Support legislation to ensure adequate hospital presence in Georgia communities

Georgia Watch recognizes that recent hospital closures in our State have had devastating effects on patients, employees, surrounding communities, and neighboring health systems. Georgia Watch seeks to identify opportunities through policy to hold hospitals and health systems accountable to prevent destabilizing closures such as the untimely closing of the Atlanta Medical Center and Atlanta Medical Center South by WellStar and Southwest Georgia Medical Center in Cuthbert.

Georgia Watch supports the proposed revision to the Hospital Permit Requirement, Ga. Comp. R. & Regs. R. 111-8-40-.03, by the Georgia Department of Community Health (DCH), which would require 180 days prior written notice of specified changes materially affecting the organized services offered by a hospital. The amendment specifies that hospitals must provide DCH 180 days prior written notice of anticipated closures (increased from 30 days) and revises hospital responsibilities prior to closure, subject to monetary penalties for late notice. The amendment further states that DCH shall review such proposed changes within its regulatory authority. The DCH Commissioner gave public notice of this proposed rule change on January 13, 2023. As of May 11, 2023, the DCH Board had not yet voted to adopt this proposed amendment.

While this proposed DCH rule change is a step in the right direction, Georgia Watch believes that additional hospital accountability is necessary to keep providers where they are needed and reduce disparities in access. To that end**, Georgia Watch offers the following policy concepts for consideration:**

Increased Hospital Closure Oversight:

If a rural hospital, critical access hospital, or safety net hospital chooses to close its doors, convert to a freestanding emergency department (ED), or eliminate service lines[1], such decision must be reviewed by the Georgia Attorney General (AG) and the Department of Community Health (DCH). The State Office of Rural Health must also review the decision if closure or conversion is set to occur within a rural county. This would require amending the Hospital Acquisition Act (O.C.G.A. §§ 31-7-400 – 31-7-412) and Chapters 6 and 7 of Title 31. Prior to the closure of a rural hospital, critical access hospital, or safety net hospital, the governing body of the hospital and/or the hospital authority shall:

- Provide at least 180 days advance written notice to DCH, the AG, the city mayor, the city council, and the public of the governing body's decision to close the hospital, eliminate a service line, or convert to a freestanding ED.
- Provide a financial analysis to DCH and the AG demonstrating why it is not feasible to keep the hospital or service line open, taking into consideration the overall financial health of the hospital authority and the healthcare system that may own, manage, operate, or lease the facility. This financial analysis shall be made publicly available on the website of the Office of Health Strategy and Coordination (OHSC).

[1] Service lines at issue include pediatrics, labor & delivery / obstetrics, oncology, orthopedics, cardiovascular services, neurology / neurosurgery, and behavioral health.

- This financial analysis shall contain an overview of the hospital's patient population, including a zip code breakdown of patients by payor (Medicaid, Medicare, private insurance, self-pay) and identifying those patients receiving hospital financial assistance.
- Specific hospital and health system budget line items must be included in the financial analysis as well.

The AG and/or DCH shall:

- Require that a community hearing be conducted. Require that hospitals within a thirty (30) mile radius in an urban area and a fifty (50) mile radius in a rural area attend the hearing and also submit written comments at least thirty (30) days in advance of the hearing date as to how the closure or conversion will impact their facility. A transcript or recording of the hearing shall be made publicly available on OHSC's website.
- Require that a hospital which is closing, converting to a freestanding ED, or eliminating a service line provide an independent, third-party health equity impact assessment[2] to assess the potential impact on the community and medically underserved groups[3] of the hospital's decision.
- Prior to authorizing the hospital or service line closure, DCH shall author and supervise the development of a plan to determine how neighboring hospitals and providers will meet the emergency transport and healthcare needs of the patients served by the hospital at risk of closure (participating entities in the plan development should include the governing body of the hospital and/or the hospital authority in cooperation with neighboring hospitals or health systems);
- Provide adequate time for community leaders or the hospital governing body to secure additional funding from federal, state, county, or other sources in order to keep the hospital or service line open or convert the hospital to a freestanding ED.

Georgia Watch proposes allowing DCH to allocate Indigent Care Trust Fund (ICTF) funds to keep a closing rural hospital, critical access hospital, or safety net hospital open or continue a service line, if necessary.

Increased Hospital and Hospital Authority Accountability:

To ensure that the public has meaningful access to information regarding the activities of local hospital authorities, Georgia Watch proposes the following revisions to Georgia law:

Revise O.C.G.A. §§ 31-7-90 – 31-7-92 (Georgia Hospital Authorities Law) to provide for the withholding of state grants or funds from a hospital authority that fails to comply with certain reporting requirements, including preparing and filing an annual report, annual budget, and community benefit report.

Require that any corporation that operates, leases or otherwise contracts with a hospital authority for the operation, lease or management of the hospital authority or its assets is also subject to the community benefit report requirement in O.C.G.A. § 31-7-90.1. Medicare or Medicaid losses shall not be considered a community benefit for the purpose of this report. Private insurance losses should also not be considered a community

[2] The health equity impact assessment shall be prepared for the hospital, and at the hospital's expense, by an independent entity and include the meaningful engagement of public health experts, organizations representing employees of the hospital, stakeholders, community leaders, and residents of the hospital's service area.

[3] "Medically underserved group" means: people with household incomes at or below 200% of the federal poverty level; racial and ethnic minorities; immigrants; women; lesbian, gay, bisexual, transgender, or other-than-cisgender people; people with disabilities; older adults; persons living with a prevalent infectious disease or condition; persons living in rural areas, and Medicaid eligible patients.

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benefit unless those insured patients were approved under the hospital's financial assistance policy to have their hospital bills reduced. This community benefit report must be filed with the hospital authority governing body and OHSC and should be made available for public inspection on OHSC's website.

Require a hospital authority to file annual reports, budgets, audits, and community benefit reports with the Office of Health Strategy and Coordination (OHSC) and require that such documents be made available for public inspection on OHSC's website.

Provide that any subsidiaries or foundations established by nonprofit organizations that lease assets from hospital authorities are subject to state open records laws. This would require amending Article 4 of Chapter 18 of Title 50 (Inspection of Public Records).

Improved Hospital Authority Governance:

To ensure that hospital authority boards are fully informed, representative of the communities that they serve, and protected from potential conflicts of interest, Georgia Watch proposes the following revisions to Georgia Hospital Authorities Law:

Revise O.C.G.A. §§ 31-7-70 – 31-7-96 to state that the hospital Chief Executive Officer or Chief Financial Officer must report to the Hospital Authority board at least quarterly regarding the financial health of the hospital.

Revise O.C.G.A. § 31-7-74 to state that no current employee of a hospital operated by a hospital authority or of a nonprofit organization that leases assets from a hospital authority may serve as a member of the hospital authority board.

Revise O.C.G.A. § 31-7-74 to require that each hospital authority board contain at least one lower-income community resident with a household income at or below 200% of the federal poverty level. This lower-income community resident participant shall be provided with a stipend of $100.00 per month for participation on the Board.

The above rules shall also apply to an authority created by two or more counties, or two or more municipalities, or a combination of any county and any municipality.

Indigent and Charity Care Spending Requirements:

Most Georgia hospitals are nonprofit organizations that are exempt from paying federal and state income taxes, sales tax, and property taxes, but there is no monetary requirement in current Georgia statute for community benefit or indigent or charity care spending. Georgia Watch proposes the following revisions to Georgia Certificate of Need (CON) law to ensure that all Georgia hospitals provide sufficient indigent and charity care:

Amend O.C.G.A. § 31-6-40.1 to state that DCH shall require a holder of a CON to provide uncompensated indigent or charity care in an amount that meets or exceeds 5 percent of its adjusted gross revenue as a condition of CON. The following monetary penalties shall be imposed for noncompliance with this charity care requirement. Penalty for noncompliance may also include, at the discretion of DCH, revocation of CON.

- If the amount of services actually provided is between 4.5 percent and 4.99 percent, a monetary penalty in the amount of 1 percent of its adjusted gross revenues.

- If the amount of services actually provided is between 4 percent and 4.49 percent, a monetary penalty in the amount of 2 percent of its adjusted gross revenues.
- If the amount of services actually provided is between 3.5 percent and 3.99 percent, a monetary penalty in the amount of 3 percent of its adjusted gross revenues.
- If the amount of services actually provided is between 3 percent and 3.49 percent, a monetary penalty in the amount of 4 percent of its adjusted gross revenues.
- If the amount of services actually provided is between 2.5 percent and 2.99 percent, a monetary penalty in the amount of 5 percent of its adjusted gross revenues.
- If the amount of services actually provided is between 2 percent and 2.49 percent, a monetary penalty in the amount of 6 percent of its adjusted gross revenues.
- If the amount of services actually provided is between 1.5 percent and 1.99 percent, a monetary penalty in the amount of 7 percent of its adjusted gross revenues.
- If the amount of services actually provided is between 1 percent and 1.49 percent, a monetary penalty in the amount of 8 percent of its adjusted gross revenues.
- If the amount of services actually provided is between 0.5 percent and 0.99 percent, a monetary penalty in the amount of 9 percent of its adjusted gross revenues.
- If the amount of services actually provided is less than 0.5 percent, a monetary penalty in the amount of 10 percent of its adjusted gross revenues.

Any above monetary penalty recovered shall be paid into the state treasury dedicated and deposited by DCH into the Indigent Care Trust Fund created pursuant to O.C.G.A. § 31-8-152.

Add a definition for "uncompensated indigent or charity care" to the statutes regulating hospitals and related institutions (O.C.G.A. § 31-7-1), which reads:

- "'Uncompensated indigent or charity care' means the dollar amount of 'net uncompensated indigent or charity care after direct and indirect (all) compensation' as defined by, and calculated in accordance with, the department's Hospital Financial Survey and related instructions."
- According to the DCH Division of Health Planning's financial definitions, indigent care is defined as any unpaid charges for services to patients whose family income is less than or equal to 125% of the Federal Poverty Guidelines. *See* O.C.G.A. § 31-6-70(c). This definition explicitly does not include unpaid charges for patients who were eligible for Medicare, Medicaid, Third Party, or patients provided other free care.
- Charity Care is defined in the DCH Division of Health Planning's financial definitions as any unpaid charges for services to patients whose family income is greater than 125% of the Federal Poverty Guidelines, and which were provided in accordance with the agency's formal written charity care policy, and which were written off to a formal charity account in the agency's accounting records. Charity care represents that portion of health care services that are provided but where payment is not expected. Charity care is provided to a patient with demonstrated inability to pay for some or all of the service. Only the portion of a patient's account that meets the organization's charity care criteria is recognized as charity.