

The House Committee on Insurance offers the following substitute to HB 1234:

A BILL TO BE ENTITLED

AN ACT

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

26 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) 'Coordination of care' means early identification of members who have or may have special needs; assessment of a member's risk factors; development of a plan of care; referrals and assistance to ensure timely access to providers; coordination of care actively linking the member to providers, medical services, and residential, social, and other support services where needed; monitoring; continuity of care; and follow-up and documentation, all as further described pursuant to the terms of the contracts between the Department of Community Health and the care management organizations.

(3) '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.

(4) 'Critical access hospital' means a hospital that meets the requirements of the federal Centers for Medicare and Medicaid Services to be designated as a critical access hospital

1 and that is recognized by the Department of Community Health as a critical access  
2 hospital for purposes of Medicaid.

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

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

11 (7) 'Health care services' has the same meaning as in paragraph (5) of Code Section  
12 33-21-1.

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

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

27 (10) 'Medicaid' means the joint federal and state program of medical assistance  
28 established by Title XIX of the federal Social Security Act, which is administered in this  
29 state by the Department of Community Health pursuant to Article 7 of Chapter 4 of Title  
30 49.

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

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

1 (13) 'Post-stabilization services' means covered services related to an emergency medical  
2 condition that are provided after a member is stabilized in order to maintain the stabilized  
3 condition or to improve or resolve the member's condition.

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

6 33-21A-3.

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

14 33-21A-4.

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

20 33-21A-5.

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

25 33-21A-6.

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

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

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

1 (b) Unless the care management organization or the Department of Community Health has  
2 reason to believe that a provider is upcoding or engaging in activity violating program  
3 integrity, each claim for payment submitted by a provider of emergency health care  
4 services to a care management organization which is coded CPT Code 99283, 99284, or  
5 99285, or subsequent codes representing equivalent health care services or procedures  
6 adopted for use by the Department of Community Health, and any facility or ambulatory  
7 payment classification claim submitted by a facility for services provided in conjunction  
8 with a physician service which is coded CPT Code 99283, 99284, or 99285 shall be  
9 regarded by the care management organization as treatment of an emergency condition and  
10 shall be paid by the care management organization at the applicable emergency services  
11 rate regardless of any prior authorization requirements. All claims payment systems used  
12 by any care management organization shall be programmed to identify and pay claims with  
13 these CPT Codes as emergency health care services claims.

14 (c) Each claim for payment submitted by a provider of emergency health care services to  
15 a care management organization which is coded CPT Code 99281 or 99282, or subsequent  
16 codes representing equivalent health care services or procedures adopted for use by the  
17 Department of Community Health, shall be evaluated on a case-by-case basis to determine  
18 whether such claim should be regarded by the care management organization as treatment  
19 of an emergency condition. Such evaluation shall be based on all pertinent documentation,  
20 shall be focused on the patient's presenting symptoms and not on the final diagnosis, and  
21 shall be made in accordance with the prudent layperson standard. If it is determined under  
22 that standard that the services provided constituted treatment of an emergency medical  
23 condition, then the care management organization shall pay for the services at the  
24 applicable emergency services rate, regardless of any prior authorization requirements.

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

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

35 (f) The provisions of this Code section shall apply to emergency health care services  
36 provided to members by providers, and every care management organization shall be

1 required to pay for emergency health care services that meet the prudent layperson  
2 standard.

3 33-21A-6.1.

4 (a) Each care management organization shall include, through contract, all critical access  
5 hospitals that are in its service region as providers.

6 (b) Each care management organization shall reimburse critical access hospitals a payment  
7 rate based on the most recent available critical access hospital Medicare cost report to  
8 prospectively determine and set forth inpatient and outpatient rates for each year. The care  
9 management organization shall conduct an annual end-of-year cost report reconciliation  
10 process followed by a corresponding annual settlement transaction to ensure each critical  
11 access hospital is reimbursed all allowable costs, in accordance with the Department of  
12 Community Health's established Medicaid policies and procedures.

13 33-21A-7.

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

22 (b) In the event a newborn is disenrolled from a care management organization and  
23 re-enrolled into the Medicaid fee-for-service program conducted directly by the  
24 Department of Community Health, the care management organization shall ensure the  
25 coordination of care for that child until the child has been appropriately discharged from  
26 the hospital and placed in an appropriate care setting.

27 33-21A-8.

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

33 (b) Each care management organization shall allow a provider that has exhausted the care  
34 management organization's internal appeals process related to a denied or underpaid claim

1 or group of claims bundled for appeal the option either to pursue the administrative review  
2 process described in subsection (e) of Code Section 49-4-153 or to select binding  
3 arbitration by a private arbitrator who is certified by a nationally recognized association  
4 that provides training and certification in alternative dispute resolution. If the care  
5 management organization and the provider are unable to agree on an association, the rules  
6 of the American Arbitration Association shall apply. The arbitrator shall have experience  
7 and expertise in the health care field and shall be selected according to the rules of his or  
8 her certifying association. Arbitration conducted pursuant to this Code section shall be  
9 binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within  
10 90 days of being selected, unless the care management organization and the provider  
11 mutually agree to extend this deadline. All costs of arbitration, not including attorney's  
12 fees, shall be shared equally by the parties.

13 (c) For all claims that are initially denied or underpaid by a care management organization  
14 but eventually determined or agreed to have been owed by the care management  
15 organization to a provider of health care services, the care management organization shall  
16 pay, in addition to the amount determined to be owed, interest of 18 percent per annum,  
17 calculated from the date the claim was submitted. However, denial or underpayment due  
18 to omission or error by the provider shall not require the care management organization to  
19 incur this penalty.

20 (d) Each care management organization shall maintain a website that allows providers to  
21 submit, process, edit, rebill, and adjudicate claims electronically. Each care management  
22 organization shall submit payments to providers electronically and submit remittance  
23 advices to providers electronically within one business day of when payment is made. To  
24 the extent that any of these functions involve covered transactions under 45 C.F.R. Section  
25 162.900, et seq., then those transactions also shall be conducted in accordance with  
26 applicable federal requirements.

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

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

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

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

5 33-21A-9.

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

20 33-21A-10.

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

1 33-21A-11.

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

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

10 33-21A-12.

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

14 33-21A-13.

15 To the extent any provision in this chapter is inconsistent with applicable federal law, rule,  
16 or regulation, the applicable federal law, rule, or regulation shall govern.

17 33-21A-14.

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

21 **SECTION 2.**

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

25 "(1) A provider of medical assistance may request a hearing on a decision of a care  
26 management organization with respect to a denial or nonpayment of or the determination  
27 of the amount of reimbursement paid or payable to such provider on a certain item of  
28 medical or remedial care of service rendered by such provider by filing a written request  
29 for a hearing in accordance with Code Sections 50-13-13 and 50-13-15 with the  
30 Department of Community Health. The Department of Community Health shall, within  
31 15 business days of receiving the request for hearing from the provider, transmit a copy  
32 of the provider's request for hearing to the Office of State Administrative Hearings; but  
33 shall not be a party to the proceedings. The provider's request for hearing shall identify

1 the care management organization with which the provider has a dispute, the issues under  
2 appeal, and specify the relief requested by the provider. The request for hearing shall be  
3 filed no later than 15 business days after the provider of medical assistance receives the  
4 decision of the care management organization which is the basis for the appeal.  
5 Notwithstanding any other provision of this title, an administrative law judge appointed  
6 pursuant to paragraph (2) of this subsection shall be authorized to allow providers of  
7 medical assistance to consolidate pending complaints or claims against a care  
8 management organization that are based on the same or similar payment or coverage  
9 issues, as determined by such administrative law judge. Such consolidation shall include  
10 disposition of the same or similar claims through a single hearing that adjudicates the  
11 total amount of such consolidated claims."

12 **SECTION 3.**

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

15 **SECTION 4.**

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