

**MINUTES**  
**STATE COMMISSION ON THE EFFICACY OF CON**  
Sanders Fireplace Room at the Capitol Education Center  
180 Central Avenue, Atlanta, Georgia

October 24, 2005; 1:00 pm

**Daniel W. Rahn, MD, Chair, Presiding**

**MEMBERS PRESENT**

Jeff Anderson  
Senator Don Balfour  
Tim Burgess  
Melvin Deese, MD  
Donna Johnson, Esq.  
Robert Lipson, MD  
Dan Maddock  
Ronnie Rollins  
Joseph "Rusty" Ross, Esq.  
Representative Austin Scott

**MEMBERS ABSENT**

**GUESTS PRESENT**

Amy Hughes, Memorial Health  
Bill Boling, Powell Goldstein  
Bill Lewis, Lewis Consulting  
Billy Barron, Georgia Healthcare Association  
Bobby Franklin, House District 43  
Bryan Fiveash, Fiveash-Stanley, Inc.  
Bryan Ginn, Medical College of Georgia  
Buck Baker, MD, Atlanta Regional Health Forum  
C. Hayslett, Georgia Alliance of Community Hosp.  
Chris Smith, MD, Georgia Society of General Surgeons  
Christi Carmichael, Emory  
Cynthia George, Phoebe Putney Memorial Hosp.  
Dan Williams, DeKalb Medical Center  
Dave Williams, Albany Herald  
David Henderson, University Hospital  
Deb Bailey, Northeast Georgia Health System  
Deborah Winegard, Medical Association of Georgia  
Denming Robinson, Georgia Link  
Dodie Putman, HCA  
Don Fears, DeKalb Medical Center

**STAFF PRESENT**

Kim Anderson  
Doris Berry  
Neal Childers, JD  
Charemon Grant, JD  
Richard Greene, JD  
Matthew Jarrard, MPA  
Julie Kerlin  
Victoria Kizito, JD  
Wendella McGaha  
Robert Rozier, JD  
Rhathelia Stroud, JD  
Stephanie Taylor, MPS

Doug Holbrook, St. Joseph's Hospital of Atlanta  
Ellie Joseph, EAJPC  
Gary Horlacher, A & B  
Harold L. Kent, MD, Georgia Coast Surgical  
Helen Smith, RN, Georgia Society of General Surgeons  
Holly Snow, Piedmont  
Jane Langley, Tenet  
Jeffrey Baxter, Nelson Mullins  
Jerry Usry, Phoebe Putney Health System  
Jill Fike, Senate Research Office  
Jimmy Lewis, HomeTown Health  
John Bagnato, MD, Albany Surgical  
Joy Davis White, Rockdale Medical Center  
Judy Lilly, Tenet  
Julie Windom, Georgia Alliance of Community Hospitals  
Kevin Rowley, St. Francis Hospital  
Kim Menefee, WellStar Health System  
LaMar McGennis, Georgia Chapter, American College of Surgeons  
Larry Lloyd, Innovative Consultants  
Larry Myers  
Leah Watkins, Powell Goldstein  
Leo Reichert, Parker Hudson  
Linda Womack, Emory  
Lisa R. Norris, The Strategy House  
Lori Jenkins, Phoebe Putney Memorial Hospital  
Marvin Noles, Medical Center of Central Georgia  
Monty Veazey, Georgia Alliance of Community Hospitals  
Rick Ivy, Archbold Medical Center  
Ronea Buckley, HomeTown Health  
Roy Robinson, HCA  
Shirley Silva, Alliance Imaging  
Stuart Hackworth, United Surgical Partners  
Tarry Hodges, St. Joe/Candler Health System  
Temple Sellers, Georgia Hospital Association  
T. F. Dodson, Ga. Chapter, American College of Surgeons  
Tom Gore, MD  
Tommy Chambliss, Georgia Alliance of Community Hospitals  
Travis Lindsey, Resurgens

## **WELCOME**

Dr. Rahn called the meeting to order at 1:05 pm. He welcomed Representative Sharon Cooper and Dr. William "Buck" Baker, a member of the Health Strategies Council and Executive Director, Atlanta Regional Healthcare Forum. He said that Dr. Baker served as Chair, of the Ambulatory Surgical Services Technical Advisory Committee (TAC).

## **APPROVAL OF MINUTES OF SEPTEMBER 13, 2005**

Dr. Rahn called for a motion to approve the minutes of the September 13<sup>th</sup> meeting. He noted that there were some problems with the ability to hear large segments of the comments that were made during the discussion segment of the Commission's September meeting. He said that this was noted in the meeting minutes. He expressed concern about this and asked Commission members to use the microphones at all times during committee discussions and during the question and answer period.

Dr. Balfour inquired as to whether it would be possible to have a stenographer for Commission meetings. Department staff indicated that this would be quite expensive, approximately \$1,000.00 per meeting.

Richard Greene indicated that the Capitol Education Center only has capacity for four microphones however, he said that the facility's audiovisual staff added two additional microphones in the room earlier today. He said that it is his understanding that staff from the Capitol Education Center will be meeting with outside consultants to discuss the facility's audiovisual needs.

Dr. Rahn indicated that if Department staff continues to have problems with the quality of the audio-recordings, then the Commission would have to reconsider the services of a stenographer. Following this discussion, he asked for a motion to approve the minutes, as presented. A motion to accept the minutes was made by Rusty Ross, seconded by Dr. Lipson. The minutes were approved as submitted.

## **OVERVIEW OF MATERIALS IN MEMBER PACKETS**

Dr. Rahn brought members attention to materials that were provided in today's meeting packets. He said that these materials were sent to him directly or were forwarded to the Department for distribution to the Commission. These documents appear as Appendix A and are listed below:

- Correspondence dated September 7, 2005, received from Georgia Alliance of Community Hospitals, authored by Kurt Stuenkel.
- Correspondence dated September 27, 2005, received from Georgia Hospital Association, authored by Joseph Parker, President. He noted that in addition to the correspondence there was also a document that provided a list of suggested topics that GHA would like the Commission to carefully consider during its deliberations.
- An article, entitled: *Committee on Health Care, The Florida Senate, Interim Project Report 2006-138, September 2005*, provided by Fred Watson, President, Georgia Healthcare Association.

Dr. Rahn indicated that at the last Commission meeting, he agreed to provide a list of current Health Strategies Council members. He indicated that a current membership list is also included in the meeting materials and appears as Appendix B.

## **DISCUSSION OF MEETING FORMAT**

Dr. Rahn indicated that the plan for today's meeting is to have four presentations, two of which would be presented by the Department in an effort to provide an overview of the current regulatory environment. These presentations will be conducted by:

- Robert Rozier, JD, CON Staff Counsel, Office of General Counsel. His presentation would focus on Letters of Non-Reviewability.
- Neal Childers, JD, General Counsel, Department of Community Health. He would review the recommendations from the Office of Attorney General regarding the draft proposed ambulatory surgery rules and would review Mandamus Actions against the Department.

Two other presentations would discuss General Surgery and its categorization as a multi- specialty service in Georgia. These presentations will be conducted by:

- Thomas Gadacz, M.D., Governor, Georgia Chapter, American College of Surgeons, and
- Chris Smith, M.D., President, Georgia Chapter, Society of General Surgeons.

## **PRESENTATION BY GEORGIA DEPARTMENT OF COMMUNITY HEALTH**

### Letters of Non-Reviewability:

Dr. Rahn called on Robert Rozier to provide an overview of the process of securing a Letter of Non-Reviewability (LNR). Mr. Rozier indicated that there is a similar process to obtain an LNR for medical equipment but he noted that today's discussion would focus solely on the LNR process for ambulatory surgery centers. Mr. Rozier's presentation provided a history of the legislation surrounding ambulatory surgical centers and the statutory requirements and offered some historical data surrounding the number of applications that were received by the Department from 1996 to present. Also, he provided information regarding the specific differences between LNRs and CONs. A copy of Mr. Rozier's presentation is attached as Appendix C.

### Summary of Recommendations from Office of Attorney General & Mandamus Actions

Dr. Rahn called on Mr. Childers to offer his presentation to the Commission. He said that in member packets are copies of the draft proposed Ambulatory Surgery Center Rules (See Appendix D). He said that these draft proposed rules were reviewed by the Health Strategies Council at the November 2003 meeting. The draft proposed rules were not voted on by the Health Strategies Council but were tabled for discussion by the Council, pending review by the Office of the Attorney General (OAG). He indicated that this legal review process by the OAG is not unusual but is in keeping with the Department's planning process whenever the adoption of proposed rules is being considered. The Department asked the OAG to review the proposed draft rules as it relates to their legal efficiency before they are officially proposed by the Health Strategies Council. He noted that the OAG made five specific recommendations in order for the rules to comply with Georgia law. He reviewed the recommendations from the OAG which are attached as Appendix E.

Mr. Childers reviewed the definition of a mandamus action, noting that it is a process that requires a government official to perform some legal duty that is required to be performed by law. He said that The Georgia Supreme Court has ruled that this is the mechanism that an aggrieved party could use if they believe that the Department is not properly enforcing a CON rule. He said that a written mandamus is filed against the Commissioner of the Department of Community Health. He said that any time someone believes, for example, that the Department has granted a LNR that should not have been granted, their only remedy is to bring one of these actions. There have been a total of 10 such actions, filed over the last two years. Mr. Childers reviewed all of these Mandamus Actions (See Appendix F). He noted that approximately 100 hours, on average, is required for the OAG to address each

mandamus action. He noted that the applicant who has obtained the LNR also has to pay attorney fees to represent his interests in keeping the LNR. He said that Mandamus Actions are usually issued after the fact and this can create an issue where someone has obtained an LNR and has expended a significant amount of money only to have a judge say that it should never have been issued. Mr. Childers said that this is not fair neither is it good public policy. He indicated that the Department works very hard to ensure that good sound decisions are made.

## QUESTIONS AND ANSWERS - DIRECTED TO DEPARTMENT STAFF

**Dr. Deese**-Please explain what voluntarily withdrawn and resolved favorably to the Department means.

**Neal Childers:** It means that the challenger who filed the lawsuit dropped it.

**Donna Johnson:** Is it accurate to say that the Supreme Court has indicated that it is not proper/or inappropriate for the Alliance to bring these actions because it was a discretionary act of the Department?

**Neal Childers:** Yes, that is correct on two bases. One, the interpretation of the statute or the regulation, is a matter of discretion of the agency unless it is unreasonable or how the determination is made is also discretionary.

**Donna Johnson:** I would argue that it is not that this action is not an inappropriate action to take against the Department but never the less, it took place and would likely continue.

**Senator Balfour:** As we are going through this process, I would argue to the extent that there is a question regarding whether it is in statute or in regulation. We need to remember that if it is in regulation, regulators change, attorney generals change, administrations change, and as we rewrite statute we need to put it very clearly in the law what we think we mean so that there isn't a misinterpretation. In order to change something you have to change the law. Whether it's this specific situation we are talking about or some other issue. If we are questioning whether regulators are doing exactly what the law says. I would argue that we should consider putting things in the law-- that is a more certain way of understanding it so that when we come out with our recommendations 18 months from now that we have very clearly stated what we think ought to happen and let the legislative process set it in statute.

**Dr. Rahn:** Please clarify the issue of general surgery, for administrative process, not being classified as a single specialty service.

**Robert Rozier:** In 1987, the Department created rules to exempt limited purpose, physician-owned ambulatory surgery centers from meeting the numerical need and adverse impact standards for CON review. It was in that 1987 regulation that the Department defined limited purpose to mean that general surgery practice could not qualify for a limited purpose practice. Since 1987, single-specialty has been defined not to include general surgery.

**Dr. Deese:** I have a lot of questions and comments but in consideration of our guests and speakers, I would like to delay my questions, but reserve the right to bring that up later.

**Representative Scott:** You said that regarding general surgery, that was established by rule. Why could it not be changed by rule?

**Neal Childers:** That rule was enacted in 1987 and what the Court of Appeals has held is that when the General Assembly came later and modified the former provisions of the Limited Purpose CON to allow exemption from CON for single-specialty physician-owned office practices, that the General Assembly did that with knowledge of the preexisting rule and must have intended to preserve that definition or else it would have enacted language in the 1991 legislation that would have modified it and therefore has said, in effect, that the General Assembly ratified this definition in 1991. Only the General Assembly can change that.

**Dr. Deese:** I think what I have heard is that the Court assumed or made a determination that the Legislature intended to leave general surgery as it was because the Legislature did not act to change it. The Legislature never said that this is what we intend, they simply did not act to change it.

**Neal Childers:** That is correct.

**Robert Rozier:** Since there was a regulatory exemption in 1987 that excluded those types of ambulatory surgery centers from review for need and adverse impact, what the Court seem to suggest is that when the Legislature

created the exemption they were just trying put it into a statute what the regulatory exemption was and that's how the regulatory exemption defined what Limited Purpose or single specialty was.

**Dr. Deese:** Thank you. I suppose that the reason we are hearing this testimony today is to figure out whether this type of exclusion of general surgery is appropriate for this day and time.

**Dr. Rahn:** Among many things, yes.

**Jeff Anderson:** The three year capital threshold of \$1.M is now \$1.5M dollars? What happens after the three years? What can happen with those applications?

**Neal Childers:** As long as the practice does not change from a single-specialty to a multi-specialty practice and doesn't acquire diagnostic or rehabilitation medical equipment in a single purchase in excess of that threshold (of approximately \$800,000), as an LNR practice, they are exempt from CON review. Unless they in some way change their practice, they are exempt from CON rules.

**Dr. Deese:** I was a little concerned about the definition and interpretation of this rule. According to the information that I have heard today, the capital expenditure goes up by the increase in the cost of construction, on an annual basis, on the construction cost-price index (CPI). Where in that increased cost is the increased cost of technology, or medical equipment—meaning whatever DHR might now say is required in order to provide an adequate quality of care? It might have nothing to do with construction costs. The cost of x-ray and other diagnostic equipment is much more than what it was five years ago. Yet that is not given any consideration in your annualized collections, just construction costs.

**Neal Childers:** That is a specific requirement of the statute.

**Dr. Deese:** That is why we are here today because some of us feel those are too narrowly focused and simply do not address the issues of patient care and access today. To simply limit this financial cap to increased costs of construction is turning a blind eye and ear to the cost of increasing technology. This seems so obviously biased.

**Commissioner Burgess:** I understood what Neal was just saying. We are using that specific definition in terms of expanding the cost of each year. That is specifically what the statute requires. It goes back to the basic question, do we want to give the Department the authority to make broad interpretations and use input, conversations, public comments and other forums to allow the Department to make those interpretations or do we want the statute to be specifically defined and take that discretion out of the hands of the Department. Even if we agree with your assessment, the Department cannot change that until or unless the statute is changed.

**Dr. Deese:** I agree with what you said. The underlying question is, can you actually write CON laws that address all of these concerns adequate for patient access and delivery of healthcare or should we simply abandon the CON process entirely? If you don't have a statute, you won't have to define it. Secondly, if you put this in the discretionary mode that it's a regulation, regulators change. They can be influenced by other ways and methods and they have different biases. It has been brought to my attention that in the process of evaluating the cost analysis of some of these applications, some of the people in our society said that the cost requirements were beyond the scope of Generally Accepted Accounting Principles--capitalizing the cost of leases, etc., therefore; if you can't adequately define these things, we should do away with them. Let's not reinvent the wheel. Other states don't have these specific guidelines and they are functioning fine. These guidelines create opportunities for interpretation. They may be in your favor this time but not the next time but in the meanwhile, patients are losing the battle with increased costs and access.

## STAKEHOLDER PRESENTATIONS

Dr. Rahn called on invited speakers to offer their presentations before the Commission. The Commission welcomed Thomas Gadacz, MD, American College of Surgeons and Chris Smith, MD, President of Society of General Surgeons, Georgia Chapter. Drs. Gadacz and Smith thanked the Commission for the opportunity to provide testimony. Dr. Gadacz's presentation is attached as Appendix G. Dr. Smith's presentation is attached as Appendix H.

## STAKEHOLDER QUESTION & ANSWER SESSION

**Dr. Rahn:** Is Georgia the only state that puts General Surgery as a multi-specialty service?

**Drs. Gadacz & Smith:** Yes, Georgia is the only state.

**Dr. Gadacz:** Individuals who supported the abolition of CON from the fed government and that was done about 4 years or so after the CON went into fed regulations. The feds saw what happened and Dr. Roland actually illustrated a case from his own district where it was detrimental to his patients. Some of the examples of why CON was struck down, from the federal level, were actually from this state. I suspect that federal government and several states have recognized that if you support managed competition, a CON program will make that program very difficult to enact. You are not going to see the cost driven down in medical health if you try to maintain both types of programs.

**Dan Maddock:** You hit the nail on the head. The success of ambulatory surgery centers, as a group, depends on patient selection--patient selection by acuity or financial classification. No one is out here in rural Georgia competing for indigent care. The marketplace does not address that particular issue, at least not in my community. This is an area that the Commission has to look at overall--patient access for all Georgians regardless of payment or medical acuity.

**Dr. Rahn:** The charge to the Commission is clear. It's broad, but with regard to CON, it is to evaluate the efficacy of the current CON regulations in Georgia. We need to consider whether it contributes to the public goals of assuring access to adequate healthcare services for the population. What you are raising Mr. Maddock is very much the kind of issue that we need to get to in the next few months which is the national experience with regard to the contribution of CON programs to the achievement of those goals. There is information that is available and there are health economists both in private sector and some who are academically-based that have examined those kinds of questions. We need to call on them. To look at both the short and intermediate term and to consider the impact of the withdrawal of CON in those states that had CON and then withdrew it.

**Dan Maddock-** We are looking at maybe a single focus rather than the big picture. I realize that we all have special interest around the state. I hope that we can look at the big picture then maybe we can look at the various small facets of the healthcare delivery system.

**Representative Scott:** (directed to Dr. Smith)- We continue to hear from hospitals and associated people that if physicians are granted the right to build ambulatory surgery centers that healthcare is going to dry up and go away. How many surgeons are in your practice?

**Dr. Smith:** We have six (6).

**Representative Scott:** How many of the 6 take ER calls?

**Dr. Smith:** We all do. Regarding ER calls, there is requirement that limits the age of physicians to respond to ER calls at age 55. We have 2 surgeons who are over the age of 55. You are no longer required to take ER calls after age 55. This is a requirement of the "knife and gun" Club that your colleague discussed. General surgeons are an aging population. Georgia is having problems with recruiting doctors. Georgia Board for Physician Workforce report says that Georgia ranks 9<sup>th</sup> in population but 38<sup>th</sup> in physician supply. The Georgia workforce has declined 55 % in the last 10 years in terms of their rate of being replaced. To have general surgeons available to do the "knife and gun" club you have to have contacts in place to be a general surgeon. Right now there are articles in national surgical journals that state that Georgia is not a good place to practice for general surgeons.

**Representative Scott:** Does your hospital compensate you for ER calls?

**Dr. Smith:** No, they do not.

**Representative Scott:** If you go to the hospital at 4:00 in the morning to help one of these people from the knife and gun club and that is an indigent person, do you receive any compensation for your care?

**Dr. Smith:** Usually, not.

**Representative Scott:** Does the hospital receive compensation for the care that you provide?

**Dr. Smith:** There are mechanisms I understand that they can.

**Representative Scott:** So essentially, you provide the care for free but the hospital is compensated.

**Dr. Smith:** That's correct.

**Representative Scott:** Thanks very much.

**Donna Johnson:** Thank you Mr. Chairman. Dr. Smith, are there any studies that show that Georgia's inability to attract general surgeons is based solely on CON?

**Dr. Smith:** To my knowledge no.

**Donna Johnson:** Do you know what are the reasons given?

**Dr. Smith:** The problem with general surgery is that it's a very arduous lifestyle. Graduates and medical schools are seeking easier lifestyles. The demographics of medical students have also changed. When I was a graduate at the Medical College of Georgia in 1978; 16% of my class was female, now 52% of the class is female. Females are a lot smarter than males and they do not want to become general surgeons.

**Donna Johnson:** Thank you.

**Dr. Rahn:** I am not sure that we should relate that to intelligence.

**Senator Balfour:** There were a couple of assumptions made. One was before ya'll spoke; then one of the two of you (I am not sure who) made another assumption that I am not sure that I would make. An assumption that a judge made that because there was a regulation in place and the General Assembly, in changing the law, did not address it and therefore they silently approved it. That may have been his assumption and it's a wild assumption. Closer was the assumption that one of you made that since you did not exempt general surgery that we included it. That's probably closer but I don't know that I would assume either of those. Just like I wouldn't assume the way that sausages are being made is a good, clean process of making them. Another thing was said, and I am not sure that I disagree is that definitions made in the law ought to be closer to medical terms maybe it is a good thing to do. I think that what I was hearing is that we ought to follow the medical standard and define it when the national medical board changes, so that we automatically change with it because our definition is that of the medical board's. I don't know many states that do that. I can argue the other side because we, every year, always pass a bill that I complain about. I have complained about it for the past 14 years. It's deciding what drugs are in which classification. I cannot pronounce for you what's in there, none of us that are voting on it can, but we turn to the pharmacists in the room and say, is this right? He says yes and we vote on it. I always wonder why. When I ask for an answer, I am told that the General Assembly defines what drugs are on which classification. I am not going to argue that we shouldn't be closer to what the national organizations/boards or medical associations say but it almost sounds like we are asking the national medical organization to decide what goes where and I don't think that we at the General Assembly are ready to make that move. The General Assembly will speak for itself and just like we decide what an ophthalmologist can do or what an optometrist can do, I think that is the purview of the General Assembly and not the medical association or boards of the US.

**Dr. Gadacz:** I think that is a key point that you make. The reason that I made the recommendation that at least some standard be developed to define specialties, at this time, it seems that it is whimsical. I am not sure who really defines the specialties, whether it is the state legislature or DCH. My impression is that the legislature gave some authority to DCH to advise in this area, however there seems to be some inconsistencies about how those decisions are made regarding what is a specialty and whether this is a DCH ruling or opinion or if this is something that is legislated by the state and now the Attorney General says that cannot be modified. We are not attorneys and this seems to be somewhat confusing and there is a question about who defines it and what the agenda that is used for that definition is. I offered this as some assistance regarding how legitimate specialties in medicine have been defined at least by recognized boards in those areas.

**Senator Balfour:** I can argue both sides of this. Mr. Burgess brought it up earlier and I have argued both sides depending on what Bill it was and where I was. Sometimes, I like very strict structure which means that the General Assembly gets to define everything but then I am going to yell at the Commissioner because he is not being flexible enough and then at other times we are going to draw a very broad statute because we want to give him the ability to be flexible and then I am going to yell at him because he is being too flexible. Sometimes it is in the eye of the

beholder. Whatever the issue is we can be all over the place. To the extent that we are going to come up with something, we are going to have to be stricter. We need to define what we are talking about. In the General Assembly we need to also have a stricter definition of what things are so that it is clearer. We need to leave the DCH folks some flexibility so that they can take care of the anomalies that do take place.

**Dr. Rahn:** Thank you Senator. This is helpful as we look to the future. I would like to be corrected if I am wrong but it is my understanding is that what began as a rule was to some extent, converted to statute and now there is case law which constraints what the Department of Community Health can do without a new statute, with regard to this specific issue. Although it began as a rule, we are now in the circumstance there is now case law that says right or wrong, that this was the intent. As we look to the future this is a critical issue of what we would recommend going forward. Are we an outlier state or the only state in the nation that defines general surgery in a different category from other surgical specialties? It's a broader issue with regards to the whole issue of CON and regulatory control of ambulatory surgery and its impact on other providers and contributions or non-contributions to the goals of adequate healthcare for everyone.

**Dr. Deese:** What is a reason that you might have heard that general surgery would have been considered anything other than a single-specialty. What is the reasoning? What would have been the intent of not considering it a single specialty?

**Dr. Smith:** Clyde Reese who was the head of the State Health Planning Agency (SHPA), made statements in the TAC meeting in 2003 that general surgeons operate on too many parts of the body and that there was too much overlap for general surgeons to be considered a single specialty. I think that I addressed that and I think that anyone who is associated with medicine realized that that is an erroneous assumption.

**Dr. Gadacz:** I concur with that but at that meeting, for whatever reason, the TAC adopted a definition of general surgery that most of us and most people that we know have not recognized anything close to that definition in their careers. How that definition got into those minutes and was attributed to the American Society of General Surgeons seems to be somewhat of a mystery.

**Senator Balfour:** If the orthopedic surgeon or neurosurgeon that was on call one night was not available, would the general surgeon fix the open femur fracture or the open brain injury?

**Dr. Smith:** No, I do not consider myself skilled in those areas. My malpractice coverage would not allow me to do that and they would have to refer those cases to a facility that had those on-call specialists.

**Rusty Ross:** Dr. Smith, I am concerned with your comments about no significant affect on hospitals when an ambulatory surgery centers opens down the street. I am from a metropolitan area. When a surgery center opens down the street from us, it takes business out of our doors and that creates a problem for us. We do have the additional costs of being open 24/7. In our case, having a trauma center and neonatal center and those sorts of additional costs that surgery centers wouldn't have. My question is I believe that you also said, if a hospital offered similar facilities, that the patients could make a choice between the hospital facility and the doctors' ambulatory surgery center. Who is going to make the selection, the patient or the physician?

**Dr. Smith:** What hospital are you from sir?

**Rusty Ross:** Memorial

**Dr. Smith:** Is Memorial not now developing ambulatory surgery centers?

**Rusty Ross:** Maybe

**Dr. Smith:** It is my understanding that they are. I think that where a patient goes is now being driven by economics. I have had patients tell me that they could not use me for a follow-up endoscopy after a reflux surgery because they had to go to the ambulatory surgery center where the gastroenterologist was considerably cheaper than the hospital. The cost that the hospital charges is considerably more. Medicaid pays hospitals 350% more than the same procedure if it were performed in an ambulatory surgery center. This is a complex issue. For general surgeons, we would like to have ambulatory surgery centers because I think that it would help us to take care of the uninsured. We have offered back in 2003, to the Governor, to make us a study where we would take Medicaid, particularly the uninsured at the Medicare rate for both the facility and the professional fee which, I think that you

would agree, would be a first step in addressing some of the uninsured problems in the State of Georgia. We also agreed to take 5% indigent care more than the 3% that the hospitals are now taking and they have a tax break.

**Rusty Ross:** How would the indigent patient find your surgery center?

**Dr. Smith:** We take care of everything that comes through the door. One thing different from us and perhaps, plastic surgery is that everything (by definition) that plastic surgeons do is elective. When someone comes to me with a hernia, if I don't fix that hernia, he may die. I will end up in court. I am going to fix that hernia. If he has insurance I will fix it at the hospital. If he is a man that makes \$45,000 year and his wife makes \$25,000 they do not fit into any programs as PeachCare etc. I would have to take him to one of the local facilities. The cost of an outpatient ambulatory inguinal hernia repair at either Palmyra or Phoebe Putney is close to \$10,000.00. They don't give a discount. They are going to get every bit of that money. My chances of getting paid anything for my professional fee is none. I would much rather given them a discount for the facility and professional fee and I will come out way ahead. We are going to take care of that patient one way or the other. That is my commitment as a physician. If someone comes with symptomatic gallstones if I say no and they have a lethal case of appendicitis, I would wind up in court. I will take care of that patient. What I would like to say is that you need me available at your facility as a general surgeon and we need to have general surgeons in the state.

**Dr. Gadacz:** My experience is similar to Dr. Smith to a certain extent. I also had a patient recently who was a construction worker and he had an inguinal hernia. He did not have insurance but was willing to pay. He was referred to the hospital financial counselor and he was quoted a facility fee of \$10,000 just to fix his inguinal hernia. There is no insurance company that would pay a facility fee for inguinal hernia of \$10,000.00. He went elsewhere to get his hernia fixed. I realize that there are some problems with some hospitals but you have to be competitive. It all depends on your philosophy in practicing medicine. Will it be supply driven or managed competition.

**Dr. Deese:** I believe that I read somewhere that you are from Albany, Georgia, Dr. Smith is that correct?

**Dr. Smith:** That is correct

**Dr. Deese:** There was some press made about the cost of healthcare in Albany, Georgia but the complaint was made by local industry. Was that related to outpatient or inpatient care? Could you give me some idea what that was about?

**Dr. Smith:** It was in the newspaper on two occasions. There was a group of the largest employers in the county (Cooper Tires and Miller Brewery, Proctor & Gamble). They indicated that their plants in Albany, Georgia had the highest healthcare cost of any plant in the country. They broke down the cost into hospital costs and physician costs. Physician costs were \$82 cheaper, per person, based on covered lives; while the hospital costs (I don't have that document in front of me) but I believe that it was close to \$2,000 per covered life more expensive than the national average. There was a substantial difference in hospital costs.

**Dr. Gadacz:** There has been a study that looked at the reasons that the feds null and voided the CON. Part of that study looked at the escalation of healthcare over the 1974-78 periods, though I am not sure that that is the correct time period. The hospital costs went up much higher than other aspects of medical care. Hospital costs at that time went up 18% and physician reimbursement went up a single digit. I do not remember the exact numbers but there were very good reasons why CON was abandoned by the federal government.

**Dr. Deese:** I believe that I saw a statistic published by your society, Dr. Smith that suggested that bankruptcy associated with hospital charges was higher in Georgia than any other state. Am I misquoting that or misquoting your society?

**Dr. Smith:** I do not remember that statistic. Georgia was listed as a state that had very high bankruptcy rates, one of the highest in the country. There was a study out of Harvard that said that hospital costs were the number one cause of bankruptcy. I suppose that you can make that jump but I do not remember that specific statement. The person who wrote that article is in the audience if you would like to ask him, if that's allowed. It's Dr. Bagnato.

**Dr. Deese:** (directed to Dr. Rahn) Can I ask someone in the audience?

**Dr. Rahn:** Sure. If that is related to the general surgery issue? I am not trying to say no but if it is related. Our topic here is general surgery and ambulatory surgery.

**Dr. Bagnato:** Dr. Smith quoted that fairly accurately. The study was done by Elizabeth Warren and she very clearly indicated that the number one cause of bankruptcy in the United States is medical bills. In Georgia, we know that we have a high rate of bankruptcy because of the 100 counties in the country with the highest rates of bankruptcies, 45 of them are in Georgia. It is very clear that the article about Georgia bankruptcies appeared in the AJC and they did a very nice graph on that. That article is available to the Commission.

**Dr. Deese:** Do we know that the litigants in those bankruptcies were hospitals, doctors, JC Penny's or who?

**Dr. Bagnato:** That was the important part of the Elizabeth Warren's Study. What she actually did was grilled down the source of the debt. The debt once it is incurred in the case of hospitals, they would send out the bills to collections and creditors in which case many of them might not show up as hospitals. The important part of her study, which makes it a landmark study, is that she actually showed that the majority of debt due to medical bills, the vast majority are hospital bills. Doctor bills, as a whole, very rarely would put patients into bankruptcy.

**Dr. Rahn:** Let me thank our presenters for today. Mr. Greene, Dr. Gadacz mentioned that the Commission members do not yet have copies of his handout. Will we have copies before the members leave today?

**Richard Greene:** Hopefully. (Note: Dr. Gadacz's handouts were emailed to all Commission members subsequent to the meeting and are attached to the meeting minutes)

**Dr. Rahn:** Let's take a 10 minute break. We will reconvene and will discuss the next steps. It does seem that when we speak about individual topics it leads us to the big issues. What I would like to do is to get some work assignments so that we can address the big issues.

## COMMITTEE DISCUSSIONS AND NEXT STEPS

**Dr. Rahn:** I have been informed that the landlords in the building have committed to better audio. For the next meeting we will also investigate other rooms. Perhaps we could put the issue back on the table. We had a request for a stenographer. I am told that that will cost close to \$1000.00 per session. If the audio is adequate for good minutes and the tape serves as a good record would this suffice for the Commission or would you like us to investigate a stenographer for future minutes?

**Dr. Deese:** Where would the \$1,000 come from?

**Dr. Rahn:** The cost would have to come from DCH since there are no Appropriations for the Commission.

**Dr. Rahn:** If there are issues with the transcript then we will make the decision at that time. What I would like to do is to turn to the next steps for the Commission. We embarked on a course and we are committed to continuing to receive input from various stakeholders from various organizations in leadership positions, with regard to various components of our health system. We had a plan for the October meeting of hearing from specialized providers. We discussed that the last time. Our next meeting on November 21<sup>st</sup> we should focus on Psychiatric & Substance Abuse Services and Inpatient Physical Rehabilitation Services, Long Term Acute Care Services, and Traumatic Brain Injury Services as a group. It is important for us to continue to receive these inputs as we focus on individual components of the system. We are talking about multiple different issues that lead us back to the same high level issues. I would like us to develop a strategy and a work plan for how we can address some of the high level issues.

**Senator Balfour:** I work backwards on many of these things. I would say that by October of next year we would like to have our recommendations ready for review. By the October meeting, we should have something that we present and we hear feedback and then we have some final recommendations by early November. We are setting out to have something ready for the General Assembly that starts in 2007. I would like us to work backwards. In order to have a draft ready by September/October, we should have something soon. By July/August we should have some final things that we are looking at. We can't be all over the place. There should be 5 or 6 things that we absolutely need to looking at. I am not sure what they are, but of course, General Surgery is one of them. I would argue that we need to go backwards with this.

**Dr. Rahn:** If we did go backwards, what I think we need to do, in quick order, is to identify what external assistance and what data we would need that is not readily available. If we can get to that point by January then I think that we should be positioned reasonably well.

**Dr. Lipson:** Over the past several months, I really think that we have been side-tracked, some of them appropriately. We are not necessarily putting things in the order that we need to look at them. I really would offer a motion that the Commission adopt an agenda to move forward collecting data and we delay any specific considerations on any specific issues until such time that we can get a better feel for the agenda items that we had talked about earlier-- including the impact of CON program, the impact of CON on healthcare costs, the history of the CON program, the impact of CON on services, the impact on the safety net providers, rural hospitals, get physician input ,hospital based and private practice physicians, primary care physicians, let's look at the physician self-referral issues, the impact of physician shortages on emergency rooms, etc. I would like to offer this as an agenda. It would probably be appropriate to have stakeholders bring in their experts. I hear a lot of facts being thrown out and I hear a lot of data, some of which conflicts with what I have always believed to be true. I would like to have the opportunity to hear from these people. General Surgery, we have now heard four meetings in a row and it is important to make some recommendations whether we would like to address CON first and then move forward with specific items. It is very hard for me to say what we should do with CON as it pertains to General Surgery as a single-specialty or multispecialty. We should be looking at what CON is doing with regards to policy. What is the policy towards CON in the state? I would like to get a better feel for the policy issues and to collect the data. I would like to submit the following motion that the Commission adopt an agenda to move forward to collect data, information on CON programs, generally with specific considerations of the issue whether General Surgery is classified as a single specialty for the purposes of the ASC exemption, or any specific recommendations regarding any other specific exemption until the Commission prepares a recommendation and have an opportunity to examine other issues, including the history of the CON program, the impact of CON program on healthcare costs, cross-subsidization, financial access, etc. After the Commission has had an opportunity to address these fundamental issues in connection with our efforts to develop specific legislative recommendations, we could then determine whether the CON laws should be changed to allow concessions for general surgeons. We need a comprehensive review of the CON statute.

**Dr. Deese:** I would speak in opposition of that motion. I oppose that motion because if statistics were available, and there were black and white answers then we would have been finished our work long ago. No amount of statistical analysis is going to do any good. Secondly, in a matter of three hours, this Commission will not have the time and opportunity to be educated on all of these statistics, especially as they relate to each of the entities considered under CON therefore it is our job, as Commission members, to be educated about the issues, outside of this room. We have to dedicate some time and personal energies in order to understand these issues, beyond what we hear in this room. I believe that this is the most efficient way to manage our time and come to a reasonable conclusion and recommendation. We need to attempt to identify those areas that are covered under CON which, even I, believe it or not, think need to continue under CON and let's take them off the plate. Let's just agree that they need to continue to be managed by CON and let's consent, by majority vote, to move on. Let's not waste a lot of time laboring on all of the things that we all agree on. In the course of a single meeting, we can identify a good number of items that are covered under CON that we might say, let's leave well enough alone and let's vote on it. Let's devote our time, energy and effort to the hard stuff. Let's get focused on the hard stuff. Data, data, evaluations, and meetings, become data, data, evaluations, and meetings. I speak in opposition to the motion.

**Dan Maddock:** Mr. Chairman, in support of the motion, I think that CON is like an umbrella. It covers many facets. Georgia's healthcare system is urban and rural and for four meetings, a lot of time has been spent on trying to decide what general surgery is and that is one small facet of the delivery system. It's a very complex issue and I would like to take the time to explore what is happening in other states. We talked about Michigan and Oregon. I am trying my best to look at the big picture rather than my little small domain in rural Georgia. I would recommend that we look at the big picture rather than focus on a certain facet, which is what we have done. With meetings once a

month, there still will not be enough time to explore all of this. We need to use our time wisely which is why I will second that motion and support that motion.

**Rusty Ross:** I am also in favor of this motion but I agree with a few things that Dr. Deese has said as well. We have been given a charge to look at the effectiveness of the CON laws in the State of Georgia. We don't have to do this in a vacuum because we are not the first state to consider this issue. There are others that have done it and we have been given some reading material that I have reviewed but these materials need to be provided to us in a comprehensive fashion. Presenters could be middle of the road consultants, experts, academics, etc. who could analyze some of this information. There is never going to be a clear answer because you can play with the numbers on either side. I would like to have some time to consider those bigger issues and stop tinkering around the edges. We may very well come back to that in the end and say yes, CON laws do have a purpose and is effective in terms of controlling costs but I don't know that yet. I would speak in support of this motion so that we could move forward.

**Dr. Rahn:** I have had a great deal of difficulty in conceptualizing a work plan that is manageable without saying let's overhaul the American health system. We all know that everything is connected to everything else. It seems to me that what we are talking about is how we approach the work plan from looking at specific issues that are problematic, like general surgery, or can we approach it from the umbrella of trying to concentrate on the national experience that in states that have a much less regulatory environment than Georgia compared with those states that have retained CON. What has been the experience on cost, quality, and access, of those states that have done away with CON? These are two different approaches to the work that we have before us. I think that that is what I would like us to decide today. Dr. Deese's approach would allow us to identify those areas that are problematic and let's concentrate them.

**Senator Balfour:** I can see the benefit of both approaches. To me, I don't know that there are too many people in this room who are in favor of getting rid of CON altogether. So if you start with the first question, are you going to keep it or totally get rid of it, that's the ultimate first question. I think that we are kind of wasting our time if we need to study that question. The decision would probably to keep it in some form. Dr. Deese talked about certain things that I can agree to and take them off the table. I threw out some things in the first meeting. There are some things that the Commissioner and his Department probably approve 99.9% of the time as soon as the application is submitted. If that is the case maybe those services shouldn't be regulated by CON. There should not be a CON for putting on a new roof on a building or painting or if it's costing more than X amount of dollars. Whatever the issues are that we can agree with, let's take those off the table. At the same time, we are asking what's happening in Texas. I have always heard that CON in Georgia is so different from every where else and then I found out that some states don't have CON but they have all of these other regulations which equal CON. Some of that we need to understand and we can make our way through both of these options. At some point, by July/August we have to make some final decisions on stuff and realize that late November/ early December that people are going to be worried about holidays, New Years. We will lose a month in this process at some point. I am not sure that we can't do both but it needs to be a structured approach. Either top-down or bottom-up. At the same time, realizing that our final goal is that in July we are coming to some final conclusions so that we can come up with a report in September/October that gets disseminated so that people can come back and say you missed this or that you need to think about this. When we come up with our final report in October /November, we should have something that is very defined. It is not right or wrong but do you make it so specific that it gets struck down by regulators. If so, we may realize that we have no room for coming up with those exceptions because we won't be able to anticipate every possible scenario. Alternatively, do we leave room for the Department to do things so that legislators don't say; this is not what I meant when I wrote that bill. This is why this is a two year project. The decision is not whether we are going to keep CON or get rid of it or that we are going to modify it or we are going to redefine general surgery. If we are going to keep CON then once that's off the table, then there are X amount of issues that we can seek easy agreement with and get those off the table. Then, we are down to the 5-6 issues. This is just a thought. I think what I heard is that we are moving around but we are frustrated because we are not getting

anywhere. We are hearing from folks but we are not making any decisions and we need at some point to get all of the facts on all of the states and make decisions. I would assume that the subject that we are discussing probably will not be decided until next July anyhow. What other things can we look at? There are merits in both approaches.

**Jeff Anderson:** I would like to comment that this Commission's charge is to look at CON and its efficacy. The Commission needs to respond to Senator Balfour's statement regarding whether we keep CON or not. We have read the letters and heard the testimonies. The first thing that we have to do is decide, is it in or out? Let's talk to some of those states that had CON and abolished it and find out if they would like to have it back and why? Also, let's find out what bugs most people about CON. We need to decide, as a group, whether we should keep CON in some form.

**Dr. Rahn:** We have constructed a series of presentations for the purposes of informing us. These presentations are focused on the 19 services that are regulated by CON. The presentations were set up to provide us with information of how CON contributes or don't contribute in this area. I made a list for myself. This is what I saw are the high level arguments in favor of CON and the high level arguments against CON. This may or may not be the same as yours.

Some argument in favor of CON

- Ensures that adequate volume for specialized services to which higher volumes are linked to higher outcomes ( i.e. cardiovascular services, neonatal clinical care, radiation therapy)
- Ensure that new entrants do not financially harm, financially vulnerable providers who are currently in the market, especially safety net providers, who provide services of critical importance to the public (education, indigent & charity care)
- Limits the geographic range of replacement facilities to ensure that under-served populations don't experience a barrier to care (flight from urban to suburban)
- Protects against possible market segmentation according to ability to pay
- Protects financial cross-subsidies by safety net providers
- Protects against overbuilding not linked to a demonstrated need (could drive higher utilization and higher cost )
- Ensures quality and access for the uninsured through requirement of accreditation and indigent and charity care minimum standards

Some arguments against CON

- Anticompetitive-creates a barrier to entry by protecting the market share of existing providers
- Doesn't support innovation (protects the status quo)
- Criteria are primarily numerically driven, not driven by costs, patient satisfaction or quality.
- CON artificially inflates reimbursement rates for certain services for which providers have a regional monopoly
- Protects providers who have certain services from having to compete on quality, cost and allows too much market power
- Process is cumbersome, expensive and time consuming

All of these are right. It is not a binary decision. It is not yes or no. It is not all or none. In certain circumstances, each one of these is correct and there is an element of truth to all of them. Our issue is to shape the environment that optimizes the complexity of these various competing influences. There are experts in the field. Dr. Frank Sloan, authored two papers, including a Michigan Study on the impact of eliminating CON, published in 1998. He is at Duke, at the Health Policy Center. He doesn't have a horse in the race. We could contact him and we could ask him to come to present to us and I know that they have updated that information in 2003. We could seek additional information with regard to the national landscape. Also, there is certain information about healthcare cost that is available in the public sector. I don't know how valid that is, but there are audited financial statements, Medicare

Cost Reports, etc. There is information that should be available to us about the financial operating environment of our hospitals, rural or large tertiary referral centers, or both. We can assign tasks to staff and take some time to identify what information is available in the public arena. Is that reliable and sufficient for us to get a sense of whether those providers that we see as our safety net providers are operating in a fiscal environment that is hazardous? What are the realities of urban, rural and suburban providers? This is system level information. We can continue to entertain presentations from components of the healthcare industry.

**Dr. Deese:** I heard that this Commission will suffer from paralysis by analysis. We have been analyzing this information for years. If we can't focus our attention and our efforts on the things that really brought us to the table, then what will we really accomplish. I would suggest that we shift the focus as quickly as possible. My comment is regarding the Chair's mention of financial information regarding healthcare institutions. It is my opinion and my experience that valid financial information coming from non-profit hospitals is not helpful at all because so much of these systems have for-profit entities through which other funds are channeled, profits are generated and not all of this information is reported. There have been numerous institutions in this state who have sought financial information from non-profit hospitals and it simply is not available. I would not recommend that this Commission wastes its time seeking information that simply isn't available unless you are willing to subpoena the information. I will make a personal comment, once and only once that as I look around the table, I don't see anyone out here who is missing work today but me. I don't get paid to be here today. I am not at work. I am not earning a salary being here today. I am very focused on getting information to the table. When I show up here, I want this to be a meaty presentation. We all showed up with pressures from our own businesses, hospital relationships, etc. That's no secret. Let us talk about it. More and more information is just more and more information. If we are going to get things accomplished in a reasonable period of time, I would suggest that you create subcommittees. Those interested in nursing homes, assisted living facilities, gamma knives, etc., let those subcommittees bring recommendations back to the Commission and let's vote on them. If those recommendations pass, then they are off the table. To continue going back to rehash these things in such detail and to think that we are going to get valid financial information out of these huge hospital systems is beyond the scope of this Commission.

**Dan Maddock:** Please don't paint all not-for-profit hospital with the same brush stroke.

**Jeff Anderson:** I would like to focus on the macro-economics. Let's look at those states that did away with CON and those that kept CON and determine why. If they did do away with CON, what regulatory processes did they put in place to protect some version of access, quality and affordable care? What happened to urban/suburban/rural hospital providers? What happened to physician practices? What happened to ASCs in general? We need to decide whether we would like to keep CON. What about those presentations? Those were all good. We all decided at the first meeting that we would have those discussions to learn more from stakeholders about industries that we are not personally apart of. Just to get more collective knowledge. I would look at the macro-economic issues then we can start going from there.

**Rusty Ross:** That's exactly what I understood Dr. Lipson's motion to be about. I would also ask that we not characterize anyone at this point, whether they are from the physician community or the hospital community. It is disingenuous and isn't going to help our efforts whatsoever.

**Dr. Rahn:** Can we have a vote on the motion. Members voting in favor of the motion (6); members voting in opposition of the motion (1). The motion carried. Note (1) member departed the meeting prior to this vote. The intent of the motion is to focus on high level issues while at the same time continuing to receive stakeholder presentations.

**Dr. Lipson:** One of the things that we talk about with regard to CON is what is driving the issues today? What I think that you will find is that the pricing structure, because of the way managed care forces hospitals to price inpatient services, hospitals come back to get enormous increases on the outpatient side because they never gave away the percent of charges on that business.

**Dr. Rahn:** We will proceed with plans to invite stakeholders for the November 21<sup>st</sup> meeting, including representatives from the Psychiatric & Substance Abuse and Long Term Care components of the industry. We

may be able to take these off the table, if we agree that no changes should be made and the consensus is that everyone agrees with that. What I would like, with the Commission's permission, is to try to engage, Dr. Sloan because that is the name that comes up over and over again as the individual from the Health Policy Center at Duke who has done the most work nationally. Dr. Sloan could provide information about those states that have limited CON and determine what the impact on cost and access has been. I would like permission to invite him to come to speak to us, probably some time in January or February.

**Dr. Deese:** I would welcome that. I would however suggest that if we are going to invite experts in the field that we are given information about materials that they have produced in advance of the meeting. Let me also follow-up with Mr. Ross. My comments were certainly not meant to be disingenuous. My comments were meant to be pointed. I think that it is a disservice to the Governor, the citizens, physicians and hospitals if we don't cut to the cord as quickly as we can, while we are here. My comments were seemingly sharp, but are meant to express the concerns of the people that I represent. I know the squabbles that we have had, in this arena, of trying to come up with legitimate numbers. When it comes to these matters, I made a note to myself. Mr. Maddock has mentioned about the hardships of the rural communities and how CON affects us now but right now. Anyone who chooses to enter this arena is disadvantaged to those with the deepest pockets. We have to fund lawsuits, so please don't take my comments as being disingenuous. My comments are very genuine and are meant to be helpful not harmful.

**Rusty Ross:** I was commenting on the fact that at this stage of our discussions, your comments aren't very helpful, in my opinion. In terms of having access to information from not for profits or small public hospitals, in my case, we provide an audit every year. It is filed with our County Commissioner and is available for everyone to see. I don't know how others do business differently where you are from but that's the way we do business.

**Dr. Rahn:** Everyone here is of good heart. We have strongly held opinions and it is a highly charged issue. I have one other matter that I have been asked to bring before the Commission by Representative Scott, who apologized for having to leave. He had to serve as a waiter for a charity event for a 6:30pm event in Tifton. He needed to leave. He made a commitment to business leaders in Albany that he would request that they be permitted to come to make a presentation to the Commission regarding commercial healthcare costs. It is an issue that has been eluded to here this afternoon. I told him that I would extend that request, on his behalf, to the Commission.

**Dr. Deese:** Please restate the motion.

**Senator Balfour:** The motion basically is that we do away with single issues. We have been looking at the small pieces. I understand that they are real issues there. That's the problem with getting information from single sources. What's happening down in Albany may not necessarily be what's happening in other parts of the state.

**Dr. Deese:** I am still not clear what the first motion was.

**Senator Balfour:** The motion is that the Commission has offered an agenda of moving forward and will gather information about CON programs generally and to delay any further considerations regarding single issues, like whether general surgery should be classified as a single specialty for purposes of the ASC exemption or any other specific presentation for specific exemption until the Commission has prepared and report recommendations and after the Commission has had the opportunity to examine the information, in total. After the Commission has had the opportunity to address these fundamental important issues then we will make some specific legislative recommendations. We can return to the question of whether CON ought to be changed to allow exemptions for general surgeons or other decisions. Until we can comprehend the CON statute, we should no longer be focused on any other single issue. I think that's where we are getting distracted because we are focusing on very small single issues. General Surgery has had statewide review.

**Dr. Deese:** Is the focus of the motion simply to put general surgery off the agenda as a specific item?

**Senator Balfour:** Yes. General surgery and all specific issues until we can get a better feel of the general issues.

**Dr. Deese:** I would like to know how I can focus my efforts going forward. With all due respects, Dr. Lipson, I just don't understand the two page motion.

**Dr. Rahn:** What I am going to do is to interpret the motion that we are going to continue down the pathway of receiving input from components of our healthcare industry but we are not going to make recommendations with

regard to specific components in any arena. We are merely preparing a report using the timeline that Senator Balfour proposed rather than focusing on individual components or making individual decisions at this time.

Note: No formal vote was taken but consensus was reached by membership.

**Dr. Rahn:** I am going to take that as a directive that we need to begin focusing on higher level issues.

**Senator Balfour:** How would speakers be compensated?

**Dr. Rahn:** I would have to determine how much they would charge?

**Dr. Lipson:** We have several resources. GHA could bring in an expert; general surgeons could bring in experts.

**Dan Maddock:** My only concern is that we are going to start receiving requests from Savannah, Americus, Rome, etc. I would be opposed to bringing speakers from Albany.

**Senator Balfour:** Is Albany a microcosm of the state or is this a specific issue?

**Dan Maddock:** It is the epicenter of the problem.

**Dr. Rahn:** I really don't know but it has been referred to me here this afternoon that a number of major corporations in Albany have published their per capita healthcare costs and they are the highest in the nation within their industry. That's not information that is statewide. What I pledged to Representative Scott is that I would extend this request and I will let him know that the Commission is reluctant to invite an individual industry sponsor but we would like to have them provide any information for Commission review and that might lead to an invitation.

Note: No formal vote was taken on this issue.

## **OTHER BUSINESS & ADJOURNMENT**

Note: There are some comments that were made by various members that are not included because those comments were inaudible on the tape. This is true in a small number of instances.

There being no further business, the meeting was adjourned at 4:40 pm.

Minutes taken on behalf of the Chair by Stephanie Taylor.

Respectfully Submitted,

Daniel W. Rahn, MD  
Chair

**MINUTES**  
**STATE COMMISSION ON THE EFFICACY OF CON**  
Sanders Fireplace Room at the Capitol Education Center  
October 24, 2005; 1:00 pm

# Appendix A

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- Correspondence dated September 7, 2005, received from Georgia Alliance of Community Hospitals, authored by Kurt Stuenkel.
- Correspondence dated September 27, 2005, received from Georgia Hospital Association, authored by Joseph Parker, President. Also, include a list of suggested topics that GHA would like the Commission to carefully consider during its deliberations.
- *Committee on Health Care, The Florida Senate, Interim Project Report 2006-138, September 2005*, provided by Fred Watson, President, Georgia Healthcare Association

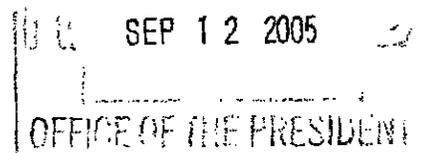


## GEORGIA ALLIANCE OF COMMUNITY HOSPITALS

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September 7, 2005

Dr. Daniel W. Rahn  
Office of the President  
Medical College of Georgia  
1120 15th Street, AA-311  
Augusta, GA 30912-7600



Dear Dr. Rahn:

Following my testimony to the Commission last month, it was called to my attention that I had made a mistake in responding to one question. My purpose with this letter is to clarify my response and, I hope, correct the record. The question, as I recall it, was whether for-profit hospitals could participate in the Indigent Care Trust Fund program. My answer was that to the best of my knowledge they could not.

While I would refer the Commission to the proper subject matter experts within the Department of Community Health for the most definitive answer to this question, I have since been informed that in fact for-profit hospitals can and do receive ICTF dollars based on the Medicaid burdens they shoulder. As I understand the current law and related regulations, the hospital funds used to attract the federal ICTF match can come only from not-for-profit hospitals, but the resulting federal match is shared among all qualifying hospitals, whether or not they were able to participate in the initial contribution.

As a point of further information, I was informed as I was preparing this letter that the state rules governing the distribution of ICTF funds may soon be revised by DCH. For that reason in particular, I would, again, refer the Commission to DCH for the most up-to-date and precise explanation of this issue.

I hope you find this helpful and would be pleased to answer any additional questions you might have.

Sincerely,

Kurt Stuenkel  
Chairman, Georgia Alliance of Community Hospitals  
CEO, Floyd Medical Center



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September 27, 2005

Daniel W. Rahn, M.D.  
Chair  
State Commission on the Efficacy of the Certificate of Need Program  
c/o Georgia Department of Community Health  
2 Peachtree Street, N.W.  
Atlanta, GA 30303

Dear Dr. Rahn:

I am writing in response to your letter dated August 22, 2005, to Richard Dwozan, Chairman, Georgia Hospital Association (GHA) Board of Trustees. In the letter, you request that Chairman Dwozan provide the State Commission on the Efficacy of the Certificate of Need Program (Commission) with specific recommendations for improvement of the Certificate of Need Statute and the administrative processes associated with the Certificate of Need Program in Georgia.

As you know, GHA's member hospitals are united in their belief that a strong Certificate of Need Program is essential to assure Georgia's citizens enjoy broad access to high quality healthcare services at an affordable cost. GHA appreciated the opportunity to speak at the August 8, 2005, Commission meeting and is eager to assist the Commission. However, as we discussed in our recent telephone conversation, I believe it is premature to recommend specific changes to Georgia's Certificate of Need Program at this time.

As Chairman Dwozan noted in his remarks during the August 8<sup>th</sup> Commission meeting, Georgia's Certificate of Need Program significantly impacts numerous aspects of the healthcare delivery system. Chairman Dwozan provided the Commission with a list of suggested topics for upcoming meetings and encouraged the careful examination of these topics. I am attaching to this letter a copy of the list of topics previously submitted by Chairman Dwozan. GHA again urges the Commission to thoroughly explore the manner in which the Certificate of Need Program impacts each of these topics. GHA believes the information gleaned from this process will assist stakeholders, including GHA, in crafting meaningful recommendations to improve the Certificate of Need Program and will also aid the Commission as it considers the various proposals.

Thank you again for the opportunity to participate in this important initiative.

Sincerely,

A handwritten signature in black ink, appearing to read "Joseph A. Parker", is written over a vertical line.

Joseph A. Parker  
President

Attachment

c: Governor Sonny Perdue; Commission Members; Glenn Richardson, Speaker, Georgia House of Representatives; Eric Johnson, Senate Pro Tempore

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**Suggested Topics  
for  
Upcoming Meetings  
of the  
Study Commission on the Efficacy of Georgia's  
Certificate-of Need System**

GHA encourages the Commission to carefully examine the following issues in considering the potential of revising the Certificate of Need Program:

- The history of the CON program and health policy goals it affects
- Impact on healthcare costs
- Impact on services volume and quality of care
- Financial access (indigent care; Medicaid; uninsured)
- Impact on safety net providers
- Impact on rural hospitals
- Impact on medical education
- Impact on trauma and emergency room services
- Physician self referral issues
- The perspectives of physicians, including hospital-based and primary care physicians
- Assurance of hospital financial viability
- Long term care options and financing

We believe Georgia's CON Program significantly impacts each of these important issues. We urge the Commission to undertake a thorough discussion of each issue with input from the pertinent provider, payor and consumer communities, and with input from researchers who have studied the issues.



# The Florida Senate

Interim Project Report 2006-138

September 2005

Committee on Health Care

Senator Durell Peaden, Jr., Chair

## REVIEW THE MORATORIUM ON CERTIFICATES OF NEED FOR NURSING HOMES

### SUMMARY

The 2001 Legislature imposed a moratorium on the approval of certificates of need (CONs) for additional community nursing home beds until July 1, 2006. The moratorium is found in s. 651.1185, F.S. The purpose of this moratorium is to slow the increase of nursing home placements and to encourage other forms of assistance to elderly individuals who need assistance. Limiting the number of nursing home beds limits the state's obligation to fund nursing home bed days for Medicaid recipients, thereby freeing state funds to pay for other types of noninstitutional community support for the elderly. If the 2006 Legislature does not extend the moratorium on CONs for nursing homes, the moratorium will expire on July 1, 2006.

This report recommends that s. 651.1185, F.S., should be moved to ch. 408, F.S., and amended to extend the moratorium on the approval of certificates of need for additional nursing home beds until July 1, 2011. In order to ensure access to needed nursing home services, an exception to the moratorium should be permitted to allow nursing homes with a 96 percent or greater occupancy rate to add 10 beds or 10 percent of the number of licensed beds if the home had no class I or class II deficiencies in the past 30 months and the occupancy rate in the planning subdistrict is 94 percent or greater. This exception is the same policy as the exemption to CON review under s. 408.036(3)(j), F.S., which is not currently available to nursing homes because of the moratorium. If the Legislature enacts this recommendation, the moratorium would stay in effect for five more years, and AHCA would have the authority to grant an exception to the moratorium for nursing homes that provide a good quality of care and that are operating at what is essentially full capacity.

### BACKGROUND

#### Florida's Supply of Nursing Home Beds

Florida regulates the entry of nursing homes into the market and the expansion of those nursing homes through the certificate-of-need (CON) process. Since 1973, the CON process has limited Florida's nursing home bed supply in accordance with projected need. The number of community nursing home beds per 1,000 individuals age 65 and older during the past 10 years is shown in the chart below<sup>1</sup>:

Year	Population Age 65 and Older	Community Beds per 1,000 Population Age 65 and Older
1994	2,552,428	28.72
1995	2,587,344	29.15
1996	2,627,624	29.49
1997	2,667,509	29.98
1998	2,715,591	30.04
1999	2,778,024	29.78
2000	2,840,445	29.34
2001	2,899,099	28.54
2002	2,990,031	27.30
2003	3,057,275	26.47
2004	3,120,312	25.8

#### The Moratorium on Certificates of Need for Nursing Home Beds

The CON regulatory process under ch. 408, F.S., requires that before specified health care services and facilities may be offered to the public they must be approved by the Agency for Health Care Administration (AHCA). The establishment of a new nursing home or the addition of beds in a community nursing home is subject to CON review, which includes determination of the level of need that exists

<sup>1</sup> Source of data: Florida Agency for Health Care Administration. 2005.

for such services in a geographical area known as a planning district. These CON reviews are not currently being conducted for nursing homes and nursing home beds because of a legislatively-imposed moratorium on the approval of CONs for additional nursing home beds through June 30, 2006.<sup>2</sup> The 2001 Legislature's intent in enacting the moratorium was "to limit the increase in Medicaid nursing home expenditures in order to provide funds to invest in long-term care that is community-based and provides supportive services in a manner that is both more cost-effective and more in keeping with the wishes of the elderly residents of this state."<sup>3</sup> The moratorium does not apply to sheltered nursing home beds in a continuing care retirement community.

Two exceptions to the moratorium have been enacted since 2001; these exceptions are specified in s. 651.1185, F.S.:

- Under s. 651.1185(4), F.S., additional community nursing home beds may be added in a county that has no community nursing home beds and the lack of community nursing home beds occurs because all nursing home beds in the county that were licensed as of July 1, 2001, have subsequently closed.
- Under s. 651.1185(5), F.S., additional community nursing home beds can be added to nursing homes located in counties of up to 50,000 residents, in a number that may not exceed 10 total beds or 10 percent of the nursing home's current licensed capacity under certain conditions. Documentation accompanying the application to AHCA must:
  - Certify that the facility has not had any class I or class II deficiencies within the 30 months preceding the request for addition.
  - Certify that the prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 94 percent and the facility had not had any class I or class II deficiencies since its initial licensure.
  - For a facility that has been licensed for less than 24 months, certify that the prior 6-month average occupancy rate for the nursing home beds at the facility meets or exceeds 94 percent and that the facility has not had any class I or class II deficiencies since its initial licensure.

Such specificity limits the application of the exceptions to only a few nursing homes and thus, the exceptions

have had minimal impact on the addition of community nursing home beds licensed under ch. 400, pt. II, F.S.

### **Requirements for CON Review for Nursing Home Beds**

Section 408.036, F.S., specifies those health care projects that are subject to full comparative review in batching cycles by AHCA, those that can undergo an expedited review, and those that may be exempt from full comparative review upon request. The nursing home projects addressed in s. 408.036, F.S., are as follows:

#### ***Projects Subject to Full Comparative Review***

- Adding beds in community nursing homes (*AHCA does not accept applications for additional community nursing home beds under this provision because of the moratorium.*)
- Constructing or establishing new health care facilities, which include skilled nursing facilities (*AHCA does not accept applications for new nursing homes under this provision because of the moratorium.*)

#### ***Projects Subject to Expedited Review***

- Replacement of a nursing home within the same district
- Relocation of a portion of a nursing home's licensed beds to a facility in the same district

#### ***Exemptions from CON Review***

- Addition of beds at a facility that is part of a retirement community which was established for 65 years prior to 1994 (*AHCA does not accept applications for additional nursing home beds under this provision because of the moratorium.*)
- State veterans nursing homes if 50 percent of the construction is federally funded
- Combining in one nursing home the beds or services authorized by two or more CONs in the same subdistrict
- Dividing into two or more nursing homes the beds or services licensed under one CON issued in the same planning subdistrict
- Adding 10 nursing home beds or 10 percent of the number of licensed beds (or for a Gold Seal facility 20 beds or 10 percent of the licensed beds) if:
  - The nursing home had no class I or class II deficiencies in the 30 months preceding the application
  - The occupancy rate for the previous 12 months was 96 percent or above

<sup>2</sup> S. 651.1185, F.S.

<sup>3</sup> S. 651.1185(2), FS.

- All beds previously authorized under this exemption have been operational for at least 12 months  
(AHCA does not accept applications for additional nursing home beds under this provision because of the moratorium.)
- Replacement of a nursing home on the same site or within 3 miles of the site provided the number of beds does not increase
- Consolidation or combination of nursing homes or transfer of beds within the same subdistrict by providers that operate multiple homes in the subdistrict provided there is no increase in the total number of beds in the subdistrict

The expedited reviews and exemptions provided in s. 408.036, F.S., have given nursing homes the flexibility to relocate nursing home beds during the years the moratorium has been in effect.

### Nursing Home Bed Need Methodology

Under s. 408.032(5), F.S., the state is divided into 11 planning districts, and under rule 59C-2.200, F.A.C., the planning districts are further divided into subdistricts. Rule 59C-1.036, F.A.C., establishes the CON review procedures for nursing facility beds. An application for nursing facility beds will not be approved in the absence, or insufficiency of, a numeric need, unless the absence or insufficiency of numeric need is outweighed by other information presented in a CON application showing special circumstances consistent with review criteria under s. 408.035, F.S. The planning horizon for applications is 3 years subsequent to the year the application is submitted. The estimate of projected population is the estimate for the planning horizon.

The need formula for nursing facility beds is based on the expected increase in the planning district's population age 65 to 74 and age 75 and over, with the age group 75 and over given 6 times more weight in projecting the population increase. The projected district bed need total is then allocated to its subdistricts consistent with the current subdistrict distribution of the total. The result for a given subdistrict is adjusted to reflect the current subdistrict occupancy of licensed beds and a desired standard of 94 percent occupancy. This subdistrict total of allocated beds is then reduced by the current number of nursing home beds in the subdistrict that are licensed or approved, resulting in the net need for additional

nursing facility beds. If the current occupancy of licensed beds is less than 85 percent, the net need in the subdistrict is zero regardless of whether the formula otherwise would show a net need.<sup>4</sup>

<sup>4</sup> The formula for determining the net need in a subdistrict for nursing home beds is as follows:

$$1. A = (POPA \times BA) + (POPB \times BB)$$

where:

A is the projected age-adjusted total number of nursing facility beds to be licensed under Chapter 400, F.S., at the planning horizon for the district in which the subdistrict is located.

POPA is the projected population age 65-74 years in the district.

POPB is the projected population age 75 years and older in the district.

BA is the estimated current bed rate for facilities licensed under Chapter 400, F.S., for the population age 65-74 years in the district.

BB is the estimated current bed rate for facilities licensed under Chapter 400, F.S., for the population age 75 years and over in the district.

$$2. BA = LB / (POPC + (6 \times POPD))$$

where:

LB is the number of nursing facility beds licensed under Chapter 400, F.S., in the district as of January 1, for fixed bed need pools published between January 1 and June 30, or as of July 1 for fixed bed need pools published between July 1 and December 31.

POPC is the current population age 65-74 years in the district.

POPD is the current population age 75 years and over in the district.

$$3. BB = 6 \times BA$$

$$4. SA = A \times (LBD/LB) \times (OR/.94)$$

where:

SA is the subdistrict allocation of community nursing facility beds to be licensed under Chapter 400, F.S., at the planning horizon.

LBD is the number of nursing facility beds licensed under Chapter 400, F.S., in the subdistrict as of January 1, for fixed bed need pools published between January 1 and June 30, or as of July 1 for fixed bed need pools published between July 1 and December 31.

OR is the average 6 month occupancy rate for nursing facility beds licensed in the subdistrict

.94 equals the desired average 6 month occupancy rate for licensed nursing home beds in the subdistrict.

5. The net bed need allocation for a subdistrict at the planning horizon is determined by subtracting the total number of licensed and approved beds for facilities licensed under Chapter 400, F.S., in the subdistrict from the bed allocation determined under subparagraphs (c)1. through (c)4. unless OR, as defined in subparagraph (c)4. is less than 85 percent, in which case the net bed need allocation is zero. The number of licensed beds that is subtracted from the bed need allocation shall be the

## METHODOLOGY

Committee staff reviewed national trends in nursing home placement and occupancy rates for nursing homes in Florida during the moratorium. Staff reviewed other types of assistance to the elderly that the state has provided during the years the moratorium has been in effect; consulted with representatives of the state’s three nursing home industry associations concerning the effects of the moratorium on the providers they represent; and consulted with AHCA staff concerning nursing home quality indicators, occupancy rates, service for Medicaid recipients, and nursing home bed-need projections.

## FINDINGS

### The Need for New Nursing Home Beds

The statewide occupancy rate for nursing homes was 88.63 percent for the first half of 2004 and it was 87.62 percent for the second half of that year<sup>5</sup>. For the planning horizon January 2008, four areas of the state have a nursing home occupancy rate above 94 percent, as follows:

Leon County	96.97%
Columbia/Hamilton/Suwannee Counties	96.78%
Nassau/N. Duval Counties	94.70%
Seminole County	94.44%

The number of beds required to address the need in these four areas will be:

Leon County	68 beds
Columbia/Hamilton/Suwannee Counties	70 beds
Nassau/N. Duval Counties	30 beds
Seminole County	111 beds

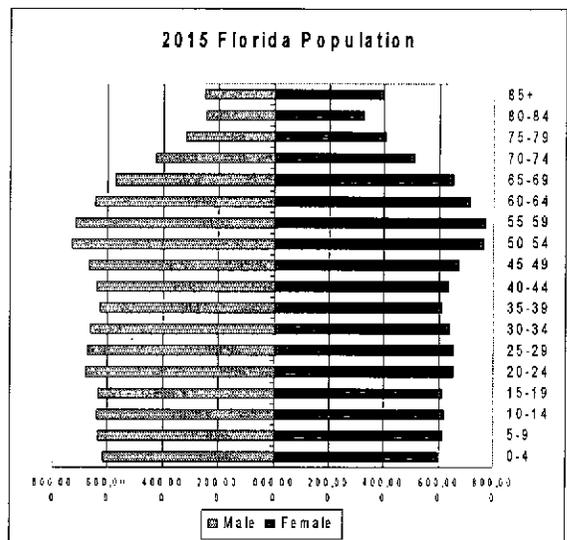
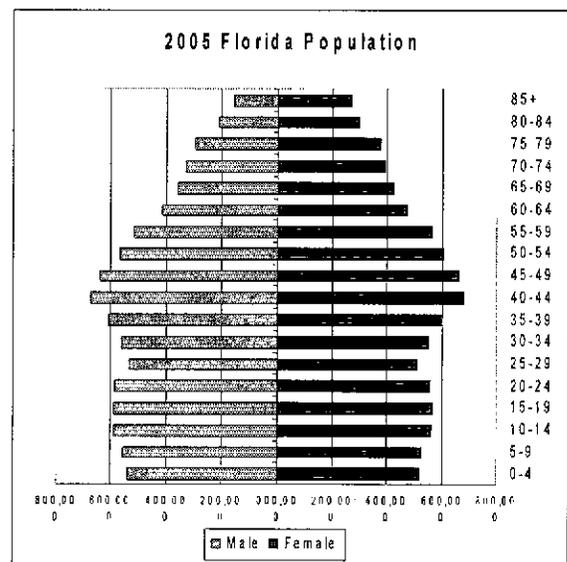
In the next 10 years, Florida’s total population will increase by 19.1 percent (from 17.8 million in 2005, to 21.2 million in 2015). The population age 65 and older

number licensed under Chapter 400, F.S., as of the most recent published deadline for agency initial decisions prior to publication of the fixed bed need pool. The number of approved beds that is subtracted shall be the number for which the agency has issued a certificate of need, a letter stating the agency’s intent to issue a certificate of need, a signed stipulated agreement, or a final order granting a certificate of need, as of the most recent published deadline for agency initial decisions prior to publication of the fixed bed need pool. (Rule 59C-1.036, F.A.C.)

<sup>5</sup> Florida Agency for Health Care Administration. 2005.

will increase at a faster rate than the population as a whole. The population age 65 or older will increase by 32.2 percent (from 3.1 million in 2005 to 4.1 million in 2015). The population age 75 and older, which receives heavier weighting in the nursing home bed-need methodology, will increase by 21.1 percent (from 1.6 million in 2005 to 1.9 million in 2015). And the oldest segment of the population—those 80 years old or older—will increase by 53.3 percent (from 422,166 in 2005 to 647,044 in 2015).

The charts below<sup>6</sup> show the age and gender distribution of Florida’s total population in 2005 and 2015.



<sup>6</sup> Source: Florida Legislature. Office of Economic and Demographic Research. Demographic Estimating Conference Database, updated July 2005.

Within the next 10 years, Florida will need more nursing home beds. Predicting how many, when, where, and what type is difficult because the factors that affect the health and independence of Florida's elderly population will be changing during that decade. A 2002 report by AHCA predicted that, based on bed ratios per 1,000 individuals aged 65 and older and assuming a 95 percent occupancy rate, Florida would need 33,046 more nursing home beds by 2015.<sup>7</sup> At 95 percent of the 2002 bed ratio, the report projected that Florida would need 27,305 more nursing home beds in 2015, and at 75 percent of the 2002 bed ratio, Florida would need 4,300 beds by that date. The use of bed-to-population ratios in the AHCA report could be considered a conservative method because Florida's nursing home bed supply had been limited by CON regulation throughout the decade preceding the study. However, national predictions of the number of older Americans who would be in nursing homes by a certain date assumed that utilization rates would be the same in the future as they were at the time of the prediction, and that did not turn out to be the case. "The number of older persons in nursing homes in 1999 was more than half a million below the number that would have been expected if 1973-74 utilization rates had continued."<sup>8</sup> Nationally, utilization of nursing home beds by persons aged 65 and older has declined for the total population but has increased for Black or African American residents.<sup>9</sup>

The factors that could have contributed to lower national utilization rates in nursing homes include declining disability among the elderly and changes in policies for the provision of long term-care that emphasize helping the individual to stay autonomous in his or her own home. The disability that accompanies old age has been declining for the past several decades.<sup>10</sup> That is, the current population age 65 and older is less disabled than comparable age cohorts in previous generations. They are able to function and live independently to a greater extent and to a later age than was the case for members of previous generations. The factors that could contribute to the decline of disability include:

- Medical care improvements such as pharmaceutical drugs to address chronic diseases and procedures such as joint replacement to permit mobility;
- Changes in health behavior such as a decline in smoking and trends toward low-fat and reduced-salt foods;
- Increased use of aids such as walkers, handrails, and bathrooms and kitchens that are accessible by persons with disabilities
- Higher socioeconomic status accompanied by increased levels of education and jobs that pose fewer health hazards
- Disease exposure throughout the lifespan, which declined in the 20th century because of discoveries for prevention and treatment; and
- Social support that improves social engagement and cognitive functioning and reduces stress.<sup>11</sup>

Alternative types of long-term care probably have contributed to a reduction in nursing home admissions by providing support for elderly individuals. These alternatives include:

- Assisted living facilities (ALFs)
- Home health care
- Home and community-based services

Florida's "oldest old" population, those age 85 and older, is projected to be 647,044 in 2015. "The size of the oldest-old population is a somewhat better indicator of the level of need for long-term care than the elderly population in general, since frailty increases with age."<sup>12</sup> A need for new nursing home beds may well occur coincidentally with the aging of the oldest old.

Nursing home access for Medicaid recipients is required in the criteria used to evaluate CON applications. At present, nursing homes throughout Florida serve Medicaid recipients and none reports a lack of capacity to do so. A likely first signal that the bed supply is becoming inadequate will be when providers cannot find a nursing home placement for Medicaid recipients.

The state's total Medicaid nursing home bed days for each of the past five years are shown in the chart below:

<sup>7</sup> Florida Agency for Health Care Administration. *Proposal to Reduce Medicaid-Funded Nursing Home Bed Days in Florida*. 2002. p. 26.

<sup>8</sup> Redfoot, D. and Pandya, S. *Before the Boom; Trends in Long-Term Supportive Services for Older Americans with Disabilities*. AARP. 2002. p. 5

<sup>9</sup> National Center for Health Statistics. *Chartbook on Trends in the Health of Americans*. 2004, p. 305

<sup>10</sup> Cutler, D. "Declining Disability among the Elderly". *Health Affairs*. Vol. 20, No. 6, 2001

<sup>11</sup> *Ibid.*

<sup>12</sup> Florida Agency for Health Care Administration. *Proposal to Reduce Medicaid-Funded Nursing Home Bed Days in Florida*. 2002. p.15.

Year	Medicaid Bed Days
2000	16,429,814
2001	16,281,639
2002	16,270,629
2003	16,476,569
2004	16,356,782

Representatives of the state's three nursing home associations—the Florida Health Care Association, the Florida Association of Homes for the Aging, and the Florida Long-Term Health Care Association—reported that their industry does not see a need to lift the moratorium at this time. They agreed that an exception to the moratorium should be provided for nursing homes where the occupancy rate exceeds 96 percent and the home has a record of providing high-quality care. They recommended that in such circumstances, a minimum occupancy level for the subdistrict should be a criterion for the exception.

While there is not currently a need for nursing home beds in Florida, and the projected need is for 279 beds in 2008, there will be a need for many more beds as the elderly population increases. In 2003, Florida ranked 48<sup>th</sup> in the nation in the number of beds per 1,000 population age 65 and older.<sup>13</sup> If Florida is to continue a policy of closely coordinating the number of beds to the need for beds, the state must plan within the next 5 years for the increase in the elderly population.

Planning for new nursing homes must take into account Florida's ethnic make-up and the differences in utilization of nursing homes and other health care services by White non-Hispanic, Black non-Hispanic, and Hispanic elderly. The ethnic make-up of Florida's population age 75 and over will change over the next 10 years. White non-Hispanic residents age 75 and older who comprise 7.6 percent of the population in 2005 will decline to 7.3 percent of the population in 2015 (from 1,351,621 in 2005, to 1,563,507 million in 2015, representing an increase in number but a decline in proportion relative to other groups). Black non-Hispanic residents age 75 and older will increase from .5 percent of the population in 2005 to .6 percent in 2015 (from 83,046 in 2005, to 124,893 in 2015). Hispanic residents who comprise .9 percent of the population in 2005 will increase to 1.1 percent of the population in 2015 (from 155,790 in 2005, to 232,020 in 2015).

## Statutory Placement of the Moratorium

The moratorium on approval of certificates of need for additional nursing home beds was enacted in s. 52 of ch. 2001-45, L.O.F.; this section was omitted from the statutes because it was a temporary provision that will expire in 2006. However, after s. 52 of ch. 2001-45, L.O.F., was amended by the 2004 Legislature, the Division of Statutory Revision codified s. 52 and the subsequent amendments to it at s. 651.1185, F.S., in a chapter that governs continuing care contracts. With the publication of the 2004 Florida Statutes, it became appropriate to cite s. 651.1185, F.S., as the law that imposes a moratorium on approval of certificates of need for additional nursing home beds.

In reviewing the moratorium, staff found that the placement of the moratorium in ch. 651, F.S., amid statutes for continuing care contracts, rather than in ch. 408, F.S., which governs health care administration, including certificate-of-need review, is confusing. In fact, a number of experts on the subject did not know that the moratorium had been codified in ch. 651, F.S. If the moratorium is continued, s. 651.1185, F.S., should be moved to ch. 408, F.S.

## RECOMMENDATION

Section 651.1185, F.S., should be moved to ch. 408, F.S., and amended to extend the moratorium on the approval of certificates of need for additional nursing home beds until July 1, 2011. In order to ensure access, an exception to the moratorium should be permitted to allow nursing homes with a 96 percent or greater occupancy rate to add 10 beds or 10 percent of the number of licensed beds if the home had no class I or class II deficiencies in the past 30 months and the occupancy rate in the planning subdistrict is 94 percent or greater. This exception is the same policy as the exemption to CON review under s. 408.036(3)(j), F.S., which is not currently available to nursing homes because of the moratorium. If the Legislature enacts this recommendation, the moratorium would stay in effect for five more years, and AHCA would have the authority to grant an exception to the moratorium for nursing homes that provide a good quality of care and that are operating at what is essentially full capacity.

<sup>13</sup> Gibson, M. Gregory, S. Houser, A. and Fox-Grange, W. *Across the States: Profiles of Long-Term Care 2004*. AARP. 2004.

**MINUTES**  
**STATE COMMISSION ON THE EFFICACY OF CON**  
Sanders Fireplace Room at the Capitol Education Center  
October 24, 2005; 1:00 pm

## Appendix B

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- Membership List, Health Strategies Council (as of October 2005)

# HEALTH STRATEGIES COUNCIL MEMBERS

(as of October 2005)

## Member and Affiliation

## Category of Representation

**Daniel W. Rahn, M.D., *Council Chairman***

President, Medical College of Georgia  
Augusta

Member at Large

**William G. Baker, Jr., MD**

Executive Director, Atlanta Regional Health Forum, Inc.  
Atlanta

Health Care Needs of  
Low-Income Persons

**The Honorable Glenda M. Battle, R.N., BSN**

Decatur County Commissioner  
Association County Commissioners of GA  
Bainbridge

County Governments

**Mr. Harve R. Bauguess**

President, Bauguess Management Company, Inc.  
Atlanta

Health Care Providers-  
Nursing Homes

**VACANT**

Health Care Needs of  
Older Persons

**Mr. Edward J. Bonn, CHE**

President/CEO, Southern Regional Health System  
Riverdale

Health Care Providers –  
Urban Hospitals

**VACANT**

Health Care Needs of Populations  
with Special Access Problems

**Ms. Elizabeth P. Brock, (*Vice Chair*)**

President, Pallets Incorporated  
Atlanta

Health Care Needs of  
Small Business

**Mr. Tary L. Brown**

CEO, Albany Area Primary Health Care, Inc.  
Albany

Health Care Providers –  
Primary Care Centers

**Member and Affiliation**

**Category of Representation**

**Mr. W. Clay Campbell**

Executive Vice President, Archbold Medical Center  
Thomasville

Health Care Providers –  
Home Health Agencies

**Nelson B. Conger, D.M.D.**

Dalton

Health Care Providers –  
Primary Care Dentist

**Ms. Katie Foster**

Ellenwood

Health Care Needs of  
Organized Labor

**Charlene M. Hanson, Ed.D., FNP**

Professor Emerita, Family Nurse Practitioner  
Georgia Southern University  
Statesboro

Health Care Providers –  
Nurse Practitioners

**VACANT**

Health Care Needs of Persons  
with Disabilities

**Reverend Ike E. Mack**

Pastor, Unionville Baptist Church  
Warner Robins

Member at Large

**Felix T. Maher, D.M.D**

Savannah

Health Care Providers-  
Primary Care Dentist

**Julia L. Mikell, M.D.**

Neurologist, Neurological Institute of Savannah  
Savannah

Health Care Providers –  
Specialty Physician

**Mr. Jim Peak**

CEO, Memorial Hospital & Manor  
Bainbridge

Health Care Needs of Populations  
with Special Access Problems

**VACANT**

Health Care Needs of  
Large Business

**Member and Affiliation**

**Category of Representation**

**Mr. Raymer Sale, Jr.**

President, E2E Resources, Inc.  
Lawrenceville

Private Insurance Industry

**Mrs. Toby D. Sidman**

Past President, Georgia Breast Cancer Coalition &  
Georgia Breast Cancer Coalition Fund  
Atlanta

Health Care Needs of Women

**Ms. Cathy P. Slade**

Director, Georgia Medical Center Authority  
Augusta

Health Care Needs of Populations  
with Special Access Problems

**Oscar S. Spivey, M.D.**

Professor and Chairman Emeritus of Pediatrics  
Mercer University School of Medicine  
Macon

Health Care Needs of Children

**Ms. Tracy Michele Strickland**

Associate, Life Science Practice Group  
Spencer Stuart  
Atlanta

Member at Large

**Mr. Kurt Stuenkel, FACHE**

President & CEO, Floyd Medical Center  
Rome

Health Care Providers –  
Rural Hospitals

**Ms. Kay L. Wetherbee, R.N.**

Atlanta

Health Care Providers –  
Registered Nurse

**David M. Williams, M.D.**

President/CEO, Southside Medical Center  
Atlanta

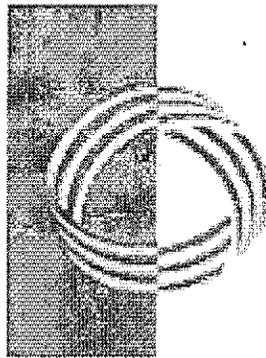
Health Care Providers-  
Primary Care Physician

**MINUTES**  
**STATE COMMISSION ON THE EFFICACY OF CON**  
Sanders Fireplace Room at the Capitol Education Center  
October 24, 2005; 1:00 pm

# Appendix C

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- Ambulatory Surgery Center-Letters of Non Reviewability  
Presentation by Rob Rozier, JD

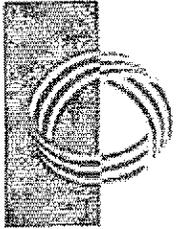


GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

# Ambulatory Surgery Center Letters of Non-Reviewability

Georgia Commission on the Efficacy of the CON Program

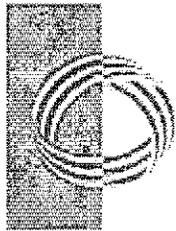
October 24, 2005



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

## History of Review of ASCs

- 1984: First CON ASC Rules Created
- 1987: Revised CON ASC Rules exempted limited purpose ASCs that were physician owned from need and adverse impact analyses
- April 24, 1991: CON statute amended to exempt from CON review certain ASCs that can be established at a cost below a specific amount
- 1991 through 1996: SHPA continued to issue CONs for these exempt ASCs

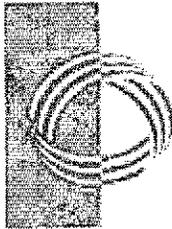


GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

## Policy Change

- 1996: SHPA discontinued CON review for these excluded ASCs and developed a separate process of review:

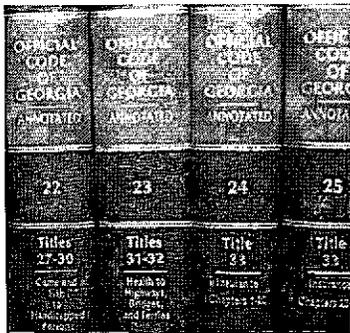
# Letters of Non-Reviewability



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

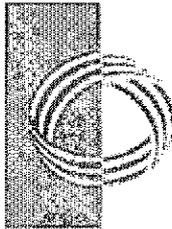
## The LNR Concept

- CON Statute, OCGA 31-6, does not mention the term, “Letters of Non-Reviewability” (“LNR”)
- But 31-6-47(c) provides that DCH may develop rules to waive the review of exempt projects



- DHR requires some form of written Department authorization prior to issuance of a license

Letters of Non-Reviewability



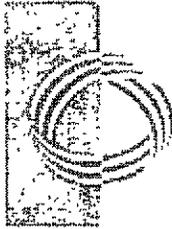
GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

## Statutory Requirements of ASC Exclusion

“New Institutional Health Service” means:

Surgery in an operating room environment, including, but not limited to ambulatory surgery; provided, however, this provision shall not apply to surgery performed in the offices of an individual private physician or single group practice of private physicians if such surgery is performed in a facility that is owned, operated, and utilized by such physicians who also are of a single specialty and the capital expenditure associated with the construction, development, or other establishment of the clinical health service does not exceed the amount of \$1 million\*

Source: OCGA 31-6-2(14)(G)(iii)

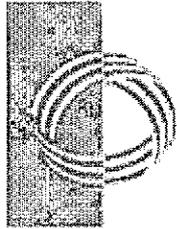


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COMMUNITY HEALTH

## Regulations

- The Department promulgated rules, which took effect in 1998, to further explain and define the requirements for the statutory ASC exclusion
- 272-2-.07(5)



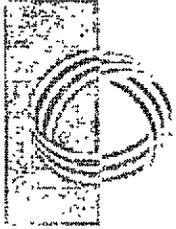


GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

## Statutory Requirements of ASC Exclusion

1. Operating room environment
2. Performed in the offices
3. Individual private physician or single group practice of private physicians
4. Owned, operated, and utilized by such physicians
5. Of a single specialty
6. Does not exceed the amount of \$1 million\*

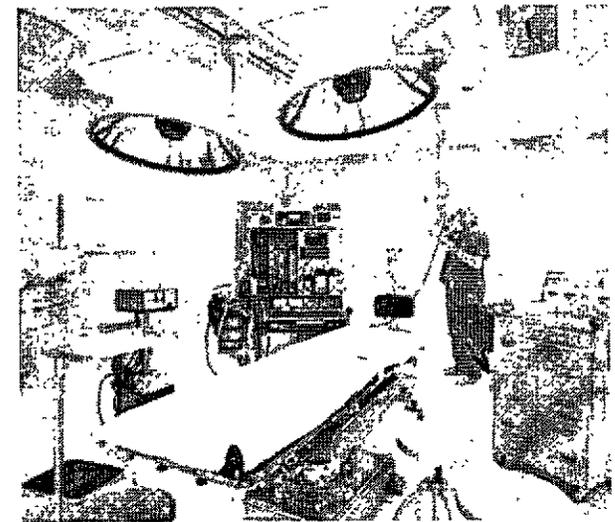




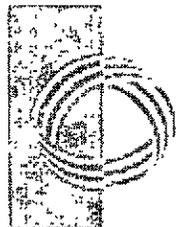
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COMMUNITY HEALTH

## Requirement: Operating Room Environment

- OCGA 31-6-2(16.1) and Department's regulations define "operating room environment"
  - Minimum physical plant standards of DHR



Source: Ga. Code of R. & Regs. r. 272-2-.07(4)(g), (h), (j)



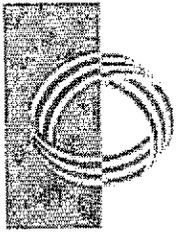
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COMMUNITY HEALTH

## Requirement: Performed in the Office

- Reasonable proximity to a clinical office space
  - Interpreted to mean in the same building as office space



Source: Ga. Code of R. & Regs. r. 272-2-.07(4)(f)



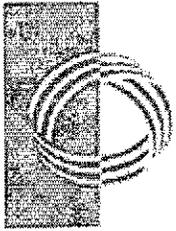
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COMMUNITY HEALTH

## Requirement: Individual Private Physician or Single Group Practice

- Evidence of Sole Physician Corporation or Group Practice, e.g. articles of incorporation, by-laws, operating agreements
- Affidavit stating that each physician belongs only to one practice



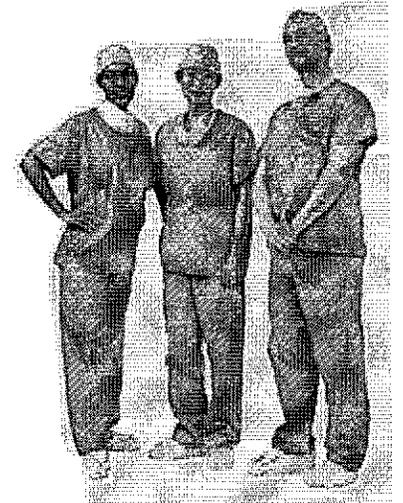
Source: Ga. Code of R. & Regs. r. 272-2-.07(4)(d), (l) - (o)



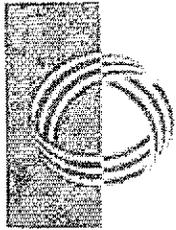
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COMMUNITY HEALTH

## Requirement: Owned, Operated, and Utilized by

- Must have at least 85% licensed physician ownership
- Ownership evidence must be submitted, e.g. stock certificates, operating agreement
- Must submit site entitlement documentation



Source: Ga. Code of R. & Regs. r. 272-2-.07(4)(b)-(e)



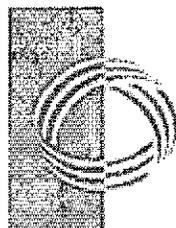
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COMMUNITY HEALTH

## Requirement: Of a Single Specialty

- All members and employed physicians must be of same surgical specialty
- Evidence generally includes an affidavit or documentation of specialty listed with Composite Medical Board



Source: Ga. Code of R. & Regs. r. 272-2-.07(4)(b)

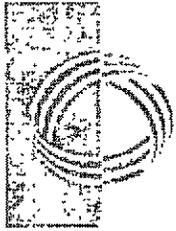


GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

## Requirement: Of a Single Specialty (cont'd)

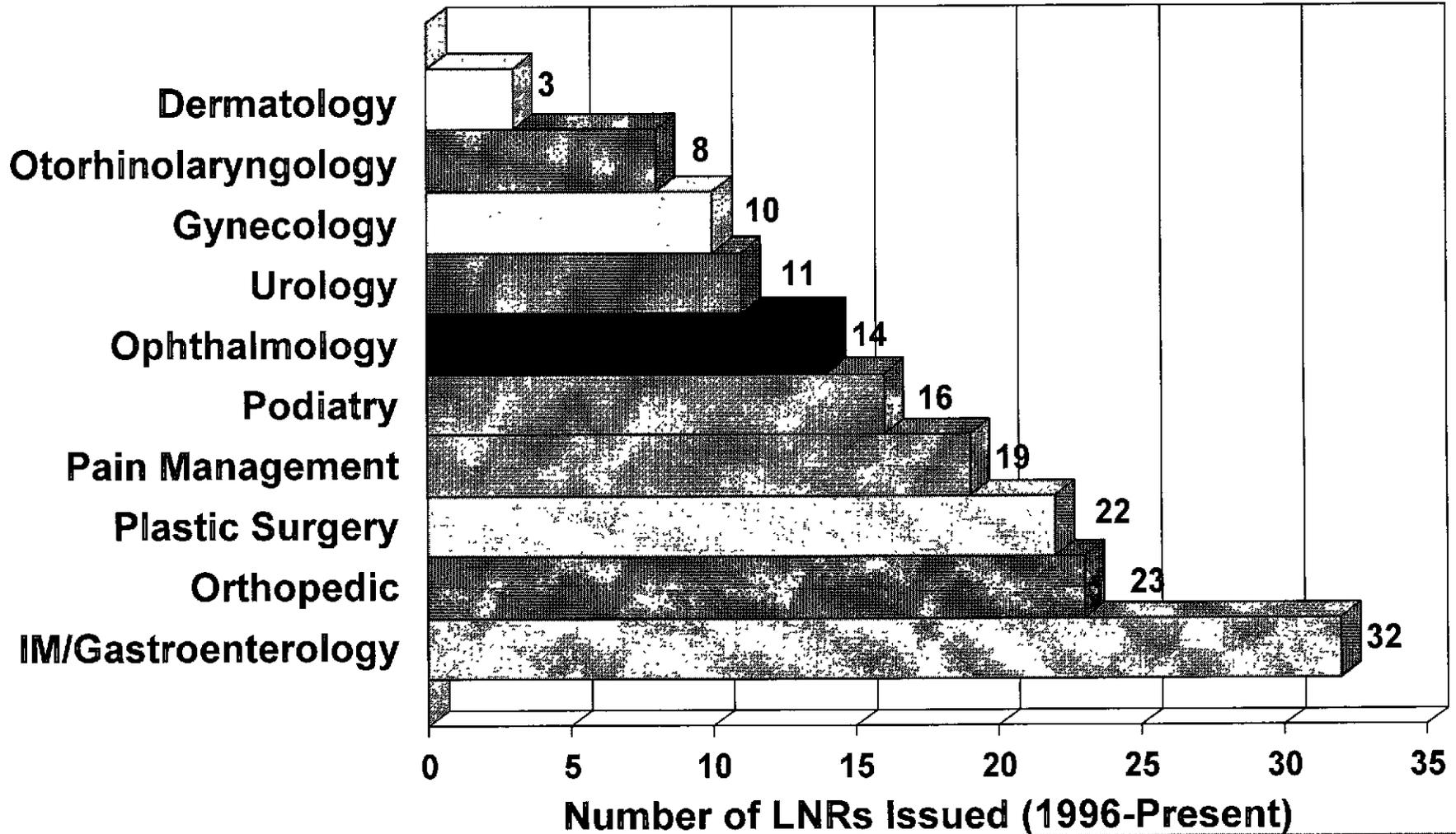
- Neither Statute nor Regulations define “single specialty”
- Regulations define “multi-specialty”
  - Any ASC offering general surgery or any combination of general surgery and any number of the following specialties:
    - Dentistry/oral surgery
    - Gastroenterology
    - OB/GYN
    - Ophthalmology
    - Podiatry
    - Pulmonary Medicine
    - Orthopedics
    - Otolaryngology
    - Pain Management/  
Anesthesiology
    - Plastic Surgery
    - Urology

Source: Ga. Code of R. & Regs. r. 111-2-2-.40(2)(j)

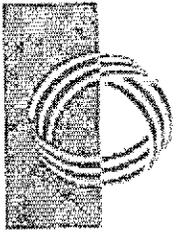


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COMMUNITY HEALTH

# Historical Data: Specialty



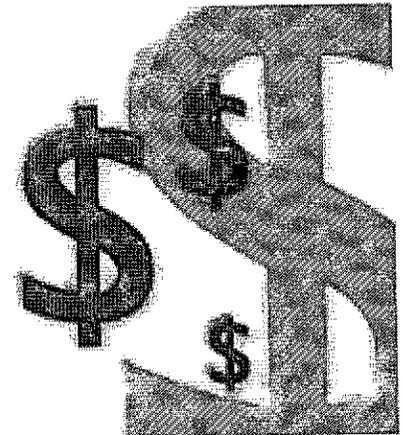
Letters of Non-Reviewability



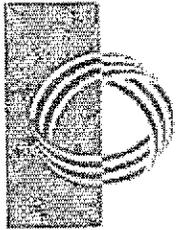
GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

**Requirement: Does not Exceed  
the Amount of \$1 Million\***

- Amount is adjusted annually for inflation in construction indices
  - Currently \$1.515 M
- Includes all capital expenditures made by or on behalf of the physician or group in establishing and developing the ASC for the first three years including:
  - Construction
  - Equipment
  - Legal, consulting, and administrative fees
  - Interest during construction
  - Furnishings



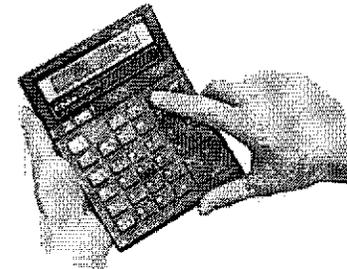
Source: Ga. Code of R. & Regs. r. 272-2-.07(4)(i), (k), (p), (q)



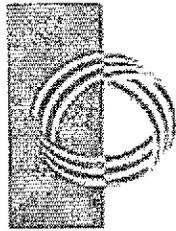
GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

## Requirement: Does not Exceed the Amount of \$1 Million\* (cont'd)

- In calculating the threshold all “associated and simultaneous” expenditures and activities must be included, for example:
  - simultaneous construction of clinical offices
- Estimates are provided during the review of the LNR request; final cost reports must be submitted to validate that the threshold has not been exceeded



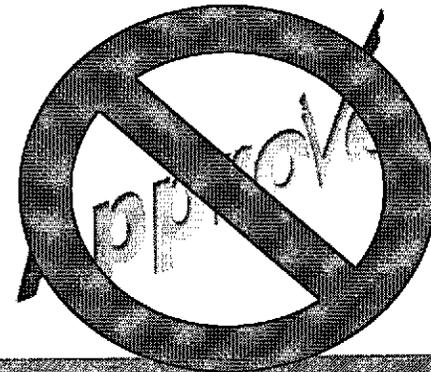
Source: OCGA 31-6-2(14) & Ga. Comp. R. & Regs. r. 111-2-2-.01(8)

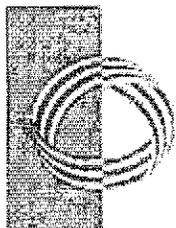


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## LNR Challenges

- During the review process, an LNR request may be challenged by any interested party
  - The Department issues weekly notice of all new LNR requests
  - Challengers submit written allegations and reasons for Departmental denial
  - Requesters have opportunity to respond to all allegations





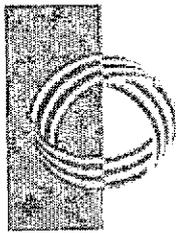
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COMMUNITY HEALTH

## Options if LNR Request Denied

- Appeal
  - Only the requesting party may appeal a denial
  - Challengers may not appeal if approved
  - Challengers may intervene in an appeal of a denial

OR

- Apply for a CON



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COMMUNITY HEALTH

# Differences between CON and LNR Processes

## LNR

- No Need Analysis
- No Commitment to Indigent and Charity Care
- Only Requesting Party may Appeal
- Limited to Statutory Restrictions
- No Review of Quality
- No Review of Fees
- No Requirement to Report Statistical Data

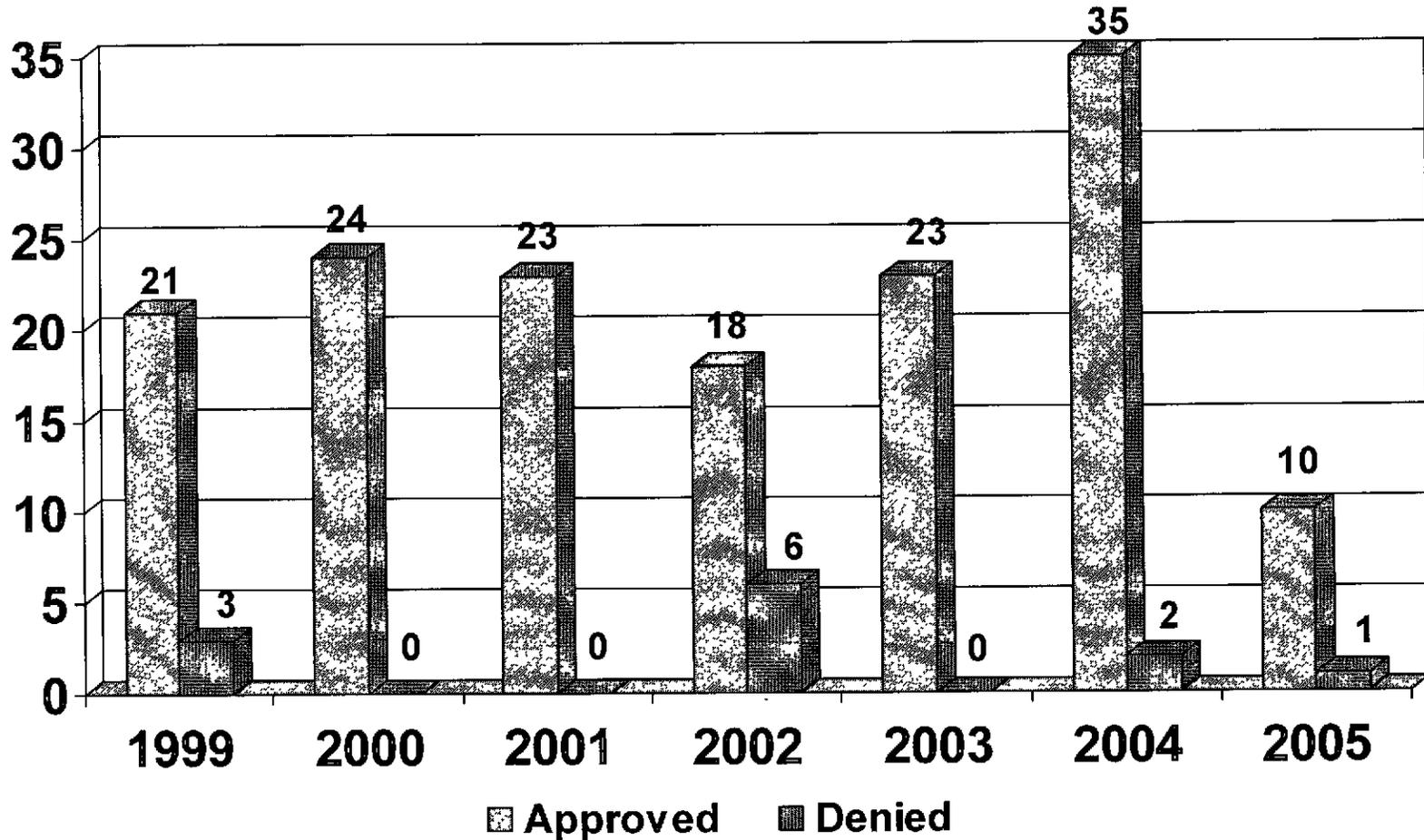
## CON

- Calculated Need Must Exist
- Must Commit to Provide 3% of annual AGR to Indigent and Charity Care
- Any Competing Entity may Appeal
- No limitations on ownership, location, cost, specialty, etc.
- Minimum quality standards must be met
- Fees must be Reasonable
- Must Report Annual Data

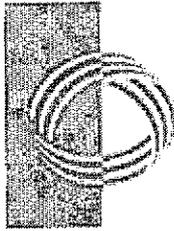


GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

# Historical Data: Requests Received



Letters of Non-Reviewability



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COMMUNITY HEALTH

# Questions



*Questions*

Letters of Non-Reviewability

**MINUTES**  
**STATE COMMISSION ON THE EFFICACY OF CON**  
Sanders Fireplace Room at the Capitol Education Center  
October 24, 2005; 1:00 pm

## Appendix D

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- Draft Proposed Ambulatory Surgery Center Rules

# **GEORGIA STATE HEALTH PLAN COMPONENT PLAN**

## **AMBULATORY SURGICAL SERVICES**

**HEALTH STRATEGIES COUNCIL  
GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
DIVISION OF HEALTH PLANNING  
2 Peachtree Street, NW  
Suite 34.262  
Atlanta, GA 30303**

For review and input by Health Strategies Council at their November 21, 2003 meeting

**DRAFT**

Revised November 18, 2003

## PREFACE

This Component Plan is a product of the Health Strategies Council and the Georgia Department of Community Health/Department of Health Planning, pursuant to the provisions of O.C.G.A. 31-5A-1 et seq., and 31-6-1, et seq., and Ga. Comp. R. and Regs. 272-2-1 et. Seq. The purpose of the Plan is to identify and address issues that affect the operation of ambulatory surgery centers and to recommend goals, objectives and system changes to achieve official state health policies.

This Plan has been produced through an open, public participatory process developed and monitored by the Health Strategies Council appointed by the Governor. The Plan is effective upon approval by the Council and the Board of Community Health and supersedes all related sections of previous editions of the State Health Plan and any existing related Component Plan.

For purposes of the administration and implementation of the Georgia Certificate of Need (CON) program, criteria and standards for review (as stated in the Ga. Comp. R. & Regs., Chapters 272-1, 272-2 and 272-3) are derived from this Component Plan. The Rules, which are published separately from the Plan and which undergo a separate public review process, are an official interpretation of any official Component Plan which the Regulatory Review Section of the Office of General Counsel has the legal authority to implement. The Rules are reviewed by the Health Strategies Council, prior to their adoption by the Board of Community Health, for their consistency with the Plan. The Rules, as a legal document, represent the final authority for all Certificate of Need review decisions.

Any questions or comments on this Component Plan should be directed to:

Georgia Department of Community Health  
Division of Health Planning  
2 Peachtree Street, N.W., Suite 34.262  
Atlanta, Georgia 30303

◆  
Telephone: (404) 656-0655

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## I. INTRODUCTION

### A. STATEMENT OF PUBLIC POLICY FROM THE DEPARTMENT OF COMMUNITY HEALTH

The Department of Community Health (DCH) was created in 1999 by the Georgia General Assembly in response to a growing concern about fragmentation of health care delivery at the state level. The legislation outlined several purposes for the Department including the development of a state health care infrastructure that would be more responsive to the consumers it serves while improving access to services and healthcare coverage and promoting wellness. The Department has embarked on this charge with great enthusiasm and fervor. Since the formation of the Department of Community Health, several components of the State Health Plan have been revised to reflect the new regulatory focus and policy integration.

The Department is responsible for managing the state's health planning program which establishes standards and criteria for awarding Certificates-of-Need to health care facilities and certain specialized diagnostic or treatment services. The Department works to contain health care costs by avoiding unnecessary duplication of services, equipment and facilities and helps to enforce quality-of-care standards. The Department is committed to ensuring that providers assume a share of the responsibility for the health care needs of low-income citizens and underserved or at-risk members of their local community. Financial access, clinical proficiency and community outreach are cornerstones of the Department's mission.

The Department of Community Health has chosen to update the Ambulatory Surgical Services Plan and Rules to describe the current regulatory framework within which providers will be required to operate and to ensure the protection of the public and payor systems. The previous state health component plan and rules governing the need for and operation of ambulatory surgery services were adopted in 1998. These rules address multi-specialty and limited-purpose freestanding ambulatory surgery services. The majority of physician-owned, single-purpose surgical centers are exempted from Certificate of Need rules by law. Since the inception of the current component plan, concern has been raised by certain providers and advocates about elements of the need methodology, the planning areas, adverse impact on other providers, and the overall scope of the plan. DCH Board Members and a wide range of stakeholders have suggested that the plan needs to be reviewed and updated.

It is the Department's hope that this revised plan and accompanying rules will incorporate a range of strategies to clarify and strengthen the planning and regulatory review process. The Department is committed to :

- Maintaining an objective need methodology for ambulatory surgical services;
- Promoting access to ambulatory surgical services by fostering an environment that encourages the delivery of services to all Georgia citizens;
- Incorporating clinical and other advances occurring in ambulatory surgical services in its planning and regulatory rules;
- Ensuring uniformity between state agencies by adopting common service delivery regions by moving away from health planning areas and utilizing State Service Delivery Regions and

- Advocating the Department's commitment to continuity of care, quality improvement standards and data reporting systems for health services, including freestanding ambulatory surgery services in the state.

## **B. PLANNING PROCESS**

The first ambulatory surgery services component of Georgia's State Health Plan was completed in 1984. This plan dealt specifically with ambulatory surgery centers that were owned and/or operated by hospitals or other entities and did not include private physician or dental offices. The plan was revised in August 1987 to allow physicians, who had been providing outpatient surgery services within their own offices, to be classified as physician-owned, limited-purpose ambulatory surgery centers so that they could receive Medicare facility fee reimbursement for services rendered in this setting. The plan was revised again in July 1989 to include the most recent Georgia-specific ambulatory surgery use rate when computing need instead of the non-specific 30% rate designated in the 1984 plan.

The rapid growth of ambulatory surgery programs in the state and the passage of HB 508, in March 1991, which regulates diagnostic, treatment, and rehabilitation centers that offer ambulatory surgery services outside of a hospital setting, provided the impetus once again to update the plan. In August 1995, Georgia's Health Strategies Council (Council), a 27-member board appointed by the Governor, responsible for developing Georgia's State Health Plan and addressing policy issues concerning access to health care services, voted to convene a Modified Technical Advisory Committee (TAC). Members consisted of the Council's Ambulatory/Primary Care Standing Committee. The Modified TAC held its first meeting in November 1995, and formed a Capacity/Utilization/Adverse Impact Subcommittee, which met in November and December 1995, and a Survey Work Group, which met in December 1995. These subcommittees focused on such issues as the availability of ambulatory surgical services in Georgia, local and national trends, and definitions of critical terms including capacity and utilization. After consideration of several options, the TAC recommended the development of a plan and rules that did not include a specific numerical need formula or a definition of 'capacity', but one that would continue to address the public policy objectives of access and quality. This strategy was based on the following considerations:

- Ambulatory surgery services provide low-cost alternatives to inpatient surgery services in Georgia;
- Ambulatory surgery services should remain under CON regulation, but 'capacity and volume' criteria of the need methodology should be eliminated. TAC members agreed that market forces, particularly those in urban areas, would serve to control excess investment;
- The public policy objectives of access and quality should continue to be addressed in the plan and rules.
- Ambulatory surgery rules should be compatible with the current healthcare market place so that economic realities (i.e. competition, managed care, and numbers of providers) can co-exist with regulation.

In February 1996, the TAC presented the draft plan and rules to the Council. The Council voted to issue the draft Plan and rules for public comment. The proposed plan and rules were issued for public comment in March 1996. A second public comment period was held in June 1996. During both comment periods, the public expressed concern about the absence of a numerical need methodology. They were concerned about whether the proposed rules would provide adequate justification for the Agency (now the Division of

Health Planning) to legally defend its regulatory review decisions. There was also some concern about the assumptions of the strength of market forces on ambulatory surgery services in Georgia. Considering the strength of the public comments, in August 1996 the Council voted not to adopt the proposed rules. Following additional staff research and input from the Council a draft plan and CON rules, which incorporated an objective need methodology, were issued for public comment in April 1998. In June 1998, the plan and rules were formally adopted.

Since the inception of the 1998 component plan, concern continued to be raised about elements of the need methodology, the planning areas, adverse impact on other providers, and the scope of the plan. DCH Board members charged the Department of Health Planning and the Council to review and update the Ambulatory Surgery Services Plan and Rules.

The revision and adoption of a component plan is a deliberate process by the Council and involves the establishment of a TAC. At their May 2002 meeting, Council members established three new standing committees, namely Acute Care, Long Term Care and Special & Other Services. Ambulatory Surgery Services fell under the purview of the latter committee. This committee was chaired by David M. Williams, M.D. and charged with periodically addressing changes occurring in the healthcare industry that would impact the way that specialized services are delivered. At its January 2003 meeting, the Special & Other Services Standing Committee recommended the establishment of a TAC for freestanding ambulatory surgical services. At its February 2003 meeting, the Council voted to convene an Ambulatory Surgical Services TAC.

Members of the Ambulatory Surgical Services TAC (See Appendix A) represented varied geographic regions of the state and are members of a wide variety of constituent groups, including state agencies, consumers, professional associations, advocates, provider groups, and payors. William G. Baker, Jr. MD, President, Atlanta Regional Health Forum, Inc and member of the Council, chaired this 18-member group. The TAC was asked to develop a new component plan and related rules to govern the establishment, replacement or expansion of ambulatory surgery services. The Council charged the TAC with producing two work products:

- A proposed new component plan for consideration by the Council that would address the development, delivery and maintenance of statewide ambulatory surgical services and
- A set of proposed rules for consideration by the Council and the Board of Community Health.

The TAC met five times between May 2003 and November 2003. They examined a plethora of statewide data and planning materials and closely examined other state methodologies and planning processes, materials from national accrediting bodies, professional associations and considerable public input. During their deliberation process, they agreed that the following concepts should be represented in the core criteria of the ambulatory surgery rules in the State of Georgia:

- Numerical Need methodology
- Exception to Need Language (cost, quality, financial and geographic access)
- Definition of "single specialty" and development of a list of core specialties
- Financial Accessibility, including Indigent and Charity Care Commitments
- Definition of operating rooms and determination as to which rooms should be counted in the need methodology (look at Medicare rules and regulations)
- Determination of whether to use "patients" or "procedures" in need determinations (look to

- Medicare definition)
- Continuity of Care Standards
- Quality of Care Standards
- Determination of planning area boundaries (health planning areas versus state service delivery regions)
- Community focus (availability of services locally)
- Clarification of Relocation/Replacement Issues

This list of planning concepts was augmented and refined during the TAC's deliberations and provided the backbone for the development of the Ambulatory Surgical Services Plan and Rules. Following three committee meetings, development of draft rules and significant committee input, the TAC appointed a subcommittee to convene a Public Forum. This subcommittee's responsibility was to preside at a forum to allow the public additional opportunities for input into the plan development and rules process. The Public Forum was held in Bibb County, a centrally located county in the state. Nearly 30 persons attended; nine (9) of whom presented oral comments. Others provided feedback through written submissions. Two additional TAC meetings were held to formally adopt all of the planning principles in the plan and rules.

The current rule incorporates certain aspects of the earlier version of the rules, but also includes a range of other considerations. Some of the key differences between these rules and the earlier version include the following:

- Expanded and updated definitions;
- Change of terminology from "limited purpose" to "single specialty" and a clear delineation of single specialties;
- Allowance for replacement facilities in narrow situations (exempt from the numerical need methodology and adverse impact standard).
- Incorporation of some straightforward options for exceptions to the numerical need methodology;
- More detailed adverse impact criteria and inclusion of some protections for safety net hospitals; and
- Enhancement of quality, continuity and financial accessibility standards;

Information used in the development of this plan and accompanying rules is the result of review of ambulatory surgical services plans from other states, research of current literature, review of the rules of the American Society of Anesthesiologists, American Association for Accreditation of Ambulatory Surgery Facilities, Accreditation Association for Ambulatory Health Care and other appropriate agencies, considerable public input and deliberation by the TAC. The Department's legal team also provided guidance to the Department and the TAC in the final development of the rules.

This planning document represents a consensus from the Ambulatory Surgical Services Technical Advisory Committee and was presented for consideration at the Council's meeting in November 2003. Upon the Council's approval of the recommendations and concepts that are outlined in the Ambulatory Surgical Services component of the state health plan, the rules were forwarded to the Board of Community Health for posting for public comment. The TAC feels confident that this document provides an excellent structure and process to assure that high quality ambulatory surgery services are provided in an efficient and cost effective manner to the citizens of the State of Georgia.

## II. OVERVIEW

### A. OVERVIEW OF NATIONAL TRENDS

Ambulatory surgical services have historically provided safe and cost effective outpatient care for patients that may have otherwise been admitted to a hospital. A report published by the Medicare Payment Advisory Committee (MedPAC) identified the following factors that impact the growth of Ambulatory Surgery Centers (ASCs): the shift of services from inpatient settings to ambulatory care settings; growth in ASCs share of ambulatory services; changes in practice patterns and medical technology; benefits to patients; and benefits to physicians.

The increase in the number of surgeries performed in freestanding ambulatory surgical facilities has outpaced the growth of hospital outpatient departments and physician offices. Payor incentives, patient convenience, and physician preference can be attributed to the growth in the volume of surgeries and procedures performed in freestanding outpatient settings. Payors may cover more of the cost for patients that receive services in an ambulatory surgery center. Some data suggest that patients may prefer the more convenient locations, lower insurance co-payments, decreased exposure to infectious agents, and timely appointment scheduling that are provided by ambulatory surgery centers.

Physicians are able to perform more surgeries in an ambulatory surgery setting because of the specialized services these centers provide. In addition, physicians are able to easily reserve appointment times in an ambulatory surgery center because there is a lack of unpredictable demands that may be encountered in a hospital outpatient department. Also, investing in ambulatory surgery centers allows physicians to increase their revenues.

#### Hospitals

Some hospital leaders have expressed concern about the proliferation of for-profit specialty services and contend that freestanding ambulatory surgery facilities and other specialty centers siphon off higher paying and insured patients as well as carve out the most profitable health services away from the hospital setting. Hospital proponents argue that this trend is detrimental to community hospitals particularly because specialty services compete with the more profitable services offered in hospital settings.

A report by the American Hospital Association acknowledges that, over the past twenty years advances in medical technology and practice patterns have dramatically changed the way healthcare is delivered in surgical settings. A growing number of medical procedures that were once delivered in a hospital-based inpatient setting are now safely performed in freestanding ambulatory surgery facilities. Advances in technology have made traditional surgeries less invasive and reduced the necessary post-surgery recovery time. These advances have allowed patients to avoid hospital overnight stays and made outpatient surgeries more convenient to physicians and patients.

Between 1980 and 2000, given the changing shifts in practice patterns primarily driven by insurance reimbursement methodologies and dramatic advances in medical technology, hospitals responded to the shift in surgical services from inpatient services to outpatient settings and began to downsize inpatient beds and shift resources to outpatient settings. The shift from inpatient to outpatient settings has continued to

grow with technological advances and has resulted in the lowering of healthcare costs to employers and payors.

### **Surgical Specialties**

The Federated Ambulatory Surgery Association (FASA), a nonprofit association representing the interests of ambulatory surgery centers, reported that the majority of procedures performed in ASCs were either ophthalmology or gastroenterology procedures. Among the procedures that are performed on an outpatient basis, include but are not limited to the following: ophthalmology, plastic and reconstructive surgery, podiatry, orthopedics, pain management, gynecology, and dermatology. Some of these specialties are operated in a single-specialty environment, where a provider offers services in one specialty area while other providers offer services in multi-specialty areas.

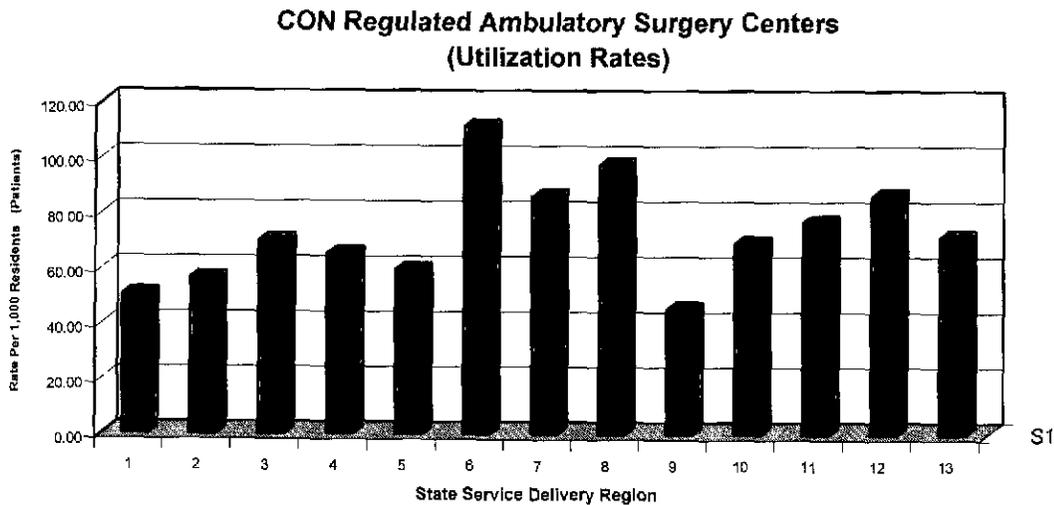
### **Single-Specialty, Physician-Owned Surgery Centers**

Emerging technological trends have led to the safe performance of complicated surgical procedures in office-based settings. In Georgia, single-specialty, physician-owned facilities, the cost of which falls below the designated CON threshold, are statutorily exempt from obtaining a Certificate of Need. A majority of the safety concerns that arise from physician offices appear to deal with factors contributed to inadequate anesthesia monitoring and the performance of too many procedures on one patient at one time. Those single-specialty, physician-owned facilities that trigger the Certificate of Need threshold must submit a CON application.

## **B. AMBULATORY SURGICAL SERVICES IN GEORGIA**

Georgia has become one of the ten most populous states in the nation with an estimated population of 8.1 million in 2000. The US Census estimated that Georgia's population grew 26.4% in a ten-year period, from 1990-2000. With an increase in population there is an increase in the demand for healthcare services. In 2002, for every 1,000 residents 71.73 people used ambulatory surgery services at either a freestanding or hospital outpatient facility. Figure 1 charts utilization rates by State Service Delivery Region for 2002. In addition to general population growth, the use-rate of ambulatory surgery services also increases with the age of the population. In a report released by the Center for Disease Control, National Center for Health Statistics, National Ambulatory Medical Care Survey, persons over the age of 45 constituted 53% of physician office visits. Increasing age was positively correlated to the increasing severity of the ailment and complexity of the procedure.

Figure 1. CON REGULATED AMBULATORY SURGERY CENTERS  
(Utilization Rates)



### Surgical Services in Georgia

There are a number of outpatient surgical facilities available to Georgia residents in both freestanding and hospital-based ambulatory environments. Since 1995, the Department of Community Health has reviewed sixty-six (66) applications for new freestanding ambulatory surgery facilities; 29 of those applicants were approved. In 2002, there were 153 operating rooms dedicated to outpatient surgeries in Georgia's 151 general hospitals. In addition to the dedicated hospital outpatient operating rooms, there were 883 shared operating rooms.

The total number of outpatient surgeries grew by almost 15% between 1998 and 2002, from 507,859 to 598,560 surgeries per year, in both freestanding and hospital-based outpatient settings.

Based on recent information provided by the Department of Human Resources/Office of Regulatory Services has licensed over 201 ambulatory surgery centers. This includes 46 freestanding ambulatory surgery facilities approved through CON review and single-specialty, physician-owned facilities that do not require CON approval. The differences in the number of freestanding facilities between the two Departments (Department of Community Health and Department of Human Resources) are due to

differences in regulatory oversight. The Department of Community Health, by statute, provide no regulatory oversight for those single-specialty, physician-owned facilities that fall below the statutory capital construction threshold. These providers are issued Letters of Non-Reviewability (LNRs) since development of their offices did not trigger the state's capital expenditure threshold.

The Department of Human Resources has the authority to license all ambulatory surgery facilities that seek licensure. Medicare requires that certified ambulatory surgery centers comply with state licensure requirements in order to be eligible for reimbursement through CMS. Ambulatory surgery facilities that wish to participate in the Medicare program must obtain state licensure.

**STANDARDS AND RATIONALE FOR RULES  
AMBULATORY SURGERY SERVICES  
272-2.09 STANDARDS AND CRITERIA. AMENDED**

**(I) AMBULATORY SURGERY SERVICES**

**(a) APPLICABILITY**

*The law and the rules of the Department of Community Health/Division of Health Planning, require a Certificate of Need (CON) prior to the establishment of new or replacement ambulatory surgery services or for applicants seeking to expand existing surgical services, the cost of which exceeds the CON threshold. This standard was fine-tuned to ensure that applicants are informed of the instances where the rules would specifically not apply and to provide guidance about the Department's regulatory authority.*

This rule applies only to those entities required to obtain a Certificate of Need (CON) and shall not apply to those entities otherwise exempt by rule or statute from obtaining a CON, including but not limited to facilities exempt under O.C.G.A.31-6-2(14)(G)(iii). For Certificate of Need purposes, an ambulatory surgery service is considered a new institutional health service if it is to be offered in a free-standing ambulatory surgery facility (ASF).

1. If the ambulatory surgery service is or will be provided as "part of a hospital", the hospital's provision of such service is not subject to CON review under this rule. For purposes of this rule, the following are always considered to be "part of a hospital":
  - a. if the service is located within a hospital; or,
  - b. if the service is located in a separate building on the hospital's main campus or on separate premises and the service is integrated with other hospital services and systems, and the services are billed through the hospital's Medicare or Medicaid provider number and/or license number issued by the Department of Human Resources.

The Department of Community Health also will make a determination of reviewability on a case-by-case basis in other situations involving hospitals.

2. The legal entity that develops any ambulatory surgery facility subject to this rule shall be the applicant.
3. A single specialty ambulatory surgery service will be issued a single specialty CON. A new CON will be required for a single specialty ambulatory surgery service to become a multi-specialty service.
4. A party requesting designation as a physician-owned, single-specialty ambulatory surgery service that exceeds the capital expenditure threshold set forth in O.C.G.A. 31-6-2 (14) (G) (iii), and thus is not exempt from CON guidelines pursuant to this statutory provision, will be required to obtain a single specialty CON.
5. These rules do not apply to adult open-heart surgery, adult cardiac catheterization, pediatric cardiac catheterization, pediatric open-heart surgery, and obstetrical services because these services are covered under other CON rules.
6. If an ambulatory surgery facility seeks to expand the number of ambulatory surgery operating rooms and the capital expenditure exceeds the CON threshold, the expansion project will be reviewed under these rules.

7. A replacement ambulatory surgery facility shall not be required to meet the need and adverse impact provisions of this chapter; but shall be required to submit an application and comply with all other provisions of the chapter.

### **Rationale for Applicability Standard**

The Applicability standard sets forth the requirement of a CON for any new, expanded or replacement freestanding ambulatory surgery facility.

Throughout the TAC's deliberation process it became clear that there was a need to clarify when the ambulatory surgical services rules would and would not be triggered. Facilities which operate under the license of or as "part of a hospital" would not be covered by these rules since these services are covered under the service-specific rules that govern short stay general hospital beds. TAC members defined the term "part of a hospital" to make it explicitly clear that the service would have to be offered within the boundaries of the physical plant of a hospital, in a separate building on the hospital's main campus or if the services are billed through the hospital's Medicare or Medicaid provider number and/or license number issued by the Department of Human Resources it would be considered part of a hospital. Additionally, the TAC wanted to continue to provide the Department with some flexibility to make determinations of reviewability on a case-by-case basis for hospital applicants.

Historically, there have been some questions regarding the identification of the applicant authorized to provide ambulatory surgery services. TAC members clarified that the legal entity that developed the ambulatory surgery facility would be applicant. Further, a facility that only offered services in one single-specialty area would be provided with a CON for a single-specialty service (see list of single specialties under definitions section). TAC members clarified that in order for single-specialty ambulatory surgery providers to become multi-specialty providers, a new CON would be required. This process would ensure that there is need for such services and assure that appropriate mechanisms, (e.g. staffing and other quality measures) are in place to support the highest quality of patient care.

At the onset of the TAC's deliberations, Department staff asked TAC members to provide some specific guidance with regard to those applicants requesting Letters of Nonreviewability (LNRs) as single-specialty, physician-owned surgery centers that exceeded the capital expenditure threshold. The TAC determined that the category "Limited Purpose Ambulatory Surgery Center", which in the past designated those facilities that essentially met the criteria for LNR designation with the exception of having exceeded the expenditure threshold, would no longer be used. Instead, any provider exceeding the capital expenditure threshold will be required to obtain a CON as a single-specialty or multi-specialty provider. This is a more streamlined process and provides better specificity around the review process.

The rules clarify that certain surgical procedures including, adult open-heart, adult cardiac catheterization, pediatric cardiac catheterization, pediatric open-heart and obstetrical services are not covered under these rules. This rule further clarifies that these procedures may not be performed in ambulatory surgical facilities. The need, expansion or relocation of these services is governed by other existing service-specific rules.

The Department sought to clarify current regulatory practices which allow health care providers to expand their existing services, providing that the expansion could be accomplished under the CON capital threshold. The Department's current regulatory review practice will continue to allow existing providers

(hospitals and freestanding ambulatory facilities) to increase the number of operating rooms in existing facilities provided that to do so would not trigger the capital expenditure or equipment threshold. Exceeding the capital expenditure threshold immediately triggers CON regulations and would require the submission of a CON.

The TAC wanted to ensure that an existing provider could replace itself should market conditions (i.e. skyrocketing rent) necessitate such a change. This replacement guideline would allow the applicant to replace itself with the same number of operating rooms within a 3-mile radius or less from its current location. TAC members said that a 3-mile radius provides a safeguard to ensure that the applicant would ostensibly continue to serve the same patient base. Applicants seeking to replace their facilities would be exempted from meeting the need and adverse impact statements because they were existing providers in the county but would be required to meet all other standards in the rules. This language is similar to the Short Stay General Hospital rules, which was enacted during the 2003 calendar year.

#### **(b) DEFINITIONS**

*The rules detail several concepts and policy considerations through the definitions section. The conceptual framework for the definitions is referenced, as appropriate, in the rationale statements throughout this component of the State Health Plan.*

1. "Ambulatory surgery" or "ASF" means surgical procedures that include but are not limited to those recognized by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association as reimbursable ambulatory surgery procedures. Ambulatory surgery is provided only to patients who are admitted to a facility which offers ambulatory surgery and which does not admit patients for treatment that normally requires stays that are overnight or exceed 24 hours and which does not provide accommodations for treatment of patients for periods of twenty-four hours or longer.
2. "Ambulatory surgery facility" means a public or private facility, not part of a hospital, which provides surgical treatment performed under general or regional anesthesia or monitored anesthesia care (MAC) in an operating room environment to patients not requiring hospitalization. In addition to operating rooms, an ambulatory surgery facility includes all components of pre and post-operative ambulatory surgery care. The term "ambulatory surgery facility" includes, but is not limited to entities such as an "ambulatory surgery center", an "ambulatory surgical treatment center", or by whatever name called meeting the within definition.
3. "Ambulatory surgery operating room" means an operating or procedure room located either in a hospital or in an ambulatory surgery facility that is equipped to perform ambulatory surgical procedures that are invasive and/or manipulative and are identified as surgical procedures in the most recent edition of the Current Procedural Terminology (CPT) coding of the American Medical Association, and is constructed to meet the specifications and standards of the Department of Human Resources. The term operating room also includes endoscopy and cystoscopy rooms and any rooms where scheduled procedures that are billed as surgical procedures are performed.
4. "Ambulatory surgery service" means the provision of ambulatory surgery including pre and post-operative care to patients not requiring hospitalization. An ambulatory surgery service may be provided within hospitals or ambulatory surgery facilities; provided, however, that an ambulatory surgery service provided as "part of a hospital" shall not be subject to these rules.

5. "Ambulatory surgery services patient" means a person who makes a single visit to an operating room during which one or more surgical procedures are performed.
6. "Expansion" or "Expanded Facility" means an existing ambulatory surgery facility that seeks to increase the number of operating and/or procedure rooms and the capital expenditures exceed the CON threshold.
7. "Health planning area" or "planning area" means the twelve (12) state service delivery regions as defined in O.C.G.A. § 50-4-7.
8. "Horizon year" means the last year of a five (5) year projection period for need determinations.
9. "Multi-specialty ambulatory surgery service" means an ambulatory surgery facility offering general surgery or surgery in two or more of the single specialties as defined in Rule 272-2-.09(b)(16).
10. "Not requiring hospitalization" means patients who do not require an inpatient admission to an acute care general hospital prior to receiving ambulatory surgery services, who normally would not require a surgical stay that is overnight or exceeds 24 hours, and who are not expected to require transfer to a hospital for continuing care following the surgical procedure.
11. "Official inventory" means the inventory of all facilities performing or authorized to perform ambulatory surgery services maintained by the Department based on responses to the most recent Annual Hospital Questionnaire (AHQ) Surgical Services Addendum and Freestanding Ambulatory Surgery Services Survey and/or the most recent appropriate surveys, questionnaires and other available official data relating to the provision of ambulatory surgery services, and any ambulatory surgery facilities that have been approved for a CON but are not currently operational or were not operational during the most recent annual survey filing cycle.
12. "Official state component plan" means the same as the "State Health Plan" as defined in Rule 272-1-.01.
13. "Operating room environment" means an environment, which meets the minimum physical plant, health and safety guidelines, and operating standards specified for ambulatory surgical treatment centers in the rules of the Department of Human Resources and the most recent edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities, American Institute of Architects Academy of Architecture for Health.
14. "Replacement" means new construction solely for the purpose of substituting another facility for an existing facility with the same or fewer number of operating rooms subject to 272-2-.09(1)(c)(1). New construction may be considered a replacement only if the replacement site is located within a three (3) mile radius or less from the ambulatory surgery facility being replaced. Any new construction of an ambulatory surgery facility not meeting the definition for a replacement shall be required to obtain a CON as a new ASF.
15. "Safety net hospital" means the same as "Safety net hospital" as defined in Rule 272-2-.09 (8).

16. "Single specialty ambulatory surgery service" means an ambulatory surgery facility meeting the definition in Rule 272-2-.09(b)(2) and offering surgery in one of the following specialties:

dentistry/oral and maxillofacial surgery,  
dermatology,  
gastroenterology,  
obstetrics/gynecology,  
ophthalmology,  
orthopedics,  
otolaryngology,  
neurology,  
pain management/anesthesiology,  
physical medicine and rehabilitation,  
plastic surgery,  
podiatry,  
pulmonary medicine, or  
urology,

as evidenced by board eligibility or certification in the specialty.

17) "Teaching hospital" means the same as "Teaching hospital" as defined in Rule 272-2-.09 (8).

### **Rationale for Definitions**

Several of the definitions that appear above were maintained from the previous edition of the ambulatory surgical services plan. The Department and the TAC felt that, where changes were made, it would be appropriate to discuss how the committee came to its conclusions.

Definition 3 "Ambulatory surgery operating room": Heretofore, surgical procedures that were performed in endoscopy or cystoscopy rooms were not consistently captured in the Department's inventory. The Department and the TAC felt that in order to get an accurate assessment of the need for services and to remove any ambiguity that endoscopy and cystoscopy rooms and other rooms where scheduled procedures are performed and billed as surgical procedures, should be accounted for in the need methodology.

Definition 4 "Ambulatory surgery service": Though ambulatory surgery services that were provided as "part of a hospital" were never reviewed under the Department's rules for freestanding ambulatory surgery services, the TAC amended this definition to ensure that there would be no misunderstanding of this practice during the regulatory review process.

Definition 7 "Health planning area": In the past, the Department used "health planning areas" as defined by Rule. However the Short Stay General Hospital TAC, during their development process to update the state health plan, recommended the use of State Service Delivery Regions (SSDRs), as set forth in statute. The ambulatory surgical services TAC concurred with the reasoning of the Short Stay General Hospital TAC.

Definition 8 : "Horizon year" means the last year of a five (5) year projection for need determinations. This language established through rule the written policy of the Department.

Definition 11 "Official inventory": This standard was changed to incorporate those facilities that have been approved but are not yet operational and those that were not operational during the survey cycle. TAC members and Department staff concurred that inclusion of these facilities would provide a more realistic inventory of authorized resources and should be counted when determining the assessment of need.

Definition 13: "Operating room environment" this standard was expanded to incorporate the most recent edition of the *Guidelines for Design and Construction of Hospital and Health Care Facilities*, issued by the American Institute of Architects Academy of Architecture for Health. Members felt that this additional requirement would ensure high quality care and would ensure conformity with current industry standards.

Definition 14 "Replacement": Historically, the Department interpreted the meaning of the word replacement of CON regulated services to mean that construction of a new facility would have been for the sole purpose of substituting another facility for an existing facility with the same number of rooms. Earlier rules governing ambulatory surgical services however did not make an allowance for replacement facilities. TAC members felt that providers should be allowed some flexibility to replace their facilities should market conditions necessitate such a change. Because TAC members expressed concern that this provision could be misused; they inserted language that specified that "replacement" is limited a new facility "with the same number of rooms" and that the replacement facility might be located within a three mile radius of the current facility to ensure continuity of care to the patients.

During the committee's deliberations some members thought that the 3-mile radius was too restrictive while other members felt that the definition was not restrictive enough and should incorporate additional constraints. Following significant committee discussion, members agreed to allow replacement with the same number of rooms within a 3-mile radius or less from the existing ambulatory surgery service. TAC members felt that the 3-miles radius seemed reasonable and justifiable and agreed that an applicant could reasonably contend that they could continue to serve essentially the same patient base within a three-mile radius.

Definition 15 "Safety net hospital": This definition was taken from the Short Stay General Hospital rules that were adopted in 2003. TAC members agreed that the state has an interest in protecting safety net hospitals. These facilities, which include teaching and trauma-designated hospitals, are vital to the state's health care system. Teaching hospitals provide training opportunities for the state's healthcare workforce, provide a disproportionate amount of care to the state's poor and uninsured population and provide highly specialized clinical services. Hospitals designated as trauma facilities require increased resources in order to maintain this designation and to provide the highest quality of care. Children's hospitals and providers of substantial uncompensated and public insurance services also are considered safety net hospitals under this definition.

During the course of the committee discussions, some members asked about the possibility of including "sole community rural hospitals" or "rural referral hospitals" as safety net hospitals. Department staff indicated that the safety net definition should be consistent throughout all of the Department's rules. Further, during the deliberation of the Short Stay General Hospital rule development process, members noted that not every hospital or sole community hospital is a safety net hospital. The list of safety net hospitals is not static and would be updated annually in conjunction with the Georgia Board for Physician Workforce, the Georgia Department of Human Resources and the Department of Community Health.

Definition 16 "Single-specialty ambulatory surgery service": Because there can be significant areas of

overlap in specialty areas and because the Department had requested guidance from the TAC regarding those disciplines that should be considered single-specialty services TAC members spent a considerable amount of time compiling this list of single-specialty providers. TAC members reviewed materials from other states, medical associations, and societies. Following considerable committee discussion, the TAC delineated those specialties that would be defined as single-specialties. The TAC's position on the list of single-specialty services was generally established by a split vote.

In addition to the single-specialty areas that were apart of the previous edition of the rules, three additional single-specialty areas were added namely, dermatology, neurology and physical medicine and rehabilitation. These single-specialty areas were added given the strength of information from other states, materials from several associations, consideration by the Department, including the issuance of previous Letters of Determination, and extensive committee member input.

Additional recommendations to add other specialties to the list of single-specialty areas were made by TAC members and via correspondence to the TAC. Some additional recommendations included the addition of such disciplines as colon and rectal surgery, general surgery, interventional radiology, and vascular surgery. The Department took the position that general surgery is a multi-specialty discipline. The committee was provided with a copy of the Statement on Scope of Practice and Credentialing issued by the American Society of General Surgeons (ASGS) which states that "general surgery is a comprehensive discipline that encompasses knowledge and experience common to all surgical specialties" and further that general surgeons have "the experience and training to manage common problems in plastic, thoracic, pediatric, gynecologic, urologic, neurologic, and orthopedic surgery". The Department said that this statement from the ASGS confirms the wide breath and scope of practice of the general surgeon and supports the Department's prior rule standard that general surgery is a multi-specialty discipline. The TAC concurred. Because general surgeons have broad latitude to perform a wide range of surgical procedures on all parts of the body, the Department contends that it is a multi-specialty and should remain as such. TAC members endorsed this position by voting overwhelming in support of its exclusion from the list of single-specialties.

The TAC recommended that to ensure greater clarity, the Department should use this list to identify those single-specialty providers that may request a Letter of Nonreviewability (LNR) for designation as a single-specialty, physician-owned, provider. These providers are exempt from CON. Under the TAC's recommendation, the Department would grant LNRs only to those single-specialty providers that appear on this list.

### **(c) STANDARDS**

#### **STANDARD 1: MINIMUM FACILITY SIZE**

*This standard was established to ensure that applicants are informed of the minimum facility size expectations.*

1. A proposed multi-specialty ambulatory surgery service shall have a minimum of three operating rooms. A proposed single-specialty ambulatory surgery service shall have a minimum of two operating rooms.

### **Rationale for Minimum Facility Size Standard**

TAC members felt that it was important to delineate the minimum size expectations for CON regulated ambulatory surgery facilities. Economic realities, including the need to offer sustainable services, coupled with the need to provide high quality care in appropriate settings makes it important to recommend some minimum number of operating rooms. Members agreed that the range of services and the quantity of procedures would justify a higher number of rooms for multi-specialty facilities.

### **STANDARD 2: NEED METHODOLOGY**

*The need methodology for ambulatory surgery is essentially the same as that which was used in the 1998 edition of the State Health Plan. However there were several areas that needed to be finetuned and explained to enhance clarity.*

2. The numerical need for a new or expanded ambulatory surgery facility shall be determined by a demographic formula which includes the number of ambulatory surgery services cases in a planning area. An ambulatory surgery patient represents one case. The following need calculation applies to each planning area.

(i) determine the current utilization rate for ambulatory surgery services for patients in each planning area by dividing the number of ambulatory surgery services patients served in ambulatory surgery operating rooms, hospital-based and free-standing, as reported in the most recent annual surveys, by the population for the planning area for the survey year;

(ii) determine the projected number of ambulatory surgery services patients in each planning area for the horizon year by multiplying the current utilization rate (step (i)) by the population for the planning area for the horizon year;

(iii) determine the number of operating rooms needed by dividing the number of projected ambulatory surgery services patients (step (ii)) by the optimal utilization per operating room. Capacity per operating room per year is 1,250 patients; optimal utilization is 1,000 patients per operating room per year. (This is based on 250 operating room days per year (50 weeks x 5 days/weeks) x 5 patients per room per day x 80 % utilization.);

(iv) determine the official inventory of ambulatory surgery operating rooms by adding:

(a) The pro-rata portion of hospital shared inpatient/ambulatory surgery operating rooms devoted to ambulatory surgery services. This portion is determined as follows:

$$\frac{(\text{number of ambulatory surgery patients} \times 90 \text{ min.})}{\{(\text{ambulatory surgery patients} \times 90 \text{ min.}) + (\text{inpatient surgery patients} \times 145 \text{ min.})\} \times \text{number of shared rooms}}$$

(b) Number of hospital dedicated ambulatory surgery operating rooms; and

(c) Number of ambulatory surgery operating rooms in ambulatory surgery facilities; and

(v) determine the projected net surplus or deficit for ambulatory surgery services by subtracting the total ambulatory surgery operating rooms needed (step (iii)) from the official inventory of ambulatory surgery services operating rooms in the planning area.

#### **Rationale for Need Methodology Standard**

The need methodology is determined through the application of a numerical need method and an assessment of the aggregate utilization rate of existing services. It has several components including the determination of the number of dedicated ambulatory surgery rooms and the allocation of shared rooms in hospitals. Capacity per operating room per year was determined by the TAC to be 1,250 patients; optimal utilization to be 1,000 patients per operating room per year. An assessment of the other state plans, including Tennessee, Mississippi, Michigan, North Carolina, South Carolina, Rhode Island, West Virginia, State of Washington, show some variation in the average number of patients or procedures per ambulatory surgery operating room per day, with a range from 800-1,377 patients or procedures per year. The TAC's recommended number falls between this range. The number of operating rooms meeting the need methodology is based on 1,000 patients per room (250 days/year by 5 patients/day at 80% utilization). The Department moved away from using procedures and moved to using patients in the calculation of the need methodology during the last update of the ambulatory surgery plan and rules. TAC members engaged in a significant amount of discussion in this area and acknowledged that there are advantages and disadvantages to this change. Some TAC members, on one hand, stated that there is a great likelihood that the need could be underestimated if the Department only captured the number of patients; conversely other members stated if the need methodology considered only the number of procedures, there could be an overestimation of the need for services.

In the numerical need, patients are forecasted for the horizon year by using current year rate population data projected forward for five years. Department staff clarified that a 5-year planning horizon has historically been used to forecast the need for acute care services and diagnostic equipment in Georgia. Because there were no major concerns raised about the continued use of the 5-year planning process, members voted unanimously to maintain the 5-year planning horizon.

During the rule development process, TAC members requested and were provided with data from several sources which justified the average time for ambulatory surgery procedures (90 minutes) in this methodology. Supporting materials were provided from Centers for Medicare and Medicaid Services, Federal Ambulatory Surgery Association (FASA) and several states including Kentucky, Montana, North Carolina, and Tennessee.

Among the major differences in these rules when compared with earlier versions is the directive to include operating rooms in freestanding ambulatory surgery centers that have been approved but are not yet operational. This change would allow a more accurate depiction of available resources. A net surplus or deficit of rooms in the numerical need is determined by subtracting the total ambulatory surgery operating rooms needed from the inventory of ambulatory surgery services operating rooms in the planning area. The inventory is determined by using annual survey data. Prior to the approval of a new or expanded ambulatory surgery service, the aggregate utilization of all existing and approved ambulatory surgery services in the planning area should equal or exceed 80% during the most recent year.

Planning area is a critical component of the need methodology. The planning area maps for several other regulated services were recently changed from health planning areas to state's service delivery regions. The Short Stay General Hospital TAC, during their plan update process, recommended the use of SSDRs.

**DRAFT**

Revised November 18, 2003

These planning boundaries are used by many agencies for economic and community development planning. In order to ensure uniformity between agencies and common delivery regions, the Short Stay General Hospital TAC recommended that the Department use SSDRs. Ambulatory Surgical Services TAC members requested and were provided copies of the SSDR maps along with an analysis of the impact of such a change. Members voted to adopt this change so that planning can be appropriately aligned with other CON services, which now use State Service Delivery Regions.

### **STANDARD 3: EXCEPTION TO NEED**

*In rare instances, the objective need methodology may not detect underlying or subtle problems in service delivery. For this reason, regulatory rules frequently establish mechanisms to seek alternative ways to address these gaps in service delivery. The TAC sanctioned the concept of creating an exception to the need standard for applicants who seek to address atypical barriers to care based on any one or some combination of four value-based criteria: cost, quality, financial access or geographic accessibility.*

(a) The Department may allow an exception to the need standards referenced above, in order to remedy an atypical barrier to ambulatory surgery services based on cost, quality, financial access, or geographic accessibility. An applicant seeking such an exception shall have the burden of proving to the Department that the cost, quality, financial access, or geographic accessibility of current services, or some combination thereof, result in a barrier to services that should typically be available to citizens in the area and/or the communities under review. In approving an application through the exception process, the Department shall document the basis or bases for granting the exception and the barrier or barriers that the successful applicant would be expected to remedy.

(b) The types of atypical barriers outlined below are intended to be illustrative and not exclusive.

1. An atypical barrier to services based on cost may include the failure of one or more existing providers of ambulatory surgery services to provide services at reasonable cost, as evidenced by the charges and/or reimbursement for ambulatory surgical services providers in a given planning area being significantly higher (one or more standard deviations from the mean) than the charges and/or reimbursement for other similar providers in the state.

2. An atypical barrier to services based on quality may include the failure of one or more existing providers of ambulatory surgery services to provide services with outcomes generally in keeping with accepted clinical guidelines of the American College of Surgeons, peer review programs and comparable state rates for similar populations and/or procedures.

3. An atypical barrier to services based on quality and geographic accessibility also may include consideration that an applicant will provide clinical trials of ambulatory surgical procedures and/or single specialty services not available elsewhere in the planning area that are recognized on the registry of clinical trials maintained by the National Institutes of Health.

4. An atypical barrier to services based on financial access may include the repeated failure, as exhibited by a documented pattern over two or more years prior to the submission of the application, of one or more existing providers of services within the community to provide services to indigent, charity and Medicaid patients.

5. An atypical barrier to services based on geographic accessibility may include a planning area or county within a planning area which does not have access to ambulatory surgical services, either through a hospital or a freestanding facility, within thirty (30) driving miles.
6. The Department also may consider an exception due to an atypical barrier to services based on geographic accessibility if the applicant is a designated, exempt physician-owned single specialty ambulatory surgery service seeking a CON as a single specialty ambulatory surgery service, and the single specialty service is the only service of its kind in the planning area, including hospital-based or freestanding ambulatory surgery services.
7. An atypical barrier to services based on geographic accessibility also may include consideration that an applicant for a single specialty ambulatory surgery service performs specialty procedures that require considerably more time than the need methodology contemplates (e.g., the complexity of the procedure(s) performed by the board certified specialty limits the number of patients that can be served a day on average) and, as such, the applicant contends that need methodology does not correctly reflect the service demand and need for the specialty. In seeking consideration for such an atypical barrier, an applicant must document to the Department the lack of availability of that discrete specialty within the planning area, either through a hospital or freestanding facility, and must sufficiently document the distinct nature of the services and procedures relative to other procedures measured by the need methodology.

**Rationale for Exception to Need Standard:**

The Department may allow an exception to the need standard to remedy an atypical barrier to ambulatory surgery services based on cost, quality, financial access, or geographic accessibility. These exceptions to the need provisions can be found in most of the Department's CON rules. The TAC concurred that these exceptions would be appropriate for incorporation into the ambulatory surgery rules. The Department is responsible for managing the state's health planning program, which establishes standards and criteria for awarding Certificates-of-Need to health care facilities and certain specialized diagnostic, or treatment services. The Department uses rigorous need methodologies to help contain health care costs and to avoid the unnecessary duplication of services, equipment and facilities.

Throughout the development of the rules, members noted that there are subtle nuances that are not always appropriately captured by the numerical need methodologies which could impact the need for services. The TAC sanctioned the concept of creating an exception to the need standard for applicants who seek to address atypical barriers to care based on any one or any combination of four value-based criteria: cost, quality, financial access or geographic accessibility. In any submission to seek consideration under the exception provisions, the burden of proof is placed on the applicant to demonstrate that these accessibility problems exist. The rules provide some examples of delivery system problems which might merit consideration as a ground for an exception.

**COST:** The TAC noted that charges do not equate to reimbursement, particularly in the case of government and third party payors; therefore they felt that it would be important to consider charges as well as reimbursement in any such review. Comparing charges with other services in the same or a similar geographic area also helps ensure equitable charges within individual communities. They agreed that "significantly higher" would be defined as one or more standard deviations from the mean of charges among similar types of providers.

QUALITY: The TAC spent a significant amount of time discussing the issue of quality of care and its importance in the provision of ambulatory surgical services. The rules reflect that an atypical barrier based on quality may include the failure of existing providers to provide services with outcomes generally in keeping with accepted clinical rules of the American College of Surgeons, peer review programs and comparable state rates for similar populations. Further, that an exception to the need could be granted for an applicant who will be participating in clinical trials, recognized on the registry of clinical trials maintained by the National Institutes of Health (NIH). The NIH clinical trials are well established and incorporate stringent quality standards, including followup protocols.

FINANCIAL ACCESS: One of the core goals of the Department is to develop and sustain a health care infrastructure that is responsive to consumers while improving access and coverage. This includes planning for coverage of uninsured and underinsured Georgians, currently estimated at 1.3 million people. As the state Medicaid agency, the Department also must ensure that citizens using this health care plan receive equitable access to coverage. The TAC felt strongly that providers should assume some of the responsibility for providing care to its local residents, particularly those that may have limited financial resources.

The Department is committed to ensuring that providers take responsibility for the health care of their local areas by serving as a conduit for the provision of local health care services regardless of the patients' ability to pay. For these reasons, the rules acknowledge that an atypical barrier to services based on financial access may include the repeated failure, as exhibited by a documented pattern over two or more years prior to the submission of the application, of existing providers within the community to provide services to indigent, charity and Medicaid patients. The comparison should be done among providers within the applicable state service delivery region.

GEOGRAPHIC ACCESS: Ambulatory surgical services should be accessible to all residents in the State of Georgia. The TAC concurred that the Department could allow an exception to the need methodology if the applicant is a designated single-specialty, physician-owned ambulatory surgery service seeking a CON as a single-specialty ambulatory surgery service and the single specialty service is the only one of its kind in the planning area. This would allow residents in local communities access to appropriate services. Members felt that it would be prudent to allow an existing provider, with an established relationship in the community the opportunity to expand existing services to address community need. Additionally, TAC members felt that those providers that perform procedures that require significantly larger amounts of time and are more highly complex in nature, as signified by the providers' inability to see a large number of patients per day, should be given some special consideration. Members agreed that the numeric need methodology, in this instance, might not adequately reflect the need for such specialized services due to the additional time demands of such procedures which fall outside of the average time for ambulatory surgery procedures as is defined in the current need methodology, and which could not be adequately accounted for in the need methodology. Applicants would be required to document the lack of availability of such specialized services within the planning area, including hospital-based services or other freestanding facilities.

#### **STANDARD 4: ADVERSE IMPACT**

*Adverse impact rules protect the human and financial investment that has been made by the state and existing providers. Starting a new program to the detriment of existing programs, particularly the state's safety net providers is not in line with sound planning principles. The TAC agreed that safety net providers should be afforded some protection given indigent and charity care missions. Members agreed that*

*ambulatory surgical services should be developed in an orderly and comprehensive manner with a goal of minimizing adverse impact on the existing delivery system.*

(a) Prior to approval of a new or expanded ambulatory surgery facility in any planning area, the aggregate utilization rate of all existing and approved ambulatory surgery services in that planning area shall equal or exceed 80 percent during the most recent survey year; and

(b) An applicant for a new or expanded ambulatory surgery facility shall demonstrate in its application that the addition of the service will not be detrimental to safety net hospitals within the planning area. Such demonstration shall be made by providing an analysis in the application that compares current and projected changes in ambulatory surgery services market share and payer mix for the applicant and any safety net hospitals. A total decrease in ambulatory surgery procedures of 10% or more for any safety net hospital shall be considered detrimental.

#### **Rationale for Adverse Impact Standard**

An applicant seeking to provide ambulatory surgical services would be required to meet the need methodology and, in addition, the aggregate utilization rate in the applicant's planning area must equal or exceed 80% during the most recent survey year before additional services can be initiated. This would ensure that all existing resources are being efficiently utilized. In addition to these standards, an applicant would be required to address impact on any safety net hospitals in the planning area.

TAC members agreed that safety net providers within the state service delivery region of an applicant should be afforded some stipulated protection. Safety net providers are defined as hospitals meeting at least two key criteria – uncompensated charges for indigent and charity care patients constitute 10% or more of hospital adjusted gross revenue, uncompensated charges for indigent patients constitute 6% or more of hospital adjusted gross revenues, Medicaid and PeachCare inpatient admissions constitute 20% or more of the total hospital inpatient admissions, trauma center designation, and teaching or children's hospitals.

The TAC agreed that the state has an interest in ensuring the stability of safety net hospitals because they, among other things, operate in high-risk environments, provide expensive services, provide valuable teaching opportunities for the state's healthcare workforce, and provide a significant amount of the state's uncompensated healthcare services.

In order to determine whether a safety net provider has been negatively impacted, an applicant should present analyses detailing projected changes in market share and payor mix for the applicant and any safety net hospitals. Impact on an existing safety net hospital shall be determined to be adverse if, based on the projected utilization, any existing safety net hospital within the planning area would have a total decrease of 10% or more in the number of ambulatory surgery procedures.

#### **STANDARD 5: FINANCIAL ACCESSIBILITY**

*TAC members agreed that financial access to care is a key component of the state's planning process. Further, they agreed that the equitable distribution of the indigent care burden among providers is the corollary to the equitable access to hospital and health care services for all citizens without regard to the ability to pay. Assessment of an ambulatory surgical service's commitment to assure financial access to services should be multifaceted.*

An applicant for an ambulatory surgery facility shall foster an environment that assures access to individuals unable to pay, regardless of payment source or circumstances, by the following:

- (i) providing evidence of written administrative policies that prohibit the exclusion of services to any patient on the basis of age, race, sex, creed, religion, disability or the patient's ability to pay;
- (ii) providing a written commitment that services for indigent and charity patients will be offered at a standard which meets or exceeds three percent (3%) of annual, adjusted gross revenues for the ambulatory surgery service;
- (iii) providing a written commitment to participate in the Medicare, Medicaid and PeachCare programs;
- (iv) providing a written commitment to participate in any other state health benefits insurance programs for which the ambulatory surgery service is eligible; and
- (v) providing documentation of the past record of performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to Medicare, Medicaid, PeachCare, and indigent and charity patients.

#### **Rationale for Financial Accessibility Standard**

The Department is fully committed to the standard of financial access and the provision of care to the state's indigent, low-income and uninsured population. This standard is a part of all of the Department's current rules. Providers in the State of Georgia are expected to adhere to these standards as critical criteria for receiving any business or operational approval from the state. Providing full access, free from financial or any other discrimination, is central to Georgia's health care purchasing and regulatory mission. These provisions are a part of a standard template that all CON applicants must address to demonstrate how they plan to meet the expectation of providing care to the state's indigent and low-income and uninsured patients.

The TAC endorsed the Department's mission and agreed that all applicants should minimize barriers to appropriate health care services. TAC members unanimously recommended the inclusion of this accessibility standard.

Applicants for new, replacement or expanded services would be required to provide evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis, including providing services to individuals regardless of race, sex, ability to pay. The TAC recommended that applicants should provide written commitment that services for indigent and charity care patients will be offered at a standard which meets or exceeds three percent (3%) of annual adjusted gross revenues for the ambulatory surgery service. The TAC agreed that this standard is critical to ensuring access to care for patients who might not otherwise have access to such services. Applicants also must provide full access to services, regardless of ability to pay or payment source, and are required to agree to participate in any state sponsored or operated health insurance program. In evaluating the past record of performance of the applicant, the Department should consider the record of the applicant and any affiliates. Failure to meet an existing or previous indigent care commitment and/or failure to serve the Medicaid or indigent population at

or above a level commensurate with the community served by the applicant and/or its affiliates may be grounds for denial of an application. The Department will use data from the three most recent prior years to make this determination.

The state's current standard commitment requires CON applicants to commit to provide indigent/charity care in an amount that is equal to or greater than 3%. At the present time, only one regulated service (Positron Emission Tomography) is required to provide a commitment higher than 3%. Members of the PET TAC agreed that increasing the indigent/charity care commitment would be a mechanism to increase access to these diagnostic services since Medicaid currently does not reimburse those services. Following significant discussion, TAC members agreed that a commitment of 3% would be appropriate and would be required for all applicants seeking to offer freestanding ambulatory surgical services.

#### **STANDARD 6: FAVORABLE CONSIDERATION**

*TAC members agreed that there might be circumstances where competing applications may have comparable characteristics. When competing applications are all worthy of merit and only one applicant can be given approval, the applicant that has historically provided increased access to care should be given favorable consideration.*

In considering applications joined for review, the Department may give favorable consideration to whichever of the applicants historically has provided the higher annual percentage of unreimbursed care to indigent and charity patients and the higher annual percentage of services to Medicare, Medicaid and Peach Care patients.

#### **Rationale for Favorable Consideration Standard:**

The favorable consideration standard is triggered only in instances where there are competing applications. In the case of competing but otherwise generally comparable applications, an applicant that has historically provided the higher annual percentage of unreimbursed care to indigent and charity care patients and the higher annual percentage of services to Medicare, Medicaid and PeachCare patients should be awarded the Department's approval. This is an issue of accessibility to appropriate services. The TAC has endorsed the Department's mission of improving health status and health outcomes for all Georgians by continuing to require providers to minimize barriers to the accessibility of health care services. The Department may give special consideration, when considering competing applications, to the applicant that has a stronger record of serving these eligible patient populations.

#### **STANDARD 7: QUALITY OF CARE**

*TAC members said that providing the highest quality care to the residents of the state is among the state's and the TAC's highest priorities. In an effort to promote improved health outcomes for families, all providers should be expected to maintain some minimal quality standards.*

(a) An applicant shall provide evidence of a credentialing process, which provides that surgical procedures will be performed only by licensed physicians or by licensed oral and maxillofacial surgeons or by licensed podiatrists who are board certified/qualified by one of the boards, recognized by a specialty board recognized by the American Board of Medical Specialties (ABMS) or by the American Osteopathic Association (AOA), or by the American Board of Oral and Maxillofacial Surgery (ABOMS) or by the Council on Podiatric Medical Education and are board certified/qualified by such other board which is nationally

recognized and has been deemed acceptable to and qualified as an equivalent such board as determined and certified at the sole discretion of the applicant's state licensing board. The applicant shall stipulate that the surgical procedures to be performed will be limited to those that are generally recognized as falling within the scope of training and practice of the surgeons providing the care.

(b) An applicant shall assure that the physicians or oral and maxillofacial surgeons performing surgical procedures will maintain privileges at an accredited or state licensed hospital in their geographic area for the procedures they perform in ambulatory surgery settings.

(c) An applicant shall assure that anesthesia will only be administered by an anesthesiologist, by a physician qualified to administer anesthesia, by an oral and maxillofacial surgeon, or by a certified registered nurse anesthetist; and that the anesthesia levels, patient selection and screening criteria, and pre-operative and post-operative guidelines of the American Society for Anesthesiologists (ASA) guidelines, or the guidelines of the American Association of Oral and Maxillofacial Surgeons (AAOMS) or the *Scope and Standards for Nurse Anesthesia Practice* issued by the American Association of Nurse Anesthetists (AANA) and will be followed and so documented.

(d). An applicant shall assure that at least one physician, oral and maxillofacial surgeon or CRNA who is currently certified in advanced resuscitative techniques equivalent to Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS) or Pediatric Advanced Cardiac Life Support (PALS), as appropriate, must be on the premises until all surgical patients have been determined to be medically stable and such determination has been properly entered in each patients' anesthesia or recovery room record by the physician, oral and maxillofacial surgeon or CRNA in charge of administering the anesthesia. Thereafter, a licensed Registered Nurse who is currently certified in ACLS, ATLS or PALS must be on the premises until all patients are medically discharged by the facility. In addition, the applicant shall assure that other medical personnel with direct patient contact will, at a minimum, be certified in Basic Cardiac Life Support (BCLS).

(e) An applicant shall submit evidence that qualified personnel will be available to insure a quality service to meet licensure, certification and/or accreditation requirements.

(f) An applicant shall submit a policy and plan for reviewing outcomes of patient care and a plan for ongoing quality improvement activities, including a stated set of criteria for identifying those patients to be reviewed and a mechanism for evaluating the patient review process.

(g) An applicant shall submit written policies and procedures for utilization review consistent with state, federal, and accreditation standards. This review shall include review of the medical necessity for the service, appropriateness of the ambulatory surgical setting, quality of patient care, and rates of utilization.

(h) An applicant shall provide a written statement of its intent to comply with all appropriate licensure requirements and operational procedures required by the Georgia Department of Human Resources.

(i) An applicant that has previously operated and/or owned any type of health facilities in Georgia also shall provide sufficient documentation that any facilities currently or previously in business have no history of licensure adverse actions and no history of conditional level Medicare and/or Medicaid certification deficiencies in the past three (3) years and have no current outstanding licensure and Medicare and/or Medicaid certification deficiencies.

(j) An applicant for a new or replacement ambulatory surgery service shall provide a statement of intent to meet, within 12 months of obtaining state licensure, the appropriate accreditation requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAASF) and/or other appropriate accrediting agency.

(k) An applicant for an expanded ambulatory surgery service shall provide documentation that they fully meet the appropriate accreditation requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (ASF) and/or other appropriate accrediting agency.

### **Rationale for Quality of Care Standard**

The State of Georgia and the TAC have an interest in ensuring that all ambulatory surgical facilities provide the highest quality of care to patients. This plan incorporates requirements that ensure, among other things, a credentialing process, appropriately trained personnel and patient care review process. Given this commitment, the ambulatory surgical services quality standards encapsulate the standards, guidelines and rules of the American Society of Anesthesiologists, American College of Surgeons (ACS), American Association of Nurse Anesthetists (AANA), and American Association for Accreditation of Ambulatory Surgery Facilities (AAASF), American Association of Oral and Maxillofacial Surgeons (AAOMS), and Council on Podiatric Medical Education (COPME), among others.

It is a recognized and accepted medical standard that physicians providing ambulatory surgery services perform only those procedures that are defined within the scope of their license and in accordance with individually granted clinical privileges. Limiting the privileges of a surgeon within an ambulatory surgery center to only those for which he/she is granted by an accredited hospital helps to ensure high quality patient care services.

The administration of anesthesia carries significant risk. To ensure quality of care and patient safety, qualified personnel who have specialized knowledge, skill and training in the administration of anesthesia should be the only persons authorized to perform this procedure and these qualified clinicians should be on hand at all times a surgical patient is present in the event of an emergency. The TAC engaged in discussions about the types of clinical personnel who are authorized to perform anesthesia services in the state. Members agreed that all clinical personnel that are authorized to provide anesthesia services should adhere to the respective practice rules of their national accrediting body. In this case, anesthesiologists or physician qualified to administer anesthesia; should adhere to the practice rules of the American Society of Anesthesiologists, oral Maxillofacial Surgeons should adhere to the practice rules of the American Association of Oral and Maxillofacial Surgeons (AAOMS), and Certified Registered Nurse Anesthetists should adhere to the practice rules of the American Association of Nurse Anesthetists. Laws of the State of Georgia require that anesthesia may be administered by CRNA, provided that it is administered under the direction and responsibility of a licensed physician, or a duly permitted oral and maxillofacial surgeon and in compliance with all applicable statutes, rules and regulations. Members recommended that this specific language be added to the rules to ensure high quality patient care for Georgia citizens and to ensure conformity with state law. Further, members wanted to ensure that no perception of an expansion of scope of services for CRNAs. Additionally, the applicant is required to have appropriate personnel on site that

are qualified to perform advanced resuscitative techniques and other appropriate care until all patients are medically discharged.

An ambulatory surgery service should demonstrate that qualified personnel would be available to insure a quality service to meet licensure, certification and/or accreditation requirements. Additionally, ambulatory surgery facilities should have a policy and plan for reviewing patient care, including criteria for identifying those patients to be reviewed and a mechanism for evaluating the patient review process. TAC members also agreed that ambulatory surgical service providers should ensure that policies that incorporate procedures for patient care management and quality assurance are in place. Members agreed that incorporating written policies and procedures for utilization review helps to ensure quality of care, patient safety, and appropriate application and utilization of ambulatory surgery services. The Department is fully committed to ensuring that providers offer the highest possible quality of patient care. The Department and the TAC want applicants to plan for services in a comprehensive manner recognizing staff limitations and keeping the best interest of patients at the forefront of the process.

Compliance with licensure and certification standards, both national and state, correlates to the successful operation and management of ambulatory surgical facilities and indicates that a facility has met certain performance standards. The Joint Commission on Accreditation of Health Care Organization (JCAHO) is the nation's major accrediting body. Accreditation by this or another nationally recognized accrediting body is usually acknowledged as a quality "seal of approval". Because these standards reflect state-of-the-art performance expectations, organizations that meet them improve their ability to provide quality patient care. JCAHO performs on-site visits and establish standards that address all aspects of care in ambulatory surgical facilities including, but not limited to, governance and administration, quality assurance and medical records. Accreditation may also be a condition of reimbursement for certain insurers and other payors. JCAHO accreditation provides deemed status for Medicare regulations. The state's current rules require accreditation by Joint Commission for Accreditation of Healthcare Organizations, (JCAHO), Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., (ASF) or other appropriate agencies.

Hospital affiliation and transfer agreements, credentialing processes and letters of intent to comply with all appropriate licensure regulations are among Georgia's required quality rules. The applicant would be required to provide sufficient documentation to prove its intent to comply with all appropriate licensure requirements and operational procedures required by the Georgia Department of Human Resources. The Department is committed to working with the Department of Human Resources/Office of Regulatory Services to ensure that applicants have a history of compliance with licensure and other operating standards. An applicant that has previously operated an/or owned any type of health facilities in Georgia also shall provide sufficient documentation that any facilities currently or previously in business have no history of licensure adverse actions and no history of conditional level Medicare and/or Medicaid certification deficiencies in the past three (3) years and have no current outstanding licensure and Medicare and/or Medicaid certification deficiencies.

Members further agreed that quality assurance standards should be included in the rules of freestanding ambulatory surgery facilities. Nationally, the rise in medical errors causes much concern to patients, providers and payors. Requiring that providers participate in a statewide or national external reporting and utilization review system will help to ensure patient safety and medical errors receive appropriate attention. Further, the facility could benefit from any outcome data that could be used to compare itself to industry benchmarks, which would address such areas as patient outcomes, consumer satisfaction, and consumer

demand.

#### **STANDARD 8: CONTINUITY OF CARE, VIABILITY AND COST CONTAINMENT**

*Services offered in freestanding ambulatory surgical settings are only one point of access in the healthcare continuum. Members agreed that these services should be coordinated and should be developed to assure patient access and resource sustainability in local communities.*

(a) Each applicant shall have a hospital affiliation agreement and/or the medical director must have admitting privileges and other acceptable documented arrangements to insure the necessary backup for medical complications. The applicant must provide written evidence of a binding transfer agreement that documents the capability to transfer a patient immediately to a hospital with adequate emergency room services.

(b) An applicant shall submit written policies and procedures regarding discharge planning. These policies should include, where appropriate, designation of responsible personnel, participation by the patient, family, guardian or significant other, documentation of any follow-up services provided and evaluation of their effectiveness.

(c) An applicant shall demonstrate that the proposed services will be coordinated with the local existing health care system.

(d) An applicant shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the facility.

(e) An applicant shall demonstrate that proposed charges and/or reimbursement rates for services shall compare favorably with charges and/or reimbursement rates for other similar services in the planning area when adjusted for annual inflation. When determining the accuracy of an applicant's projected charges for ambulatory surgery services, the Department may compare the applicant's history of charges and/or reimbursement rates, if applicable, with other services in the planning area(s) previously served by the applicant or its parent company.

#### **Rationale for Continuity of Care, Viability and Cost Containment Standard**

The ability to transfer ambulatory surgery patients to hospitals in both emergency and non-emergency situations is critical to ensuring optimum patient safety and care. This standard is in keeping with licensure, JCAHO and other appropriate accrediting agency standards. A documented plan for patient transfer helps ensure that necessary services are coordinated and in place when needed.

The Department and the TAC believe that it is important that discharge plans be carefully communicated and coordinated with appropriate healthcare facilities/agencies/providers in the community to ensure an efficient and effective delivery system. Community linkages and coordination could include agreements with other related community service providers. TAC members wanted to encourage providers to work together to provide the highest quality care for their local communities. Members said that increased communication at the local level could result in enhanced quality patient care and increased accessibility of care to patients and their families, decreased healthcare cost and improved system efficiencies.

Providers are encouraged to establish working agreements with community service agencies to enhance and to assure continuity of care through the streamlining of patient referrals and the development of cross-continuum care plans.

Average charges for ambulatory surgery procedures can vary significantly from one geographic area to another. Comparing the reasonableness of charges and or reimbursement rates for other similar services in the planning area helps to ensure reasonable access to services within individual communities. The Department also will compare the applicant's history of charges/reimbursement rates previously served by the applicant or its parent company. This historical perspective provides the Department with some baseline behavior expectations regarding the applicant's likeliness to comply with current commitments. TAC members agreed that applicants seeking new, expanded or replacement facilities should be required to provide evidence of availability of resources for the provision of services. The rules require applicants to provide evidence that they can fully support, with human resources and capital, this undertaking. Through this requirement, the Department and the TAC want to ensure that health planning is done in a comprehensive manner and in the best interest of the patient.

#### **STANDARD 9: DATA AND INFORMATION REPORTING REQUIREMENTS**

*In order to project service needs, address quality, and efficiency of ambulatory surgery services it is of critical importance to be able to collect and analyze system-wide data.*

An applicant for an ambulatory surgery facility shall document an agreement to provide all Department requested information and statistical data related to the operation and provision of ambulatory surgery and to report that data to the Department in the time frame and format requested by the Department. This information may include, but not be limited to, financial data, patient and procedure volume, utilization and charge data, and any changes in number of ambulatory surgery operating and procedure rooms that may occur as a result of service expansion.

#### **Rationale for Data and Information Reporting Requirement Standard :**

The TAC unanimously recommended the inclusion of data and information requirements. The need methodology will require provider data for certain components and uniform data is essential to assess changing patterns and to project service needs relevant to the provision of services. The Department administers an annual survey to collect uniform data from providers. The survey requests both financial data and information regarding such items as patient origin, number of operating rooms, etc.

As additional emphasis is placed on quality, patient outcomes, cost and other efficiency indicators, collection of data will allow more precise assessment of these factors as well as others which are important to health planning. Uniform data would allow more precise assessment of the level of service availability and utilization. Applicants will be required to provide data related to the operation and provision of services to the Department by the requested time.

## **GOALS, OBJECTIVES AND RECOMMENDED ACTIONS**

### **A. GOAL**

Ensure that Georgia citizens have access to cost-effective, efficient and high quality ambulatory surgery services.

### **B. OBJECTIVES**

- Improve access to ambulatory surgery services by authorizing these services based on an objective numerical need methodology;
- Minimize adverse impact on the state's safety net hospitals;
- Ensure financial access to care by requiring the provision of services to indigent and low-income patients and by ensuring provider participation in Medicaid, PeachCare and other public reimbursement programs;
- Foster an environment which assures access to services for individuals unable to pay and regardless of payment source or circumstance and on a non-discriminatory basis;
- Encourage continuity of care for ambulatory surgery patients within their local communities.
- Ensure quality and patient safety through compliance with appropriate accreditation standards and licensure rules;
- Analyze the availability, quality and effectiveness of services being provided through collection and analysis of information and statistical data.

### **C. RECOMMENDED ACTIONS**

The Ambulatory Surgical Services Technical Advisory Committee discussed and recommended the following actions:

- Implement Certificate of Need (CON) rules for ambulatory surgery services consistent with this Component Plan and approve CON applications accordingly.
- Require providers to demonstrate plans whereby their services are effectively and efficiently coordinated with other existing healthcare services within the community;
- Require providers to demonstrate the intent to achieve optimal clinical, licensure and accreditation standards recently established by JCAHO, AAAHC, ASF, or other appropriate accrediting agencies;

- Require providers to demonstrate administrative policies showing they provide services on a non-discriminatory basis;
- Require providers to demonstrate appropriate hospital affiliation agreements and transfer capabilities;
- Collect data annually, and on an ad hoc basis as needed, to maintain current, accurate information related to availability, quality and effectiveness of services being provided and;

#### **D. OTHER IDENTIFIED ISSUES OUTSIDE OF THE TAC'S PURVIEW**

During the Ambulatory Surgical Services TAC plan and rules development process several opportunities were provided for public comment and input. The TAC received correspondence that outlined several *policy recommendations*. Many of these *policy recommendations* referred specifically to single-specialty, physician-owned ambulatory surgery centers that are exempt from CON regulation pursuant to O.C.G.A. 31-6-2(14)(G)(iii). The Ambulatory Surgical Services TAC recognized that these recommendations were *outside of the purview of their work and neither addressed nor deliberated* these policy recommendations, some of which were conflicting. Some TAC members suggested that consideration be given to requiring CON exempt facilities to commit to data reporting requirements and indigent and charity care commitments.

## REFERENCES

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# **GEORGIA STATE HEALTH PLAN COMPONENT PLAN**

## **APPENDIX A**

### **Members Ambulatory Surgical Services Technical Advisory Committee**

AMBULATORY SURGICAL SERVICES TECHNICAL ADVISORY COMMITTEE  
OF THE HEALTH STRATEGIES COUNCIL

**William G. "Buck" Baker, Jr., MD, TAC Chairman**  
President, Atlanta Regional Health Forum, Inc.  
Member, Health Strategies Council

**Tary L. Brown**  
CEO, Albany Area Primary Health Care  
Member, Health Strategies Council

**Sylvia Caley, RN, JD**  
Private Practice, Health Care Advocacy

**W. Clay Campbell**  
Executive Vice President, Archbold Medical  
Center  
Member, Health Strategies Council

**Billy Carr**  
Director of Planning  
Northside Hospital

**Kevin Chilvers**  
Director of Operations  
HCA Ambulatory Surgery Division-Southeast

**Daniel DeLoach, MD**  
Savannah

**Kathy Floyd**  
Advocacy Director, American Association of  
Retired Persons (AARP)

**J. Keener Lynn**  
Administrator, Southern Surgery Center

**Wallace McLeod, MD**  
Eye Physicians and Surgeons of Augusta, PC

**Mark M. Mullin**  
Gwinnett Health Systems

**William T. Richardson, FACHE**  
President and CEO  
Tift Regional Medical Center

**Raymer Sale, Jr.**  
President, Multiple Benefits Corporation  
Member, Health Strategies Council

**William Silver, MD**  
Atlanta

**Stephanie Simmons**  
Hospital Policy Section, Medical Assistance  
Plans  
Department of Community Health

**David Tatum**  
Director, Government Affairs  
Children's Healthcare of Atlanta

**Don E. Tomberlin, Sr.**  
CEO, Effingham Hospital

**Carol Zafiratos**  
Director, Health Care Section  
Office of Regulatory Services  
Department of Human Resources

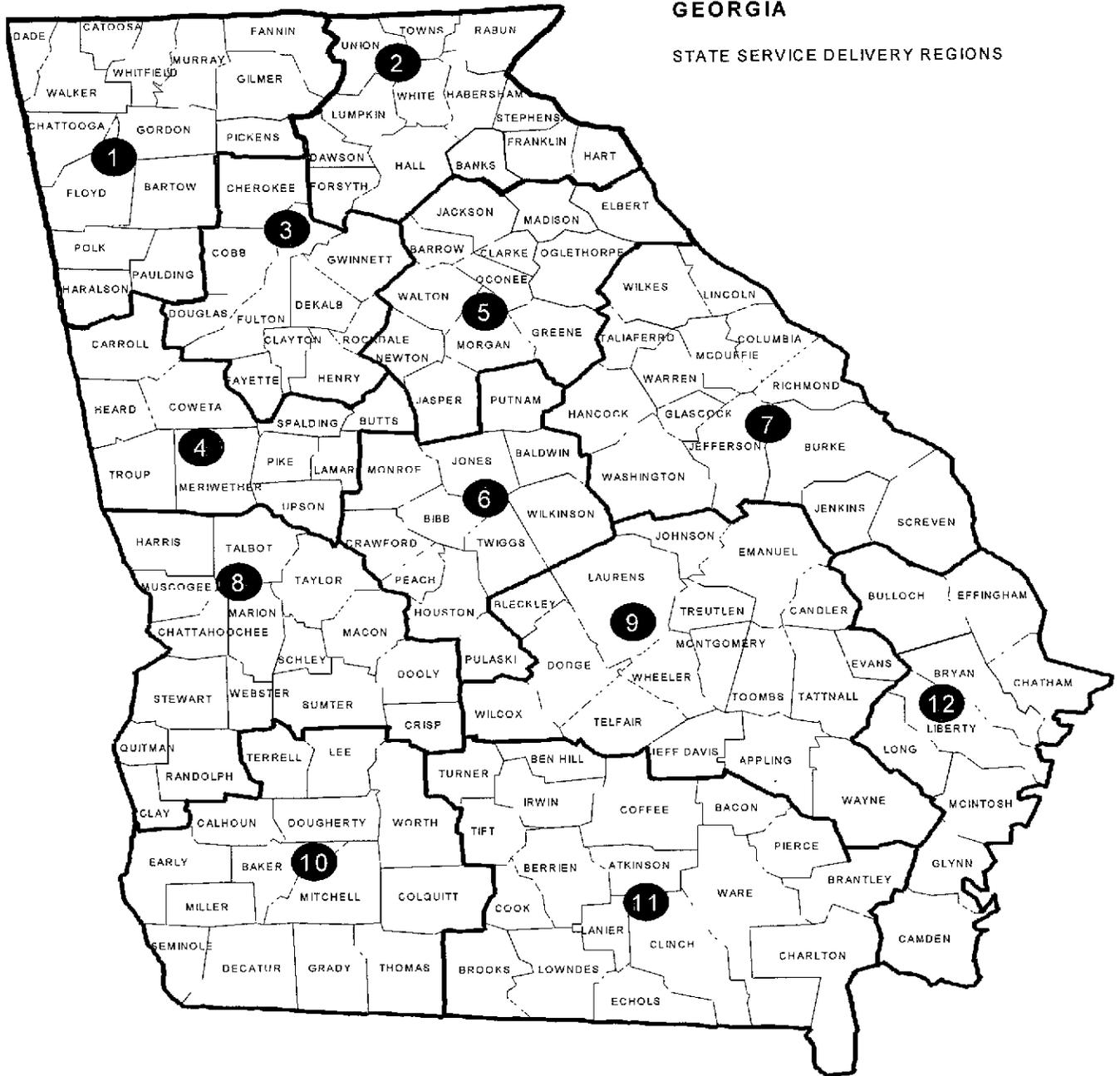
# **GEORGIA STATE HEALTH PLAN COMPONENT PLAN**

## **APPENDIX B**

### **Map Georgia State Service Delivery Regions (SSDR)**

# GEORGIA

## STATE SERVICE DELIVERY REGIONS



# **GEORGIA STATE HEALTH PLAN COMPONENT PLAN**

## **APPENDIX C**

### **Inventory of Freestanding Ambulatory Surgery Centers in Georgia By State Service Delivery Regions (as of September 17, 2003)**

**Inventory of Ambulatory Surgery Centers by State Service Delivery Region (SSDR) (As of 9/19/2003)**

<b>SSDR 1</b>					
<b>3 Facilities</b>					
	<u>County</u>	<u>Facility Name</u>	<u>Existing Operating Rooms</u>	<u>Pending Operating Rooms</u>	<u>Total Operating Rooms</u>
	Catoosa	Hutcheson Medical Center Ambulatory Surgery Center		2	2
	Floyd	Surgery Center Of Rome	3		3
	Whitfield	Hamilton Ambulatory Surgery Center	4		4
		<b>Total</b>	<b>7</b>	<b>2</b>	<b>9</b>
<b>SSDR 2</b>					
<b>2 Facilities</b>					
	<u>County</u>	<u>Facility Name</u>	<u>Existing Operating Rooms</u>	<u>Pending Operating Rooms</u>	<u>Total Operating Rooms</u>
	Forsyth	Northwoods Surgery Center	3		3
	Hall	Healthsouth Gainesville Surgery Center	3		3
		<b>Total</b>	<b>6</b>		<b>6</b>
<b>SSDR 3</b>					
<b>24 Facilities</b>					
	<u>County</u>	<u>Facility Name</u>	<u>Existing Operating Rooms</u>	<u>Pending Operating Rooms</u>	<u>Total Operating Rooms</u>
	Cherokee	Advanced Surgery Center Of Georgia	3		3
	Clayton	Surgery Center at Mt. Zion	3		3
	Cobb	East-West Surgery Center	3		3
	Cobb	Marietta Surgical Center	7		7
	DeKalb	DeKalb Medical Ambulatory Surgery Center		3	3
	DeKalb	Dunwoody Outpatient Surgicenter (DOS)	3		3
	DeKalb	Emory Clinic Ambulatory Surgery Center	6		6
	DeKalb	Emory Orthopaedic Outpatient Surgery Center		2	2
	DeKalb	Emory Spine Physiatry Outpatient Surgery Center		2	2
	DeKalb	Northlake Surgical Center	2		2
	DeKalb	Northside Women's Clinic	3		3
	Fulton	Atlanta Center for Reconstructive Foot and Ankle Surgery	4		4
	Fulton	Atlanta EyeSurgery-NovaMed Eyecare Services	2		2
	Fulton	Atlanta Outpatient Peachtree-Dunwoody Center	6		6
	Fulton	Atlanta Outpatient Surgery Center	4		4
	Fulton	Atlanta Surgicenter	2		2
	Fulton	Atlanta Women's Medical Center	2		2
	Fulton	Buckhead Surgery Center	4		4
	Fulton	Center For Reconstructive Surgery	2		2
	Fulton	Children's Healthcare of Atlanta Surgery Center (at Meridian Mark Plaza), LLC	6		6
	Fulton	Feminist Women's Health Center	2		2
	Fulton	Healthsouth Center Of Atlanta	2		2
	Fulton	North Atlanta Endoscopy Center	3		3
	Gwinnett	Healthsouth Surgery Center Of Gwinnett	2		2
		<b>Total</b>	<b>71</b>	<b>7</b>	<b>78</b>

	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Troup	Southern Surgery Center	3		3
		Total	3		3
<b>SSDR 6</b>	<b>3 Facilities</b>				
	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Bibb	Coliseum Same Day Surgery Center	3		3
	Bibb	Medical Eye Associates	2		2
	Bibb	Surgical Centers of Georgia		2	2
		Total	5	2	7
<b>SSDR 7</b>	<b>3 Facilities</b>				
	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Columbia	Doctor's Hospital Surgery Center	4		4
	Richmond	Augusta Surgical Center	4		4
	Richmond	Planned Parenthood Reproductive Health Services, Inc.	2		2
		Total	10		10
<b>SSDR 8</b>	<b>4 Facilities</b>				
	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Muscogee	Columbus Women's Health Organization, Inc.	2		2
	Muscogee	Endoscopy Center of Columbus, Inc.	2		2
	Muscogee	Novamed Eye Services, Surgery & Laser Center of Columbus	3		3
	Muscogee	The Surgery Center, LLC	4		4
		Total	11		11
<b>SSDR 11</b>	<b>1 Facility</b>				
	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Tift	Affinity Outpatient Service	2		2
		Total	2		2
<b>SSDR 12</b>	<b>5 Facilities</b>				
	County	Facility Name	Existing Operating Rooms	Pending Operating Rooms	Total Operating Rooms
	Chatham	Savannah Medical Clinic	1		1
	Chatham	Savannah Outpatient Foot Surgery Center	2		2
	Chatham	Schulze Surgery Center, Inc.	2		2
	Glynn	Brunswick Endoscopy Center	2		2
	Glynn	Premier Surgery Center	2		2
		Total	9		9
<b>** SOURCE: Georgia Department of Community Health/Division of Health Planning (9/2003)</b>					
<b>** Report Criteria: ([facility type] in('Amb Surgery Center') AND [status] in('Operational', 'Not Yet Operational'))</b>					

# **GEORGIA STATE HEALTH PLAN COMPONENT PLAN**

## **APPENDIX D**

### **Rules Ambulatory Surgical Services**

**PROPOSED RULES  
OF THE  
GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
DIVISION OF HEALTH PLANNING  
CHAPTER 272-2  
CERTIFICATE OF NEED**

**272-2-.09 Standards and Criteria. Amended.**

**(1) AMBULATORY SURGERY SERVICES.**

**(a) Applicability.**

This rule applies only to those entities required to obtain a Certificate of Need (CON) and shall not apply to those entities otherwise exempt by rule or statute from obtaining a CON, including but not limited to facilities exempt under O.C.G.A. § 31-6-2(14)(G)(iii). For Certificate of Need purposes, an ambulatory surgery service is considered a new institutional health service if it is to be offered in a free-standing ambulatory surgery facility (ASF).

1. If the ambulatory surgery service is or will be provided as "part of a hospital", the hospital's provision of such service is not subject to CON review under this rule. For purposes of this rule, the following are always considered to be "part of a hospital":
  - c. if the service is located within a hospital; or,
  - d. if the service is located in a separate building on the hospital's main campus or on separate premises and the service is integrated with other hospital services and systems, and the services are billed through the hospital's Medicare or Medicaid provider number and/or license number issued by the Department of Human Resources.The Department of Community Health also will make a determination of reviewability on a case-by-case basis in other situations involving hospitals.

2. The legal entity that develops any ambulatory surgery facility subject to this rule shall be the applicant.

3. A single specialty ambulatory surgery service will be issued a single specialty CON. A new CON will be required for a single specialty ambulatory surgery service to become a multi-specialty service.

4. A party requesting designation as a physician-owned, single-specialty ambulatory surgery service that exceeds the capital expenditure threshold set forth in O.C.G.A. § 31-6-2(14)(G)(iii), and thus is not exempt from CON guidelines pursuant to this statutory provision, will be required to obtain a single specialty CON.

5. These rules do not apply to adult open-heart surgery, adult cardiac catheterization, pediatric cardiac catheterization, pediatric open-heart surgery, and obstetrical services because these services are covered under other CON rules.

6. If an ambulatory surgery facility seeks to expand the number of ambulatory surgery operating rooms and the capital expenditure exceeds the CON threshold, the expansion project will be reviewed under these rules.

7. A replacement ambulatory surgery facility shall not be required to meet the need and adverse impact provisions of this chapter; but shall be required to submit an application and comply with all other provisions of the chapter.

**(b) Definitions.**

1. "Ambulatory surgery" or "ASF" means surgical procedures that include but are not limited to those recognized by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association as reimbursable ambulatory surgery procedures. Ambulatory surgery is provided only to patients who are admitted to a facility which offers ambulatory surgery and which does not admit patients for treatment that normally requires stays that are overnight or exceed 24 hours and which does not provide accommodations for treatment of patients for periods of twenty-four hours or longer.

2. "Ambulatory surgery facility" means a public or private facility, not part of a hospital, which provides surgical treatment performed under general or regional anesthesia or monitored anesthesia care (MAC) in an operating room environment to patients not requiring hospitalization. In addition to operating rooms, an ambulatory surgery facility includes all components of pre and post-operative ambulatory surgery care. The term "ambulatory surgery facility" includes, but is not limited to entities such as an "ambulatory surgery center", an "ambulatory surgical treatment center", or by whatever name called meeting the within definition.

3. "Ambulatory surgery operating room" means an operating or procedure room located either in a hospital or in an ambulatory surgery facility that is equipped to perform ambulatory surgical procedures that are invasive and/or manipulative and are identified as surgical procedures in the most recent edition of the Current Procedural Terminology (CPT) coding of the American Medical Association, and is constructed to meet the specifications and standards of the Department of Human Resources. The term operating room also includes endoscopy and cystoscopy rooms and any rooms where scheduled procedures that are billed as surgical procedures are performed.

4. "Ambulatory surgery service" means the provision of ambulatory surgery including pre and post-operative care to patients not requiring hospitalization. An ambulatory surgery service may be provided within hospitals or ambulatory surgery facilities; provided, however, that an ambulatory surgery service provided as "part of a hospital" shall not be subject to these rules.

5. "Ambulatory surgery services patient" means a person who makes a single visit to an operating room during which one or more surgical procedures are performed.

6. "Expansion" or "Expanded Facility" means an existing ambulatory surgery facility that seeks to increase the number of operating and/or procedure rooms and the capital expenditures exceed the CON threshold.

7. "Health planning area" or "planning area" means the twelve (12) state service delivery regions as defined in O.C.G.A. § 50-4-7.

8. "Horizon year" means the last year of a five (5) year projection period for need determinations.
9. "Multi-specialty ambulatory surgery service" means an ambulatory surgery facility offering general surgery or surgery in two or more of the single specialties as defined in Rule 272-2-.09(b)(16).
10. "Not requiring hospitalization" means patients who do not require an inpatient admission to an acute care general hospital prior to receiving ambulatory surgery services, who normally would not require a surgical stay that is overnight or exceeds 24 hours, and who are not expected to require transfer to a hospital for continuing care following the surgical procedure.
11. "Official inventory" means the inventory of all facilities performing or authorized to perform ambulatory surgery services maintained by the Department based on responses to the most recent Annual Hospital Questionnaire (AHQ) Surgical Services Addendum and Freestanding Ambulatory Surgery Services Survey and/or the most recent appropriate surveys, questionnaires and other available official data relating to the provision of ambulatory surgery services, and any ambulatory surgery facilities that have been approved for a CON but are not currently operational or were not operational during the most recent annual survey filing cycle.
12. "Official state component plan" means the same as the "State Health Plan" as defined in Rule 272-1-.01.
13. "Operating room environment" means an environment, which meets the minimum physical plant, health and safety guidelines, and operating standards specified for ambulatory surgical treatment centers in the rules of the Department of Human Resources and the Guidelines for Design and Construction of Hospital and Health Care Facilities, American Institute of Architects Academy of Architecture for Health.
14. "Replacement" means new construction solely for the purpose of substituting another facility for an existing facility with the same or fewer number of operating rooms subject to 272-2-.09 (1)(c)(1). New construction may be considered a replacement only if the replacement site is located within a three (3) mile radius or less from the ambulatory surgery facility being replaced. Any new construction of an ambulatory surgery facility not meeting the definition for a replacement shall be required to obtain a CON as a new ASF.
15. "Safety net hospital" means the same as "Safety net hospital" as defined in Rule 272-2-.09 (8).
16. "Single specialty ambulatory surgery service" means an ambulatory surgery facility meeting the definition in Rule 272-2-.09(b)(2) and offering surgery in one of the following specialties:

- dentistry/oral and maxillofacial surgery,
- dermatology,
- gastroenterology,
- obstetrics/gynecology,
- ophthalmology,
- orthopedics,
- otolaryngology,
- neurology,
- pain management/anesthesiology,

physical medicine and rehabilitation,  
plastic surgery,  
podiatry,  
pulmonary medicine, or  
urology,

as evidenced by board eligibility or certification in the specialty.

17) "Teaching hospital" means the same as "Teaching hospital" as defined in Rule 272-2-.09 (8).

## **(C) STANDARDS.**

### **1. Minimum Facility Size.**

A proposed multi-specialty ambulatory surgery service shall have a minimum of three operating rooms. A proposed single specialty ambulatory surgery service shall have a minimum of two operating rooms.

### **2. Need Methodology.**

The numerical need for a new or expanded ambulatory surgery facility shall be determined by a demographic formula which includes the number of ambulatory surgery services cases in a planning area. An ambulatory surgery patient represents one case. The following need calculation applies to each planning area.

(i) determine the current utilization rate for ambulatory surgery services for patients in each planning area by dividing the number of ambulatory surgery services patients served in ambulatory surgery operating rooms, hospital-based and free-standing, as reported in the most recent annual surveys, by the population for the planning area for the survey year;

(ii) determine the projected number of ambulatory surgery services patients in each planning area for the horizon year by multiplying the current utilization rate (step (i)) by the population for the planning area for the horizon year;

(iii) determine the number of operating rooms needed by dividing the number of projected ambulatory surgery services patients (step (ii)) by the optimal utilization per operating room. Capacity per operating room per year is 1,250 patients; optimal utilization is 1,000 patients per operating room per year. (This is based on 250 operating room days per year (50 weeks x 5 days/weeks) x 5 patients per room per day x 80 % utilization.);

(iv) determine the official inventory of ambulatory surgery operating rooms by adding:

(a) The pro-rata portion of hospital shared inpatient/ambulatory surgery operating rooms devoted to ambulatory surgery services. This portion is determined as follows:

$$\frac{(\text{number of ambulatory surgery patients} \times 90 \text{ min.})}{\{(\text{ambulatory surgery patients} \times 90 \text{ min.}) + (\text{inpatient surgery patients} \times 145 \text{ min.})\} \times \text{number of shared rooms}}$$

- (b) Number of hospital dedicated ambulatory surgery operating rooms; and
- (c) Number of ambulatory surgery operating rooms in ambulatory surgery facilities; and

(v) determine the projected net surplus or deficit for ambulatory surgery services by subtracting the total ambulatory surgery operating rooms needed (step (iii)) from the official inventory of ambulatory surgery services operating rooms in the planning area.

### **3. Exception to Need.**

(a) The Department may allow an exception to the need standards referenced above, in order to remedy an atypical barrier to ambulatory surgery services based on cost, quality, financial access, or geographic accessibility. An applicant seeking such an exception shall have the burden of proving to the Department that the cost, quality, financial access, or geographic accessibility of current services, or some combination thereof, result in a barrier to services that should typically be available to citizens in the area and/or the communities under review. In approving an application through the exception process, the Department shall document the basis or bases for granting the exception and the barrier or barriers that the successful applicant would be expected to remedy.

(b) The types of atypical barriers outlined below are intended to be illustrative and not exclusive.

1. An atypical barrier to services based on cost may include the failure of one or more existing providers of ambulatory surgery services to provide services at reasonable cost, as evidenced by the charges and/or reimbursement for ambulatory surgical services providers in a given planning area being significantly higher (one or more standard deviations from the mean) than the charges and/or reimbursement for other similar providers in the state.

2. An atypical barrier to services based on quality may include the failure of one or more existing providers of ambulatory surgery services to provide services with outcomes generally in keeping with accepted clinical guidelines of the American College of Surgeons, peer review programs and comparable state rates for similar populations and/or procedures.

3. An atypical barrier to services based on quality and geographic accessibility also may include consideration that an applicant will provide clinical trials of ambulatory surgical procedures and/or single specialty services not available elsewhere in the planning area that are recognized on the registry of clinical trials maintained by the National Institutes of Health.

4. An atypical barrier to services based on financial access may include the repeated failure, as exhibited by a documented pattern over two or more years prior to the submission of the

application, of one or more existing providers of services within the community to provide services to indigent, charity and Medicaid patients.

5. An atypical barrier to services based on geographic accessibility may include a planning area or county within a planning area which does not have access to ambulatory surgical services, either through a hospital or a freestanding facility, within thirty (30) driving miles.

6. The Department also may consider an exception due to an atypical barrier to services based on geographic accessibility if the applicant is a designated, exempt physician-owned single specialty ambulatory surgery service seeking a CON as a single specialty ambulatory surgery service, and the single specialty service is the only service of its kind in the planning area, including hospital-based or freestanding ambulatory surgery services.

7. An atypical barrier to services based on geographic accessibility also may include consideration that an applicant for a single specialty ambulatory surgery service performs specialty procedures that require considerably more time than the need methodology contemplates (e.g., the complexity of the procedure(s) performed by the board certified specialty limits the number of patients that can be served a day on average) and, as such, the applicant contends that need methodology does not correctly reflect the service demand and need for the specialty. In seeking consideration for such an atypical barrier, an applicant must document to the Department the lack of availability of that discrete specialty within the planning area, either through a hospital or freestanding facility, and must sufficiently document the distinct nature of the services and procedures relative to other procedures measured by the need methodology.

#### **4. Adverse Impact.**

(a) Prior to approval of a new or expanded ambulatory surgery facility in any planning area, the aggregate utilization rate of all existing and approved ambulatory surgery services in that planning area shall equal or exceed 80 percent during the most recent survey year.

(b) An applicant for a new or expanded ambulatory surgery facility shall demonstrate in its application that the addition of the service will not be detrimental to safety net hospitals within the planning area. Such demonstration shall be made by providing an analysis in the application that compares current and projected changes in ambulatory surgery services market share and payer mix for the applicant and any safety net hospitals. A total decrease in ambulatory surgery procedures of 10% or more for any safety net hospital shall be considered detrimental.

#### **5. Financial Accessibility.**

An applicant for an ambulatory surgery facility shall foster an environment that assures access to individuals unable to pay, regardless of payment source or circumstances, by the following:

- (vi) providing evidence of written administrative policies that prohibit the exclusion of services to any patient on the basis of age, race, sex, creed, religion, disability or the patient's ability to pay;

- (vii) providing a written commitment that services for indigent and charity patients will be offered at a standard which meets or exceeds three percent (3%) of annual, adjusted gross revenues for the ambulatory surgery service;
- (viii) providing a written commitment to participate in the Medicare, Medicaid and PeachCare programs;
- (ix) providing a written commitment to participate in any other state health benefits insurance programs for which the ambulatory surgery service is eligible; and
- (x) providing documentation of the past record of performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to Medicare, Medicaid, PeachCare, and indigent and charity patients.

## **6. Favorable Consideration.**

In considering applications joined for review, the Department may give favorable consideration to whichever of the applicants historically has provided the higher annual percentage of unreimbursed care to indigent and charity patients and the higher annual percentage of services to Medicare, Medicaid and Peach Care patients.

## **7. Quality of Care.**

(a) An applicant shall provide evidence of a credentialing process, which provides that surgical procedures will be performed only by licensed physicians or by licensed oral and maxillofacial surgeons or by licensed podiatrists who are board certified/qualified by one of the boards, recognized by a specialty board recognized by the American Board of Medical Specialties (ABMS) or by the American Osteopathic Association (AOA), or by the American Board of Oral and Maxillofacial Surgery (ABOMS) or by the Council on Podiatric Medical Education and are board certified/qualified by such other board which is nationally recognized and has been deemed acceptable to and qualified as an equivalent such board as determined and certified at the sole discretion of the applicant's state licensing board. The applicant shall stipulate that the surgical procedures to be performed will be limited to those that are generally recognized as falling within the scope of training and practice of the surgeons providing the care.

(b) An applicant shall assure that the physicians or oral and maxillofacial surgeons performing surgical procedures will maintain privileges at an accredited or state licensed hospital in their geographic area for the procedures they perform in ambulatory surgery settings.

(c) An applicant shall assure that anesthesia will only be administered by an anesthesiologist, by a physician qualified to administer anesthesia, by an oral and maxillofacial surgeon, or by a certified registered nurse anesthetist; and that the anesthesia levels, patient selection and screening criteria, and pre-operative and post-operative guidelines of the American Society for Anesthesiologists (ASA) guidelines, or the guidelines of the American Association of Oral and Maxillofacial Surgeons (AAOMS) or

the *Scope and Standards for Nurse Anesthesia Practice* issued by the American Association of Nurse Anesthetists (AANA) and will be followed and so documented.

(d) An applicant shall assure that at least one physician, oral and maxillofacial surgeon or CRNA who is currently certified in advanced resuscitative techniques equivalent to Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS) or Pediatric Advanced Cardiac Life Support (PALS), as appropriate, must be on the premises until all surgical patients have been determined to be medically stable and such determination has been properly entered in each patients' anesthesia or recovery room record by the physician, oral and maxillofacial surgeon or CRNA in charge of administering the anesthesia. Thereafter, a licensed Registered Nurse who is currently certified in ACLS, ATLS or PALS must be on the premises until all patients are medically discharged by the facility. In addition, the applicant shall assure that other medical personnel with direct patient contact will, at a minimum, be certified in Basic Cardiac Life Support (BCLS).

(e) An applicant shall submit evidence that qualified personnel will be available to insure a quality service to meet licensure, certification and/or accreditation requirements.

(f) An applicant shall submit a policy and plan for reviewing outcomes of patient care and a plan for ongoing quality improvement activities, including a stated set of criteria for identifying those patients to be reviewed and a mechanism for evaluating the patient review process.

(g) An applicant shall submit written policies and procedures for utilization review consistent with state, federal, and accreditation standards. This review shall include review of the medical necessity for the service, appropriateness of the ambulatory surgical setting, quality of patient care, and rates of utilization.

(h) An applicant shall provide a written statement of its intent to comply with all appropriate licensure requirements and operational procedures required by the Georgia Department of Human Resources.

(i) An applicant that has previously operated and/or owned any type of health facilities in Georgia also shall provide sufficient documentation that any facilities currently or previously in business have no history of licensure adverse actions and no history of conditional level Medicare and/or Medicaid certification deficiencies in the past three (3) years and have no current outstanding licensure and Medicare and/or Medicaid certification deficiencies.

(j) An applicant for a new or replacement ambulatory surgery service shall provide a statement of intent to meet, within 12 months of obtaining state licensure, the appropriate accreditation requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAHC), the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAASF) and/or other appropriate accrediting agency.

(k) An applicant for an expanded ambulatory surgery service shall provide documentation that they fully meet the appropriate accreditation requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAHC), the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (ASF) and/or other appropriate accrediting agency.

## **8. Continuity of Care, Viability and Cost Containment.**

(a) Each applicant shall have a hospital affiliation agreement and/or the medical director must have admitting privileges and other acceptable documented arrangements to insure the necessary backup for medical complications. The applicant must provide written evidence of a binding transfer agreement that documents the capability to transfer a patient immediately to a hospital with adequate emergency room services.

(b) An applicant shall submit written policies and procedures regarding discharge planning. These policies should include, where appropriate, designation of responsible personnel, participation by the patient, family, guardian or significant other, documentation of any follow-up services provided and evaluation of their effectiveness.

(c) An applicant shall demonstrate that the proposed services will be coordinated with the local existing health care system.

(d) An applicant shall demonstrate the availability of funds for capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the facility.

(e) An applicant shall demonstrate that proposed charges and/or reimbursement rates for services shall compare favorably with charges and/or reimbursement rates for other similar services in the planning area when adjusted for annual inflation. When determining the accuracy of an applicant's projected charges for ambulatory surgery services, the Department may compare the applicant's history of charges and/or reimbursement rates, if applicable, with other services in the planning area(s) previously served by the applicant or its parent company.

## **9. Data and Information Reporting Requirements.**

An applicant for an ambulatory surgery facility shall document an agreement to provide all Department requested information and statistical data related to the operation and provision of ambulatory surgery and to report that data to the Department in the time frame and format requested by the Department. This information may include, but not be limited to, financial data, patient and procedure volume, utilization and charge data, and any changes in number of ambulatory surgery operating and procedure rooms that may occur as a result of service expansion.

**MINUTES**  
**STATE COMMISSION ON THE EFFICACY OF CON**  
Sanders Fireplace Room at the Capitol Education Center  
October 24, 2005; 1:00 pm

# Appendix E

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- Summary of Law Department Review

**Summary of Law Department Review  
of  
TAC-Proposed Revisions to Ambulatory Surgery Services Rule**

As you are aware, the Department asked the Department of Law to review the TAC-proposed revisions to the ambulatory surgery services regulation. Staff at the Department of Law carefully reviewed the proposed revisions and provided feedback to the Department. The Department has summarized the Law Department's findings below.

**1. Exclusion of freestanding facilities remote from hospital campuses but owned by a hospital or billed under a hospital's provider number is in contravention of the CON Statute**

The CON Statute precludes defining the term, "part of a hospital," to include freestanding facilities integrated with and billed under a hospital's provider number if such facilities are not on a hospital's campus. The CON statute, at OCGA § 31-6-2(1), defines an "ambulatory surgical service" as a facility, which is not part of a hospital. The phrase, "not part of a hospital" refers to geographic location, and not just to ownership. Comparatively, other provisions within the statute use terms such as "owned by," "operated by," and "utilized by" certain entities or individuals. *C.f.* OCGA § 31-6-2(14)(G)(iii)(exempting from CON review ASCs that are "owned, operated and utilized by private physicians.") Furthermore, the statute clearly maintains that Certificates of Need are location specific and places particular emphasis on location throughout.

**Action Needed:** Freestanding facilities which are not located on a hospital's campus must be reviewed in the same manner as all other freestanding facilities. As the proposed revision provides to the contrary, it must be revised.

**2. Distinct criteria for replacement facilities is authorized as long as such distinctions have a rational basis**

As long as a rational basis for distinguishing criteria for replacement and new facilities is identified, replacement facilities may be reviewed under separate and distinct review criteria. Since the revisions were proposed, the Department has developed and promulgated several generally applicable rules regarding replacement facilities.

**Action Needed:** The component plan should be revised to identify a rational basis for distinct review criteria for replacement facilities. In addition, the proposed revisions must be revised to comport with the Department's current regulations regarding replacement facilities.

- 3. Inclusion of rooms where surgical treatment is performed solely without anesthesia, with a level of anesthesia less than regional, or in an environment that does not meet the standards for operating rooms established by the Department of Human Resources is not authorized by Statute**

The CON statute, at OCGA § 31-6-2(1), defines an "ambulatory surgical service" as a facility, which provides surgical treatment performed under general or regional anesthesia in an operating room environment. The proposed revision's definition of operating room may include rooms in which surgical treatment is performed without anesthesia or under minor or local anesthetics, such as endoscopies.

**Action Needed:** The proposed revision must be revised to exclude rooms that are used solely for surgical procedures not requiring anesthesia or requiring anesthesia at a level below regional. If a room will be licensed by DHR as an operating room it should be counted in the inventory of operating rooms, if it will not be so licensed, it cannot be counted in the inventory.

- 4. The term "expansion" needs clarification to define the exact instances in which an application would be reviewed under the ASC rules and the general considerations as opposed to solely the general considerations**

The proposed revision states that a project would be reviewed under the ASC rule only when operating rooms are added and the cost exceeds the threshold. The revision does not clarify what would occur when operating rooms are added below the threshold or what would happen when the threshold is exceeded but no operating rooms are added. It is currently the practice of the Department to apply the ASC-specific rules whenever ORs are added regardless of cost.

**Action Needed:** The proposed revision should be modified to clarify when an ASC expansion project would be reviewed under the ASC rule and when it would be reviewed solely under the general considerations.

- 5. Exhaustive lists of surgical specialties must provide rational bases for excluding non-included specialties or, in the alternative, a non-exhaustive listing should be employed along with regulatory criteria for determining a single specialty**

The CON statute does not specifically define "single specialty." Therefore, it is within the Department's authority to define this term (except for the inclusion of general surgery) The proposed revision employs an exhaustive listing of specialties which qualify as a single specialty. When certain items are excluded from an exhaustive list, administrative law requires that a reasonable basis for distinction be articulated.

**Action Needed:** The component plan must document a reasonable basis for the exclusion of specialties from an exhaustive list, or in the alternative, a non-exhaustive list should be employed. If a non-exhaustive list is employed, then the rule should specify objective criteria by which the Department can judge the eligibility of a specialty not specifically listed, e.g. by reference to a medical certification board.

**MINUTES**  
**STATE COMMISSION ON THE EFFICACY OF CON**  
Sanders Fireplace Room at the Capitol Education Center  
October 24, 2005; 1:00 pm

# Appendix F

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- Mandamus Actions

## **Mandamus Actions**

### **What is a Mandamus Action?**

In a mandamus action, a party is asking a court to "mandate" a governmental official to perform some ministerial act the requesting party claims the law requires the official to perform.

### **How Many Mandamus Actions Have Been Filed Over the Last Two (2) Years?**

Over the course of the last two (2) years, approximately ten (10) mandamus actions have been filed regarding Letters of Non-Reviewability that have been issued by the Department of Community Health.

### **How Much Time is Required to Respond to a Mandamus Action?**

Approximately 100 hours, on average, were required for the Attorney General's Office to address each mandamus action. DCH is unable to estimate how many hours applicants and their counsel have utilized to defend their interests in these actions.

### **List of Mandamus Actions:**

#### **A. Open Case**

##### **1. Georgia Alliance of Community Hospitals v. Tim Burgess (Imaging Associates of Canton, LLC), Fulton Superior Court No. 2004cv90244 (J. Johnson) (filed August 25, 2004)**

<b>LNR Issue Date:</b>	<b>January 23, 2004</b>
<b>Business Entity:</b>	<b>Imaging Associates of Canton, LLC</b>
<b>Location:</b>	<b>Canton, Georgia</b>
<b>Proposed Capital Expenditure:</b>	<b>\$711,021.71</b>
<b>Actual Capital Expenditure:</b>	<b>NA</b>

The Georgia Alliance of Community Hospitals ("Alliance") filed a complaint and application for Writ of Mandamus seeking a determination and judgment that the applicant had developed the project in violation of CON requirements.

The applicant intervened by Consent Order dated April 27, 2005. The Alliance asserts the following:

- a. the capital expenditure for the ASC exceeded the established threshold because certain construction costs specific to other equipment were excluded

The parties filed Motions for Summary Judgment on September 20, 2005 and responses are due October 31, 2005. The hearing is set for November 14, 2005.

**B. Closed Cases**

**1. Georgia Alliance of Community Hospitals v. Tim Burgess (North Atlanta Scan Associates, Inc.)(Superior Court No. 2004cv89690)(Tusan)(Filed May 29, 2003)**

**LNR Issue Date:** March 9, 2001  
**Applicant:** North Atlanta Scan Associates, Inc.  
**Location:** Atlanta, Georgia  
**Proposed Capital Expenditure:** \$424,720  
**Actual Capital Expenditure:** N/A

This case involved the filing of two complaints and applications for Writs of Mandamus by the Georgia Alliance of Community Hospitals ("Alliance") and Diagnostic Imaging of Atlanta. The two cases were consolidated before Fulton Superior Judge Tusan. The Alliance and Diagnostic Imaging of Atlanta made the following assertions in their complaints:

- a. the relocation of a diagnostic treatment rehabilitative center requires CON review
- b. the applicant failed to include the expenditure of new diagnostic and therapeutic equipment which exceeded the applicable equipment expenditure

Subsequent to the filings of the complaints, DCH rescinded the LNR and issued a Cease and Desist Order against NASA. The Alliance then dismissed its mandamus action.

**2. Georgia Alliance of Community Hospitals v. Timothy Burgess (Renaissance Surgical Centre, LLC) Fulton Superior Court No.2004cv78301 (J. Brogdon) (filed November 2003).**

**LNR Issue Date:** August 7, 2003  
**Practice:** Renaissance Plastic Surgery, P.C.  
**ASC:** Renaissance Surgical Centre, LLC  
**Specialty:** Plastic surgery  
**Location:** Macon, Georgia  
**Proposed Capital Expenditure:** \$1,083,046  
**Actual Capital Expenditure:** \$951,720

The Alliance filed a complaint and application for Writ of Mandamus seeking a determination and judgment that the applicant had developed the project in violation of CON requirements. The Alliance asserted the following:

- a. the request failed to provide all costs associated with the design and construction of the ASC
- b. the ASC is owned by separate entity, and therefore is not in the "offices" of the physicians
- c. the applicant provided insufficient documentation regarding square footage associated with business offices and common areas
- d. the request failed to provide sufficient information regarding costs associated with consultants

On November 18, 2004 a settlement agreement was executed regarding the case and a dismissal was granted on November 16, 2004.

**3. Georgia Alliance of Community Hospitals v. Timothy Burgess(Lanier Eye Associates, LLC d/b/a Advanced Eye Surgery and Laser Center)**(Fulton Superior Court No. 2004cv95309)(J. Lane)(Filed December 28, 2004)

**LNR Issue Date:** January 30, 2002  
**Practice:** Lanier Eye Associates, LLC  
**ASC:** Advanced Eye Surgery and Laser Center  
**Specialty:** Ophthalmology  
**Location:** Gainesville, Georgia  
**Proposed Capital Expenditure:** \$1,136,531  
**Actual Capital Expenditure:** Unknown

The Alliance filed a complaint and application for Writ of Mandamus seeking a determination and judgment that the applicant had developed an ASC in violation of CON requirements. The Alliance asserted the following:

- a. the ASC licensed by DHR under O.C.G.A. § 31-7-1 cannot be a "physician owned" office-based clinic eligible for the exemption of OCGA § 31-6-2(14)(G)(iii)
- b. applicant failed to document all expenditures for construction, equipment and furnishings for the project

The parties executed a settlement agreement and the Alliance dismissed its case in June 2005.

**4. West Paces Diagnostic Imaging v. Timothy Burgess(The Palisades at West Paces Imaging Center, LLC)**(Fulton Superior Court No.2004cv84820)(J. Dempsey)(filed April 19, 2004)

**LNR Issue Date:** February 17, 2004  
**Applicant:** The Palisades at West Paces Imaging Center, LLC  
**Location:** Atlanta, Georgia  
**Proposed Capital Expenditure:** \$707,148  
**Actual Capital Expenditure:** N/A

The Alliance filed a complaint and application for Writ of Mandamus seeking a determination and judgment that the applicant had developed the project in violation of CON requirements. The Alliance asserted the following:

- a. the applicant failed to include costs associated with the purchase of additional MRI equipment
- b. the applicant did not include, or improperly valued, certain categories in its line item valuation sheet such as transportation, insurance and rigging and no-equipment capital expenditures

The Alliance dismissed its case when DCH revoked the Letter of Non-Reviewability on August 15, 2005 upon making a determination that additional costs were attributable to the project which would result in the project exceeding the capital expenditure threshold.

**5. Georgia Alliance of Community Hospitals v. Timothy Burgess(Albany Diagnostic Center, LLC)**(Superior Court No. 2004cv88735 (J. Goger)(Filed July 23, 2004)

**LNR Issue Date:** May 18, 2004  
**Applicant:** Albany Diagnostic Center, LLC  
**Location:** Albany, Georgia  
**Proposed Capital Expenditure:** \$725,790  
**Actual Capital Expenditure:** N/A

The Alliance filed a complaint and application for Writ of Mandamus seeking a determination and judgment that the applicant had developed the project in violation of CON requirements. The Alliance asserted the following:

- a. applicant intended to install and operate a MRI unit that was initially installed and operated by Royston Diagnostic Clinic in Royston, GA who had previously received a Cease and Desist Order from the Department regarding the same piece of equipment
- b. applicant failed to include all expenditures associated with the installation of the MRI

On April 21, 2005, the Superior Court heard the parties' Motions for Summary Judgment and granted DCH's motion as well as Albany Diagnostic Center. On September 19, 2005, the Supreme Court of Georgia dismissed the Alliance's appeal of the Superior Court's decision in favor of DCH.

**6. Georgia Alliance of Community Hospitals v. Tim Burgess(Hand & Upper Extremity Center of Georgia, P.C., Hand & Upper Extremity Surgery Center of Georgia LLC)**, Fulton Superior Court No. 2004cv84330 (J. Baxter)(April 8, 2004)

**LNR Issue Date:** March 5, 2004  
**Practice:** Hand & Upper Extremity Center of Georgia, PC  
**ASC:** Hand & Upper Extremity Surgery Center of Georgia, LLC  
**Specialty:** Orthopedic  
**Location:** Atlanta, Georgia  
**Proposed Capital Expenditure:** \$1,149,688  
**Actual Expenditure:** \$1,119,471

The Alliance filed a complaint and application for Writ of Mandamus, seeking a determination and judgment that the applicant had developed the ASC in violation of CON requirements. The Alliance made the following assertions in its complaint:

- a. the ASC was not in the principal "office" of the owning physicians or group practice and that the ASC was owned by separate entity set up by the physicians
- b. the ASC was not within reasonable proximity of the clinical offices of the group practice;
- c. the capital expenditure for the ASC exceeded the established threshold
- d. the applicant failed to show site entitlement

DCH and the two other defendants filed Motions for Summary Judgment in September 2004 and June 2004, respectively. During the hearing on October 7, 2005, the Judge announced from the bench his decision to dismiss the Alliance's case.

**7. Georgia Alliance of Community Hospitals v. Tim Burgess (Ear, Nose and Throat of Atlanta, LLC)**, Fulton Superior Court No. 2004cv87081 (J. Moore) (filed June 14, 2004)

**LNR Issue Date:** April 8, 2004  
**Practice:** Ear Nose & Throat of Atlanta, LLC  
**ASC:** ENT Surgery Center of Atlanta, LLC  
**Specialty:** Otorhinolaryngology  
**Location:** Atlanta, Georgia  
**Proposed Capital Expenditure:** \$1,048,296  
**Actual Capital Expenditure:** N/A as of April 2005

The Alliance filed a complaint and application for Writ of Mandamus seeking a determination and judgment that the applicants had developed an ASC in violation of CON requirements.

The Alliance asserted the following:

- a. the ASC is owned by a separate entity, and therefore is not in the "offices" of the physicians
- b. the ASC is not owned by a physician or group practice
- c. the ASC is not within reasonable proximity of the group practice
- d. the capital expenditure for the ASC exceeded the established threshold
- e. the applicant provided insufficient documentation regarding site entitlement, plans, loans and guarantees

ENT Surgery Center of Atlanta, LLC (ENT) intervened. ENT filed a Motion for Summary Judgment on November 29, 2004 and DCH filed a Motion for Summary Judgment on January 14, 2005. The Alliance filed a response Cross-motion for Summary Judgment on February 1, 2005. The Superior Court entered judgment against the Alliance on August 8, 2005. The Alliance's Application for Discretionary Appeal was filed with the Georgia Supreme Court on September 12, 2005 and the opposing brief was filed on September 22, 2005.

On October 12, 2005, the Georgia Supreme Court denied the Alliance's Application for Discretionary Appeal from the Superior Court's decision, which therefore affirmed the Superior Court's decision.

**8. Georgia Alliance of Community Hospitals v. Tim Burgess(Gastroenterology Associates of Central Georgia, LLC)**, Fulton Superior Court No. 2004cv84749 (J. Campbell) (filed April 19, 2004)

**LNR Issue Date:** March 8, 2004  
**Practice:** Gastroenterology Associates of Central Georgia, LLC  
**ASC:** Endoscopy Center of Middle Georgia, LLC  
**Specialty:** Gastroenterology  
**Location:** Macon, Georgia  
**Proposed Capital Expenditure:** \$1,342,506  
**Actual Expenditure:** \$1,130,876

The Alliance filed a complaint and application for Writ of Mandamus seeking a determination and judgment that the applicants had developed an ASC in violation of CON requirements.

The Alliance made the following assertions in its complaints:

- a. the ASC was not in the "offices" of the physician owners because it was located on a separate floor;
- b. the ASC is operated by a separate entity and not by physicians or group practice
- c. the ASC not in reasonable proximity to the physicians' offices
- d. the capital expenditure for the ASC exceeded the established threshold

e. the applicant provided insufficient documentation

The Alliance filed a Motion for Summary Judgment on May 23, 2005 and DCH filed a Response and Cross-motion for Summary Judgment on June 22, 2005. After the ruling by the Supreme Court of Georgia in case 7 above, the Alliance voluntarily dismissed this case on October 18, 2005.

**9. Georgia Alliance of Community Hospitals v. Tim Burgess (Specialty Clinics of Georgia Orthopaedics, PC)**, Fulton Superior Court No. 2004cv95307 (J. Gianville) (filed December 28, 2004)

<b>LNR Issue Date:</b>	<b>September 16, 2004</b>
<b>Practice:</b>	<b>Specialty Clinics of Georgia Orthopaedics, P.C.</b>
<b>ASC:</b>	<b>Specialty Orthopaedics Surgery Center, LLC</b>
<b>Specialty:</b>	<b>Orthopedics</b>
<b>Location:</b>	<b>Gainesville, Georgia</b>
<b>Proposed Capital Expenditure:</b>	<b>\$1,248,127</b>
<b>Actual Capital Expenditure:</b>	<b>\$40,413 as of April 2005</b>

The Alliance filed a complaint and application for Writ of Mandamus seeking a determination and judgment that the applicant had developed the project in violation of CON requirements. The Alliance asserted the following:

- a. the total cost of the ASC exceeds the capital expenditure threshold
- b. the LNR request omitted and understated substantial items of cost
- c. the LNR request failed to contain information required by DCH regulation
- d. the ASC licensed by DHR under O.C.G.A. § 31-7-1 cannot be a "physician owned" office-based clinic eligible for the exemption of OCGA § 31-6-2(14)(G)(iii)
- e. the ASC is not owned and operated by a "single specialty" because a multi-specialty group actually proposed, developed and constructed the ASC
- f. the ASC is not owned and operated by physicians because it is operated under a separate corporate entity

The applicant intervened by Consent Order presented February 10, 2005. A Motion to Compel was filed by the Alliance. In response, the applicant filed a Motion for Protective Order in September 2005. After the ruling by the Supreme Court of Georgia in case 7 above, the Alliance voluntarily dismissed this case on October 18, 2005.

**MINUTES**  
**STATE COMMISSION ON THE EFFICACY OF CON**  
Sanders Fireplace Room at the Capitol Education Center  
October 24, 2005; 1:00 pm

# Appendices G & H

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## Stakeholder Presentations

**Thomas Gadacz, MD**

Governor, American College of Surgeons, Georgia Chapter

**Chris Smith, MD**

President, Society of General Surgeons, Georgia Chapter

Both of these presentations can be downloaded directly by accessing the following website:

[http://dch.georgia.gov/00/channel\\_title/0,2094,31446711\\_40970865,00.html](http://dch.georgia.gov/00/channel_title/0,2094,31446711_40970865,00.html)