House Bill 1234

By: Representatives Channell of the 116th, Cooper of the 41st, Parrish of the 156th, Stephens of the 164th, Hugley of the 133rd, and others

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to enact the "Medicaid Care Management Organizations Act"; to provide that care management organizations that contract with the Department of Community Health to provide health care services for Medicaid and PeachCare for Kids recipients meet certain requirements; to provide a short title; to provide for definitions; to provide that care management organizations are subject to certain laws relating to health maintenance organizations, managed health care plans, and insurance generally; to provide requirements relating to reimbursement for emergency health care services; to provide for coverage for newborn infants until discharged from the hospital; to provide for bundling of provider complaints and appeals; to provide for binding arbitration; to provide for interest payments on denied claims which are reversed; to require care management organizations to maintain a website for the processing of claims and to search for health care providers; to provide for standardized processing times for claims; to prohibit care management organizations from requiring health care providers to purchase or participate in other plans of the organization as a condition; to provide for reimbursement for a health care provider which complies with eligibility verification procedures; to provide for enforcement by the Commissioner of Insurance; to require that the provisions of this Act are included in new and renewal agreements with care management organizations and health care providers; to provide for Hospital Statistical and Reimbursement Reports from the Department of Community Health; to provide for applicability; to provide for rules and regulations; to amend Code Section 31-8-171 of the Official Code of Georgia Annotated, relating to definitions relative to quality assessment fees on care management organizations, so as to revise a definition relating to quality assessment fees on care management organizations for purposes of conformity; to amend Code Section 49-4-153 of the Official Code of Georgia Annotated, relating to administrative hearings and appeals relative to the Medicaid program, so as to provide that an administrative law judge can consolidate complaints or claims against a care management organization; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by adding a new chapter to read as follows:

"CHAPTER 21A

33-21A-1.

This chapter shall be known and may be cited as the 'Medicaid Care Management Organizations Act.'

33-21A-2.

As used in this chapter, the term:

(1) 'Care management organization' means an entity that is organized for the purpose of providing or arranging health care, which has been granted a certificate of authority by the Commissioner of Insurance as a health maintenance organization pursuant to Chapter 21 of this title, and which has entered into a contract with the Department of Community Health to provide or arrange health care services on a prepaid, capitated basis to members.

(2) 'CPT Code' means the certain coding reference established by the American Medical Association and more fully known as 'Current Procedural Terminology,' which is a generally accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians, which codes reflect not only the components of the treatment provided but also the complexity of medical decision making, and which is utilized by the Department of Community Health as its coding system for purposes of Medicaid and PeachCare for Kids; provided, however, that nothing in this chapter shall prohibit the Department of Community Health from adopting and utilizing another system of coding.

(3) 'Emergency health care services' means health care services provided for treatment of an emergency medical condition, including those health care services which are coded CPT Code 99283, 99284, or 99285 and may include those health care services which are coded CPT Code 99281 or 99282, as determined on a case-by-case basis.

(4) 'Health care provider' or 'provider' means any person, partnership, professional association, corporation, facility, or institution certified, licensed, or registered by the State of Georgia that has contracted with a care management organization to provide health care services to members.

(5) 'Health care services' has the same meaning as in paragraph (5) of Code Section 33-21-1.

(6) 'Health maintenance organization' means an entity which has been issued a certificate of authority by the Commissioner of Insurance pursuant to Chapter 21 of this title to establish and operate a health maintenance organization.

(7) 'Hospital Statistical and Reimbursement Report' or 'HS&R report' means a consolidated report created by the Department of Community Health that includes data related to an individual hospital, including aggregate statistics and reimbursement data for all Medicaid recipients who received health care services at such hospital during a specific fiscal year, including data for Medicaid recipients for whom the Department of Community Health reimburses directly, data for all care management organization members, and data regarding services provided for out-of-network care management organization patients. HS&R reports are utilized by the Department of Community Health for purposes of the Indigent Care Trust Fund´s disproportionate share hospital survey and are also utilized by hospitals to claim payments under Medicare´s disproportionate share hospital program.

(8) 'Medicaid' means the joint federal and state program of medical assistance established by Title XIX of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 7 of Chapter 4 of Title 49.

(9) 'Member' means a Medicaid or PeachCare for Kids recipient who is currently enrolled in a care management organization plan.

(10) 'PeachCare for Kids' means the State of Georgia´s State Children´s Health Insurance Program established pursuant to Title XXI of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 13 of Chapter 5 of Title 49.

(11) 'Prudent layperson standard' means the standard defined in Section 1932(b)(2) of the federal Social Security Act.

33-21A-3.

A care management organization shall be required to obtain a certificate of authority as a health maintenance organization pursuant to Chapter 21 of this title prior to providing or arranging health care for members pursuant to a contract with the Department of Community Health. On and after the date of issuance of its certificate of authority as a health maintenance organization, a care management organization shall comply with all provisions relating to health maintenance organizations, including, but not limited to, Chapter 21 of this title and all regulations established pursuant to such chapter.

33-21A-4.

On and after the date of issuance of its certificate of authority as a health maintenance organization, a care management organization shall comply with all provisions relating to managed health care plans, including, but not limited to, Chapter 20A of this title, with the exception of Code Section 33-20A-9.1, and all regulations established pursuant to such chapter, except those established pursuant to Code Section 33-20A-9.1.

33-21A-5.

On and after the date of issuance of its certificate of authority as a health maintenance organization, a care management organization shall comply with all applicable provisions of Chapter 24 of this title and all applicable regulations established pursuant to such chapter, including but not limited to Code Section 33-24-59.5.

33-21A-6.

(a) In particular, but without limitation, a care management organization shall not:

(1) Deny or inappropriately reduce payment to a provider of emergency health care services for any evaluation, diagnostic testing, or treatment provided to a recipient of medical assistance for an emergency condition; or

(2) Make payment for emergency health care services contingent on the recipient or provider of emergency health care services providing any notification, either before or after receiving emergency health care services.

(b) Each claim for payment submitted by a provider of emergency health care services to a care management organization which is coded CPT Code 99283, 99284, or 99285, or subsequent codes representing equivalent health care services or procedures adopted for use by the Department of Community Health, and any facility or ambulatory payment classification claim submitted by a facility for services provided in conjunction with a physician service which is coded CPT Code 99283, 99284, or 99285 shall be regarded by the care management organization as treatment of an emergency condition and shall be paid by the care management organization at the applicable emergency services rate regardless of any prior authorization requirements. All claims payment systems used by any care management organization shall be programmed to automatically identify and pay claims with these CPT Codes as emergency health care services claims.

(c) Each claim for payment submitted by a provider of emergency health care services to a care management organization which is coded CPT Code 99281 or 99282, or subsequent codes representing equivalent health care services or procedures adopted for use by the Department of Community Health, shall be evaluated on a case-by-case basis to determine whether such claim should be regarded by the care management organization as treatment

of an emergency condition. Such evaluation shall be based on all pertinent documentation, shall be focused on the patient´s presenting symptoms and not on the final diagnosis, and shall be made in accordance with the prudent layperson standard. If it is determined under that standard that the services provided constituted treatment of an emergency medical condition, then the care management organization shall pay for the services at the applicable emergency services rate, regardless of any prior authorization requirements.

(d) If a provider that has not entered into a contract with a care management organization provides emergency health care services to that care management organization´s member, the care management organization shall reimburse the noncontracted provider at a rate equal to the rate paid by the Department of Community Health for Medicaid claims that it reimburses directly.

(e) Any care management organization which violates this Code section shall be subject to a penalty of $1,000.00 per violation. Such penalty shall be collected by the Department of Community Health and deposited into the Indigent Care Trust Fund created pursuant to Code Section 31-8-152. A care management organization shall not reduce the funding available for health care services for members as a result of payment of such penalties.

(f) The provisions of this Code section shall apply to emergency health care services provided to members by providers, and every care management organization shall be required to pay for emergency health care services that meet the prudent layperson standard.

33-21A-7.

Each care management organization shall pay for health care services provided to a newborn infant who is born to a mother who is a member currently enrolled with that care management organization until such time as the newborn is finally discharged from all inpatient care to a home environment. For a newborn infant whose mother is enrolled in a Medicaid program under which she receives Medicaid benefits directly from the Department of Community Health, the Department of Community Health shall pay for health care services provided to the newborn until such time as the newborn is finally discharged from all inpatient care to a home environment.

33-21A-8.

(a) In reviewing provider complaints or appeals related to denial of claims, a care management organization shall allow providers to consolidate complaints or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal.

(b) Each care management organization shall allow a provider that has exhausted the care management organization´s internal appeals process related to a denied or underpaid claim or group of claims bundled for appeal the option either to pursue the administrative review process described in subsection (e) of Code Section 49-4-153 or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the care management organization and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless the care management organization and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney´s fees, shall be shared equally by the parties.

(c) For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 18 percent per annum, calculated from the date the claim was submitted.

(d) Each care management organization shall maintain a website that allows providers to submit, process, edit, rebill, and adjudicate claims electronically. Each care management organization shall submit payments to providers electronically and submit remittance advices to providers electronically on the same business day that payment is made. To the extent that any of these functions involve covered transactions under 45 C.F.R. Section 162.900, et seq., then those transactions also shall be conducted in accordance with applicable federal requirements.

(e) Each care management organization shall post on its website a searchable list of all providers with which the care management organization has contracted. At a minimum, this list shall be searchable by provider name, specialty, and location. At a minimum, the list shall be updated once each month.

(f) The Department of Community Health shall require each care management organization to utilize the same timeframes and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid claims as the timeframes and deadlines that the Department of Community Health uses on claims it pays directly.

(g) No care management organization shall, as a condition of contracting with a provider, require that provider to participate or accept other plans or products offered by the care management organization unrelated to providing care to members. Any care management

organization which violates this prohibition shall be subject to a penalty of $1,000.00 per violation. Such penalty shall be collected by the Department of Community Health. A care management organization shall not reduce the funding available for members as a result of payment of such penalties.

33-21A-9.

If a provider complies with the published procedures, whether published electronically or in print, of the Department of Community Health for verifying a patient´s eligibility for Medicaid benefits, the Department of Community Health shall reimburse that provider for all covered health care services the provider provides to the patient during the 72 hours after obtaining verification of enrollment if such services are denied, either initially or after review, by a care management organization or by the Department of Community Health, because the patient was not enrolled as indicated through the eligibility verification process. The amount of reimbursement to the provider shall be equal to the amount to which the provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After reimbursing the provider, the Department of Community Health may pursue a cause of action against any person whose conduct or inaction contributed to the incorrect verification of enrollment, including but not limited to the fiscal agent of the Department of Community Health or any care management organization.

33-21A-10.

The Commissioner of Insurance shall revoke or suspend the health maintenance organization certificate of authority issued to a care management organization or in lieu thereof impose a monetary penalty in accordance with Chapter 2 of this title if the Commissioner determines that such care management organization no longer meets the applicable requirements for such certificate of authority or violates any provision of this chapter or other applicable laws. Before imposing any such sanction, the Commissioner shall provide the care management organization with notice and opportunity for a hearing on the proposed sanctions. Nothing in this Code section shall be construed as precluding or limiting the Commissioner´s authority under other Code sections, including but not limited to the authority granted in Code Section 33-21-5, or as precluding any other remedies at law, including but not limited to remedies available to the Department of Community Health under its contract with a care management organization or remedies available to the Commissioner of the Department of Human Resources.

33-21A-11.

(1) On and after the effective date of this chapter, the Department of Community Health shall include provisions in all new or renewal agreements with a care management organization, which require the care management organization to comply with all provisions of this chapter.

(2) On and after the effective date of this chapter, a care management organization shall not include any provisions in new or renewal agreements with providers entered into pursuant to the contract between the Department of Community Health and the care management organization, which are inconsistent with the provisions of this chapter.

33-21A-12.

Upon request by a hospital provider related to a specific fiscal year, the Department of Community Health shall, within 30 days of the request, provide that hospital with an HS&R report for the requested fiscal year.

33-21A-13.

To the extent any provision in this chapter is inconsistent with applicable federal law, the applicable federal law shall govern.

33-21A-14.

The Commissioner of Insurance and the Department of Community Health, as appropriate, shall be authorized to adopt rules and regulations to effect the implementation of this chapter.″

SECTION 2.

Code Section 31-8-171 of the Official Code of Georgia Annotated, relating to definitions relative to quality assessment fees on care management organizations, is amended by revising paragraph (1) as follows:

″(1) 'Care management organization' ~~means an entity granted a certificate of authority under Chapter 21 of Title 33 of the Official Code of Georgia Annotated and which meets the definition found in 42 U.S.C. Sec. 1396b(w)(7)(A)(viii) as it now exists or as it may be amended in the future~~ has the same meaning as in paragraph (1) of Code Section 33-21A-2.″

SECTION 3.

Code Section 49-4-153 of the Official Code of Georgia Annotated, relating to administrative hearings and appeals relative to the Medicaid program, is amended by revising paragraph (1) of subsection (e) as follows:

"(1) A provider of medical assistance may request a hearing on a decision of a care management organization with respect to a denial or nonpayment of or the determination of the amount of reimbursement paid or payable to such provider on a certain item of medical or remedial care of service rendered by such provider by filing a written request for a hearing in accordance with Code Sections 50-13-13 and 50-13-15 with the Department of Community Health. The Department of Community Health shall, within 15 business days of receiving the request for hearing from the provider, transmit a copy of the provider´s request for hearing to the Office of State Administrative Hearings~~,~~ but shall not be a party to the proceedings. The provider´s request for hearing shall identify the care management organization with which the provider has a dispute, the issues under appeal, and specify the relief requested by the provider. The request for hearing shall be filed no later than 15 business days after the provider of medical assistance receives the decision of the care management organization which is the basis for the appeal. Notwithstanding any other provision of this title, an administrative law judge appointed pursuant to paragraph (2) of this subsection shall be authorized to allow providers of medical assistance to consolidate pending complaints or claims against a care management organization that are based on the same or similar payment or coverage issues, as determined by such administrative law judge. Such consolidation shall include disposition of the same or similar claims through a single hearing that adjudicates the total amount of such consolidated claims."

SECTION 4.

This Act shall become effective upon its approval by the Governor or upon its becoming law without such approval.

SECTION 5.

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