Georgia State Senate
Office of Policy and Legislative Analysis

FINAL REPORT OF THE SENATE CERTIFICATE OF NEED REFORM STUDY COMMITTEE (SR 279)

COMMITTEE MEMBERS

Senator Greg Dolezal, Chairman
District 27

Senator Ben Watson
District 1

Senator Matt Brass
District 28

Mark Baker
Hughston Clinic

Senator Bill Cowsert
District 46

Matt Hasbrouck
Memorial Meadows

Senator Ed Harbison
District 15

Christine Macewen
Piedmont Healthcare

Senator Kay Kirkpatrick
District 32

Jesse Wealthington
Georgia Association of Health Plans

Senator Freddie Powell Sims
District 12

Dr. Stephen Wertheim
Independent Physician

Prepared by the Office of Policy & Legislative Analysis, 2023
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STUDY COMMITTEE CREATION, FOCUS, AND DUTIES

The Senate Certificate of Need (CON) Reform Study Committee was created by Senate Resolution 279 during the 2022 Legislative Session of the Georgia General Assembly. The Study Committee was tasked with reviewing Georgia’s CON laws and making recommendations regarding potential reforms to these CON policies to better support the survival and growth of Georgia’s healthcare industry.

Senator Greg Dolezal of the 27th served as Chair of this Study Committee. The other Senate members were Senator Matt Brass of the 28th; Senator Bill Cowsert of the 46th; Senator Ed Harbison of the 15th; Senator Kay Kirkpatrick of the 32nd; Senator Freddie Powell Sims of the 12th and Senator Ben Watson of the 1st. Additional members appointed to the Study Committee included Mark Bakor, CEO of Hughston Clinic; Matt Hasbrouck, CEO of Memorial Meadows in Vidalia; Christine Macewen, Corporate Counsel at Piedmont Healthcare; Jesse Wealthington, President and CEO of the Georgia Association of Health Plans; and Dr. Stephen Wertheim, Former Co-President of Resurgens.

The following legislative staff members were assigned to the Study Committee: Sydney Horwitz, Senate Press Office; Josselyn Hill, Office of Policy and Legislative Analysis; McKenzie Rhoades, Office of Senator Greg Dolezal; Betsy Howerton, Office of Legislative Counsel; and Mary Enloe, Senate Budget and Evaluation Office.

The Study Committee held meetings on:
- June 13, 2023 (State Capitol);
- August 28, 2023 (Columbus, GA);
- October 16, 2023 (Savannah, GA); and
- November 28, 2023 (State Capitol).

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BACKGROUND

A certificate of need (CON) program is a state regulatory tool that controls the number of healthcare resources in an area. CON laws require a hospital or health system to demonstrate community need before establishing or expanding a healthcare facility or service. State CON laws differ, but generally address: (1) the types of healthcare facilities requiring CONs; (2) activities that trigger CON review; (3) the agency or board that reviews applications; and (4) the information considered during a CON review.

States have not been the only entities to utilize CON laws. The federal government’s intervention in the services provided by healthcare providers’ spans back to 1946. After WWII, the United States experienced increased mortality rates and an inability to develop effective disease treatments due to the shortage of hospital beds, physicians, and supporting healthcare workers. This shortage resulted in the Hospital Survey and Construction Act of 1946 (“Hill-Burton Act”). The Hill-Burton Act’s purpose was to encourage the development of rural hospitals. In order to receive funding, states were required to implement health policy planning programs, to inventory existing facilities, and designate a single agency in charge of health policy planning.²

Prior to the federal policy planning mandate, only five states had state health policy planning regulations. After the enactment of Section 1122 of the Social Security Act of 1972, thirty-seven states implemented CON laws. Section 1122 required states to review capital expenditures exceeding $100,000.00, bed capacity changes, or substantial changes in services. Additionally, Section 1122 required states to designate a health planning agency in charge of reviewing these mandates. States that failed to comply would lose out on Medicare and Medicaid cost reimbursements.³

The National Health Planning and Resource Development Act of 1974 was designed to develop a “national health planning policy” to support the cost containment efforts. The Act required federal agencies to provide guidelines and establish specific goals, priorities, and success criteria. These requirements resulted in a majority of states replacing their Section 1122 review process with CON programs. In the 1980s, the deregulation movement resulted in the repeal of the National Health Planning and Resource Development Act of 1974. The reason given for the repeal was that the CON scheme “failed to reduce the nation’s aggregate healthcare costs, and it was beginning to produce a detrimental effect on local communities.”⁴ Subsequently, several states repealed or modified their CON laws.

The purpose of CON programs are to ensure the availability of health care services adequate enough to meet the needs of the people.⁵ Georgia’s CON program is intended to achieve three goals: (1) to measure need and defined need; (2) to control costs; and (3) to guarantee access to healthcare services.

States vary on the type of health care services that trigger a CON. However, in Georgia the following triggers the necessity of a CON: hospitals, cancer hospitals, special care units (defined as “Podiatric facilities; Skilled nursing facilities; Intermediate care facilities; Personal care homes; Ambulatory surgical or obstetrical facilities; Health maintenance organizations; Home health agencies; and Diagnostic, treatment, or rehabilitation centers”) and certain capital expenditures.⁶

³ Source Book at pp. 5–6.
⁴ Source Book at pp.6–7.
⁶ Fact Sheet, Certificate of Need (expenditures that require a CON: “Establishing new hospitals, including general, acute care and specialty hospitals; Establishing or expanding nursing homes and home health agencies; All multi-specialty and certain single-specialty ambulatory surgery centers; Providing radiation therapy, positron emission tomography, open heart surgery and neonatal services; Purchasing or leasing major medical equipment that exceeds equipment thresholds; Renovating major hospitals or other capital activities by any health care facility that exceed the capital expenditure thresholds; and Offering new health care services”) (Sept. 2017).
States with CON programs tend to have a similar process that applicants must follow to receive a CON. In Georgia, CON applications fall into two categories: batched and non-batched. Non-batched applications are accepted throughout the year, while batched applicants must be submitted during the four designated batching cycles. Prior to submitting an application, an applicant must first send a letter of intent 30 days prior to its application. Applicants must electronically submit via Department of Community Health’s (DCH) web portal a signed copy of the application and a copy of the certified check or money order. The original money order or certified check must be payable to the “State of Georgia.” Then DCH conducts the review of the application. During the review process, DCH applies the specific considerations and standards codified in Georgia law. After the completion of the review process, an application is either approved or denied. If approved, an applicant has 12 months from the date of approval to implement their project (i.e., the applicant must show “substantial performance”); in the case of CONs for equipment, an applicant must be in possession of the equipment within 12 months from the date of approval. Post-approval, there are reporting requirements that applicants must submit to demonstrate “timely project implementation and completion.”

Georgia’s CON program has an appeal process that is done by an independent panel of five individuals appointed by the Governor for a term of up to four years each. Failing to comply with the CON regulations may result in an injunction, monetary penalties, and/or a revocation of a CON in whole or in part.

Georgia’s CON law does provide a number of exemptions to the CON laws including:

1. Replacement of existing therapeutic or diagnostic equipment that received prior CON authorization;
2. Projects that bring facilities into compliance with licensing requirements, life safety codes or to comply with accreditation standards; and
3. Expenditures for non-clinical projects, including parking lots, parking decks, medical office buildings.

Unless otherwise specified in the rules or statute, all applicants seeking an exemption must provide prior notice to and receive written approval from DCH for the exempted activity.

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7 Fact Sheet at 2.
8 O.C.G.A. § 31-6-43. According to O.C.G.A. § 31-6-43, “[n]o 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. During this past summer DCH amended Ga. Comp. R. & Regs. r. 111-2-2, which narrowed the parties who are eligible to file an opposition to a Georgia CON application to those whose services are within Georgia’s borders.
9 Fact Sheet at 3; see also O.C.G.A § 31-6-47.
SUMMARY OF TESTIMONY AND DISCUSSION

Meeting One – June 13, 2023 (State Capitol)

Chairmen Dolezal opened the meeting. He explained that this Study Committee will meet four times: 1) today at the Capitol; 2) in August in Columbus; 3) in October in Savannah; and 4) in November back at the Capitol. He explained that currently people have their own ideas of what Georgia should do with its CON laws. He further explained that this Committee can be considered a success when at the end of this process people have learned and their ideas have been enhanced or amended based off the information presented. He indicated that the reason this Committee is reviewing Georgia’s CON laws is for the purpose investigating how Georgia can have better healthcare outcomes.

The Chairmen explained that today’s speakers were going to provide background information into CON laws in the United States with a focus on Georgia. He indicated that he asked the Office of Policy and Legislative Analysis10 (OPLA) for a memorandum that provides a brief history of CON laws in the United States, specifically, looking into states that had CON laws and then repealed them and the impact on their healthcare industry as a result of that repeal. OPLA explained that information regarding the Chairmen’s requested was not available because most of the CON research looks at CON programs across the nation and compares and contrasts states with CON laws with states without CON laws. The CON research that is done does not track the impact on individual states before and after either a CON program is overhauled or completely repealed. OPLA explained that due to this information limitation, they were unable to provide detailed information regarding the Chairmen’s specific request. However, OPLA focused their response memorandum on the research that has been conducted which compares states with and without CON laws and their impact on certain healthcare outcomes.

OPLA began their presentation by providing a brief history of CON laws in the United States. OPLA indicated that the idea and usage of CON laws within the United States can be traced back as far as the 1940s. OPLA further indicated that the proliferation of states adopting such laws is a result of Federal mandates on states to implement such laws. Even though each state in the United States has had CON regulations at some point since the 1940s—currently, only 12 states have completely repealed all their CON laws. OPLA highlighted three studies that analyzed the impact of CON regulations on procedural volume, market share, outcomes among Medicare Beneficiaries, and hospital quality. The studies generally concluded that with regard to these health outcomes, CON programs which are meant to limit spending and overexpansion to avoid excess capacity and improve quality of care, are likely not meeting these intended objectives. Moreover, their impact generally does not improve access to care or the quality of care; but may result in these programs having more costs than benefits, if they have an impact on a health outcome.

Professor Thomas Stramann from George Mason University in Virginia also provided a brief history of CON laws in the United States. His presentation primarily focused on Georgia’s CON program in comparison to statistically similar states without CON laws. He indicated that the goal of CON laws was to contain costs. However, because CON laws did not help to contain costs, the federal government repealed its CON law in the early 1980s. He further indicated that the typical justifications for CON laws include:

1. Ensuring an adequate supply of healthcare resources;
2. Protecting access in rural and underserved communities;
3. Promoting high-quality care;
4. Supporting charity care; and
5. Controlling costs.

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10 Formerly known as the Senate Research Office.
He explained that in four separate data-driven studies that he coauthored, he found that keeping CON laws has resulted in negative consequences for patients. He further explained that their studies, which are consistent with the positions of the Federal Trade Commission, the Federal Department of Justice, showed that CON laws:

1. Harm patients by reducing healthcare quality;
2. Harm patients by reducing access to healthcare; and
3. Harm patients by reducing the availability of medical equipment such as MRI machines and CT scanners that help diagnose illnesses and prevent premature death.

Professor Stratmann indicated that Georgia ranks seventh highest among the states with the highest number of CON laws. He explained that in 2017 Georgia had approximately 175 hospitals, which is 30 percent less than states without CON laws which had approximately 227. He further explained that comparing Georgia to statistically similar states without CON laws shows that without a CON, Georgia likely would have over 500 centers instead of the 356 it had in 2017. He also explained that CON proponents argue that CON laws increase access to medical care in rural areas. He indicated that the data showed that CON does the opposite. Georgia has fewer ambulatory surgery centers (ASCs) and fewer hospitals, thus fewer choices. He explained that Georgians in both urban and rural areas have fewer choices because of Georgia’s CON laws. He provided the following example: states comparable to Georgia without CON have seven additional rural hospitals instead of roughly 58 rural hospitals as of 2011 in Georgia.

Professor Stratmann indicated that CON laws also reduce hospital quality, which is due to the lack of competition among medical providers. A study conducted by Professor Stratmann and others, found that states with CON laws have a lower quality of service, as measured by their hospital mortality rates and hospital readmission rates. He explained that states with CON laws have:

1. A 0.5 percent more deaths for surgery patients with serious complications;
2. A 0.6 percentage point higher pneumonia mortality rate;
3. A 0.3 percentage point higher heart failure mortality rate; and
4. A 0.4 percentage point higher heart attack mortality rate.

He found that Georgia generally lacks in comparison to statistically similar states without CON laws with regard to access to medical care in facilities; access to imagining and other services; quality of hospital care; and quality of indigent care. He concluded that Georgia’s health industry would be better off without its CON program.

The Georgia Hospital Association (GHA) explained that they are the largest hospital association in Georgia. GHA indicated that they represent more than 142 member hospitals ranging in size from small rural critical access all the way up to large urban metropolitan systems, along with having specialty hospitals and behavioral health facilities within their membership. GHA also indicated that as these meetings commence that the Committee should focus on what problem it is trying to solve, whether it is the lack of access to all services, some services, affordability of services, etc. GHA explained that it has created a CON workforce which created CON Comprehensive Study Materials for the Committee that contains information regarding Georgia’s CON program. GHA indicated that at the conclusion of their workforce meetings, it will provide recommendations to the Committee regarding CON reforms.

GHA explained that it was here to work together to help find solutions. However, it noted that CON cannot be considered in a vacuum; but rather, GHA requested that the Committee take a holistic approach and recognize that some of the healthcare issues facing Georgia are not necessarily linked to CON laws. GHA briefly went over the study materials that they provided. GHA explained that even though Georgia’s CON program has been in place since 1975, it has gone through multiple changes which are provided in the study materials. Moreover, Georgia’s CON program provides for various exceptions to the CON rules which allow under certain criteria for MRIs, CTs, and single specialty.
surgery centers to name a few. GHA further indicated that CON is not a barrier rather a gateway to protect the quality of services not just a proliferation of one service.

GHA explained that the studies discussed are not apple to apple comparisons because the studies do not consider the scope of practice laws; the Medicaid program of the state; financial situation of the rural area; the healthcare workforce available; and so many factors that can impact the outcomes and what the quality of care looks like within a region. Moreover, the comparisons discuss correlations between CON states and non-CON states without discussing the causation in terms of why there are more facilities in one state than in another. GHA pointed out that these studies did not do a Georgia specific analysis. GHA explained that the researcher took the average of states with and without CON laws and then compared these numbers with Georgia. The research was not Georgia specific in terms of practical feasibility, meaning these correlations cannot provide a complete analysis of Georgia’s situation.

GHA explained that these new additional hospitals which were discussed earlier are likely not going to open next door to a tiny critical access hospital in a rural county. However, there may be a risk to outlier rural counties that are close to the Metro areas if they open specialty providers near smaller rural hospitals. Such occurrences could have a detriment to the hospital’s ability to serve the rural population.

GHA indicated that healthcare is not a free market where a patient gets to decide where to get their care. But rather, it is often dictated by insurer and in emergency situations. Patients are just happy to have access to services. They also indicated that the pulling of patients out of hospitals to receive care at other types of facilities is justified as a cost saving. However, this switching of facilities may be less costly for that particular service—it ends up increasing cost on the back end to maintain access to all of the other services such as emergency care. Moreover, hospitals do not have the ability to increase their pricing, so when costs go up for things such as workforce or overhead the hospital has to find a way to make up those costs as it cannot change its pricing to account for such changes.

Public Testimony

Ms. Jaimie Cavanaugh, an attorney for the Institute of Justice, explained that the institute has been working for over a decade to repeal and reform CON laws in the United States. She indicated that nine states that exclude rural areas from their CON program or do not regulate any type of hospital with CON laws. She reference Profession Stratmann’s findings that states with CON laws have 30 percent per capita fewer rural hospitals which Ms. Cavanaugh explains is supported by the trend among states to exclude rural areas from their CON laws. She also explained that since 2005 Georgia has had 10 rural hospital closures. She further explained that only five states that have had zero rural hospital closures since 2005. Of these five states, none of them have CON laws for rural hospitals. She clarified that Florida, North Carolina, and South Carolina have done significant reform to their CON laws, eliminating a lot of their regulations. Florida only regulates nursing homes, hospice, and intermediate care facilities for the developmentally disabled with CON laws. North Carolina repealed CON for psychiatric and rehabilitation facilities; it increased its cost thresholds for a variety of facilities and equipment; and eliminated CON for ASCs and MRIs in counties of a certain size. South Carolina only regulates nursing homes with CON laws.

Georgia Council on Aging explained that it has continued to advocate for expanded opportunities for quality long-term care to serve Georgia’s at-risk older adults. The Council requests the Committee consider CON reform for nursing homes. The Council indicated that currently if a provider wanted to open a new facility it would be to show a 95 percent occupancy rate of nursing home beds in that region and considering that often the occupancy rate is generally 68 percent, along with a bed deficit need, it makes it difficult for new facilities to be established. The Council also explained that without additional nursing homes being built, the five to 10 year projections show that the bed deficits will
continue to grow exponentially. It explained that nursing home CONs limit the supply of nursing and benefit existing homes without encouraging:
1. Facility renovations;
2. Innovative care models;
3. Consumer options;
4. Workforce attraction and retention;
5. Improved quality of care;
6. Infection control best practices; and
7. Affordable new provider entry.

The Council explained that there are new innovative care models which yield the solutions that the Council wants to encourage. It indicated that using alternative care operations could result in a better use of Medicare and lower its costs along with lowering the demand for nursing homes. The Council requested that the Committee consider CON reforms that could help control cost; widen access to underserved populations; and improve care quality.

Chris Denson from the Georgia Public Policy Foundation explained that it was providing an economic report that it published which included a comprehensive history of the legislative efforts regarding CON in Georgia, along with a summary of the academic research on the topic. He explained that since Florida repealed most of its CON laws, 64 ASCs have announced their opening in Florida. Of those ASCs, 63 were in counties that were deemed urban by the Florida Office of Rural Health. He highlighted the testimony of an attorney from DOJ who testified before the General Assembly who explained that CON is not supposed to protect cross-subsidization of patient services. He also explained that as the process goes forward, when the Committee hears that a provider or facility did not go through with an innovative project it is because they know the CON process is an uphill battle.

John Gleason from Georgia Society of ASCs explained their mission is to provide excellent innovative patient-focused orthopedic care to Georgians regardless of their ability to pay. He also explained that they support the notion of abolishing CON regulations but they are not opposed to reasonable regulations. He explained that CON has not improved the quality of care; the access to care; and the cost of care has gone up. The negative impact of CONs have made ASCs more economical and useful to reduce the cost of care in Georgia. He also explained that they support the modernization of these rules while still maintaining some form of charity care but recognizing that charity care includes more than just surgery. His recommendations included:
1. Limiting who can appeal an application, DCH should be the deciding factor not an incumbent;
2. Elimination of different caps for single specialty ASCs and joint ventures ASCs because the cost of the procedure is the same whether it is done at an ASC or a hospital; and
3. Allow for multiple providers to share a facility which Medicare allows for such licensing.

Barry Herron explained that CON laws are central planning mechanisms, which allow the non-elected state agency personnel to dictate the type, number, and location of healthcare facilities in the state. He further explained that these people develop their data from the people they are regulating who have no incentive to be honest about their utilization and production. This results in rationing of care that is not equitable to existing providers. He brought an example of a CON for a radiation therapy center. He provided excerpts from support letters outlining how people feel about the costs for services as a result of allowing hospitals to keep a monopoly on services offered. He indicated that CON laws subsidize a monopoly. Moreover, CON laws do not cost the people less in terms of their out-of-pocket costs and thus, Georgia’s CON laws need to be repealed.

Victor Muldiven explained that he was going to defer his comments for a later date. He reminded the Committee that the CON laws were established as a federal mandate. He explained that CON was adopted because everything was cost-based at the time (meaning it was retrospective since the federal government effectively reimburse the cost of building it). He explained that the plan was not for it to
be used as an anti-competition tool. Rather, it was used to keep cost down so there was not a proliferation of facilities that the government would have to pay for. He further explained that this reason is gone because the federal government repealed its mandate. He also indicated the desire to reduce cost, however, is still in place and one way that provider's do this is by transferring care to out-patient services. He further indicated that while healthcare is complicated, CON is not because its reason for implementation is no longer in place and now, Georgia needs to remove barriers to accesses.

Meeting Two – August 28, 2023 (Columbus, Georgia)

Chairman Dolezal called the meeting to order and encouraged the Committee interact with the speakers and presenter and make this meeting more of a dialog for people to express ideas and questions regarding Georgia's CON program.

Mark Baker from Hughston Clinic explained that the Clinic is in four states, three of which are CON states and one that is not. His presentation focused on Georgia and his organization's experience going through the CON process in Georgia. Hughston applied for a CON in 2005 and was denied in 2008. They went through the first committee hearing with DCH and ended up appealing their determination to a Superior Court where they won. He explained that this win was appealed by a company out of Nashville Tennessee. He indicated that they were told that there was no need for such services in Muskogee County. He explained that the Clinic was still looking to expand, so they bought a hospital in Alabama. He also explained that they now own 100 percent of acute care hospitals in Alabama. He indicated that they took on average 600 cases to Alabama per month because Georgia's CON decided to say that they was no need. He further indicated that when they moved to Alabama, Georgia intensely opposed their movement in Alabama. He explained that since 2005 they have gotten what they originally asked for. They have also gained a procedural room; another surgery center; and have opened two more rooms in Muskogee County. He further explained that since 2005, there has been a net gain of 20 ORs in their service area, and they still have an access issues in their region.

Mr. Baker explained that their Clinic has served all 159 counties. He further explained that when looking at a few of Georgia's most impoverished counties, Telfair; Lanier; and Stewart County, the Clinic has (over an 18-month time period) treated 14 percent of their entire population. He indicated the argument that CCN stops the cherry picking of services is not a valid argument because the proliferation of ORs does not hurt the viability of healthcare in Georgia. Moreover, Muskogee County demonstrates this point because the addition of 20 ORs has resulted in both hospitals on average having an increase in their net patient service revenue over 100 percent. He further explained that if a hospital has the right leadership and vision they will succeed. He further explained that CON is supposed to control cost but as a big health organization they have access to cost information across Georgia. He provided an example of the cost for an ACL surgery in a local town in South Georgia cost $64,000 but at their ASC it would be $55,500. He also indicated that there is something wrong with these cost differences and clearly, CON laws are not controlling costs.

Dr. Shane Darrah from the Southeastern Cardiology Associates indicated that his purpose for speaking before the Committee was to request that the Committee adopt a recommendation to allow the specialty of cardiology to operate a single specialty surgery center as an exemption to CON laws. He explained that while the CON laws have changed over the years it has not done so in a meaningful way to recognize the evolution of cardiology. He further explained that at its beginning requiring every cardiac procedure to be performed in a hospital made sense. But these procedures have evolved since their inception and the law should as well. He provided an example of different cardiac procedures that may be required in a hospital versus those that do not necessarily need to be done at a hospital. He also explained that other states allow for such single specialty surgery centers such as Florida. He further explained that these states are doing these procedures and have been doing them safely for a long time.
Dr. Darrah explained that the cost has increased 20 percent in the past two years for businesses such as theirs. He indicated that having these procedures at ASCs cost significantly less money which will bring down their cost for providers and patients. As of 2020, CMS' coverage for PCI procedures has evolved to include all such procedures. He explained that CMS has paid for PCI procedures at ASCs in 28 states. Based on 2020 data, CMS estimated that moving only five percent (a small number of coordinate interventions nationwide) from a hospital outpatient setting to ASCs would reduce Medicare payments by $20,000,000 and cut co-pays cost of senior citizens out-of-pocket costs by $5,000,000. The reduction in cost will result in more access to such procedures for patients. Moreover, the pandemic showed that such procedures are vulnerable to possible significant limitation on availability during state-wide medical emergencies because they are performed in hospitals. Moreover, the pandemic showed the need for out-patient care options for such procedures in Georgia, if it were ever to face another public health emergency. He indicated that CON stands in the way of access to care for patients as it does not allow for such single specialty hospitals.

Commissioner Billy Mathis from the Lee County Board of Commissioners explained that he was going to present on their story in trying to get a CON for a small acute care hospital. He explained that his county only has one hospital. He explained that after a CON is received the facility spends the first couple of years fighting litigation. He indicated that in their case, right after their CON was granted, three different organizations filed oppositions against their CON. He explained that they spent the first couple of years fighting these suits and winning them. He provided their timeline of their first couple of years as follows: for the first two years they were in litigation; afterward the pandemic hit and no one was building; and then they had trouble with the bond market. However, when they finally got to everything sorted, they requested a six-month extension from DCH to let the bond market settle. DCH denied their extension claiming that their reason for an extension was not being sought based on a matter outside of their control and thus, they denied their request. Ultimately, the CON was withdrawn from them.

The Commissioner indicated CON laws hurt patients who cannot go outside their immediate area for care because they do not have any alternatives. He explained that CON laws stifle competition and breed monopolies, which in turn breed inefficiencies at the detriment of the patient. He further explained that for his county having two hospitals would be better because they used to have two hospitals in their county.

**Public Testimony**

There were three individuals who testified at this meeting. The individuals who testified all supported the complete repeal of Georgia’s CON laws. Dr. Joe Stubbins who is a certified internal medicine specialists used a large center by the name of Phoebe Putney Hospital as an example of an organization whose use of CON laws has negatively impacted access to quality care. Dr. Price Kohr from Albany, Georgia used similar examples as Dr. Stubbins. He explained if the Committee only suggests reforms for CON laws that the Committee recommend for the allowance of multi-specialty surgery centers. Dr. Sams explained that the problems with CONs are not regional but state wide. He similarly indicated that CONs encourage monopolies and stifle innovation. He further explained that competition encourages healthcare workers to be better and makes them busier.

**Meeting Three – October 16, 2023 (Savannah, Georgia)**

The Chairman opened the Committee meeting and explained that there were four speakers and the ability for public testimony.

DCH explained that it was asked to provide information on Medicaid Direct Payment Programs (DPPs). DCH indicated that there are important points regarding DPPs that the Department wants the Committee to remember, they are:
1. DPPs are beneficial to providers, the communities, and the patients. However, these benefits are not a solve-all solution to the financial challenges that hospitals face;
2. DPPs are highly variable in terms of their impact because the impact is dependent on a number of variable such as a hospital’s patient mix, the services they provide, and ultimately their size. The size of their payment is based on the mothers and babies that they serve who are on Medicaid; and
3. DPPs do not have a State General Revenue that supports these programs because of the way that they are designed through provider assessments and intergovernmental transfers by public hospitals.

DCH explained that there are five programs that work in concert to provide significant benefit to Georgia’s providers which are listed below.

<table>
<thead>
<tr>
<th>Programs</th>
<th>Physician DPP</th>
<th>Public Hospital DPP</th>
<th>Private Hospital DPP</th>
<th>GA-STRONG</th>
<th>GA-AIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>Increase supplemental payments to providers affiliated with a governmental teaching hospital at the Commercial equivalent</td>
<td>Increase supplemental payments to public hospitals at the Medicare equivalent.</td>
<td>Penalty for private hospitals</td>
<td>State requirement: 10-20% of funds dedicated to specific workforce activities to stabilize, develop, and diversify</td>
<td>10% of total payment at-risk depending on performance of at-risk metrics. Improve health outcomes by supporting preventive care, chronic disease management, maternal care, and health equity.</td>
</tr>
<tr>
<td>Metrics</td>
<td>• Diabetes Care—Hemoglobin A1c Control • Controlling High Blood Pressure • Screening for Depression and Follow-Up Plan Ages 13-17</td>
<td>Decrease hospitalizations and ER utilization rates • All Cause Readmissions • Total Inpatient Average Length of Stay</td>
<td>Mitigate Workforce shortages to • Improve maternal health outcomes (NTW Care and Births) • Increase access to primary &amp; specialty services • Reduce Days on ER Diversions due to staffing</td>
<td>At-Risk Metrics: • 10 evaluation measures • 4 reporting only measures</td>
<td>Program Evaluation: 5 measures</td>
</tr>
<tr>
<td>Number of Providers</td>
<td>14 Physician Practices Affiliated with Public Hospitals</td>
<td>56 Public Hospitals</td>
<td>43 Private Hospitals</td>
<td>22 Teaching Hospitals</td>
<td>1 Grady</td>
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<tr>
<td>Program Size (all funds)</td>
<td>~$210M</td>
<td>~$285M</td>
<td>~$170M</td>
<td>~$930M</td>
<td>~$400M</td>
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<td>Non-Federal Share</td>
<td>Intergovernmental Transfer (IGT)</td>
<td>Intergovernmental Transfer (IGT)</td>
<td>Provider Fee</td>
<td>Intergovernmental Transfer (IGT) &amp; Provider Fee</td>
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<td>Initial CMS Approval Date</td>
<td>Jan 14, 2021</td>
<td>Nov 17, 2021</td>
<td>Dec 15, 2022</td>
<td>Dec 14, 2022</td>
<td>July 23, 2022</td>
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</tbody>
</table>

DCH explained that the Disproportionate Share Hospital (DSH) reallocation allows for funding to flow to small rural hospitals. The Department explained each of the five programs are calculated differently and there have different variability in their impact. For example 53 hospitals benefit from $15,000 to $1,000,000; 40 hospitals benefit from $1,000,000 to $5,000,000; 19 hospitals benefit from $5,000,000 to $25,000,000; and 13 hospitals benefit from $25,000,000 to $100,000,000.

DCH provided the formula used to determine a provider’s Hospital Specific Limit (HSL). (See Formula below).

\[
\text{Medicaid Costs} - \text{Medicaid Payments (Including UPL, DPP, GME)} + \text{Uninsured Costs} - \text{(Uninsured Payments)} = \text{HSL}
\]

DCH indicated that the HSL is an annual limit which determines their DSH annually. DCH explained that this formula does not account for bad debt; indigent care; and charity care which are major problems for rural hospitals. DCH provided a chart that demonstrated the impact of the Rural Hospital Tax Credit; DPPs; and DSH versus a rural hospital’s bad debt; indigent care; and charity care. (See Chart below).
DCH explained how even with these programs providing aid to rural hospitals, this aid is not nearly enough to reach their needs. DCH indicated that this information was meant to provide the Committee working information while pointing out that the health industry cannot be simplified as a one option can fix it all type of solution.

Katie Chubb from the August Birthing Center provided her personal experience trying to get a CON which ultimately was not approved. She explained that her application was considered a success except for one part which was her ability to obtain a transfer agreement from the local hospital. She indicated that they did not want to partner with her organization. She further indicated that the hospital openly admitted that they would not sign such an agreement which she explained was then exercising a competitor’s veto against her organization. She explained that CON laws allow for such monopolistic control over the healthcare market. She also explained that the goal of their birth center was to take the burden off of OBs by taking easier cases and leaving them open for more complicated cases. She requested that the Committee recommend that CON requirements are removed for obstetrical facilities, so organizations may open birth centers to better serve women who feel underserved by their current communities.

GHA explained that they are returning to provide their recommendations for CON reforms. GHA provided a document containing their 14 recommendations for CON reform. (See Appendix A). Their presentation expanded on their recommendations.

Byron Colley from the Dentistry for Children Savannah provided information on his dentistry practice and the problems they have with regard to access to ORs. He explained that lack of access to ORs for surgical dentistry procedures hinders Georgians ability to access oral care. His recommendation is for CON laws to be amended to allow for multi-practice surgery centers. He explained that often when it comes down to whether hospital provides access to dental surgery or other surgeries, oral surgery generally loses. He further explained that this is likely to due to dentistry treatment not being valued for its importance. He also explained that he often has patients who have to wait months to receive surgery which can have detrimental results such as abscesses. He indicated that dental dentistry specific ASCs would provide an answer to these problems by providing equitable access at a lower cost. He further indicated that other states have recognized this need and have made changes to resolve this lack of access problem. He also testified in support of a complete repeal of Georgia’s CON laws.
Public Testimony

There were four individuals who testified at the meeting. Mr. Roland Ban from the Georgia Chapter of the American Foundation for Suicide Prevention testified in support of CON reform to allow for the establishment and operation of rural healthcare clusters consisting of freestanding emergency departments and empath units.

Mr. Herron who testified at the first meeting wanted to provide an update on their CON application. He explained that his CON has been denied. He also indicated that there is no physician-based cancer treatment for radiation therapy in Augusta and that they explained this in their hospital support letter to DCH. He further explained that DCH’s denial letter stated that there were four reasons they were denied. Two of which Mr. Herron wanted the Committee to hear which provide that the applicant presented no evidence of excessive or atypical costs or charges from existing providers and the applicant did not demonstrate that patients are currently unable to access radiation therapy because of cost. He indicated that in 2006, the state passed legislation to improved access to quality care for all Georgians. He explained this denial contradicts that objective.

Ms. Cavanagh, who also testified at the first meeting, reiterated similar points to her first testimony. She further explained that while claims have been made that CON laws cannot address Medicaid reimbursements and costs; this is not accurate as CON laws impact costs. She explained that keeping costs at hospital prices negatively impacts access to care because people are choosing not to get care or are going into medical debt to receive such care. She indicated that the Pennsylvania Hospital Association has since its repeal of its CON laws, come out in opposition to the re-enactment of such laws. She explained that repealing the CON laws would be the best option to simplify the CON process, but if Georgia wants to follow possible reform legislation, states like Indiana; Louisiana; Michigan; Nebraska; New York; and New Jersey that do not allow competitors to intervene in the CON process would provide good sample legislation.

Gary Galloway provided a personal story of his cancer journey and his personal experience using health facilities and centers during this journey. He explained that throughout his journey he preferred being able to receive all of his care in one location.

Meeting Four – November 28, 2023 (State Capitol)

The final meeting of the Study Committee was held on November 28, 2023 at the State Capitol in CAP 450. Senator Ben Watson indicated that a letter was sent to the Committee from Dr. Mark Beaty for the Committee and expressed a desire for it to be made part of the official record. (See Appendix E). The Study Committee discussed and voted upon this Report and Recommendations. There were nine members present: Chairman Greg Dolezal of the 27th; Senator Ed Harbison of the 15th; Senator Kay Kirkpatrick of the 32nd; Senator Ben Watson of the 1st; Mark Baker; Matt Hasbrouck; Christine Macwenn; Jesse Wealthington; and Stephen Wertheim. The Committee adopted this report and its recommendations before adjourning.
FINDINGS AND RECOMMENDATIONS

Based upon the testimony, research presented, and information received, the Study Committee on Certificate of Need Reform has found that the problem which Georgia’s CON laws were intended to combat no longer exists. The CON process is used by market incumbents to prevent competition and deny patients the benefits therefrom. The CON laws prevent the citizens of Georgia from benefiting from advances in health care delivery, especially in rural communities.

In accordance with these findings, the Study Committee recommends that Georgia’s CON laws should be repealed in their entirety (9 committee members out of 12 recommended a full repeal prior to this final meeting). Repealing Georgia’s CON requirements would eliminate the anti-competitive effects of, and abusive practices under, these laws.

Most recently, South Carolina repealed its CON law. The Study Committee members and the Senate will utilize South Carolina’s model for potential legislation for the 2024 session.

If the General Assembly is unable to enact a full repeal in the upcoming session, the Committee recommends that the Georgia General Assembly pursue the following changes to the current CON laws:

1. Repeal CON requirements for Obstetrics Services, Neonatal Intensive Care, Birth Centers and all services related to Maternal and Neonatal care across the state of Georgia (Chairman recommendation/Georgia Hospital Association (GHA) recommendation for hospital based Obstetric Services);
2. Sunset requirements for hospital-based CON on January 1, 2025 (Committee member recommendation);
3. Reform CON laws to eliminate CON review for new and expanded inpatient psychiatric services and beds that serve Medicaid patients and the uninsured (Committee member recommendation);
4. Repeal all cost expenditure triggers for CON (Multiple committee members recommendation/Georgia Hospital Association (GHA) recommendation);
5. All medical and surgery specialties should be considered a single specialty, including cardiology and general surgery (Multiple committee members recommendation);
6. Multi-specialty centers should be allowed, particularly in rural areas (Multiple committee members recommendation);
7. Remove CON for hospital bed expansion (Committee member recommendation);
8. Revise freestanding emergency department requirements such that they must be within 35 miles of an affiliated hospital, and remove CON requirement (Committee member recommendation); and
9. Remove CON for research centers (Committee member recommendation).
Respectfully Submitted,

FINAL REPORT OF THE SENATE CERTIFICATE OF NEED REFORM STUDY COMMITTEE (SR 279)

Senator Greg Dolezal – Committee Chairman
District 27
APPENDIX A
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Category</th>
<th>Is a Statutory Change Necessary?</th>
<th>Which Providers or Services are Impacted?</th>
<th>Is There a Budget Impact?</th>
<th>How Does It Impact the Department of Community Health?</th>
<th>Concurrent Policy Changes?</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>As policymakers study the Certificate of Need program, GHA recommends any modifications be considered in the context of the state’s entire health care system, including affordability access to all types of care for all Georgia’s residents; efficient use of the state’s finite health care resources; and the varied, comprehensive needs of communities and patients across the state. Major modifications to the CON program should be enacted only after other changes to stabilize the state’s health care safety net are in place.</td>
<td>General</td>
<td>N/A</td>
<td>All providers and services.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>GHA recommends the state be statutorily required to enforce the CON law and to update the State Health Plans at least every five years. GHA further recommends the state ensure the Department of Community Health has the necessary resources to implement and enforce the CON law as written by the legislature.</td>
<td>Regulatory Process</td>
<td>Yes</td>
<td>All providers and services.</td>
<td>Yes</td>
<td>Requires DOI to create Technical Advisory Committees for each of the State-Specific Health Plans. May require DOI to increase the number of CON compliance investigations.</td>
<td>No</td>
<td>Updates to the service-specific State Health Plans, which include the need methodologies, will help address the concerns of some stakeholders about the ability to obtain a CON under the current regulations. Changes to the need methodologies DO NOT require any changes to the CON statutes.</td>
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<td>GHA recommends eliminating the capital expenditure threshold for construction-only projects while maintaining CON requirements for new, expanded, or relocated services consistent with our other recommendations. GHA further recommends maintaining a meaningful review of projects, with the opportunity for stakeholder input regarding community impact, prior to the issuance of a Letter of Determination that a CON is not required.</td>
<td>Capital Expenditures</td>
<td>Yes</td>
<td>All providers and services.</td>
<td>Yes</td>
<td>Decreases the number of CON applications.</td>
<td>No</td>
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<td>GHA recommends eliminating the equipment expenditure threshold for hospitals and physicians and eliminating the replacement equipment expenditure threshold for freestanding imaging centers that were grandfathered prior to the 2008 legislative changes. GHA further recommends maintaining a meaningful review of equipment purchases, with the opportunity for stakeholder input regarding community impact, prior to the issuance of a Letter of Determination that a CON is not required.</td>
<td>Equipment</td>
<td>Yes</td>
<td>Acute Care Hospitals, Psychiatric Hospitals, Rehabilitation Hospitals, Long-Term Acute Care Hospitals, Physicians, Freestanding Imaging Centers in operation prior to 2008</td>
<td>Yes</td>
<td>Decreases the number of CON applications.</td>
<td>No</td>
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<tr>
<td>GHA recommends no changes to the existing CON requirements related to single-specialty or multi-specialty ambulatory surgery centers. The recommendation for the department to update the service-specific CON regulations, including need methodologies, would address concerns regarding the ability to obtain a CON for new ambulatory surgery services.</td>
<td>Ambulatory Surgery Centers</td>
<td>No</td>
<td>Acute Care Hospitals, Ambulatory Surgery Centers</td>
<td>Yes</td>
<td>Requires DOI to create Technical Advisory Committees for the Ambulatory Surgery Component Plans and revisit the CON regulations for ACSs.</td>
<td>No</td>
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<td>Recommendation</td>
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<td>GHA recommends the state provide additional resources to stabilize the behavioral health safety net prior to adopting any OCM changes related to psychiatric or substance abuse services, to help stabilize the behavioral health safety net. GHA recommends that:</td>
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<tr>
<td>a. The Department of Community Health:</td>
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<td>i. provide all Medicaid beneficiaries equitable access to services in institutes for mental disease in both the in-home and managed care Medicaid programs;</td>
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<td>ii. enhance Medicaid payments for inpatient psychiatric services to fully cover the cost of care; and</td>
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<td>iii. create a new Medicaid domiciliary payment program for private psychiatric hospitals.</td>
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<td>b. The Department of Behavioral Health and Developmental Disabilities:</td>
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<td>i. create sufficient inpatient bed capacity to meet the needs of all public/insured and uninsured behavioral health patients;</td>
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<td>ii. enhance payments for state contracted inpatient psychiatric beds to fully cover the cost of care for patients; and</td>
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<td>iii. establish a direct funding mechanism to reimburse hospitals for the cost of boarding behavioral patients in the emergency department and transporting patients to an emergency住院, evaluation or treatment facility when a bed becomes available.</td>
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Once these recommendations to stabilize the behavioral health safety net have been implemented, GHA recommends enacting new or expanded inpatient psychiatric and substance abuse beds from CON review if those new beds are included in the state’s inventory of beds available to treat uninsured/Behavioral health patients in crisis. GHA further recommends that the state budget reflect the additional resources necessary to reduce the boarding of behavioral health patients in hospital emergency departments in accordance with the recommendations of the Behavioral Health Reform and Innovation Commission.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>GHA recommends the state implement policies to increase access to pre- and postnatal care in Georgia’s maternity care deserts, including:</td>
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<tr>
<td>a. increased financial support for obstetricians, certified nurse midwives and family medicine practitioners;</td>
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<tr>
<td>b. expanded access to telehealth services;</td>
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<tr>
<td>c. optimize scope of practice regulations to maximize access to safe and affordable care; and</td>
</tr>
<tr>
<td>d. tort reform measures that ensure providers feel safe to practice in varied settings.</td>
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</tbody>
</table>

Once these recommendations to increase access to perinatal providers have been implemented, GHA recommends enacting new or expanded hospital basic obstetric services from CON review if the hospital licensure requirements are revised to include the necessary quality and patient safety standards, including volume and adverse impact requirements.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>GHA recommends increasing the time a closed facility or service line can operate without a new Certificate of Need from 12 months to 24 months unless the closure was the result of revocation of or other adverse action regarding the facility’s license.</td>
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<thead>
<tr>
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<tbody>
<tr>
<td>GHA recommends creating a new Certificate of Need exemption to allow health systems to transfer existing beds or services from one hospital or campus to another existing hospital with the same service within the same system and within a 10-mile radius of the original location.</td>
</tr>
</tbody>
</table>

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### Table

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<tr>
<td>GHA recommends the state provide additional resources to stabilize the behavioral health safety net prior to adopting any OCM changes related to psychiatric or substance abuse services, to help stabilize the behavioral health safety net. GHA recommends that:</td>
<td>Behavioral Health</td>
<td>Yes</td>
<td>Acute Care Hospitals, Psychiatric Hospitals, Crisis Stabilization Units, Behavioral Health Crisis Centers</td>
<td>Yes</td>
<td>Requires OCM to create a Technical Advisory Committee for the Inpatient Psychiatric and Substance Abuse Component Plan and revise the corresponding CON regulations.</td>
<td>Yes</td>
<td>Changes to the CON requirements for psychiatric and substance abuse beds will not improve the ongoing crisis of behavioral health patients being housed for extended periods of time in hospital emergency departments.</td>
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<tr>
<td>GHA recommends the state implement policies to increase access to pre- and postnatal care in Georgia’s maternity care deserts, including:</td>
<td>Obstetric Services</td>
<td>Yes</td>
<td>Hospitals, Physicians, Nurse Midwives</td>
<td>Yes</td>
<td>Requires OCM to create a Technical Advisory Committee for the Perinatal Health Services Component Plan and revise the CON regulations for Perinatal Services.</td>
<td>Requires OCM to revise the Hospital Licensure Regulations.</td>
<td>Requires review of the Department of Public Health telehealth maternity care pilot program and expand as appropriate.</td>
</tr>
<tr>
<td>GHA recommends increasing the time a closed facility or service line can operate without a new Certificate of Need from 12 months to 24 months unless the closure was the result of revocation of or other adverse action regarding the facility’s license.</td>
<td>Closures</td>
<td>Yes</td>
<td>All providers and services</td>
<td>No</td>
<td></td>
<td></td>
<td>Decreases the number of CON applications.</td>
</tr>
<tr>
<td>GHA recommends creating a new Certificate of Need exemption to allow health systems to transfer existing beds or services from one hospital or campus to another existing hospital with the same service within the same system and within a 10-mile radius of the original location.</td>
<td>Inpatient Services</td>
<td>Yes</td>
<td>Acute Care Hospitals, Psychiatric Hospitals, Rehabilitation Hospitals, Long-Term Acute Care Hospitals, Nursing Homes</td>
<td>No</td>
<td></td>
<td></td>
<td>Decreases the number of CON applications.</td>
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<tr>
<td>Recommendation</td>
<td>Category</td>
<td>In a Statutory Change Necessary?</td>
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<td>GHAs recommends expanding the Certificate of Need exemption to allow existing hospitals to increase bed capacity by the greater of 10 beds or 20% every three years if the hospital has maintained at least a 95% occupancy rate for the previous 12 months (occupancy rate is calculated based on the total number of annual patient days as defined by the American Hospital Association) divided by the number of licensed beds multiplied by 355).</td>
<td>Hospital Services</td>
<td>Yes</td>
<td>Acute Care Hospitals Psychiatric Hospitals Rehabilitation Hospitals Long-Term Acute Care Hospitals</td>
<td>No</td>
<td>Decreases the number of CON applications.</td>
<td>No</td>
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<tr>
<td>GHAs recommends expanding the Certificate of Need exemption to allow health care facilities in urban counties to operate within 5 miles of the existing facility.</td>
<td>Healthcare Facility Services</td>
<td>Yes</td>
<td>Acute Care Hospitals Psychiatric Hospitals Rehabilitation Hospitals Long-Term Acute Care Hospitals Ambulatory Surgery Centers ER/Billing Centers Freestanding Emergency Departments Freestanding Imaging Centers</td>
<td>No</td>
<td>Decreases the number of CON applications.</td>
<td>No</td>
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<tr>
<td>GHAs recommends further limiting the stakeholders eligible to oppose a CON application to those providers whose service area substantially overlaps the applicant's proposed service area, meaning that at least 80% of the opposing provider's annual new patient admissions or new encounters reside in a zip code included in the applicant's primary or secondary service area (annual patient admissions or encounters are calculated using an average from the previous three calendar years). GHAs further recommends that the limits on which stakeholders are eligible to oppose a request for a letter of determination mirror those for CON applications and that the prohibition on opposition from out-of-state entities be codified.</td>
<td>Application Process</td>
<td>Yes</td>
<td>All providers and services.</td>
<td>No</td>
<td>Decreases the number of opponents to CON applications and requests for letters of determination and likely decreases the number of appeals filed by opponents.</td>
<td>No</td>
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<tr>
<td>GHAs recommends the Certificate of Need Appeal Panel be eliminated and that appeal hearings be conducted by the Office of State Administrative Hearings (OSA). GHAs further recommends that the Commissioner have 30 days to complete their review of an OSAH decision.</td>
<td>Appeals Process</td>
<td>Yes</td>
<td>All providers and services.</td>
<td>Yes</td>
<td>Improves efficiency of the administrative hearing level of appeal and requires OCH to issue a decision from the Commissioner in a shorter timeframe. Removes 80% of OCH’s administrative responsibilities for the Certificate of Need Appeal Panel. May require the Office of State Administrative Hearings to increase resources to handle the increased workload.</td>
<td>No</td>
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<tr>
<td>GHAs recommends a complete update of Chapter 6 of Title 81 to streamline the statutes and make the CON law easier to understand.</td>
<td>Statutory Organization</td>
<td>Yes</td>
<td>All providers and services.</td>
<td>No</td>
<td>Makes the CON law easier to interpret and may lead to a decrease in opposition to CON applications and requests for Letters of Determination.</td>
<td>No</td>
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APPENDIX B
October 14, 2023

Mark M Beaty, MD  
Beaty Facial Plastic Surgery  
1100 Peachtree St NE, Suite 850  
Atlanta, GA 30309  

770-753-0053  mmbeaty60@gmail.com

Re: Letter to the Senate Committee on Certificate of Need Reform

To Members of the Committee:

My name is Mark M Beaty, MD and I am a physician at Beaty Facial Plastic Surgery in midtown Atlanta. I am a 25-year resident of Atlanta and have practiced here in both midtown and northern suburbs since completing residency training. My practice provides cosmetic and reconstructive care to patients needing both surgical and non-surgical procedures. I have also served in leadership capacities within the American Academy of Facial Plastic Surgery, the world’s largest organization representing facial plastic surgeons, for many years.

I know from firsthand experience that certificate of need laws artificially limit the choices available to patients for obtaining operative care. Unfortunately, this leads to unnecessary delay of needed and desired surgical procedures which may negatively impact health and wellbeing. Especially now, as a large cohort of Baby Boomers enter their later years and likely require more care, restricting access to facilities is quite the opposite from what is needed to serve the best interest of patients. In addition to extending operative wait times, costs are driven up due to scarcity of available facilities, further damaging patients, and our health care system, economically. In states without CON laws it is easier for qualified practices to open operative centers, fulfill local needs and mitigate excessive patient waiting times. It also allows independent practices to operate more efficiently, contributing to reduced costs.

Without certificate of need laws, I and other physicians like me would be able to open high quality and cost-efficient ambulatory surgery centers to take care of the coming higher volume of patients needing surgical procedures. With a CON requirement in place, physicians become frustrated or simply give up the idea of opening a surgery center as they realize that a CON is impossible to obtain for an independent practice.

In addition to being cost-efficient and flexible, independent centers can and do offer an array of pro-bono services to needy community members which is often not possible within a larger hospital-based system. An example would be a program managed by my academy, the AAFPRS, called Face to Face which provides pro-bono services to victims of domestic abuse. I could contribute to a greater degree if it were possible to open and manage an independent surgery center.
I am also aware of the extensive academic literature that finds certificate of need laws increase the costs of healthcare, decrease access to healthcare, and decrease the quality of available services. In my experience, those findings are true in Georgia. Repealing certificate of need would enhance access to high-quality, cost-efficient care throughout the state and particularly may encourage improving access to care in rural or underserved areas.

Thank you for considering my testimony. Please let me know if you have any questions.

Sincerely,

Mark M Beaty, MD  
CEO/Medical Director, Beaty FPS  
mmbeaty60@gmail.com  
404-374-5513