted conclusion of law or interpretation of administrative rule is as or more reasonable than that which was rejected or modified. Rejection or modification of conclusions of law may not form the basis for rejection or modification of findings of fact. The commissioner may not reject or modify the findings of fact unless the commissioner first determines from a review of the entire record, and states with particularity in the order, that the findings of fact were not based upon any competent substantial evidence or that the proceedings on which the findings were based did not comply with the essential requirements of law.

(2) If, before the date set for the commissioner's decision, application is made to the commissioner for leave to present additional evidence and it is shown to the satisfaction of the commissioner that the additional evidence is material and there were good reasons for failure to present it in the proceedings before the hearing officer, the commissioner may order that the additional evidence be taken before the same hearing officer who rendered the initial decision upon conditions determined by the commissioner. The hearing officer may modify the initial decision by reason of the additional evidence and shall file that evidence and any modifications, new findings, or decision with the commissioner. Unless leave is given by the commissioner in accordance with the provisions of this subsection, the appeal panel may not consider new evidence under any circumstances. In all circumstances, the commissioner's decision shall be based upon considerations as set forth in Code Section 31-6-42 and the department's rules.

(l) If, based upon the findings of fact by the hearing officer, the commissioner determines that 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, the commissioner may enter an award in his or her written order against such party and in favor of the successful party or parties, including the department, of all or any part of their respective reasonable and necessary attorney's fees and expenses of litigation, as the commissioner deems just. Such award may be enforced by any court undertaking judicial review of the final decision. In the absence of any petition for judicial review, then such

award shall be enforced, upon due application, by any court having personal jurisdiction over the party against whom such an award is made.

(m) Unless the hearing officer's decision becomes the department's final decision by operation of law as provided in subsection (j) of this Code section, the decision of the commissioner shall become the department's final decision by operation of law. Such final decision shall be the final department decision for purposes of Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act.' The appeals process provided by this Code section shall be the administrative remedy only for decisions made by the department pursuant to Code Section 31-6-43 which involve the approval or denial of applications for certificates of need.

(n) A party responding to an appeal to the commissioner may be entitled to reasonable attorney's fees and costs of such appeal if it is determined that the appeal lacked substantial justification and was undertaken primarily for the purpose of delay or harassment; provided, however, that the department shall not be required to pay attorney's fees or costs. This subsection shall not apply to the portion of attorney's fees accrued on behalf of a party responding to or bringing a challenge to the department's authority to enact a rule or regulation or the department's jurisdiction or another challenge that could not have been decided in the administrative proceeding, nor shall it apply to costs accrued when the only argument raised by the appealing party is one described in this subsection.

31-6-44.1.

(a) Any party to the initial administrative appeal hearing conducted by the appointed appeal panel hearing officer, excluding the department, may seek judicial review of the final decision in accordance with the method set forth in Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act,' except as otherwise modified by this Code section; provided, however, that in conducting such review, the court may reverse or modify the final decision only if substantial rights of the appellant have been prejudiced because the procedures followed by the department, the hearing officer, or the commissioner or the administrative findings, inferences, and conclusions contained in the final decision are:

(1) In violation of constitutional or statutory provisions;

(2) In excess of the statutory authority of the department;

(3) Made upon unlawful procedures;

(4) Affected by other error of law;

(5) Not supported by substantial evidence, which shall mean that the record does not contain such relevant evidence as a reasonable mind might accept as adequate to support such findings, inferences, conclusions, or decisions, which such evidentiary standard shall be in excess of the 'any evidence' standard contained in other statutory provisions; or

(6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(b) In the event a party seeks judicial review, the department shall, within 30 days of the filing of the notice of appeal with the superior court, transmit certified copies of all documents and papers in its file together with a transcript of the testimony taken and its findings of fact and decision to the clerk of the superior court to which the case has been appealed. The case so appealed may then be brought by either party upon ten days' written notice to the other before the superior court for a hearing upon such record, subject to an assignment of the case for hearing by the court; provided, however, that if the court does not hear the case within 120 days of the date of docketing in the superior court, the decision of the department shall be considered affirmed by operation of law unless a hearing originally scheduled to be heard within the 120 days has been continued to a date certain by order of the court. In the event a hearing is held later than 90 days after the date of docketing in the superior court because same has been continued to a date certain by order of the court, the decision of the department shall be considered affirmed by operation of law if no order of the court disposing of the issues on appeal has been entered within 30 days after the date of the continued hearing. If a case is heard within 120 days from the date of docketing in the superior court, the decision of the department shall be considered affirmed by operation of law if no order of the court dispositive of the issues on appeal has been entered within 30 days of the date of the hearing.

(c) A party responding to an appeal to the superior court shall be entitled to reasonable attorney's fees and costs if such party is the prevailing party of such appeal as decided by final order; provided, however, that the department shall not be required to pay attorney's fees or costs. This subsection shall not apply to the portion of attorney's fees accrued on behalf of a party responding to or bringing a challenge to the department's authority to enact a rule or regulation or the department's jurisdiction or another challenge that could not have been raised in the administrative proceeding.

31-6-45.

(a) The department may revoke a certificate of need, in whole or in part, after notice to the holder of the certificate and a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act,' for the following reasons:

(1) Failure to comply with the provisions of Code Section 31-6-41;

(2) The intentional provision of false information to the department by an applicant in that applicant's application;

(3) Repeated failure to pay any fines or moneys due to the department;

(4) Failure to maintain minimum quality of care standards that may be established by the department;

(5) Failure to participate as a provider of medical assistance for Medicaid purposes pursuant to Code Section 31-6-45.2 or any other applicable Code section; or

(6) The failure to submit a timely or complete report within 180 days following the date the report is due pursuant to Code Section 31-6-70~~; or~~

~~(7) Failure of a destination cancer hospital to meet an annual patient base composed of a minimum of 65 percent of patients who reside outside this state for three calendar years in any five-year period~~.

The department may not, however, revoke a certificate of need if the applicant changes the defined location of the project within the same county less than three miles from the location specified in the certificate of need for financial reasons or other reasons beyond its control, including, but not limited to, failure to obtain any required approval from zoning or other governmental agencies or entities, provided that such change in location is otherwise consistent with the considerations and rules applied in the evaluation of the project.

(a.1) The department may revoke a certificate of need, in whole or in part, after notice to the holder of the certificate and a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act,' if the services or units of services for which the certificate of need was issued are not implemented in a timely manner, as established by the department in its rules. This subsection shall apply only to certificates of need issued on or after July 1, 2008.

(b) Any health care facility offering a new institutional health service without having obtained a certificate of need and which has not been previously licensed as a health care facility shall be denied a license to operate.

(c) In the event that a new institutional health service is knowingly offered or developed without having obtained a certificate of need as required by this chapter, or the certificate of need for such service is revoked according to the provisions of this Code section, a facility or applicant may be fined an amount of $5,000.00 per day up to 30 days, $10,000.00 per day from 31 days through 60 days, and $25,000.00 per day after 60 days for each day that the violation of this chapter has existed and knowingly and willingly continues; provided, however, that the expenditure or commitment of or incurring an obligation for the expenditure of funds to take or perform actions not subject to this chapter or to acquire, develop, or prepare a health care facility site for which a certificate of need application is denied shall not be a violation of this chapter and shall not be subject to such a fine. The commissioner shall determine, after notice and a hearing, whether the fines provided in this Code section shall be levied.

(d) In addition, for purposes of this Code section, the State of Georgia, acting by and through the department, or any other interested person, shall have standing in any court of competent jurisdiction to maintain an action for injunctive relief to enforce the provisions of this chapter.

(e) The department shall have the authority to make public or private investigations or examinations inside or outside of this state to determine whether all provisions of this Code section or any other law, rule, regulation, or formal order relating to the provisions of Code Section 31-6-40 has been violated. Such investigations may be initiated at any time in the discretion of the department and may continue during the pendency of any action initiated by the department pursuant to subsection (a) of this Code section. For the purpose of conducting any investigation or inspection pursuant to this subsection, the department shall have the authority, upon providing reasonable notice, to require the production of any books, records, papers, or other information related to any certificate of need issue.

31-6-45.1.

(a) A health care facility which has a certificate of need or is otherwise authorized to operate pursuant to this chapter shall have such certificate of need or authority to operate automatically revoked by operation of law without any action by the department when that facility's permit to operate pursuant to Code Section 31-7-4 is finally revoked by order of the department. For purposes of this subsection, the date of such final revocation shall be as follows:

(1) When there is no appeal of the order pursuant to Chapter 5 of this title, the one hundred and eightieth day after the date upon which expires the time for appealing the revocation order without such an appeal being filed; or

(2) When there is an appeal of the order pursuant to Chapter 5 of this title, the date upon which expires the time to appeal the last administrative or judicial order affirming or approving the revocation or revocation order without such appeal being filed.

(b) The services which had been authorized to be offered by a health care facility for which a certificate of need has been revoked pursuant to subsection (a) of this Code section may continue to be offered in the service area in which that facility was located under such conditions as specified by the department notwithstanding that some or all of such services could not otherwise be offered as new institutional health services.

31-6-45.2.

(a) The department may require that any applicant for a certificate of need agree to participate as a provider of medical assistance for Medicaid purposes pursuant to Article 7 of Chapter 4 of Title 49.

(b) Any proposed or existing health care facility which obtains a certificate of need on or after April 6, 1992, based in part upon assurances that it will participate as a provider of medical assistance, as defined in paragraph (6) of Code Section 49-4-141, and which terminates its participation as a provider of medical assistance or violates any conditions imposed by the department relating to such participation, shall be subject to a monetary penalty in the amount of the difference between the Medicaid covered services which the facility agreed to provide in its certificate of need application and the amount actually provided and may be subject to revocation of its certificate of need by the department pursuant to Code Section 31-6-45; provided, however, that this Code section shall not apply if:

(1) The proposed or existing health care facility's certificate of need application was approved by the Health Planning Agency prior to April 6, 1992, and the Health Planning Agency's approval of such application was under appeal on or after April 6, 1992, and the Health Planning Agency's approval of such application is ultimately affirmed;

(2) Such facility's participation as a provider of medical assistance is terminated by the state or federal government; or

(3) Such facility establishes good cause for terminating its participation as a provider of medical assistance. For purposes of this Code section, 'good cause' shall mean:

(A) Changes in the adequacy of medical assistance payments, as 'medical assistance' is defined in paragraph (5) of Code Section 49-4-141, provided that at least 10 percent of the facility's utilization during the preceding 12 month period was attributable to services to recipients of medical assistance, as defined in paragraph (7) of Code Section 49-4-141. Medical assistance payments to a facility shall be presumed adequate unless the revenues received by the facility from all sources are less than the total costs set forth in the cost report for the preceding full 12 month period filed by such facility pursuant to the state plan as defined in paragraph (8) of Code Section 49-4-141 which are allowed under the state plan for purposes of determining such facility's reimbursement rate for medical assistance and the aggregate amount of such facility's medical assistance payments (including any amounts received by the facility from recipients of medical assistance) during the preceding full 12 month cost reporting period is less than 85 percent of such facility's Medicaid costs for such period. Medicaid costs shall be determined by multiplying the allowable costs set forth in the cost report, less any audit adjustments, by the percentage of the facility's utilization during the cost reporting period which was attributable to recipients of medical assistance;

(B) Changes in the overall ability of the facility to cover its costs if such changes are of such a degree as to seriously threaten the continued viability of the facility; or

(C) Changes in the state plan, statutes, or rules and regulations governing providers of medical assistance which impose substantial new obligations upon the facility which are not reimbursed by Medicaid and which adversely affect the financial viability of the facility in a substantial manner.

(c) A facility seeking to terminate its enrollment as a provider of medical assistance shall submit a written request to the department documenting good cause for termination. The department shall grant or deny the facility's request within 30 days. If the department denies the facility's request, the facility shall be entitled to a hearing conducted in the same manner as an evidentiary hearing conducted by the department pursuant to the provisions of Code Section 49-4-153 within 30 days of the department's decision.

(d) The imposition of the monetary penalty provided in this Code section shall commence upon the date that said facility has terminated its participation as a provider of medical assistance, as determined by the commissioner. The monetary penalty shall be levied and collected by the department on an annual basis for every year in which the facility fails to participate as a provider of medical assistance. Penalties authorized under this Code section shall be subject to the same notices and hearings as provided for levy of fines under Code Section 31-6-45.

31-6-46.

The department shall prepare and submit an annual report to the board and to the Senate Health and Human Services Committee ~~of the Senate~~ and the House Committee on Health and Human Services ~~Committee of the House of Representatives~~ about its operations and decisions for the preceding 12 month period, not later than 30 days prior to each convening of the General Assembly in regular session. Either committee may request any additional reports or information, including decisions, from the department at any time, including a period in which the General Assembly is not in regular session. The annual report shall include information and updates relating to the state health plan and the certificate of need program and an annual analysis of proactive and prospective approaches to need methodologies and access to health care services. The annual report shall include information for Georgia's congressional delegation which highlights issues regarding federal laws and regulations influencing Medicaid and medicare, insurance and related tax laws, and long-term health care.

31-6-47.

(a) Notwithstanding the other provisions of this chapter, this chapter shall not apply to:

~~(1) Infirmaries operated by educational institutions for the sole and exclusive benefit of students, faculty members, officers, or employees thereof;~~

~~(2) Infirmaries or facilities operated by businesses for the sole and exclusive benefit of officers or employees thereof, provided that such infirmaries or facilities make no provision for overnight stay by persons receiving their services;~~

~~(3)~~(1) Institutions operated exclusively by the federal government or by any of its agencies;

~~(4) Offices of private physicians or dentists whether for individual or group practice, except as otherwise provided in paragraph (3) or (7) of subsection (a) of Code Section 31-6-40;~~

~~(5)~~(2) Religious, nonmedical health care institutions as defined in 42 U.S.C. § 1395x(ss)(1), listed and certified by a national accrediting organization;

~~(6)~~(3) Site acquisitions for health care facilities or preparation or development costs for such sites prior to the decision to file a certificate of need application;

~~(7)~~(4) Expenditures related to adequate preparation and development of an application for a certificate of need;

~~(8)~~(5) The commitment of funds conditioned upon the obtaining of a certificate of need;

~~(9)~~(6) Expenditures for the acquisition of existing health care facilities by stock or asset purchase, merger, consolidation, or other lawful means unless the facilities are owned or operated by or on behalf of a:

(A) Political subdivision of this state;

(B) Combination of such political subdivisions; or

(C) Hospital authority, as defined in Article 4 of Chapter 7 of this title;

~~(9.1)~~(7) Expenditures for the restructuring of or for the acquisition by stock or asset purchase, merger, consolidation, or other lawful means of an existing health care facility which is owned or operated by or on behalf of any entity described in subparagraph (A), (B), or (C) of paragraph ~~(9)~~(6) of this subsection only if such restructuring or acquisition is made by any entity described in subparagraph (A), (B), or (C) of paragraph ~~(9)~~(6) of this subsection;

~~(9.2) The purchase of a closing hospital or of a hospital that has been closed for no more than 12 months by a hospital in a contiguous county to repurpose the facility as a micro-hospital;~~

~~(10) Expenditures of less than $870,000.00 for any minor or major repair or replacement of equipment by a health care facility that is not owned by a group practice of physicians or a hospital and that provides diagnostic imaging services if such facility received a letter of nonreviewability from the department prior to July 1, 2008. This paragraph shall not apply to such facilities in rural counties;~~

~~(10.1)~~(8) ~~Except as provided in paragraph (10) of this subsection, expenditures~~ Expenditures for the minor or major repair of a health care facility or a facility that is

exempt from the requirements of this chapter, parts thereof or services provided or equipment used therein; or the replacement of equipment~~, including but not limited to CT scanners previously approved for a certificate of need~~;

~~(11)~~(9) Capital expenditures otherwise covered by this chapter required solely to eliminate or prevent safety hazards as defined by federal, state, or local fire, building, environmental, occupational health, or life safety codes or regulations, to comply with licensing requirements of the department, or to comply with accreditation standards of a nationally recognized health care accreditation body;

~~(12)~~(10) Cost overruns whose percentage of the cost of a project is equal to or less than the cumulative annual rate of increase in the composite construction index, published by the federal Bureau of the Census of the Department of Commerce, ~~of the United States government,~~ calculated from the date of approval of the project;

~~(13)~~(11) Transfers from one health care facility to another such facility of major medical equipment previously approved under or exempted from certificate of need review, except where such transfer results in the institution of a new clinical health service for which a certificate of need is required in the facility acquiring said equipment, provided that such transfers are recorded at net book value of the medical equipment as recorded on the books of the transferring facility;

~~(14)~~(12) New institutional health services provided by or on behalf of health maintenance organizations or related health care facilities in circumstances defined by the department pursuant to federal law;

~~(15) Increases in the bed capacity of a hospital up to ten beds or 10 percent of capacity, whichever is greater, in any consecutive two-year period, in a hospital that has maintained an overall occupancy rate greater than 75 percent for the previous 12 month period;~~

~~(16)~~(13) Expenditures for nonclinical projects, including parking lots, parking decks, and other parking facilities; and computer systems, software, and other information technology; ~~medical office buildings; and state mental health facilities;~~

~~(17)~~(14) Continuing care retirement communities, provided that the skilled nursing component of the facility is for the exclusive use of residents of the continuing care retirement community and that a written exemption is obtained from the department; provided, however, that new sheltered nursing home beds may be used on a limited basis by persons who are not residents of the continuing care retirement community for a period up to five years after the date of issuance of the initial nursing home license, but such beds shall not be eligible for Medicaid reimbursement. For the first year, the continuing care retirement community sheltered nursing facility may utilize not more than 50 percent of its licensed beds for patients who are not residents of the continuing

care retirement community. In the second year of operation, the continuing care retirement community shall allow not more than 40 percent of its licensed beds for new patients who are not residents of the continuing care retirement community. In the third year of operation, the continuing care retirement community shall allow not more than 30 percent of its licensed beds for new patients who are not residents of the continuing care retirement community. In the fourth year of operation, the continuing care retirement community shall allow not more than 20 percent of its licensed beds for new patients who are not residents of the continuing care retirement community. In the fifth year of operation, the continuing care retirement community shall allow not more than 10 percent of its licensed beds for new patients who are not residents of the continuing care retirement community. At no time during the first five years shall the continuing care retirement community sheltered nursing facility occupy more than 50 percent of its licensed beds with patients who are not residents under contract with the continuing care retirement community. At the end of the five-year period, the continuing care retirement community sheltered nursing facility shall be utilized exclusively by residents of the continuing care retirement community, and at no time shall a resident of a continuing care retirement community be denied access to the sheltered nursing facility. At no time shall any existing patient be forced to leave the continuing care retirement community to comply with this paragraph. The department is authorized to promulgate rules and regulations regarding the use and definition of 'sheltered nursing facility' in a manner consistent with this Code section. Agreements to provide continuing care include agreements to provide care for any duration, including agreements that are terminable by either party;

~~(18) Any single specialty ambulatory surgical center that:~~

~~(A)(i) Has capital expenditures associated with the construction, development, or other establishment of the clinical health service which do not exceed $2.5 million; or~~

~~(ii) Is the only single specialty ambulatory surgical center in the county owned by the group practice and has two or fewer operating rooms; provided, however, that a center exempt pursuant to this division shall be required to obtain a certificate of need in order to add any additional operating rooms;~~

~~(B) Has a hospital affiliation agreement with a hospital within a reasonable distance from the facility or the medical staff at the center has admitting privileges or other acceptable documented arrangements with such hospital to ensure the necessary backup for the center for medical complications. The center shall have the capability to transfer a patient immediately to a hospital within a reasonable distance from the facility with~~

~~adequate emergency room services. Hospitals shall not unreasonably deny a transfer agreement or affiliation agreement to the center;~~

~~(C)(i) Provides care to Medicaid beneficiaries and, if the facility provides medical care and treatment to children, to PeachCare for Kids beneficiaries and provides uncompensated indigent and charity care in an amount equal to or greater than 2 percent of its adjusted gross revenue; or~~

~~(ii) If the center is not a participant in Medicaid or the PeachCare for Kids Program, provides uncompensated care to Medicaid beneficiaries and, if the facility provides medical care and treatment to children, to PeachCare for Kids beneficiaries, uncompensated indigent and charity care, or both in an amount equal to or greater than 4 percent of its adjusted gross revenue;~~

~~provided, however, single specialty ambulatory surgical centers owned by physicians in the practice of ophthalmology shall not be required to comply with this subparagraph; and~~

~~(D) Provides annual reports in the same manner and in accordance with Code Section 31-6-70.~~

~~Noncompliance with any condition of this paragraph shall result in a monetary penalty in the amount of the difference between the services which the center is required to provide and the amount actually provided and may be subject to revocation of its exemption status by the department for repeated failure to pay any fines or moneys due to the department or for repeated failure to produce data as required by Code Section 31-6-70 after notice to the exemption holder and a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act.' The dollar amount specified in this paragraph shall be adjusted annually by an amount calculated by multiplying such dollar amount (as adjusted for the preceding year) by the annual percentage of change in the composite index of construction material prices, or its successor or appropriate replacement index, if any, published by the United States Department of Commerce for the preceding calendar year, commencing on July 1, 2009, and on each anniversary thereafter of publication of the index. The department shall immediately institute rule-making procedures to adopt such adjusted dollar amounts. In calculating the dollar amounts of a proposed project for purposes of this paragraph, the costs of all items subject to review by this chapter and items not subject to review by this chapter associated with and simultaneously developed or proposed with the project shall be counted, except for the expenditure or commitment of or incurring an obligation for the expenditure of funds to develop certificate of need applications, studies, reports, schematics, preliminary plans and specifications or working drawings, or to acquire sites;~~

~~(19) Any joint venture ambulatory surgical center that:~~

~~(A) Has capital expenditures associated with the construction, development, or other establishment of the clinical health service which do not exceed $5 million;~~

~~(B)(i) Provides care to Medicaid beneficiaries and, if the facility provides medical care and treatment to children, to PeachCare for Kids beneficiaries and provides uncompensated indigent and charity care in an amount equal to or greater than 2 percent of its adjusted gross revenue; or~~

~~(ii) If the center is not a participant in Medicaid or the PeachCare for Kids Program, provides uncompensated care to Medicaid beneficiaries and, if the facility provides medical care and treatment to children, to PeachCare for Kids beneficiaries, uncompensated indigent and charity care, or both in an amount equal to or greater than 4 percent of its adjusted gross revenue; and~~

~~(C) Provides annual reports in the same manner and in accordance with Code Section 31-6-70.~~

~~Noncompliance with any condition of this paragraph shall result in a monetary penalty in the amount of the difference between the services which the center is required to provide and the amount actually provided and may be subject to revocation of its exemption status by the department for repeated failure to pay any fines or moneys due to the department or for repeated failure to produce data as required by Code Section 31-6-70 after notice to the exemption holder and a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act.' The dollar amount specified in this paragraph shall be adjusted annually by an amount calculated by multiplying such dollar amount (as adjusted for the preceding year) by the annual percentage of change in the composite index of construction material prices, or its successor or appropriate replacement index, if any, published by the United States Department of Commerce for the preceding calendar year, commencing on July 1, 2009, and on each anniversary thereafter of publication of the index. The department shall immediately institute rule-making procedures to adopt such adjusted dollar amounts. In calculating the dollar amounts of a proposed project for purposes of this paragraph, the costs of all items subject to review by this chapter and items not subject to review by this chapter associated with and simultaneously developed or proposed with the project shall be counted, except for the expenditure or commitment of or incurring an obligation for the expenditure of funds to develop certificate of need applications, studies, reports, schematics, preliminary plans and specifications or working drawings, or to acquire sites;~~

~~(20) Expansion of services by an imaging center based on a population needs methodology taking into consideration whether the population residing in the area served by the imaging center has a need for expanded services, as determined by the department in accordance with its rules and regulations, if such imaging center.~~

~~(A) Was in existence and operational in this state on January 1, 2008;~~

~~(B) Is owned by a hospital or by a physician or a group of physicians comprising at least 80 percent ownership who are currently board certified in radiology;~~

~~(C) Provides three or more diagnostic and other imaging services;~~

~~(D) Accepts all patients regardless of ability to pay; and~~

~~(E) Provides uncompensated indigent and charity care in an amount equal to or greater than the amount of such care provided by the geographically closest general acute care hospital; provided, however, this paragraph shall not apply to an imaging center in a rural county;~~

~~(21) Diagnostic cardiac catheterization in a hospital setting on patients 15 years of age and older;~~

~~(22) Therapeutic cardiac catheterization in hospitals selected by the department prior to July 1, 2008, to participate in the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) Study and therapeutic cardiac catheterization in hospitals that, as determined by the department on an annual basis, meet the criteria to participate in the C-PORT Study but have not been selected for participation; provided, however, that if the criteria requires a transfer agreement to another hospital, no hospital shall unreasonably deny a transfer agreement to another hospital;~~

~~(23)~~(15) ~~Infirmaries or facilities~~ Facilities operated by, on behalf of, 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 in a secure environment to prisoners within a penal institution, penitentiary, prison, detention center, or other secure correctional institution, including correctional institutions operated by private entities in this state which house inmates under the Department of Corrections or the Department of Juvenile Justice; and

~~(24)~~(16) The relocation of any skilled nursing facility~~;~~ or intermediate care facility~~, or micro-hospital~~ 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~~ so long as ~~the~~ such facility does not propose to offer any new or expanded clinical health services at the new location~~;~~.

~~(25) Facilities which are devoted to the provision of treatment and rehabilitative care for periods continuing for 24 hours or longer for persons who have traumatic brain injury, as defined in Code Section 37-3-1; and~~

~~(26) Capital expenditures for a project otherwise requiring a certificate of need if those expenditures are for a project to remodel, renovate, replace, or any combination thereof, a medical-surgical hospital and:~~

~~(A) That hospital:~~

~~(i) Has a bed capacity of not more than 50 beds;~~

~~(ii) Is located in a county in which no other medical-surgical hospital is located;~~

~~(iii) Has at any time been designated as a disproportionate share hospital by the department; and~~

~~(iv) Has at least 45 percent of its patient revenues derived from medicare, Medicaid, or any combination thereof, for the immediately preceding three years; and~~

~~(B) That project:~~

~~(i) Does not result in any of the following:~~

~~(I) The offering of any new clinical health services;~~

~~(II) Any increase in bed capacity;~~

~~(III) Any redistribution of existing beds among existing clinical health services; or~~

~~(IV) Any increase in capacity of existing clinical health services;~~

~~(ii) Has at least 80 percent of its capital expenditures financed by the proceeds of a special purpose county sales and use tax imposed pursuant to Article 3 of Chapter 8 of Title 48; and~~

~~(iii) Is located within a three-mile radius of and within the same county as the hospital's existing facility.~~

(b) By rule, the department shall establish a procedure for expediting or waiving reviews of certain projects the nonreview of which it deems compatible with the purposes of this chapter, in addition to expenditures exempted from review by this Code section.

31-6-47.1.

The department shall require prior notice from a new health care facility for approval of any activity which is believed to be exempt pursuant to Code Section 31-6-47 or excluded from the requirements of this chapter under other provisions of this chapter. The department may require prior notice and approval of any activity which is believed to be exempt pursuant to paragraphs ~~(10), (15), (16), (17), (20), (21), (23), (25), and (26)~~ (13), (14), and (15) of subsection (a) of Code Section 31-6-47. The department shall be authorized to establish timeframes, forms, and criteria relating to its certification that an activity is properly exempt or excluded under this chapter prior to its implementation. The department shall publish notice of all requests for approval of an exempt activity and opposition to such request. Persons opposing a request for approval of an exempt activity shall be entitled to file an objection with the department and the department shall consider any filed objection when determining whether an activity is exempt. After the department's decision, an opposing party shall have the right to a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act,' on an adverse decision of the

department and judicial review of a final decision in the same manner and under the same provisions as in Code Section 31-6-44.1.

31-6-48.

The State Health Planning and Development Agency, the State-wide Health Coordinating Council, and the State Health Planning Review Board existing immediately prior to July 1, 1983, are abolished, and their respective successors on and after July 1, 1983, shall be the Health Planning Agency, the Health Policy Council, and the Health Planning Review Board, as established in this chapter, except that on and after July 1, 1991, the Health Strategies Council shall be the successor to the Health Policy Council, and except that on and after July 1, 1999, the Department of Community Health shall be the successor to the Health Planning Agency, and except that on and after July 1, 2008, the Board of Community Health shall be the successor to the duties of the Health Strategies Council with respect to adoption of the state health plan, and except that on June 30, 2008, the Health Planning Review Board is abolished and the terms of all members on such board on such date shall automatically terminate and the Certificate of Need Appeal Panel shall be the successor to the duties of the Health Planning Review Board on such date. For purposes of any existing contract with the federal government, or federal law referring to such abolished agency, council, or board, the successor department, council, or board established in this chapter or in Chapter 2 of this title shall be deemed to be the abolished agency, council, or board and shall succeed to the abolished agency's, council's, or board's functions. The State Health Planning and Development Commission is abolished.

31-6-49.

All matters transferred to the Health Planning Agency by the previously existing provisions of this Code section and that are in effect on June 30, 1999, shall automatically be transferred to the Department of Community Health on July 1, 1999. All 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 established pursuant to Code Section 31-6-44.

31-6-50.

The review and appeal considerations and procedures set forth in Code Sections 31-6-42 through 31-6-44, respectively, shall apply to and govern the review of capital expenditures under the Section 1122 program of the federal Social Security Act of 1935, as amended, including, but not limited to, any application for approval under Section 1122 which is under consideration by the Health Planning Agency or on appeal before the Certificate of

Need Appeal Panel, successor to the former Health Planning Review Board as of June 30, 2008.

31-6-70.

(a) There shall be required from each health care facility in this state requiring a certificate of need ~~and all ambulatory surgical centers and imaging centers, whether or not exempt from obtaining a certificate of need under this chapter,~~ an annual report of certain health care information to be submitted to the department. The report shall be due on the last day of January and shall cover the 12 month period preceding each such calendar year.

(b) The report required under subsection (a) of this Code section shall contain the following information:

(1) Total gross revenues;

(2) Bad debts;

(3) Amounts of free care extended, excluding bad debts;

(4) Contractual adjustments;

(5) Amounts of care provided under a Hill-Burton commitment;

(6) Amounts of charity care provided to indigent persons;

(7) Amounts of outside sources of funding from governmental entities, philanthropic groups, or any other source, including the proportion of any such funding dedicated to the care of indigent persons; and

(8) For cases involving indigent persons:

(A) The number of persons treated;

(B) The number of inpatients and outpatients;

(C) Total patient days;

(D) The number of patients categorized by county of residence; and

(E) The indigent care costs incurred by the health care facility by county of residence.

(c) As used in subsection (b) of this Code section, 'indigent persons' means persons having as a maximum allowable income level an amount corresponding to 125 percent of the federal poverty guideline.

(d) The department shall provide a form for the report required by subsection (a) of this Code section and may provide in said form for further categorical divisions of the information listed in subsection (b) of this Code section.

(e)(1) In the event the department does not receive ~~information responsive to subparagraph (c)(2)(A) of Code Section 31-6-40 by December 30, 2008, or~~ an annual report from a health care facility requiring a certificate of need ~~or an ambulatory surgical center or imaging center, whether or not exempt from obtaining a certificate of need under this chapter,~~ on or before the date such report was due or receives a timely but

incomplete report, the department shall notify the health care facility ~~or center~~ regarding the deficiencies and shall be authorized to fine such health care facility ~~or center~~ an amount not to exceed $500.00 per day for every day up to 30 days and $1,000.00 per day for every day over 30 days for every day of such untimely or deficient report.

(2) In the event the department does not receive an annual report from a health care facility within 180 days following the date such report was due or receives a timely but incomplete report which is not completed within such 180 days, the department shall be authorized to revoke such health care facility's certificate of need in accordance with Code Section 31-6-45.

(f) No application for a certificate of need under Article 3 of this chapter shall be considered as complete if the applicant has not submitted the annual report required by subsection (a) of this Code section.″

PART II

SECTION 2-1.

Said title is further amended by adding a new chapter to read as follows:

″CHAPTER 6A

31-6A-1.

As used in this chapter, the term:

(1) 'Ambulatory surgical center' means a public or private facility, not a part of a hospital, which meets the criteria contained in subparagraph (4)(C) of Code Section 31-7-1; provided, however, that if a private facility, at least 51 percent must be owned directly or indirectly by a hospital or a physician or physicians licensed to practice in Georgia.

(2) 'Bed capacity' means space used exclusively for inpatient care, including space designed or remodeled for inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the department, except that single beds in single rooms shall be counted even if the room contains inadequate square footage.

(3) 'Board' means the Board of Community Health.

(4) 'Clinical health services' means diagnostic, treatment, or rehabilitative services provided in a health care facility, or parts of the physical plant where such services are located in a health care facility, and includes, but is not limited to, the following:

radiation therapy; biliary lithotripsy; surgery; intensive care; coronary care; pediatrics; gynecology; obstetrics; general medical care; medical/surgical care; inpatient nursing care, whether intermediate, skilled, or extended care; cardiac catheterization; open-heart surgery; and inpatient rehabilitation.

(5) 'Commissioner' means the commissioner of community health.

(6) 'Department' means the Department of Community Health established under Chapter 2 of this title.

(7) 'Destination cancer hospital' means an institution with a licensed bed capacity of 50 or fewer which provides diagnostic, therapeutic, treatment, and rehabilitative care services to cancer inpatients and outpatients, by or under the supervision of physicians, and whose proposed annual patient base is composed of a minimum of 65 percent of patients who reside outside of this state.

(8) 'Develop' with reference to a project, means constructing, remodeling, installing, or proceeding with a project, or any part of a project, or a capital expenditure project, the cost estimate for which exceeds $3,068,601.00. The dollar amount specified in this paragraph shall be adjusted annually by an amount calculated by the department to reflect inflation, which may be calculated by multiplying such dollar amount, as adjusted for the preceding year, by the annual percentage of change in the composite index of construction material prices, or its successor or appropriate replacement index, if any, published by the United States Department of Commerce for the preceding calendar year, commencing on July 1, 2019, and on each anniversary thereafter of the publication of the index. The department shall immediately institute rule-making procedures to adopt such adjusted dollar amounts. In calculating the dollar amount of a proposed project for purposes of this paragraph, the costs of all items subject to review by this chapter and items not subject to review by this chapter associated with and simultaneously developed or proposed with the project shall be counted; provided, however, that the expenditure or commitment or incurring an obligation for the expenditure of funds to develop special health care services license applications, studies, reports, schematics, preliminary plans and specifications, or working drawings or to acquire, develop, or prepare sites shall not be considered to be the developing of a project.

(9) 'Diagnostic imaging' means magnetic resonance imaging, computed tomography (CT) scanning, positron emission tomography (PET), positron emission tomography/computed tomography, X-rays, fluoroscopy, or ultrasound services, and other imaging services as defined by the department by rule.

(10) 'Diagnostic, treatment, or rehabilitation center' means any professional or business undertaking, whether for profit or not for profit, which offers or proposes to offer any clinical health service in a setting which is not part of a hospital; provided, however, that

any such diagnostic, treatment, or rehabilitation center that offers or proposes to offer surgery in an operating room environment and to allow patients to remain more than 23 hours shall be considered a hospital for purposes of this chapter.

(11) 'Exception acknowledgment' means a written notice from the department confirming that a person is exempt from the requirements of this chapter pursuant to subsection (b) of Code Section 31-6A-3 or pursuant to subsection (b) or (d) of Code Section 31-6A-10.

(12) 'Freestanding emergency department' means a facility that provides emergency services, but that is structurally separate and distinct from a hospital and has no more than one inpatient bed and that:

(A) Is operated pursuant to a hospital's license and located within 35 miles of such hospital;

(B) Is subject to the federal Emergency Medical Treatment and Labor Act;

(C) Operates 24 hours per day, 365 days per year; and

(D) Is a Medicaid provider and treats Medicaid recipients.

(13) 'Health care facility' means hospitals; other special care units, including but not limited to, podiatric facilities; ambulatory surgical centers; freestanding emergency departments; health maintenance organizations; and diagnostic, treatment, or rehabilitation centers, but only to the extent subparagraph (a)(3)(B) of Code Section 31-6A-3 is applicable thereto.

(14) 'Health maintenance organization' means a public or private organization organized under the laws of this state which:

(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physicians' services, hospitalization, laboratory, X-ray, emergency and preventive services, and out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily:

(i) Directly through physicians who are either employees or partners of such organization; or

(ii) Through arrangements with individual physicians organized on a group practice or individual practice basis.

(15) 'Hospital' means an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such

term includes micro-hospitals and public, private, psychiatric, rehabilitative, geriatric, osteopathic, and other specialty hospitals.

(16) 'Joint venture ambulatory surgical center' means a freestanding ambulatory surgical center that is jointly owned by a hospital in the same county as the center or a hospital in a contiguous county if there is no hospital in the same county as the center and a single group of physicians practicing in the center and that provides surgery or where cardiologists perform procedures in a single specialty as defined by the department; provided, however, that general surgery, a group practice which includes one or more physiatrists who perform services that are reasonably related to the surgical procedures performed in the center, and a group practice in orthopedics which includes plastic hand surgeons with a certificate of added qualifications in Surgery of the Hand from the American Board of Plastic and Reconstructive Surgery shall be considered a single specialty. The ownership interest of the hospital shall be no less than 30 percent and the collective ownership of the physicians or group of physicians shall be no less than 30 percent.

(17) 'Micro-hospital' means a hospital in a rural county which has at least two and not more than seven inpatient beds and which provides emergency services seven days per week and 24 hours per day.

(18) 'Nonclinical health services' means services or functions provided or performed by a health care facility, and the parts of the physical plant where they are located in a health care facility that are not diagnostic, therapeutic, or rehabilitative services to patients and are not clinical health services defined in this chapter.

(19) 'Offer' means that the health care facility is open for the acceptance of patients or performance of services and has qualified personnel, equipment, and supplies necessary to provide specified clinical health services.

(20) 'Operating room environment' means an environment which meets the minimum physical plant and operational standards specified in the rules of the department which shall consider and use the design and construction specifications as set forth in the *Guidelines for Design and Construction of Health Care Facilities* published by the American Institute of Architects.

(21) 'Person' means any individual, trust or estate, partnership, limited liability company or partnership, corporation (including associations, joint-stock companies, and insurance companies), state, political subdivision, hospital authority, or instrumentality (including a municipal corporation) of a state as defined in the laws of this state. This term shall include all related parties, including individuals, business corporations, general partnerships, limited partnerships, limited liability companies, limited liability partnerships, joint ventures, nonprofit corporations, or any other for profit or not for profit

entity that owns or controls, is owned or controlled by, or operates under common ownership or control with a person.

(22) 'Project' means a proposal to take an action for which a special health care services license is required under this chapter. A project or proposed project may refer to the proposal from its earliest planning stages up through the point at which the new special health care services are offered.

(23) 'Rural county' means a county having a population of less than 50,000 according to the United States decennial census of 2010 or any future such census.

(24) 'Special health care services' means any facilities or services described in paragraphs (1) through (4) of subsection (a) of Code Section 31-6A-3.

(25) 'Specialty ambulatory surgical center' means:

(A) An ambulatory surgical center where surgery is performed or where cardiologists perform procedures in the offices of an individual private physician or single group practice of private physicians if such surgery or cardiology procedures are performed in a facility that is owned, operated, and utilized by such physicians who also are of a single specialty; provided, however, that general surgery, a group practice which includes one or more physiatrists who perform services that are reasonably related to the surgical procedures performed in the center, and a group practice in orthopedics which includes plastic hand surgeons with a certificate of added qualifications in Surgery of the Hand from the American Board of Plastic and Reconstructive Surgery shall be considered a single specialty; or

(B) A multispecialty physician group owning, operating, and utilizing no more than three specialty ambulatory surgical centers located in the same or different counties in which the group has provided medical services in a clinical office for at least five years and which limits each center to a single specialty which may be different single specialties; provided, however, that the specialty ambulatory surgical centers may be colocated.

(26) 'Specialty hospital' means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following: patients with a cardiac condition, patients with an orthopedic condition, patients receiving a surgical procedure, or patients receiving any other specialized category of services defined by the department.

(27) 'Uncompensated indigent or charity care' means the dollar amount of 'net uncompensated indigent or charity care after direct and indirect (all) compensation' as defined by, and calculated in accordance with, the department's Hospital Financial Survey and related instructions.

(28) 'Urban county' means a county having a population equal to or greater than 50,000 according to the United States decennial census of 2010 or any future such census.

31-6A-2.

(a) On and after January 1, 2020, no person shall operate or provide any new special health care services without acquiring a special health care services license under this chapter unless such person has an exception acknowledgment from the department.

(b) The department shall adopt rules to specify:

(1) The minimal requirements for quality and safety for patients receiving each special health care service;

(2) The procedure for applying for and maintaining a special health care services license including, but not limited to, the frequency of licensing inspections, submission of information and data to evaluate the performance and ongoing operation of services and enforcement under this chapter;

(3) The fees for applying for and maintaining a special health care services license in order to fully offset the cost to the department, including consultant fees and other related expenses necessary to process the application, and for any ongoing expenses to the department for maintaining a special health care services license; and

(4) The procedure and criteria for requesting and approving an exception acknowledgment.

31-6A-3.

(a) A special health care services license shall be required for:

(1) The construction, development, or other establishment of a new health care facility;

(2) Any increase in the bed capacity of a health care facility except as provided in subsection (b) of this Code section;

(3) Clinical health services which are offered in or through:

(A) A health care facility, which were not offered on a regular basis in or through such health care facility within the 12 month period prior to the time such services would be offered; and

(B) A diagnostic, treatment, or rehabilitation center, which were not offered on a regular basis in or through such center within the 12 month period prior to the time such services would be offered, but only if the clinical health services are any of the following:

(i) Radiation therapy;

(ii) Biliary lithotripsy;

(iii) Surgery in an operating room environment, including, but not limited to, ambulatory surgery; and

(iv) Cardiac catheterization; and

(4) Any conversion or upgrading of any general acute care hospital to a specialty hospital or of a facility such that it is converted from a type of facility not covered by this chapter to any of the types of health care facilities which are covered by this chapter; and

(b) A special health care services license shall not be required for:

(1) Infirmaries operated by educational institutions for the sole and exclusive benefit of students, faculty members, officers, or employees thereof;

(2) Infirmaries or facilities operated by businesses for the sole and exclusive benefit of officers or employees thereof, provided that such infirmaries or facilities make no provision for overnight stay by persons receiving their services;

(3) Institutions operated exclusively by the federal government or by any of its agencies;

(4) Offices of private physicians or dentists whether for individual or group practice;

(5) Religious, nonmedical health care institutions as defined in 42 U.S.C. § 1395x(ss)(1), listed and certified by a national accrediting organization;

(6) Site acquisitions for health care facilities or preparation or development costs for such sites prior to the decision to file an application for a special health care services license;

(7) Expenditures related to adequate preparation and development of an application for a special health care services license;

(8) The commitment of funds conditioned upon the obtaining of a special health care services license;

(9) Expenditures for the acquisition of existing health care facilities by stock or asset purchase, merger, consolidation, or other lawful means unless the facilities are owned or operated by or on behalf of a:

(A) Political subdivision of this state;

(B) Combination of such political subdivisions; or

(C) Hospital authority, as defined in Article 4 of Chapter 7 of this title;

(10) Expenditures for the restructuring of or for the acquisition by stock or asset purchase, merger, consolidation, or other lawful means of an existing health care facility which is owned or operated by or on behalf of any entity described in subparagraph (A), (B), or (C) of paragraph (9) of this subsection only if such restructuring or acquisition is made by any entity described in subparagraph (A), (B), or (C) of paragraph (9) of this subsection;

(11) The purchase of a closing hospital or of a hospital that has been closed for no more than 12 months by a hospital in a contiguous county to repurpose the facility as a micro-hospital;

(12) Expenditures for the purchase, lease, replacement, upgrade, or repair of diagnostic imaging equipment, diagnostic or therapeutic equipment, or medical equipment or the provision of diagnostic imaging services;

(13) Expenditures for the minor or major repair of a health care facility or a facility that is exempt from the requirements of this chapter or parts thereof or services provided therein;

(14) Capital expenditures otherwise covered by this chapter required solely to eliminate or prevent safety hazards as defined by federal, state, or local fire, building, environmental, occupational health, or life safety codes or regulations, to comply with licensing requirements of the department, or to comply with accreditation standards of a nationally recognized health care accreditation body;

(15) Cost overruns whose percentage of the cost of a project is equal to or less than the cumulative annual rate of increase in the composite construction index, published by the federal Bureau of the Census of the Department of Commerce, calculated from the date of approval of the project;

(16) Transfers from one health care facility to another such facility of major medical equipment previously approved under or exempted from special health care services license review, except where such transfer results in the institution of a new clinical health service for which a special health care services license is required in the facility acquiring said equipment;

(17) New special health care services provided by or on behalf of health maintenance organizations or related health care facilities in circumstances defined by the department pursuant to federal law;

(18) Increases in the bed capacity of a hospital up to ten beds or 20 percent of capacity, whichever is greater, in any consecutive two-year period, in a hospital that has maintained an overall occupancy rate greater than 60 percent for the previous 12 month period;

(19) Expenditures for nonclinical projects, including parking lots, parking decks, and other parking facilities; computer systems, software, and other information technology; and medical office buildings;

(20) Continuing care retirement communities, home health agencies, intermediate care facilities, personal care homes, and skilled nursing facilities, as all such terms are defined in Code Section 31-6-2;

(21) Any specialty ambulatory surgical center that:

(A) Has a hospital affiliation agreement with a hospital within a reasonable distance from the facility or the medical staff at the center has admitting privileges or other acceptable documented arrangements with such hospital to ensure the necessary backup

for the center for medical complications. The center shall have the capability to transfer a patient immediately to a hospital within a reasonable distance from the facility with adequate emergency room services. Hospitals shall not unreasonably deny a transfer agreement or affiliation agreement to the center;

(B) Provides care to Medicaid beneficiaries and, if the facility provides medical care and treatment to children, to PeachCare for Kids beneficiaries and provides uncompensated indigent and charity care in accordance with Code Section 31-6A-6; provided, however, that specialty ambulatory surgical centers owned by physicians in the practice of ophthalmology shall not be required to comply with this subparagraph; and

(C) Provides annual reports in the same manner and in accordance with Code Section 31-6A-7.

Noncompliance with any condition of this paragraph shall result in a monetary penalty in the amount of the difference between the services which the center is required to provide and the amount actually provided and may be subject to revocation of its exemption status by the department for repeated failure to pay any fines or moneys due to the department or for repeated failure to produce data as required by Code Section 31-6A-7 after notice to the exemption holder and a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act.' Any penalty so recovered shall be dedicated and deposited by the department into the Indigent Care Trust Fund created pursuant to Code Section 31-8-152 for the purposes set out in Code Section 31-8-154, including expanding Medicaid eligibility and services; programs to support rural and other health care providers, primarily hospitals, who serve the medically indigent; and for primary health care programs for medically indigent citizens and children of this state;

(22) Any joint venture ambulatory surgical center that:

(A) Provides care to Medicaid beneficiaries and, if the facility provides medical care and treatment to children, to PeachCare for Kids beneficiaries and provides uncompensated indigent and charity care in accordance with Code Section 31-6A-6; and

(B) Provides annual reports in the same manner and in accordance with Code Section 31-6A-7.

Noncompliance with any condition of this paragraph shall result in a monetary penalty in the amount of the difference between the services which the center is required to provide and the amount actually provided and may be subject to revocation of its exemption status by the department for repeated failure to pay any fines or moneys due to the department or for repeated failure to produce data as required by Code Section 31-6A-7 after notice to the exemption holder and a fair hearing pursuant to Chapter 13

of Title 50, the 'Georgia Administrative Procedure Act.' Any penalty so recovered shall be dedicated and deposited by the department into the Indigent Care Trust Fund created pursuant to Code Section 31-8-152 for the purposes set out in Code Section 31-8-154, including expanding Medicaid eligibility and services; programs to support rural and other health care providers, primarily hospitals, who serve the medically indigent; and for primary health care programs for medically indigent citizens and children of this state;

(23) Diagnostic cardiac catheterization in a hospital setting on patients 15 years of age and older;

(24) Therapeutic cardiac catheterization in hospitals selected by the department prior to July 1, 2008, to participate in the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) Study and therapeutic cardiac catheterization in hospitals that, as determined by the department on an annual basis, meet the criteria to participate in the C-PORT Study but have not been selected for participation; provided, however, that if the criteria requires a transfer agreement to another hospital, no hospital shall unreasonably deny a transfer agreement to another hospital;

(25) Infirmaries or facilities operated by, on behalf of, 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 in a secure environment to prisoners within a penal institution, penitentiary, prison, detention center, or other secure correctional institution, including correctional institutions operated by private entities in this state which house inmates under the Department of Corrections or the Department of Juvenile Justice;

(26) The relocation of any micro-hospital 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 so long as the facility does not propose to offer any new or expanded clinical health services at the new location;

(27) Facilities which are devoted to the provision of treatment and rehabilitative care for periods continuing for 24 hours or longer for persons who have traumatic brain injury, as defined in Code Section 37-3-1;

(28) Capital expenditures for a project otherwise requiring a special health care services license if those expenditures are for a project to remodel, renovate, replace, or any combination thereof, a medical-surgical hospital and:

(A) That hospital:

(i) Has a bed capacity of not more than 50 beds;

(ii) Is located in a county in which no other medical-surgical hospital is located;

(iii) Has at any time been designated as a disproportionate share hospital by the department; and

(iv) Has at least 45 percent of its patient revenues derived from medicare, Medicaid, or any combination thereof, for the immediately preceding three years; and

(B) That project:

(i) Does not result in any of the following:

(I) The offering of any new clinical health services;

(II) Any increase in bed capacity;

(III) Any redistribution of existing beds among existing clinical health services; or

(IV) Any increase in capacity of existing clinical health services;

(ii) Has at least 80 percent of its capital expenditures financed by the proceeds of a special purpose county sales and use tax imposed pursuant to Article 3 of Chapter 8 of Title 48; and

(iii) Is located within a three-mile radius of and within the same county as the hospital's existing facility;

(29) Public or private psychiatric hospitals; mental health or substance abuse facilities or programs; or mental health or substance abuse services; and

(30) A freestanding ambulatory surgical center with no more than six operating rooms developed on the same site as a sports training and educational facility that includes sports training facilities and fields; a medical education facility and program for physicians and other health care professionals training in sports medicine; a medical research program; ancillary services, including physical therapy and diagnostic imaging; a community education program for student athletic programs on injury prevention and treatment and related topics, and that provides uncompensated indigent or charity care in accordance with Code Section 31-6A-6, provides care to Medicaid patients, and, if the facility provides medical care and treatment to children, participates as a provider for PeachCare for Kids beneficiaries; and demonstrates a positive economic impact of no less than $25 million, taking into consideration the full-time and part-time jobs generated by the initial construction and ongoing operation of the center, new state and local tax revenue generated by the initial construction and ongoing operation of the center, and other factors deemed relevant as determined by the department based on a report prepared by an independent consultant or expert retained by the center.

31-6A-4.

(a) An application for a special health care services license shall include:

(1) Certification that the applicant is licensed or will seek licensure under Chapter 7 of this title, if subject to the requirements of such chapter;

(2) Certification that the applicant has notified the public of the intent to file the application with a description of the facility or special health care services to be licensed

by publishing a notice in a newspaper of general circulation covering the area where the service is to be located in at least two separate issues of the newspaper no less than ten business days prior to the filing of the application;

(3) Certification that the applicant has given written notice of the intent to file the application by registered mail no less than ten business days prior to the filing of the application to the chief executive officer of each existing facility that:

(A) Is located within a ten-mile radius of the applicant's proposed new facility or services;

(B) Is the same type of facility or offers the same type of services as the proposed new facility or services; and

(C) Has a special health care services license issued pursuant to this chapter; and

(4) Any other information deemed necessary by the department.

(b) In addition to publication on the department's website, any application for a special health care services license shall be available for inspection and copying by any person immediately upon it being filed.

(c) Any complete application for a special health care services license shall be approved by the department within 45 days of the filing of such application unless a timely objection in writing to such application is received by the department in accordance with subsection (a) of Code Section 31-6A-5.

31-6A-5.

(a)(1) No written objection may be made to an application for a special health care services license for a new special health care service located in a county within health planning area three of the department's established health planning areas, as such exists on June 30, 2019, except by:

(A) An existing hospital or health care facility within health planning area three that has a payer mix of greater than 75 percent combined government payer and uncompensated indigent and charity care and a system-wide average net operating margin over the most recent five-year period of less than five percent; or

(B) An existing health care facility that is located outside of health planning area three but is within a ten-mile radius of the proposed new facility or service.

(2) Except as provided in paragraph (1) of this subsection, a written objection to an application for a special health care services license may be submitted by an existing health care facility within 30 days of the filing of such application with the department, on the grounds that the application is not in the public interest of the community, if such existing health care facility:

(A) Is located within a ten-mile radius of the applicant's proposed new facility or services;

(B) Is the same type of facility or offers the same type of services as the proposed new facility or services; and

(C) Has a special health care services license issued pursuant to this chapter.

(b) No later than 30 days of receipt of a timely written objection pursuant to paragraph (2) of subsection (a) of this Code section, the commissioner shall conduct a public interest review and make a written determination as to whether the application is in the public interest of the community, taking into consideration any material adverse impact on the objecting party or parties, unique health care needs of the community (not based on a numerical need formula), atypical barriers or factors, whether the new special health care services would foster competition or make services less costly or more accessible, and whether the applicant performs or proposes to perform activities outside of inpatient or outpatient care in the community for underserved populations. The commissioner may not deny an application based on an objection unless the objecting party shows by a preponderance of the evidence that the project does not meet the criteria set forth in this subsection.

(c) If the special health care services license is granted by the department over a timely objection, the person who objected shall have a right to request a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act.'

(d) If the special health care services license is denied by the department after a timely objection, the applicant shall have a right to request a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act.'

(e) Any party to the initial administrative appeal hearing, excluding the department, may seek judicial review of the final decision in accordance with the method set forth in Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act.'

31-6A-6.

(a) As a condition for special health care services licenses issued on and after January 1, 2020, the department shall require that an applicant or licensee agrees:

(1) To provide uncompensated indigent or charity care in an amount which meets or exceeds the percentage of such applicant's adjusted gross revenues equivalent to:

(A) The state-wide average of net uncompensated indigent and charity care provided based on the previous two most recent years if a nonprofit entity; provided, however, that in no event shall this be less than 2 percent; or

(B) The state-wide average of net uncompensated indigent and charity care provided based on the previous two most recent years less 3 percent if a for profit entity; provided, however, that in no event shall this be less than 1 percent; and

(2) To participate as a provider of medical assistance for Medicaid purposes, and, if the facility provides medical care and treatment to children, to participate as a provider for PeachCare for Kids beneficiaries.

(a.1) For purposes of calculating uncompensated indigent or charity care pursuant to this Code section, uncompensated indigent or charity care provided by a physician, who has an ownership interest in an ambulatory surgical center, to a patient in a hospital or other setting outside such ambulatory surgical center shall be counted toward the uncompensated indigent or charity care required for the ambulatory surgical center in which the physician has an ownership interest in an amount equal to the cost of such care provided multiplied by the percentage ownership of the physician and shall not be counted toward the uncompensated indigent or charity care required for a hospital or other setting.

(b) A grantee or successor in interest for a special health care services license or an authorization to operate under this chapter which violates such an agreement or violates any conditions imposed by the department relating to such services shall be liable to the department for a monetary penalty in the amount of 1.0 percent of its net revenue for every 0.5 percent of uncompensated indigent and charity care not provided and may be subject to revocation of its special health care services license, in whole or in part, by the department pursuant to Code Section 31-6A-8. Any penalty so recovered shall be dedicated and deposited by the department into the Indigent Care Trust Fund created pursuant to Code Section 31-8-152 for the purposes set out in Code Section 31-8-154, including expanding Medicaid eligibility and services; programs to support rural and other health care providers, primarily hospitals, who serve the medically indigent; and for primary health care programs for medically indigent citizens and children of this state.

(c) Penalties authorized under this Code section shall be subject to the same notices and hearing for the levy of fines under Code Section 31-6A-8.

(d)(1) This Code section shall not apply to a hospital or any health care facilities owned by a hospital or health care system that:

(A) Has a payer mix of greater than 40 percent Medicaid recipients and uncompensated indigent and charity care of at least 2 percent; provided, however, that a hospital's cost gap between its Medicaid reimbursement rate and the medicare reimbursement shall count toward such uncompensated indigent and charity care amount; or

(B) Has an inpatient population of catastrophic injury patients that exceeds 60 percent of total inpatients treated annually.

(2) As used in this subsection, the term:

(A) 'Catastrophic injury' means an injury to the spinal cord, an acquired brain injury, and other paralyzing neuromuscular conditions.

(B) 'Payer mix' means the proportionate share of itemized charges attributable to patients assignable to a specific payer classification to total itemized charges for all patients.

(e) The department may withhold all or any portion of disproportionate share hospital funds to any hospital that is subject to the requirements contained in paragraph (1) of subsection (a) of this Code section that fails to meet the minimum indigent and charity care requirements for two consecutive years.

(f) For purposes of this Code section, uncompensated indigent and charity care shall be based on the medicare base allowable rate for the unpaid service provided multiplied by a factor of 1.5, and shall not be based on the hospital's charge for such services.

(g) A licensee may include up to 15 percent of its Medicaid payments toward the uncompensated indigent and charity care amounts required of it pursuant to this Code section.

(h) A rural hospital organization that is ranked by the department in the top 25 eligible rural hospital organizations in financial need pursuant to paragraph (1) of subsection (b) of Code Section 31-8-9.1 shall be exempt from this Code section so long as it continues to be ranked as such.

31-6A-7.

(a) Each health care facility in this state that is required by the department to provide uncompensated indigent or charity care pursuant to Code Section 31-6A-6 shall submit an annual report of certain health care information to the department. The report shall be due on the last day of January and shall cover the 12 month period preceding each such calendar year.

(b) The annual report required under subsection (a) of this Code section shall contain the following information:

(1) Total gross revenues;

(2) Bad debts;

(3) Amounts of free care extended, excluding bad debts;

(4) Contractual adjustments;

(5) Amounts of care provided under a Hill-Burton commitment;

(6) Amounts of charity care provided to indigent persons;

(7) Amounts of outside sources of funding from governmental entities, philanthropic groups, or any other source, including the proportion of any such funding dedicated to the care of indigent persons; and

(8) For cases involving indigent persons:

(A) The number of persons treated;

(B) The number of inpatients and outpatients;

(C) Total patient days;

(D) The number of patients categorized by county of residence; and

(E) The indigent care costs incurred by the health care facility by county of residence.

As used in this subsection, the term 'indigent persons' means persons having as a maximum allowable income level an amount corresponding to 125 percent of the federal poverty guideline.

(c) The department shall provide a form for the report required by this Code section and may provide in said form for further categorical divisions of the information listed in subsection (b) of this Code section.

(d)(1) In the event the department does not receive an annual report from an institution, on or before the date such report was due or receives a timely but incomplete report, the department shall notify the institution regarding the deficiencies and shall be authorized to fine such institution an amount not to exceed $500.00 per day for every day up to 30 days and $1,000.00 per day for every day over 30 days of such untimely or deficient report. Any fine so recovered shall be dedicated and deposited by the department into the Indigent Care Trust Fund created pursuant to Code Section 31-8-152 for the purposes set out in Code Section 31-8-154, including expanding Medicaid eligibility and services; programs to support rural and other health care providers, primarily hospitals, who serve the medically indigent; and for primary health care programs for medically indigent citizens and children of this state.

(2) In the event the department does not receive an annual report from an institution within 180 days following the date such report was due or receives a timely but incomplete report which is not completed within such 180 days, the department shall be authorized to revoke such institution's permit in accordance with Code Section 31-7-4.

31-6A-8.

(a) The department may revoke a special health care services license, in whole or in part, after notice to the holder of the special health care services license and a fair hearing pursuant to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act,' for the following reasons:

(1) Failure to comply with the provisions of this chapter;

(2) The intentional provision of false information to the department by a licensee in that licensee's application;

(3) Repeated failure to pay any fines or moneys due to the department;

(4) Failure to maintain minimum quality of care standards that may be established by the department;

(5) Failure to participate as a provider of medical assistance for Medicaid purposes or the PeachCare for Kids Program, if applicable; or

(6) The failure to submit a timely or complete report within 180 days following the date the report is due pursuant to Code Section 31-6A-7.

(b) In the event that a new special health care service is knowingly offered or developed without having obtained a special health care services license as required by this chapter, or the special health care services license for such service is revoked according to the provisions of this Code section, a facility or applicant may be fined an amount of $5,000.00 per day up to 30 days, $10,000.00 per day from 31 days through 60 days, and $25,000.00 per day after 60 days for each day that the violation of this chapter has existed and knowingly and willingly continues; provided, however, that the expenditure or commitment of or incurring an obligation for the expenditure of funds to take or perform actions not subject to this chapter or to acquire, develop, or prepare a health care facility site for which a special health care services license application is denied shall not be a violation of this chapter and shall not be subject to such a fine. The commissioner shall determine, after notice and a hearing, whether the fines provided in this Code section shall be levied. Any fine so recovered shall be dedicated and deposited by the department into the Indigent Care Trust Fund created pursuant to Code Section 31-8-152 for the purposes set out in Code Section 31-8-154, including expanding Medicaid eligibility and services; programs to support rural and other health care providers, primarily hospitals, who serve the medically indigent; and for primary health care programs for medically indigent citizens and children of this state.

(c) In addition, for purposes of this Code section, the State of Georgia, acting by and through the department, or any other interested person, shall have standing in any court of competent jurisdiction to maintain an action for injunctive relief to enforce the provisions of this chapter.

(d) The department shall have the authority to make public or private investigations or examinations inside or outside of this state to determine whether any provisions of this chapter or any other law, rule, regulation, or formal order relating to the provision of special health care services has been violated. Such investigations may be initiated at any time in the discretion of the department and may continue during the pendency of any action initiated by the department pursuant to this Code section. For the purpose of conducting any investigation or inspection pursuant to this subsection, the department shall have the authority, upon providing reasonable notice, to require the production of any

books, records, papers, or other information related to any special health care services license issue.

31-6A-9.

Any person who acquires a health care facility by stock or asset purchase, merger, consolidation, or other lawful means shall notify the department of such acquisition, the date thereof, and the name and address of the acquiring person. Such notification shall be made in writing to the department within 45 days following the acquisition and the acquiring person may be fined by the department in the amount of $500.00 for each day that such notification is late. Any fine so recovered shall be dedicated and deposited by the department into the Indigent Care Trust Fund created pursuant to Code Section 31-8-152 for the purposes set out in Code Section 31-8-154, including expanding Medicaid eligibility and services; programs to support rural and other health care providers, primarily hospitals, who serve the medically indigent; and for primary health care programs for medically indigent citizens and children of this state.

31-6A-10.

(a) Except as provided in subsection (c) of this Code section, on and after January 1, 2020, health care facilities, as defined in Code Section 31-6A-1, shall not be subject to the former provisions of Chapter 6, as such existed on December 31, 2019, and shall not be required to obtain or retain a certificate of need in order to operate, but all such valid certificates of need in existence on December 31, 2019, shall be converted by operation of law to special health care services licenses and all such license holders shall be subject to the provisions of this chapter on and after such date; provided, however that such health care facilities shall not be subject to the requirements of Code Section 31-6A-6 but shall instead be subject to any conditions previously imposed by the department relating to indigent or charity care and participation as a Medicaid provider that were in effect on December 31, 2019, pursuant to the former provisions of Chapter 6, as such existed on December 31, 2019. The department may withhold all or any portion of disproportionate share hospital funds to any hospital exempt pursuant to this subsection that fails to meet any conditions previously imposed by the department relating to indigent and charity care for two consecutive years. In the event a health care facility operating pursuant to this subsection receives any modification of its special health care services license, it shall immediately become subject to the requirements contained in Code Section 31-6A-6 in lieu of the conditions previously imposed by the department relating to indigent or charity care and participation as a Medicaid provider or PeachCare for Kids Program provider that were in effect on December 31, 2019.

(b)(1) On and after January 1, 2020, any person who had a valid exemption from certificate of need requirements under the former provisions of Chapter 6, as such existed on December 31, 2019, shall not be required to obtain or retain a special health care services license under this chapter in order to operate, but any such valid exemption in existence on December 31, 2019, shall be converted by operation of law to an exemption to special health care services license requirements under this chapter but shall be subject to any conditions previously imposed pursuant to the former provisions of Chapter 6, as such existed on December 31, 2019.

(2) In the event a person that is exempt pursuant to paragraph (1) of this subsection makes any modification to the special health care services it provides, it shall immediately become subject to the requirements contained in Code Section 31-6A-6 in lieu of the conditions previously imposed by the department relating to indigent or charity care and participation as a Medicaid provider or PeachCare for Kids Program provider that were in effect on December 31, 2019.

(c)(1) On and after January 1, 2020, a destination cancer hospital that was granted a certificate of need pursuant to the former provisions of Chapter 6, as such existed on December 31, 2019, may convert to a hospital by notifying the department in writing as to the date of conversion. Upon such conversion, the hospital may continue to provide all institutional health services and other services it provided as of the date of such conversion, including, but not limited to, inpatient beds, outpatient services, surgery, radiation therapy, imaging, and positron emission tomography (PET) scanning, without any further approval from the department; provided, however, that upon such conversion, such hospital shall immediately become subject to the requirements of Code Section 31-6A-6. On and after the date of conversion, the hospital shall be classified as a hospital under this chapter and shall be subject to all requirements and conditions for any new special health care services license requirements, exemptions, and for all other purposes, except as otherwise provided herein.

(2) In the event that a destination cancer hospital does not convert to a hospital, it shall remain subject to all requirements and conditions previously in effect as of December 31, 2019, under the provisions of Chapter 6 of this title as they existed on such date.

(d) Any outstanding appeals before the Certificate of Need Appeal Panel as of December 31, 2019, relating to health care facilities, as defined in Code Section 31-6A-1, shall be deemed moot and dismissed by operation of law as of January 1, 2020.

31-6A-11.

No freestanding emergency facility shall be permitted in this state unless it meets the criteria contained in paragraph (12) of Code Section 31-6A-1.

31-6A-12.

The department shall be authorized to promulgate rules and regulations to implement the provisions of this chapter."

PART III

SECTION 3-1.

Said title is further amended by adding new Code sections to Article 1 of Chapter 7, relating to regulation of hospitals and related institutions, to read as follows:

"31-7-22.

(a) As used in this Code section, the term 'hospital' means a nonprofit hospital, a hospital owned or operated by a hospital authority, or a nonprofit corporation formed, created, or operated by or on behalf of a hospital authority.

(b) Beginning July 1, 2020, each hospital in this state shall post a link in a prominent location on the main page of its website to the most recent version of the following documents:

(1) Federal related disclosures:

(A) Copies of audited financial statements that are general purpose financial statements, which express the unqualified opinion of an independent certified public accounting firm for the most recently completed fiscal year for the hospital; each of its affiliates, except those affiliates that were inactive or that had an immaterial amount of total assets; and the hospital's parent corporation that include the following:

(i) A PDF version of all audited financial statements;

(ii) A note in the hospital's audited financial statements that identifies individual amounts for such hospital's gross patient revenue, allowances, charity care, and net patient revenue;

(iii) Audited consolidated financial statements for hospitals with subsidiaries and consolidating financial statements that at a minimum contain a balance sheet and statement of operations and that provide a breakout of the hospital's and each subsidiary's numbers with a report from independent accountants on other financial information; and

(iv) Audited consolidated financial statements for the hospital's parent corporation and consolidating financial statements that at a minimum contain a balance sheet and statement of operations and that provide a breakout of the hospital's and each affiliate's numbers with a report from independent accountants on other financial information; and

(B) Copy of audited Internal Revenue Service Form 990, including Schedule H for hospitals and other applicable attachments; provided, however, that for any hospital not required to file IRS Form 990, the department shall establish and provide a form that collects the same information as is contained in Internal Revenue Service Form 990, including Schedule H for hospitals, as applicable; and

(2) Georgia supplemental disclosures:

(A) Copy of the hospital's completed annual hospital questionnaire, as required by the department;

(B) The community benefit report prepared pursuant to Code Section 31-7-90.1, if applicable;

(C) The disproportionate share hospital survey, if applicable;

(D) Listing of all property holdings of the hospital, including the location and size, parcel ID number, purchase price, current use, and any improvements made to such property at the end of each fiscal year;

(E) Listing of any ownership or interest the nonprofit hospital has in any joint venture, business venture foundation, operating contract, partnership, subsidiary holding company, or captive insurance company; where any such entity is domiciled; and the value of any such ownership or interest at the end of each fiscal year;

(F) Listing of any bonded indebtedness, outstanding loans, and bond defaults, whether or not in forbearance; and any bond disclosure sites of the hospital;

(G) A report that identifies by purpose, the ending fund balances of the net assets of the hospital and each affiliate as of the close of the most recently completed fiscal year, distinguishing between donor permanently restricted, donor temporarily restricted, board restricted and unrestricted fund balances. The hospital's interest in its foundation shall be deducted from the foundation's total fund balance;

(H) Report of all cash reserves of the hospital;

(I) Copy of all going concern statements regarding the hospital;

(J) The most recent legal chart of corporate structure, including the hospital, each of its affiliates and subsidiaries, and its parent corporation, duly dated;

(K) Report listing the salaries and fringe benefits for the ten highest paid administrative positions in the hospital. Each position shall be identified by its complete, unabbreviated title. Fringe benefits shall include all forms of compensation, whether actual or deferred, made to or on behalf of the employee, whether full or part-time;

(L) Evidence of accreditation by accrediting bodies, including, but not limited to, the Joint Commission and DNV; and

(M) Copy of the hospital's policies regarding the provision of charity care and reduced cost services to the indigent, excluding medical assistance recipients, and its debt collection practices.

(c) Each hospital shall update the documents in the links posted pursuant to subsection (b) of this Code section on July 1 of each year or more frequently at its discretion. Noncurrent documents shall remain posted and accessible on the hospital's website indefinitely.

(d) All documents listed in subsection (b) of this Code section shall be prepared in accordance with generally accepted accounting principles, as applicable.

(e) The department shall also post a link in a prominent location on its website to the documents listed in subsection (b) of this Code section for each hospital in this state.

(f) Any hospital that fails to post the documents required pursuant to subsection (b) of this Code section within 30 days of the dates required in this Code section shall be suspended from receiving any state funds or any donations pursuant to Code Section 48-7-29.20.

(g) The department shall have jurisdiction to enforce this Code section and to promulgate rules and regulations required to administer this Code section.

(h) Any person who knowingly and willfully includes false, fictitious, or fraudulent information in any documents required to be posted pursuant to this Code section shall be subject to a violation of Code Section 16-10-20.

31-7-23.

(a) As used in this Code section, the term:

(1) 'Hospital' shall have the same meaning as in Code Section 31-7-22.

(2) 'Medical use rights' means rights or interests in real property in which the owner of the property has agreed not to sell or lease such real property for identified medical uses or purposes.

(b) It shall be unlawful for any hospital to purchase, renew, extend, lease, maintain, or hold medical use rights.

(c) This Code section shall not be construed to impair any contracts in existence as of the effective date of this Code section."

SECTION 3-2.

Said title is further amended by revising Code Section 31-7-75.1, relating to proceeds of sale of hospital held in trust to fund indigent hospital care, as follows:

"31-7-75.1.

(a) The proceeds from any sale or lease of a hospital owned by a hospital authority or political subdivision of this state, which proceeds shall not include funds required to pay off the bonded indebtedness of the sold hospital or any expense of the authority or political

subdivision attributable to the sale or lease, shall be held by the authority or political subdivision in an irrevocable trust fund. Such proceeds in that fund may be invested in the same way that public moneys may be invested generally pursuant to general law and as permitted under Code Section 31-7-83, but money in that trust fund shall be used exclusively for funding the provision of ~~hospital~~ health care for the indigent residents of the political subdivision which owned the hospital or by which the authority was activated or for which the authority was created. If the funds available for a political subdivision in that irrevocable trust fund are less than $100,000.00, the principal amount may be used to fund the provision of indigent ~~hospital~~ health care; otherwise, only the income from that fund may be used for that care. Such funding or reimbursement for indigent care shall not exceed the diagnosis related group rate for that hospital in each individual case.

(b) In the event a hospital authority which sold or leased a hospital was activated by or created for more than one political subdivision or in the event a hospital having as owner more than one political subdivision is sold or leased by those political subdivisions, each such constituent political subdivision's portion of the irrevocable trust fund for indigent ~~hospital~~ health care shall be determined by multiplying the amount of that fund by a figure having a numerator which is the population of that political subdivision and a denominator which is the combined population of all the political subdivisions which owned the hospital or by which or for which the authority was activated or created.

(c) For purposes of ~~hospital~~ health care for the indigent under this Code section, the standard of indigency shall be that determined under Code Section 31-8-43, relating to standards of indigency for emergency care of pregnant women, based upon 125 percent of the federal poverty level.

(d) This Code section shall not apply to the following actions:

(1) A reorganization or restructuring;

(2) Any sale of a hospital, or the proceeds from that sale, made prior to April 2, 1986; and

(3) Any sale or lease of a hospital when the purchaser or lessee pledges, by written contract entered into concurrently with such purchase or lease, to provide an amount of ~~hospital~~ health care equal to that which would have otherwise been available pursuant to subsections (a), (b), and (c) of this Code section for the indigent residents of the political subdivisions which owned the hospital, by which the hospital authority was activated, or for which the authority was created. However, the exception to this Code section provided by this paragraph shall only apply to:

(A) Hospital authorities that operate a licensed hospital pursuant to a lease from the county which created the appropriate authority; ~~and~~

(B) Hospitals that have a bed capacity of more than 150 beds; ~~and~~

(C) Hospitals located in a county in which no other medical-surgical licensed hospital is located; ~~and~~

(D) Hospitals located in a county having a population of less than 45,000 according to the United States decennial census of 1990; and

(E) Hospitals operated by a hospital authority that entered into a lease-purchase agreement between such hospital and a private corporation prior to July 1, 1997.″

SECTION 3-3.

Said title is further amended by adding a new Code section to Article 4 of Chapter 7, relating to hospital authorities, to read as follows:

″31-7-74.4.

Members on the board of a hospital authority at the time of a sale or lease of a hospital owned by such hospital authority shall be deemed directors and subject to the provisions of Part 6 of Article 8 of Chapter 3 of Title 14, relating to conflicting interest transactions with respect to the proceeds of such sale or lease.″

SECTION 3-4.

Said title is further amended by revising Code Section 31-7-83, relating to investment of surplus moneys and moneys received through issuance of revenue certificates, as follows:

″31-7-83.

(a) Pending use for the purpose for which received, each hospital authority created by and under this article is authorized and empowered to invest all moneys or any part thereof received through the issuance and sale of revenue certificates of the authority in any securities which are legal investments or which are provided for in the trust indenture securing such certificates or other legal investments; provided, however, that such investments ~~will~~ shall be used at all times while held, or upon sale, for the purposes for which the money was originally received and no other. Contributions or gifts received by any authority shall be invested as provided by the terms of the contribution or gift or in the absence thereof as determined by the authority.

(b) In addition to the authorized investments in subsection (a) of this Code section and in Code Section 36-83-4, hospital authorities that have ceased to own or operate medical facilities for a minimum of seven years, have paid off all bonded indebtedness and outstanding short-term or long-term debt obligations, and hold more than $20 million in funds for charitable health care purposes may invest a maximum of 30 percent of their funds in the following:

(1) Shares of mutual funds registered with the Securities and Exchange Commission of the United States under the Investment Company Act of 1940, as amended; and

(2) Commingled funds and collective investment funds maintained by state chartered banks or trust companies or regulated by the Office of the Comptroller of the Currency of the United States Department of the Treasury, including common and group trusts, and, to the extent the funds are invested in such collective investment funds, the funds shall adopt the terms of the instruments establishing any group trust in accordance with applicable United States Internal Revenue Service Revenue Rulings."

SECTION 3-5.

Code Section 50-18-70 of the Official Code of Georgia Annotated, relating to legislative intent and definitions relative to open records laws, is amended by revising subsection (b) as follows:

"(b) As used in this article, the term:

(1) 'Agency' shall have the same meaning as in Code Section 50-14-1 and shall additionally include any association, corporation, or other similar organization that has a membership or ownership body composed primarily of counties, municipal corporations, or school districts of this state, their officers, or any combination thereof and derives more than 33 1/3 percent of its general operating budget from payments from such political subdivisions. Such term shall also include any nonprofit organization to which is leased and transferred hospital assets of a hospital authority through a corporate restructuring and any subsidiaries or foundations established by such nonprofit organization in furtherance of the public mission of the hospital authority.

(2) 'Public record' means all documents, papers, letters, maps, books, tapes, photographs, computer based or generated information, data, data fields, or similar material prepared and maintained or received by an agency or by a private person or entity in the performance of a service or function for or on behalf of an agency or when such documents have been transferred to a private person or entity by an agency for storage or future governmental use, including, but not limited to, any such material in the possession or control of a nonprofit organization to which is leased and transferred hospital assets of a hospital authority through a corporate restructuring which are related to the operation of the hospital and other leased facilities in the performance of services on behalf of the hospital authority."

PART IV

SECTION 4-1.

Chapter 8 of Title 31 of the Official Code of Georgia Annotated, relating to care and protection of indigent and elderly patients, is amended by revising Code Section 31-8-9.1,

relating to eligibility to receive tax credits and obligations of rural hospitals after receipt of funds, as follows:

"31-8-9.1.

(a) As used in this Code section, the term:

(1) 'Critical access hospital' means a hospital that meets the requirements of the federal Centers for Medicare and Medicaid Services to be designated as a critical access hospital and that is recognized by the department as a critical access hospital for purposes of Medicaid.

(2) 'Rural county' means a county having a population of less than 50,000 according to the United States decennial census of 2010 or any future such census; provided, however, that for counties which contain a military base or installation, the military personnel and their dependents living in such county shall be excluded from the total population of such county for purposes of this definition.

(3) 'Rural hospital organization' means an acute care hospital licensed by the department pursuant to Article 1 of Chapter 7 of this title that:

(A) Provides inpatient hospital services at a facility located in a rural county or is a critical access hospital;

(B) Participates in both Medicaid and medicare and accepts both Medicaid and medicare patients;

(C) Provides health care services to indigent patients;

(D) Has at least 10 percent of its annual net revenue categorized as indigent care, charity care, or bad debt;

(E) Annually files IRS Form 990, Return of Organization Exempt From Income Tax, with the department, or for any hospital not required to file IRS Form 990, the department will provide a form that collects the same information to be submitted to the department on an annual basis;

(F) Is operated by a county or municipal authority pursuant to Article 4 of Chapter 7 of this title or is designated as a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code; ~~and~~

(G) Is current with all audits and reports required by law; and

(H) Does not have a margin above expenses of greater than 15 percent, as calculated by the department.

(b)(1) By December 1 of each year, the department shall approve a list of rural hospital organizations eligible to receive contributions from the tax credit provided pursuant to Code Section 48-7-29.20 ranked in order of financial need and transmit such list to the Department of Revenue.

(2) Before any rural hospital organization is included on the list as eligible to receive contributions from the tax credit provided pursuant to Code Section 48-7-29.20, it shall submit to the department a five-year plan detailing the financial viability and stability of the rural hospital organization. The criteria to be included in the five-year plan shall be established by the department.

(3) The department shall create an operations manual for identifying rural hospital organizations and ranking such rural hospital organizations in order of financial need. Such manual shall include:

(A) All deadlines for submitting required information to the department;

(B) The criteria to be included in the five-year plan submitted pursuant to paragraph (2) of this subsection; and

(C) The formula applied to rank the rural hospital organizations in order of financial need.

(c)(1) A rural hospital organization that receives donations pursuant to Code Section 48-7-29.20 shall:

(A) Utilize such donations for the provision of health care related services for residents of a rural county or for residents of the area served by a critical access hospital; and

(B) Report on a form provided by the department:

(i) All contributions received from individual and corporate donors pursuant to Code Section 48-7-29.20 detailing the manner in which the contributions received were expended by the rural hospital organization; and

(ii) Any payments made to a third party to solicit, administer, or manage the donations received by the rural hospital organization pursuant to this Code section or Code Section 48-7-29.20. In no event shall payments made to a third party to solicit, administer, or manage the donations received pursuant to this Code section exceed 3 percent of the total amount of the donations.

(2) The department shall annually prepare a report compiling the information received pursuant to paragraph (1) of this subsection for the chairpersons of the House Committee on Ways and Means and the Senate Health and Human Services Committee.

(d) The department shall post the following information in a prominent location on its website:

(1) The ranked list of rural hospital organizations eligible to receive contributions established pursuant to paragraph (1) of subsection (b) of this Code section;

(2) The operations manual created pursuant to paragraph (3) of subsection (b) of this Code section;

(3) The annual report prepared pursuant to paragraph (2) of subsection (c) of this Code section;

(4) The total amount received by each third party that participated in soliciting, administering, or managing donations; and

(5) A link to the Department of Revenue's website containing the information included in subsection (d) of Code Section 48-7-29.20."

SECTION 4-2.

Code Section 48-7-29.20 of the Official Code of Georgia Annotated, relating to tax credits for contributions to rural hospital organizations, is amended as follows:

"48-7-29.20.

(a) As used in this Code section, the term:

(1) 'Qualified rural hospital organization expense' means the contribution of funds by an individual or corporate taxpayer to a rural hospital organization for the direct benefit of such organization during the tax year for which a credit under this Code section is claimed.

(2) 'Rural hospital organization' means an organization that is approved by the Department of Community Health pursuant to Code Section 31-8-9.1.

(b) An individual taxpayer shall be allowed a credit against the tax imposed by this chapter for qualified rural hospital organization expenses as follows:

(1) In the case of a single individual or a head of household, the actual amount expended;

(2) In the case of a married couple filing a joint return, the actual amount expended; or

(3) In the case of an individual who is a member of a limited liability company duly formed under state law, a shareholder of a Subchapter 'S' corporation, or a partner in a partnership, the amount expended; provided, however, that tax credits pursuant to this paragraph shall be allowed only for the portion of the income on which such tax was actually paid by such individual.

(b.1) From January 1 to June 30 each taxable year, an individual taxpayer shall be limited in its qualified rural hospital organization expenses allowable for credit under this Code section, and the commissioner shall not approve qualified rural hospital organization expenses incurred from January 1 to June 30 each taxable year, which exceed the following limits:

(1) In the case of a single individual or a head of household, $5,000.00;

(2) In the case of a married couple filing a joint return, $10,000.00; or

(3) In the case of an individual who is a member of a limited liability company duly formed under state law, a shareholder of a Subchapter 'S' corporation, or a partner in a partnership, $10,000.00.

(c) A corporation or other entity shall be allowed a credit against the tax imposed by this chapter for qualified rural hospital organization expenses in an amount not to exceed the

actual amount expended or 75 percent of the corporation's income tax liability, whichever is less.

(d) In no event shall the total amount of the tax credit under this Code section for a taxable year exceed the taxpayer's income tax liability. Any unused tax credit shall be allowed the taxpayer against the succeeding five years' tax liability. No such credit shall be allowed the taxpayer against prior years' tax liability.

(e)(1) In no event shall the aggregate amount of tax credits allowed under this Code section exceed ~~$60~~ $100 million per taxable year.

(2)(A) No more than $4 million of the aggregate limit established by paragraph (1) of this subsection shall be contributed to any individual rural hospital organization in any taxable year. From January 1 to June 30 each taxable year, the commissioner shall only preapprove contributions submitted by individual taxpayers in an amount not to exceed $2 million, and from corporate donors in an amount not to exceed $2 million. From July 1 to December 31 each taxable year, subject to the aggregate limit in paragraph (1) of this subsection and the individual rural hospital organization limit in this paragraph, the commissioner shall approve contributions submitted by individual taxpayers and corporations or other entities.

(B) In the event an individual or corporate donor desires to make a contribution to an individual rural hospital organization that has received the maximum amount of contributions for that taxable year, the Department of Community Health shall provide the individual or corporate donor with a list, ranked in order of financial need, as determined by the Department of Community Health, of rural hospital organizations still eligible to receive contributions for the taxable year.

(C) In the event that an individual or corporate donor desires to make a contribution to an unspecified or undesignated rural hospital organization, either directly to the department or through a third party that participates in soliciting, administering, or managing donations, such donation shall be attributed to the rural hospital organization ranked with the highest financial need that has not yet received the maximum amount of contributions for that taxable year, regardless of whether a third party has a contractual relationship or agreement with such rural hospital organization.

(D) Any third party that participates in soliciting, advertising, or managing donations shall provide the complete list of rural hospital organizations eligible to receive the tax credit provided pursuant to this Code section including their ranking in order of financial need as determined by the Department of Community Health pursuant to Code Section 31-8-9.1, to any potential donor regardless of whether a third party has a contractual relationship or agreement with such rural hospital organization.

(3) For purposes of paragraphs (1) and (2) of this subsection, a rural hospital organization shall notify a potential donor of the requirements of this Code section. Before making a contribution to a rural hospital organization, the taxpayer shall electronically notify the department, in a manner specified by the department, of the total amount of contribution that the taxpayer intends to make to the rural hospital organization. The commissioner shall preapprove or deny the requested amount within 30 days after receiving the request from the taxpayer and shall provide written notice to the taxpayer and rural hospital organization of such preapproval or denial which shall not require any signed release or notarized approval by the taxpayer. In order to receive a tax credit under this Code section, the taxpayer shall make the contribution to the rural hospital organization within 60 days after receiving notice from the department that the requested amount was preapproved. If the taxpayer does not comply with this paragraph, the commissioner shall not include this preapproved contribution amount when calculating the limits prescribed in paragraphs (1) and (2) of this subsection.

(4)(A) Preapproval of contributions by the commissioner shall be based solely on the availability of tax credits subject to the aggregate total limit established under paragraph (1) of this subsection and the individual rural hospital organization limit established under paragraph (2) of this subsection.

(B) Any taxpayer preapproved by the department pursuant to this subsection ~~(e) of this Code section~~ shall retain their approval in the event the credit percentage in ~~subsection (b) of~~ this Code section is modified for the year in which the taxpayer was preapproved.

(C) Upon the rural hospital organization's confirmation of receipt of donations that have been preapproved by the department, any taxpayer preapproved by the department pursuant to subsection (c) of this Code section shall receive the full benefit of the income tax credit established by this Code section even though the rural hospital organization to which the taxpayer made a donation does not properly comply with the reports or filings required by this Code section.

(5) Notwithstanding any laws to the contrary, the department shall not take any adverse action against donors to rural hospital organizations if the commissioner preapproved a donation for a tax credit prior to the date the rural hospital organization is removed from the Department of Community Health list pursuant to Code Section 31-8-9.1, and all such donations shall remain as preapproved tax credits subject only to the donor's compliance with paragraph (3) of this subsection.

(f) In order for the taxpayer to claim the tax credit under this Code section, a letter of confirmation of donation issued by the rural hospital organization to which the contribution was made shall be attached to the taxpayer's tax return. However, in the event the taxpayer files an electronic return, such confirmation shall only be required to be electronically

attached to the return if the Internal Revenue Service allows such attachments when the return is transmitted to the department. In the event the taxpayer files an electronic return and such confirmation is not attached because the Internal Revenue Service does not, at the time of such electronic filing, allow electronic attachments to the Georgia return, such confirmation shall be maintained by the taxpayer and made available upon request by the commissioner. The letter of confirmation of donation shall contain the taxpayer's name, address, tax identification number, the amount of the contribution, the date of the contribution, and the amount of the credit.

(g) No credit shall be allowed under this Code section with respect to any amount deducted from taxable net income by the taxpayer as a charitable contribution to a bona fide charitable organization qualified under Section 501(c)(3) of the Internal Revenue Code.

(h) The commissioner shall be authorized to promulgate any rules and regulations necessary to implement and administer the provisions of this Code section.

(i) The department shall post the following information in a prominent location on its website:

(1) All pertinent timelines relating to the tax credit, including, but not limited to:

(A) Beginning date when contributions can be submitted for preapproval by donors for the January 1 to June 30 period;

(B) Ending date when contributions can be submitted for preapproval by donors for the January 1 to June 30 period;

(C) Beginning date when contributions can be submitted for preapproval by donors for the July 1 to December 31 period;

(D) Ending date when contributions can be submitted for preapproval by donors for the July 1 to December 31 period; and

(E) Date by which preapproved contributions are required to be sent to the rural hospital organization;

(2) The list and ranking order of rural hospital organizations eligible to receive contributions established pursuant to paragraph (1) of subsection (b) of Code Section 31-8-9.1;

(3) A monthly progress report including:

(A) Total preapproved contributions to date by rural hospital organization;

(B) Total contributions received to date by rural hospital organization;

(C) Total aggregate amount of preapproved contributions made to date; and

(D) Aggregate amount of tax credits available;

(4) A list of all preapproved contributions that were made to an unspecified or undesignated rural hospital organization and the rural hospital organizations that received such contributions.

(j) The Department of Audits and Accounts shall annually conduct an audit of the tax credit program established under this Code section, including the amount and recipient rural hospital organization of all contributions made, all tax credits received by individual and corporate donors, and all amounts received by third parties that solicited, administered, or managed donations pertaining to this Code section and Code Section 31-8-9.1.

~~(i)~~(k) This Code section shall stand automatically repealed on December 31, ~~2021~~ 2024."

PART V

SECTION 5-1.

Title 31 of the Official Code of Georgia Annotated, relating to health, is amended in Code Section 31-7-3, relating to requirements for permits to operate institutions, by revising subsection (a) as follows:

"(a) Any person or persons responsible for the operation of any institution, or who may hereafter propose to establish and operate an institution and to provide specified clinical services, shall submit an application to the department for a permit to operate the institution and provide such services, with such application to be made on forms prescribed by the department. No institution shall be operated in this state without such a permit, which shall be displayed in a conspicuous place on the premises. No clinical services shall be provided by an institution except as approved by the department in accordance with the rules and regulations established pursuant to Code Section 31-7-2.1. Failure or refusal to file an application for a permit shall constitute a violation of this chapter and shall be dealt with as provided for in Article 1 of Chapter 5 of this title. Following inspection and classification of the institution for which a permit is applied for, the department may issue or refuse to issue a permit or a provisional permit. Permits issued shall remain in force and effect until revoked or suspended; provisional permits issued shall remain in force and effect for such limited period of time as may be specified by the department. Upon conclusion of the Atlantic Cardiovascular Patient Outcomes Research Team (C-PORT) Study, the department shall consider and analyze the data and conclusions of the study and promulgate rules pursuant to Code Section 31-7-2.1 to regulate the quality of care for therapeutic cardiac catheterization. All hospitals that participated in the study and ~~are~~ were exempt from obtaining a certificate of need based on paragraph (22) of subsection (a) of former Code Section 31-6-47 as it existed on December 31, 2019, shall apply for a permit

to continue providing therapeutic cardiac catheterization services once the department promulgates the rules required by this Code section."

SECTION 5-2.

Said title is further amended in Code Section 31-7-75, relating to the functions and powers of county and municipal hospital authorities, by revising paragraph (24) as follows:

"(24) To provide management, consulting, and operating services including, but not limited to, administrative, operational, personnel, and maintenance services to another hospital authority, hospital, health care facility, as said term is defined in ~~Chapter 6 of this title~~ Code Section 31-6A-1, person, firm, corporation, or any other entity or any group or groups of the foregoing; to enter into contracts alone or in conjunction with others to provide such services without regard to the location of the parties to such transactions; to receive management, consulting, and operating services including, but not limited to, administrative, operational, personnel, and maintenance services from another such hospital authority, hospital, health care facility, person, firm, corporation, or any other entity or any group or groups of the foregoing; and to enter into contracts alone or in conjunction with others to receive such services without regard to the location of the parties to such transactions;"

SECTION 5-3.

Said title is further amended in Code Section 31-7-94.1, the "Rural Hospital Organization Assistance Act of 2017," by revising paragraph (1) of subsection (e) as follows:

"(1) Infrastructure development, including, without being limited to, health information technology, facility renovation, or equipment acquisition; provided, however, that ~~the amount granted to any qualified hospital may not exceed the expenditure thresholds that would constitute a new institutional health service requiring a certificate of need under Chapter 6 of this title and~~ the grant award may be conditioned upon obtaining local matching funds;"

SECTION 5-4.

Said title is further amended in Code Section 31-7-116, relating to provisions contained in obligations and security for obligations, procedures for issuance of bonds and bond anticipation notes, interest rates, and limitations and conditions, by revising subsection (i) as follows:

"(i) No bonds or bond anticipation notes except refunding bonds shall be issued by an authority under this article unless its board of directors ~~shall adopt~~ adopts a resolution finding that the project for which such bonds or notes are to be issued will promote the

objectives stated in subsection (b) of Code Section 31-7-111 and will increase or maintain employment in the territorial area of such authority. Nothing contained in this Code section shall be construed as permitting any authority created under this article or any qualified sponsor to finance, construct, or operate any project without obtaining any ~~certificate of need or other~~ approval, permit, or license which, under the laws of this state, is required in connection therewith."

SECTION 5-5.

Said title is further amended by revising Code Section 31-8-153.1, relating to irrevocable transfer of funds to trust fund and provision for indigent patients, as follows:

"31-8-153.1.

After June 30, 1993, any hospital authority, county, municipality, or other state or local public or governmental entity is authorized to transfer moneys to the trust fund. Transfer of funds under the control of a hospital authority, county, municipality, or other state or local public or governmental entity shall be a valid public purpose for which those funds may be expended. The department is authorized to transfer to the trust fund moneys paid to the state by a health care facility as a monetary penalty for the violation of an agreement to provide a specified amount of ~~clinical health services to indigent patients~~ uncompensated indigent or charity care pursuant to a ~~certificate of need~~ license held by such facility. Such transfers shall be irrevocable and shall be used only for the purposes contained in Code Section 31-8-154."

SECTION 5-6.

Said title is further amended in Code Section 31-11-100, relating to definitions relative to the Georgia Trauma Care Network Commission, by revising paragraph (3) as follows:

"(3) 'Trauma center' means a facility designated by the Department of Public Health as a Level I, II, III, or IV or burn trauma center. However, a burn trauma center shall not be considered or treated as a trauma center ~~for purposes of certificate of need requirements under state law or regulations, including exceptions to need and adverse impact standards allowed by the department for trauma centers or~~ for purposes of identifying safety net hospitals."

SECTION 5-7.

Code Section 33-45-1 of the Official Code of Georgia Annotated, relating to definitions relative to continuing care providers and facilities, is amended by revising paragraphs (1), (6), and (13) as follows:

"(1) 'Continuing care' means furnishing pursuant to a continuing care agreement:

(A) Lodging that is not:

(i) In a skilled nursing facility, as such term is defined in paragraph ~~(34)~~(19) of Code Section 31-6-2;

(ii) An intermediate care facility, as such term is defined in paragraph ~~(22)~~(13) of Code Section 31-6-2;

(iii) An assisted living community, as such term is defined in Code Section 31-7-12.2; or

(iv) A personal care home, as such term is defined in Code Section 31-7-12;

(B) Food; and

(C) Nursing care provided in a facility or in another setting designated by the agreement for continuing care to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee including skilled or intermediate nursing services and, at the discretion of the continuing care provider, personal care services including, without limitation, assisted living care services designated by the continuing care agreement, including such services being provided pursuant to a contract to ensure the availability of such services to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee.

Such term shall not include continuing care at home."

"(6) 'Limited continuing care' means furnishing pursuant to a continuing care agreement:

(A) Lodging that is not:

(i) In a skilled nursing facility, as such term is defined in paragraph ~~(34)~~(19) of Code Section 31-6-2;

(ii) An intermediate care facility, as such term is defined in paragraph ~~(22)~~(13) of Code Section 31-6-2;

(iii) An assisted living community, as such term is defined in Code Section 31-7-12.2; or

(iv) A personal care home, as such term is defined in Code Section 31-7-12;

(B) Food; and

(C) Personal services, whether such personal services are provided in a facility such as a personal care home or an assisted living community or in another setting designated by the continuing care agreement, to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee.

Such term shall not include continuing care at home."

"(13) 'Residential unit' means a residence or apartment in which a resident lives that is not a skilled nursing facility as defined in paragraph ~~(34)~~(19) of Code Section 31-6-2, an

intermediate care facility as defined in paragraph ~~(22)~~(13) of Code Section 31-6-2, an assisted living community as defined in Code Section 31-7-12.2, or a personal care home as defined in Code Section 31-7-12."

SECTION 5-8.

Code Section 33-45-3 of the Official Code of Georgia Annotated, relating to certificate of authority required for operation of continuing care facilities, is amended by revising subsection (d) as follows:

"(d) A provider of continuing care at home may contract with a licensed home health agency to provide home health services to a resident. In order to provide home health services directly, a provider of continuing care at home shall obtain a certificate of need for a home health agency, as such term is defined in paragraph ~~(20)~~(12) of Code Section 31-6-2, pursuant to the same criteria and rules as are applicable to freestanding home health agencies that are not components of continuing care retirement communities."

SECTION 5-9.

Code Section 37-1-29 of the Official Code of Georgia Annotated, relating to crisis stabilization units, is amended by revising subsection (j) as follows:

"(j) ~~Any program certified as a crisis stabilization unit pursuant to this Code section shall be exempt from the requirements to obtain a certificate of need pursuant to Article 3 of Chapter 6 of Title 31.~~ Reserved."

SECTION 5-10.

Code Section 43-26-7 of the Official Code of Georgia Annotated, relating to requirements for licensure as a registered professional nurse, is amended by revising paragraph (4) of subsection (c) as follows:

"(4)(A)(i) Meet continuing competency requirements as established by the board;

~~(B)~~(ii) If the applicant entered a nontraditional nursing education program as a licensed practical nurse whose academic education as a licensed practical nurse included clinical training in pediatrics, obstetrics and gynecology, medical-surgical, and mental illness, have practiced nursing as a registered professional nurse in a health care facility for at least one year in the three years preceding the date of the application, and such practice is documented by the applicant and approved by the board; provided, however, that for an applicant who does not meet the experience requirement of this subparagraph, the board shall require the applicant to complete a 320 hour postgraduate preceptorship arranged by the applicant under the oversight of a registered nurse where such applicant is transitioned into the role of a registered

professional nurse. The preceptorship shall have prior approval of the board, and successful completion of the preceptorship shall be verified in writing by the preceptor; or

~~(C)~~(iii) If the applicant entered a nontraditional nursing education program as anything other than a licensed practical nurse whose academic education as a licensed practical nurse included clinical training in pediatrics, obstetrics and gynecology, medical-surgical, and mental illness, have graduated from such program and practiced nursing as a registered professional nurse in a health care facility for at least two years in the five years preceding the date of the application, and such practice is documented by the applicant and approved by the board; provided, however, that for an applicant who does not meet the experience requirement of this subparagraph, the board shall require the applicant to complete a postgraduate preceptorship of at least 480 hours but not more than 640 hours, as determined by the board, arranged by the applicant under the oversight of a registered professional nurse where such applicant is transitioned into the role of a registered professional nurse. The preceptorship shall have prior approval of the board, and successful completion of the preceptorship shall be verified in writing by the preceptor.

(B) For purposes of this paragraph, the term 'health care facility' means an acute care inpatient facility, a long-term acute care facility, an ambulatory surgical center ~~or obstetrical facility~~ as defined in Code Section ~~31-6-2~~ 31-6A-1, and a skilled nursing facility, so long as such skilled nursing facility has 100 beds or more and provides health care to patients with similar health care needs as those patients in a long-term acute care facility;"

PART VI

SECTION 6-1.

For purposes of rule-making, this Act shall become effective upon its approval by the Governor or upon its becoming law without such approval. For all other purposes, this Act shall become effective on January 1, 2020.

SECTION 6-2.

All laws and parts of laws in conflict with this Act are repealed.