House Bill 1339 (AS PASSED HOUSE AND SENATE)

By: Representatives Parrish of the 158th, Burns of the 159th, Hawkins of the 27th, Beverly of the 143rd, Taylor of the 173rd, and others

A BILL TO BE ENTITLED

AN ACT

To amend Title 31 of the Official Code of Georgia Annotated, relating to health, so as to revise provisions relative to certificate of need; to revise definitions; to provide for review of the state health plan every five years; to eliminate capital expenditure thresholds in certain circumstances; to revise provisions relating to acceptance and review of applications; to provide a timeframe for opposing an application; to revise provisions relating to appeals; to revise exemptions from certificate of need requirements; to provide for a review of the statutory framework of the certificate of need program; to provide for automatic repeal; to increase fines for reporting deficiencies; 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 increase the tax credit limit for contributions by corporate donors; to increase the aggregate limit for tax credits for contributions to rural hospital organizations; to provide for preapproval of proportional amounts of contributions under certain circumstances; to provide for certain timelines; to extend the sunset provision; to amend Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally, so as to provide for the creation of the Comprehensive Health Coverage Commission; to provide for its members; to provide for its purpose and duties; to provide for assistance from experts and consultants; to provide for semiannual reports; to provide for the automatic repeal of the commission; to provide for related matters; to provide

for effective dates; to provide for applicability; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 31 of the Official Code of Georgia Annotated, relating to health, is amended by revising paragraphs (23) and (33) of Code Section 31-6-2, relating to definitions relative to state health planning and development, as follows:

"(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. Such ambulatory surgical center shall only be utilized by physicians who are of the same single specialty, who may include physicians who are not owners or employees of the single group practice of physicians that own and operate the center; 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. Nothing in this paragraph shall prohibit the owners of the center from entering into an arrangement with an outside entity for practice management, administrative services, or both."

"(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~~,~~ and operated~~, and utilized~~ by ~~such~~ the individual physician or single group practice of private physicians or single group of physicians who ~~also~~ are of a single specialty. Such ambulatory surgical center shall only be utilized by physicians who are of the same single specialty, who may include physicians who are not owners or employees of the individual private physician or single group practice of private physicians that own and operate the center; 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. Nothing in this paragraph shall prohibit an individual private physician or a single group practice of private physicians from entering into an arrangement with an outside entity for practice management, administrative services, or both."

SECTION 2.

Said title is further amended in Code Section 31-6-21, relating to Department of Community Health functions and powers with respect to state health planning and development, by revising subsection (a) as follows:

"(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 review and update the state health plan at least every

five years beginning no later than January 1, 2025, to ensure the plan meets the evolving needs of the state. The department shall provide, by rule, for procedures to administer its functions until otherwise provided by the board."

SECTION 3.

Said title is further amended in Code Section 31-6-40, relating to certificate of need required for new institutional health services and exemption, by revising subsections (a), (b), and (c) as follows:

"(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, expanded, or relocated health care facility, except as otherwise provided in Code Section 31-6-47;

(2) ~~Any expenditure by or on behalf of a health care facility in excess of $10 million which, under generally accepted accounting principles consistently applied, is a capital expenditure, except expenditures for acquisition of an existing health care facility. The dollar amounts specified in this paragraph and in 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, 2019, 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 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;~~ Reserved;

(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, except as otherwise provided in Code Section 31-6-47;

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

(5) 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;

(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; and

(8) The conversion of a destination cancer hospital to a general cancer hospital.

(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 annual reports in the same manner and in accordance with Code Section 31-6-70; and

(B)(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, and on and after January 1, 2026, in an amount equal to or greater than the minimum amount established by the department which shall be reviewed by the department every 12 months; 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, and on and after January 1, 2026, in an amount equal to or greater than the minimum amount established by the department which shall be reviewed by the department every 12 months, 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 (B) 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.″

SECTION 4.

Said title is further amended by revising Code Section 31-6-43, relating to acceptance or rejection of application for certificate, as follows:

"31-6-43.

(a) At least ~~30~~ 25 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~~ received 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,~~ and 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)(1) 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~~ receives the application. 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; provided, however, that such rules shall provide that any party permitted to oppose an application shall submit a notice of opposition no later than 30 days of receipt by the department of such application.

(2) No party may oppose an application for a certificate of need for a proposed project unless:

(A) Such party offers substantially similar services as proposed within a 35 mile radius of the proposed project or has a service area that overlaps the applicant's proposed service area; or

(B) Such party has submitted a competing application in the same batching cycle and is proposing to establish the same type of facility proposed or offers substantially similar services as proposed and has a service area that overlaps the applicant's proposed service area.

(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, 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 within 30 days of receipt of the application provide the applicant an opportunity to meet with the department to discuss ~~the~~ such application and to provide the applicant 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 permitted to oppose an application pursuant to paragraph (2) of subsection (d) of this Code section to meet with the department and to provide additional information to the department. In order for any such 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, the term '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."

SECTION 5.

Said title is further amended by revising subsections (h), (i), (j), (k), (l), (m), and (n) of Code Section 31-6-44, relating to the Certificate of Need Appeal Panel, as follows:

"(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~~;~~ or 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~~ department. ~~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~~ shall constitute 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.~~"

SECTION 6.

Said title is further amended by revising subsection (a) of Code Section 31-6-44.1, relating to judicial review, as follows:

"(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~~,~~ or 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."

SECTION 7.

Said title is further amended by revising Code Section 31-6-47, relating to exemptions from certificate of need requirements, as follows:

"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) 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) Religious, nonmedical health care institutions as defined in 42 U.S.C. Section 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 a certificate of need application;

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

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

(9) Expenditures for the restructuring or acquisition of existing health care facilities by stock or asset purchase, merger, consolidation, or other lawful means;

(9.1) The purchase of a closing hospital or of a hospital that has been closed for no more than ~~12~~ 24 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~~ The acquisition, replacement, or repair of diagnostic, therapeutic, or other imaging equipment by ~~a~~ any existing health care facility that is not owned by a group practice of physicians or a hospital and that provides diagnostic imaging services so long as it does not result in the offering of any new clinical health 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) ~~Except as provided in paragraph (10) of this subsection,~~ An expenditure 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, magnetic resonance imaging, positron emission tomography (PET), and positron emission tomography/computed tomography previously approved for a certificate of need;~~

(11) 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) 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 United States Bureau of the Census of the Department of Commerce, calculated from the date of approval of the project;

(13) 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 such 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) 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~~ 20 percent of capacity, whichever is greater, in any consecutive ~~two-year~~ three-year period, in a hospital that has maintained an overall occupancy rate greater than ~~75~~ 60 percent for the previous 12 month period;

(16) Expenditures for nonclinical projects, including parking lots, parking decks, and other parking facilities; computer systems, software, and other information technology; medical office buildings; administrative office space; conference rooms; education facilities; lobbies; common spaces; clinical staff lounges and sleep areas; waiting rooms; bathrooms; cafeterias; hallways; engineering facilities; mechanical systems; roofs; grounds; signage; family meeting or lounge areas; other nonclinical physical plant renovations or upgrades that do not result in new or expanded clinical health services, and state mental health facilities;

(17) Life plan communities, provided that the skilled nursing component of the facility is for the exclusive use of residents of the life plan 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 life plan 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 life plan community sheltered nursing facility may utilize not more than 50 percent of its licensed beds for patients who are not residents of the life plan community. In the second year of operation, the life plan community shall allow not more than 40 percent of its licensed beds for new patients who are not residents of the life plan community. In the third year of operation, the life plan community shall allow not more than 30 percent of its licensed beds for new patients who are not residents of the life plan community. In the fourth year of operation, the life plan community shall allow not more than 20 percent of its licensed beds for new patients who are not residents of the life plan community. In the fifth year of operation, the life plan community shall

allow not more than 10 percent of its licensed beds for new patients who are not residents of the life plan community. At no time during the first five years shall the life plan community sheltered nursing facility occupy more than 50 percent of its licensed beds with patients who are not residents under contract with the life plan community. At the end of the five-year period, the life plan community sheltered nursing facility shall be utilized exclusively by residents of the life plan community, and at no time shall a resident of a life plan community be denied access to the sheltered nursing facility. At no time shall any existing patient be forced to leave the life plan community to comply with this paragraph. The department is authorized to promulgate rules and regulations regarding the use and definition of the term '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~~ with 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, and on and after January 1, 2026, in an amount equal to or greater than the minimum amount established by the department which shall be reviewed by the department every 12 months; 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 on and after January 1, 2026, in an amount equal to or greater than the minimum amount established by the department which shall be reviewed by the department every 12 months;

provided, however, that 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, and on and after January 1, 2026, in an amount equal to or greater than the minimum amount established by the department which shall be reviewed by the department every 12 months; 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 on and after January 1, 2026, in an

amount equal to or greater than the minimum amount established by the department which shall be reviewed by the department every 12 months; 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, that 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~~ with another hospital, no hospital shall unreasonably deny a transfer agreement ~~to~~ with another hospital;

(23) 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;

(24) The relocation of any skilled nursing facility, 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~~ five-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;

(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;

(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~~ five-mile radius of and within the same county as the hospital's existing facility;

(27) The renovation, remodeling, refurbishment, or upgrading of a health care facility, so long as the project does not result in any of the following:

(A) The offering of any new or expanded clinical health services;

(B) Any increase in inpatient bed capacity; or

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

~~(D) A capital expenditure exceeding the threshold contained in paragraph (2) of subsection (a) of Code Section 31-6-40;~~

(28) ~~Other than for equipment used to provide positron emission tomography (PET) services, the~~ The acquisition of diagnostic, therapeutic, or other imaging equipment ~~with a value of $3 million or less,~~ by or on behalf of:

(A) A hospital; or

(B) An individual private physician or single group practice of physicians exclusively for use on patients of such private physician or single group practice of physicians and such private physician or member of such single group practice of physicians is physically present at the practice location where the diagnostic or other imaging equipment is located at least 75 percent of the time that the equipment is in use~~.~~;

~~The amount specified in this paragraph 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 and in paragraph (10) of this subsection 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; and~~

(29) Any capital expenditures ~~A capital expenditure of $10 million or less~~ by a hospital at such hospital's primary campus for:

(A) The expansion or addition of the following clinical health services: operating rooms, other than dedicated outpatient operating rooms; medical-surgical services; gynecology; procedure rooms; intensive care; pharmaceutical services; pediatrics; cardiac care or other general hospital services; provided, however, that such expenditure does not include the expansion or addition of inpatient beds or the conversion of one type of inpatient bed to another type of inpatient bed; or

(B) The movement of clinical health services from one location on the hospital's primary campus to another location on such hospital's primary campus;

(30) New or expanded psychiatric or substance abuse inpatient programs or state funded beds that serve Medicaid and uninsured patients that:

(A) Are open 365 days per year, seven days per week, and 24 hours per day;

(B) Provide uncompensated indigent and charity care in an amount equal to or greater than 3 percent of its adjusted gross revenue, and on and after January 1, 2026, in an amount equal to or greater than the minimum amount established by the department by rule which shall be at least 3 percent and which shall be reviewed by the department every 12 months;

(C) Participate as providers of medical assistance for Medicaid purposes;

(D) Have hospital affiliation agreements with acute care hospitals within a reasonable distance from the programs or state funded beds or the medical staffs at the programs or state funded beds have admitting privileges or other acceptable documented arrangements with such hospitals to ensure the necessary backup for the programs or state funded beds for medical complications. The programs or state funded beds shall have the capability to transfer a patient immediately to a hospital within a reasonable

distance from the programs or state funded beds with adequate emergency room services. Acute care hospitals shall not unreasonably deny a transfer agreement or affiliation agreement with the programs or state funded beds; and

(E) Provide annual reports in the same manner and in accordance with Code Section 31-6-70;

(31) The offering of new or expanded basic perinatal services by a hospital in a rural county provided that:

(A) Such services are available 365 days per year, seven days per week, and 24 hours per day;

(B) The hospital participates as a provider of medical assistance for Medicaid purposes;

(C) The hospital has a hospital affiliation agreement with an acute care hospital with at least Level III perinatal services within a reasonable distance from the hospital providing the perinatal services or the medical staff at the hospital providing the perinatal services has admitting privileges or other acceptable documented arrangements with such acute care hospital to ensure the necessary backup for the hospital providing the perinatal services for medical complications. The hospital providing the perinatal services shall have the capability to transfer a patient immediately to the acute care hospital within a reasonable distance from the hospital providing the perinatal services with adequate emergency room services. Acute care hospitals shall not unreasonably deny a transfer agreement or affiliation agreement with the hospital providing the perinatal services. This subparagraph shall not apply if the hospital providing the basic perinatal services is itself an acute care hospital with at least Level III perinatal services; and

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

(31.1) Any new or expanded building or facility where human births occur on a regular and ongoing basis and which is classified as a birthing center by the department for purposes of Chapter 7 of this title, provided that:

(A) Services are available 365 days per year, seven days per week, and 24 hours per day;

(B) The birthing center participates as a provider of medical assistance for Medicaid purposes;

(C) The birthing center has a hospital affiliation agreement with an acute care hospital with at least Level III perinatal services within a reasonable distance from the birthing center or the medical staff at the birthing center has admitting privileges or other acceptable documented arrangements with such acute care hospital to ensure the necessary backup for the birthing center for medical complications. The birthing center shall have the capability to transfer a patient immediately to the acute care hospital within a reasonable distance from the birthing center. Acute care hospitals shall not unreasonably deny a transfer agreement or affiliation agreement with the birthing center;

(D) The birthing center:

(i) Provides basic perinatal services, as defined by the department, which shall include but not be limited to a combination of such services as determined by the department;

(ii) Meets the standards for certification established by the American Association of Birth Centers, or equivalent or higher standards as determined by the department;

(iii) Schedules routine visits and visits with other appropriate providers, as necessary, and tracks patients to verify that services have been received;

(iv) Prior to 20 weeks gestation, certifies that a patient has been deemed to be a low risk patient, as defined by the department for purposes of this paragraph;

(v) Admits and provides services only to patients certified as low risk; and

(vi) Refers patients to other appropriate providers if, at any point between the 20 weeks gestation certification and antepartum, the birthing center determines that a patient no longer qualifies as a low risk patient for any reason; and

(E) The birthing center provides annual reports in the same manner and in accordance with Code Section 31-6-70;

(32) A new general acute care hospital in a rural county that:

(A)(i) Attains status as a teaching hospital within 36 months of opening, and maintains such status thereafter; or

(ii) Obtains verification as a Level I, II, III, or IV trauma center from the American College of Surgeons within 36 months of opening, and maintains such verification thereafter;

(B) Provides emergency, inpatient, and outpatient psychiatric and behavioral health services;

(C) Has an emergency department that is open 365 days per year, seven days per week, and 24 hours per day;

(D) Provides uncompensated indigent and charity care in an amount equal to or greater than 3 percent of its adjusted gross revenue, and on and after January 1, 2026, in an amount equal to or greater than the minimum amount established by the department by rule which shall be no less than 3 percent and which shall be reviewed by the department every 12 months;

(E) Participates as a provider of medical assistance for Medicaid purposes; and

(F) Provides annual reports in the same manner and in accordance with Code Section 31-6-70;

(33) A new acute care hospital where a short-stay general hospital in a rural county has been closed for more than 12 months and a new replacement hospital has not opened that:

(A) Is located in the same rural county where the short-stay general hospital was closed;

(B) Has no more than the number of licensed beds that were previously licensed in the closed hospital;

(C) Has an emergency department that is open 365 days per year, seven days per week, and 24 hours per day;

(D) Provides all required clinical health services as generally offered by a short-stay general hospital to meet licensure requirements; and

(E) Provides uncompensated indigent and charity care in an amount equal to or greater than 3 percent of its adjusted gross revenue, and on and after January 1, 2026, in an amount equal to or greater than the minimum amount established by the department by rule which shall be no less than 3 percent and which shall be reviewed by the department every 12 months.

Such new acute care hospital may provide basic perinatal services;

(34)(A) A new short-stay general hospital to address the underserved population previously served by a short-stay general hospital that was closed within the 48 months preceding the filing of a request for a letter of determination that:

(i) Is located within a county with a population of more than 1 million according to the United States decennial census of 2020 or any future such census;

(ii) Is located within five miles of and in the same county as the main campus of a medical school that is accredited by the Liaison Committee on Medical Education to confer Doctor of Medicine (M.D.) degrees;

(iii) Has in place at the time of filing of a request for a letter of determination a written agreement to serve as a teaching hospital for students of the medical school described in division (ii) of this subparagraph;

(iv) Has a maximum number of short-stay general hospital beds not greater than 50 percent of the maximum number of short-stay general hospital beds for which the closed short-stay general hospital had previously been licensed at any time during the 12 months prior to its closure;

(v) Has an emergency department that is open 365 days per year, seven days per week, and 24 hours per day; and

(vi) Provides uncompensated indigent and charity care in an amount equal to or greater than 3 percent of its adjusted gross revenue, and on and after January 1, 2026, in an amount equal to or greater than the minimum amount established by the department by rule which shall be no less than 3 percent and which shall be reviewed by the department every 12 months;

(B) An exemption for a new short-stay general hospital under this paragraph shall include an exemption for all clinical services and equipment generally utilized at an acute care short-stay general hospital and required for licensure, including, but not limited to, an emergency department; Level II perinatal/neonatal services, including labor, delivery, recovery, and Level II neonatal intermediate care services; diagnostic imaging services; and surgical services; and

(C) For a period of ten years following the issuance of its original license, a new short-stay general hospital approved for an exemption pursuant to this paragraph shall be entitled to one or more determinations from the department to add additional short-stay general hospital beds, so long as the total licensed capacity of such hospital does not exceed the maximum number of short-stay general hospital beds for which the closed short-stay general hospital had previously been licensed at any time during the 12 months prior to its closure; and

(35) Transfer of existing beds from one general acute care hospital's primary campus to another general acute care hospital's primary campus within the same hospital system within a 15 mile radius of the original campus, provided that all of the following are satisfied:

(A) Both hospitals involved in the transfer are general acute care hospitals and neither is a specialty hospital;

(B) Both hospitals involved in the transfer are under common ownership or control;

(C) The transferring hospital may not, for a period of 12 months after the transfer is effective, seek to expand the bed type which was transferred; and

(D) The transferring hospital is open and operational at the time of transfer and shall not close within 12 months after the transfer is effective.

(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."

SECTION 8.

Said title is further amended by revising Code Section 31-6-47.1, relating to prior notice and approval of certain activities, as follows:

"31-6-47.1.

(a) 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 shall require prior notice and approval of any activity which is believed to be exempt pursuant to paragraphs (31.1), (32), (33), and (34) of subsection (a) of Code Section 31-6-47. 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), (26), (27), (28), ~~and~~ (29), (30), and (31) of subsection (a) of Code Section 31-6-47. The department shall establish timeframes, forms, and criteria to request a letter of determination that an activity is properly exempt or excluded under this chapter prior to its implementation. The department shall publish notice of all requests for letters of determination regarding 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. If no objection to a request for determination is filed within 30 days of the department's receipt of such request for determination, the department shall have 60 days from the date of the department's receipt of such request to review the request and issue a letter of determination. The department may adopt rules for deciding when it is not practicable to provide a determination in 60 days and may extend the review period upon written notice to the requestor but only for an extended period of no longer than an additional 30 days.

(b) Noncompliance with any condition of paragraph (30), (31), (31.1), or (32) of subsection (a) of Code Section 31-6-47 shall result in a monetary penalty in the amount of the difference between the services which the exemption holder is required to provide and the amount actually provided and shall be subject to revocation of its exemption status by the department for repeated failure to meet any one or more requirements for the exemption, 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.'"

SECTION 9.

Said title is further amended in Article 3 of Chapter 6, relating to the Certificate of Need Program, by adding a new Code section to read as follows:

"31-6-51.

(a) The department, in conjunction with the Office of Legislative Counsel, shall review the statutory framework and provisions of this chapter and the certificate of need program generally and shall make recommendations relating to rewriting, reorganizing, and

clarifying the provisions of this chapter. Such review shall also include recommendations to streamline the statutory procedures required to obtain a certificate of need or a letter of determination.

(b) The department may consult with and obtain input from certificate of need applicants, certificate of need holders, local government representatives, citizens, or other interested parties in conducting such review.

(c) The department shall submit its recommendations to the General Assembly, which may include proposed legislation, no later than December 1, 2024.

(d) This Code section shall stand repealed on December 31, 2024."

SECTION 10.

Said title is further amended in Code Section 31-6-70, relating to reports to the department by certain health care facilities an all ambulatory surgical centers and imaging centers and public availability, by revising subsection (e) as follows:

"(e)(1) In the event the department does not receive 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~~ $2,000.00 per day for every day up to 30 days and ~~$1,000.00~~ $5,000.00 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."

SECTION 11.

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 by revising subsections (b.1), (e), and (k) as follows:

"(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~~ $25,000.00."

"(e)(1) In no event shall the aggregate amount of tax credits allowed under this Code section exceed ~~$75~~ $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 an individual or corporate donor desires to make a contribution to an individual rural hospital organization that would cause such rural hospital organization to exceed its maximum amount of contributions for that year, the commissioner shall not deny such desired contribution, but shall approve the proportional amount of the desired contribution up to the rural hospital organization's maximum allowed amount and any remainder shall be attributed as provided for in subparagraph (D) of this paragraph.

~~(C)~~(D) 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)~~(E) 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 or a portion of such amount, if applicable pursuant to subparagraph (C) of paragraph (2) of this subsection, 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 180 days after receiving notice from the department that the requested amount was preapproved.~~ In order to receive a tax credit under this Code section, a taxpayer preapproved by the commissioner on or before September 30 shall make the contribution to the rural hospital organization within 180 days after receiving notice of preapproval from the commissioner, but not later than October 31. A taxpayer preapproved by the commissioner after September 30 shall make the contribution to the rural hospital organization on or before December 31. 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~~ commissioner pursuant to this subsection shall retain their approval in the event the credit percentage in 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~~ commissioner, any taxpayer preapproved by

the ~~department~~ commissioner 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."

"(k) This Code section shall stand automatically repealed and reserved on December 31, ~~2024~~ 2029."

SECTION 12.

Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally, is amended by adding a new Code section to read as follows:

"49-4-156.

(a) There is created the Comprehensive Health Coverage Commission. The commission shall be attached to the Department of Community Health for administrative purposes only as provided by Code Section 50-4-3.

(b) The commission shall consist of nine members, who shall be appointed no later than July 1, 2024, as follows:

(1) The chairperson, who shall be a subject matter expert on health policy, and shall not be an employee of the State of Georgia, to be appointed by the Governor;

(2) Three nonlegislative members to be appointed by the Speaker of the House of Representatives;

(3) Three nonlegislative members to be appointed by the President of the Senate;

(4) One nonlegislative member to be appointed by the minority leader of the Senate; and

(5) One nonlegislative member to be appointed by the minority leader of the House of Representatives.

(c) Members of the commission shall not be registered lobbyists in the State of Georgia.

(d) Members of the commission shall serve without compensation.

(e) The purpose of the commission shall be to advise the Governor, the General Assembly, and the Department of Community Health, as the administrator of the state medical assistance program, on issues related to access and quality of healthcare for Georgia's low-income and uninsured populations. The commission shall be tasked with reviewing the following:

(1) Opportunities related to reimbursement and funding for Georgia healthcare providers, including premium assistance programs;

(2) Opportunities related to quality improvement of healthcare for Georgia's low-income and uninsured populations; and

(3) Opportunities to enhance service delivery and coordination of healthcare among and across state agencies.

(f) Subject to appropriations, the commission shall contract with experts and consultants to produce a semiannual report on its findings for the Governor and the General Assembly. The commission shall provide its initial report to the Governor and the General Assembly no later than December 1, 2024.

(g) The commission shall stand abolished on December 31, 2026, unless extended by the General Assembly prior to such date."

SECTION 13.

(a) Sections 2, 9, 12, 13, and 14 of this Act shall become effective upon approval of the Act by the Governor or upon its becoming law without such approval.

(b) Sections 1, 3, 4, 5, 6, 7, 8, and 10 of this Act shall become effective on July 1, 2024.

(c) Section 11 of this Act shall become effective on January 1, 2025, and shall be applicable to taxable years beginning on or after January 1, 2025.

SECTION 14.

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