

House Bill 1234 (AS PASSED HOUSE AND SENATE)

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

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
16 requirements for participation by dentists; to provide for claims to a responsible health
17 organization; to require that the provisions of this Act are included in new and renewal
18 agreements with care management organizations and health care providers; to provide for
19 Hospital Statistical and Reimbursement Reports from the Department of Community Health;
20 to provide for applicability; to amend Code Section 49-4-153 of the Official Code of Georgia
21 Annotated, relating to administrative hearings and appeals relative to the Medicaid program,
22 so as to provide that an administrative law judge can consolidate complaints or claims against
23 a care management organization; to provide for related matters; to provide for an effective
24 date; to repeal conflicting laws; and for other purposes.

25 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; 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) '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 and that is recognized by the Department of Community Health as a critical access hospital for purposes of Medicaid.

(4) 'Emergency health care services' means health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

- (A) Placing the patient's health in serious jeopardy;
- (B) Serious impairment to bodily functions; or
- (C) Serious dysfunction of any bodily organ or part.

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

5 (6) 'Health care services' has the same meaning as in paragraph (5) of Code Section
6 33-21-1.

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

10 (8) 'Hospital Statistical and Reimbursement Report' or 'HS&R report' means a report
11 created by a care management organization, using the same format that is used by the
12 Department of Community Health in completing HS&R reports, that includes data related
13 to an individual hospital, including aggregate statistics and reimbursement data for all
14 Medicaid recipients who are covered by the care management organization and who
15 received health care services at such hospital during a specific fiscal year, including data
16 regarding services that were provided out of network. HS&R reports are utilized by the
17 Department of Community Health for purposes of the Indigent Care Trust Fund's
18 disproportionate share hospital survey and are also utilized by hospitals to claim
19 payments under medicare's disproportionate share hospital program.

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

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

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

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

32 (13) 'Responsible health organization' means the entity that a health care provider
33 reasonably identifies to be responsible for providing or arranging health care services for
34 a patient who is a Medicaid or PeachCare for Kids recipient after the provider has
35 properly conducted an eligibility verification in accordance with the procedures of the
36 Department of Community Health.

1 33-21A-3.

2 (a) A care management organization shall be required to obtain a certificate of authority
3 as a health maintenance organization pursuant to Chapter 21 of this title prior to providing
4 or arranging health care for members pursuant to a contract with the Department of
5 Community Health. On and after the date of issuance of its certificate of authority as a
6 health maintenance organization, a care management organization shall comply with all
7 provisions relating to health maintenance organizations and all provisions relating to
8 managed health care plans, with the exception of Code Section 33-20A-9.1.

9 (b) The Commissioner of Insurance shall not have the authority to approve, disapprove,
10 or set rates paid by the Department of Community Health to a care management
11 organization or paid by a care management organization to a health care provider.

12 (c) The Commissioner of Insurance shall not have the authority to approve, disapprove,
13 or modify any plan offered by a care management organization or any contract between a
14 care management organization and the Department of Community Health.

15 (d) Nothing in this chapter shall be interpreted as altering the authority of the
16 commissioner of community health.

17 33-21A-4.

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

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

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

25 (b) In processing claims for emergency health care services, a care management
26 organization shall consider, at the time that a claim is submitted, at least the following
27 criteria:

28 (1) The age of the patient;

29 (2) The time and day of the week the patient presented for services;

30 (3) The severity and nature of the presenting symptoms;

31 (4) The patient's initial and final diagnosis; and

32 (5) Any other criteria prescribed by the Department of Community Health, including
33 criteria specific to patients under 18 years of age.

34 A care management organization shall configure or program its automated claims
35 processing system to consider at least the conditions and criteria described in this
36 subsection for claims presented for emergency health care services. The Department of

1 Community Health may develop and publish a list of additional standards to be used by
2 care management organizations to maximize the identification and accurate payment of
3 claims for emergency health care services.

4 (c) If a provider that has not entered into a contract with a care management organization
5 provides emergency health care services or post-stabilization services to that care
6 management organization's member, the care management organization shall reimburse
7 the noncontracted provider for such emergency health care services and post-stabilization
8 services at a rate equal to the rate paid by the Department of Community Health for
9 Medicaid claims that it reimburses directly.

10 33-21A-5.

11 (a) A critical access hospital must provide notice to a care management organization and
12 the Department of Community Health of any alleged breaches in its contract by such care
13 management organization.

14 (b) If a critical access hospital satisfies the requirement of subsection (a) of this Code
15 section, and if the Department of Community Health concludes, after notice and hearing,
16 that a care management organization has substantively and repeatedly breached a term of
17 its contract with a critical access hospital, the department is authorized to require the care
18 management organization to pay damages to the critical access hospital in an amount not
19 to exceed three times the amount owed. Notwithstanding the foregoing, nothing in this
20 Code section shall be interpreted to limit the authority of the Department of Community
21 Health to establish additional penalties or fines against a care management organization for
22 failure to comply with the contract between a care management organization and the
23 Department of Community Health.

24 33-21A-6.

25 (a) Each care management organization shall pay for health care services provided to a
26 newborn infant who is born to a mother who is a member currently enrolled with that care
27 management organization until such time as the newborn is finally discharged from all
28 inpatient care to a home environment subject to approval by the federal Centers for
29 Medicare and Medicaid Services. For a newborn infant whose mother is enrolled in a
30 Medicaid program under which she receives Medicaid benefits directly from the
31 Department of Community Health, the Department of Community Health shall pay for
32 health care services provided to the newborn until such time as the newborn is finally
33 discharged from all inpatient care to a home environment.

34 (b) In the event a newborn is disenrolled from a care management organization and
35 re-enrolled into the Medicaid fee-for-service program conducted directly by the

1 Department of Community Health, the care management organization shall ensure the
2 coordination of care for that child until the child has been appropriately discharged from
3 the hospital and placed in an appropriate care setting.

4 33-21A-7.

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

10 (b) Each care management organization shall allow a provider that has exhausted the care
11 management organization's internal appeals process related to a denied or underpaid claim
12 or group of claims bundled for appeal the option either to pursue the administrative review
13 process described in subsection (e) of Code Section 49-4-153 or to select binding
14 arbitration by a private arbitrator who is certified by a nationally recognized association
15 that provides training and certification in alternative dispute resolution. If the care
16 management organization and the provider are unable to agree on an association, the rules
17 of the American Arbitration Association shall apply. The arbitrator shall have experience
18 and expertise in the health care field and shall be selected according to the rules of his or
19 her certifying association. Arbitration conducted pursuant to this Code section shall be
20 binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within
21 90 days of being selected, unless the care management organization and the provider
22 mutually agree to extend this deadline. All costs of arbitration, not including attorney's
23 fees, shall be shared equally by the parties.

24 (c) For all claims that are initially denied or underpaid by a care management organization
25 but eventually determined or agreed to have been owed by the care management
26 organization to a provider of health care services, the care management organization shall
27 pay, in addition to the amount determined to be owed, interest of 20 percent per annum,
28 calculated from 15 days after the date the claim was submitted. A care management
29 organization shall pay all interest required to be paid under this provision or Code Section
30 33-24-59.5 automatically and simultaneously whenever payment is made for the claim
31 giving rise to the interest payment. All interest payments shall be accurately identified on
32 the associated remittance advice submitted by the care management organization to the
33 provider. A care management organization shall not be responsible for the penalty
34 described in this subsection if the health care provider submits a claim containing a
35 material omission or inaccuracy in any of the data elements required for a complete
36 standard health care claim form as prescribed under 45 C.F.R. Part 162 for electronic

1 claims, a CMS Form 1500 for nonelectronic claims, or any claim prescribed by the
2 Department of Community Health.

3 (d) Each care management organization shall maintain a website that allows providers to
4 submit, process, edit, rebill, and adjudicate claims electronically. To the extent a provider
5 has the capability, each care management organization shall submit payments to providers
6 electronically and submit remittance advices to providers electronically within one business
7 day of when payment is made. To the extent that any of these functions involve covered
8 transactions under 45 C.F.R. Section 162.900, et seq., then those transactions also shall be
9 conducted in accordance with applicable federal requirements.

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

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

18 (g) No care management organization shall, as a condition of contracting with a provider,
19 require that provider to participate or accept other plans or products offered by the care
20 management organization unrelated to providing care to members. Any care management
21 organization which violates this prohibition shall be subject to a penalty of \$1,000.00 per
22 violation. Such penalty shall be collected by the Department of Community Health. A
23 care management organization shall not reduce the funding available for members as a
24 result of payment of such penalties.

25 (h) No health care provider shall, as a condition of contracting with a care management
26 organization, require that a care management organization contract with or not contract
27 with another health care provider. Any health care provider which violates this subsection
28 shall be subject to a penalty of \$1,000.00 per violation. Such penalty shall be collected by
29 the Department of Community Health. A health care provider shall not terminate an
30 agreement with a care management organization as a result of payment of such penalties.

31 33-21A-8.

32 (a) Except as provided in subsection (b) of this Code section, no care management
33 organization or agent of such care management organization shall deny any dentist from
34 participating in the Medicaid and PeachCare for Kids dental program administered by such
35 care management organization if:

1 (1) Such dentist has obtained a license to practice in this state and is an enrolled provider
 2 who has met all of the requirements of the Department of Community Health for
 3 participation in the Medicaid and PeachCare for Kids program; and

4 (2)(A) The licensed dentist will provide dental services to members pursuant to a state
 5 or federally funded educational loan forgiveness program that requires such services;
 6 provided, however, each care management organization shall be required to offer
 7 dentists wishing to participate through such loan forgiveness programs the same
 8 contract terms offered to other dentists in the service region who participate in the care
 9 management organization's Medicaid and PeachCare for Kids dental programs;

10 (B) The geographic area in which the dentist intends to practice has been designated
 11 as having a dental professional shortage as determined by the Department of
 12 Community Health, which may be based on the designation of the Health Resources
 13 and Services Administration of the United States Department of Health and Human
 14 Services; or

15 (C) Such care management organization fails to establish to the satisfaction of the
 16 Department of Community Health that a sufficient number of general dentists and
 17 specialists have contracted with the care management organization to provide covered
 18 dental services to members in the geographic region.

19 (b) A care management organization may decline to contract with a dentist who meets the
 20 requirements of subsection (a) of this Code section if such dentist has had his or her license
 21 to practice dentistry sanctioned in any manner or fails to meet the credentialing criteria
 22 established by the care management organization. Any dentist denied on this basis shall
 23 be entitled to a hearing before an administrative law judge as set forth in subsection (e) of
 24 Code Section 49-4-153.

25 (c) The Department of Community Health shall also provide a means for dentists to
 26 request an annual hearing to determine whether a condition described in subparagraph (B)
 27 or (C) of paragraph (2) of subsection (a) of this Code section exists. The department may
 28 compel the attendance of care management organizations or agents of care management
 29 organizations to attend such hearings. The department may request additional information
 30 as a result of the hearing, and it shall consider matters raised in the hearing when deciding
 31 whether a condition described in subparagraph (A) or (B) of paragraph (2) of subsection
 32 (a) of this Code section exists.

33 33-21A-9.

34 (a) If a provider submits a claim to a responsible health organization for services rendered
 35 within 72 hours after the provider verifies the eligibility of the patient with that responsible
 36 health organization, the responsible health organization shall reimburse the provider in an

1 amount equal to the amount to which the provider would have been entitled if the patient
 2 had been enrolled as shown in the eligibility verification process. After resolving the
 3 provider's claim, if the responsible health organization made payment for a patient for
 4 whom it was not responsible, then the responsible health organization may pursue a cause
 5 of action against any person who was responsible for payment of the services at the time
 6 they were provided but may not recover any payment made to the provider.

7 (b) If a provider verifies the eligibility of a patient as set forth in subsection (a) of this
 8 Code section, and if a provider determines that a person other than the responsible health
 9 organization to which it has submitted a claim is responsible for Medicaid or PeachCare
 10 for Kids coverage of the patient at the time the service was rendered, the provider may
 11 submit the claim to the person that is responsible for Medicaid or PeachCare for Kids
 12 coverage and that person shall reimburse all medically necessary services, without
 13 application of any penalty for failure to file claims in a timely manner, for failure to obtain
 14 prior authorization, or for the provider not being a participating provider in the person's
 15 network, and the amount of reimbursement shall be that person's applicable rate for the
 16 service if the provider is under contract with that person or the rate paid by the Department
 17 of Community Health for the same type of claim that it pays directly if the provider is not
 18 under contract with that person.

19 33-21A-10.

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

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

28 33-21A-11.

29 Upon request by a hospital provider related to a specific fiscal year, a care management
 30 organization shall, within 30 days of the request, provide that hospital with an HS&R
 31 report for the requested fiscal year. Any care management organization which violates this
 32 Code section by not providing the requested report within 30 days shall be subject to a
 33 penalty of \$1,000.00 per day, starting on the thirty-first day after the request and continuing
 34 until the report is provided. It is the intent of the General Assembly that such penalty be
 35 collected by the Department of Community Health and deposited into the Indigent Care

1 Trust Fund created pursuant to Code Section 31-8-152. A care management organization
 2 shall not reduce the funding available for health care services for members as a result of
 3 payment of such penalties.

4 33-21A-12.

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

7 SECTION 2.

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

11 "(1) A dentist acting pursuant to subsection (b) of Code Section 33-21A-8 or a provider
 12 of medical assistance may request a hearing on a decision of a care management
 13 organization with respect to the provisions set forth in subsection (b) of Code Section
 14 33-21A-8 or with respect to a denial or nonpayment of or the determination of the amount
 15 of reimbursement paid or payable to such provider on a certain item of medical or
 16 remedial care of service rendered by such provider by filing a written request for a
 17 hearing in accordance with Code Sections 50-13-13 and 50-13-15 with the Department
 18 of Community Health. The Department of Community Health shall, within 15 business
 19 days of receiving the request for hearing from the provider, transmit a copy of the
 20 provider's request for hearing to the Office of State Administrative Hearings; but shall
 21 not be a party to the proceedings. The provider's request for hearing shall identify the
 22 care management organization with which the provider has a dispute, the issues under
 23 appeal, and specify the relief requested by the provider. The request for hearing shall be
 24 filed no later than 15 business days after the provider of medical assistance receives the
 25 decision of the care management organization which is the basis for the appeal.
 26 Notwithstanding any other provision of this title, an administrative law judge appointed
 27 pursuant to paragraph (2) of this subsection shall be authorized to allow a provider of
 28 medical assistance to consolidate pending complaints or claims against a care
 29 management organization that are based on the same or similar payment or coverage
 30 issues, as determined by such administrative law judge. Such consolidation shall include
 31 disposition of the same or similar claims through a single hearing that adjudicates the
 32 total amount of such consolidated claims."

1 **SECTION 3.**

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

4 **SECTION 4.**

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