

House Bill 307

By: Representatives Cole of the 125th and Ramsey of the 72nd

A BILL TO BE ENTITLED
AN ACT

1 To amend Chapter 8 of Title 31 of the Official Code of Georgia Annotated, relating to the
2 care and protection of indigent and elderly patients, so as to provide for a fee to be imposed
3 on hospitals to be used to obtain federal financial participation for medical assistance
4 payments under Medicaid; to provide for definitions; to establish a segregated account within
5 the Indigent Care Trust Fund for the deposit of provider fees; to provide for a method for
6 calculating and collecting the provider fee; to authorize the Department of Community
7 Health to inspect hospital records for purposes of auditing provider fees; to provide for
8 penalties for failure to pay a provider fee; to authorize the department to withhold Medicaid
9 payments equal to amounts owed as a provider fee and penalty; to provide for the collection
10 of fees by civil action and tax liens; to provide for the appropriation of funds in the
11 segregated account for medical assistance payments; to provide for application of the
12 "Georgia Medical Assistance Act of 1977"; to revise definitions relating to quality
13 assessment fees on care management organizations; to revise language relating to the
14 maximum aggregate quality assessment fees which may be imposed; to provide for related
15 matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

16 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

17 **SECTION 1.**

18 Chapter 8 of Title 31 of the Official Code of Georgia Annotated, relating to the care and
19 protection of indigent and elderly patients, is amended by adding a new article to read as
20 follows:

21 "ARTICLE 6C

22 31-8-179.

23 This article is enacted pursuant to the authority of Article III, Section IX, Paragraph VI(i)
24 of the Constitution.

25 31-8-179.1.

26 As used in this article, the term:

27 (1) 'Department' means the Department of Community Health.

28 (2) 'Hospital' means an institution licensed pursuant to Chapter 7 of this title which is
29 primarily engaged in providing to inpatients, by or under the supervision of physicians,
30 diagnostic services and therapeutic services for medical diagnosis, treatment, and care of
31 injured, disabled, or sick persons or rehabilitation services for the rehabilitation of
32 injured, disabled, or sick persons. Such term includes public, private, rehabilitative,
33 geriatric, osteopathic, and other specialty hospitals but shall not include psychiatric
34 hospitals as defined in paragraph (7) of Code Section 37-3-1 or any state owned or state
35 operated hospitals.

36 (3) 'Net patient revenue' means the total gross patient revenue of a hospital less
37 contractual adjustments; charity care; bad debt; Hill-Burton commitments; and indigent
38 care as defined by and calculated in accordance with department guidelines.

39 (4) 'Provider fee' means the fee imposed pursuant to this article for the privilege of
40 operating a hospital.

41 (5) 'Segregated account' means an account for the dedication and deposit of provider fees
42 which is established within the Indigent Care Trust Fund created pursuant to Code
43 Section 31-8-152.

44 (6) 'Trust fund' means the Indigent Care Trust Fund created pursuant to Code Section
45 31-8-152.

46 31-8-179.2.

47 There is established within the trust fund a segregated account for revenues raised through
48 the imposition of the provider fee. All revenues raised through provider fees shall be
49 credited to the segregated account within the trust fund, except as otherwise provided for
50 in Code Section 31-8-179.4, and shall be invested in the same manner as authorized for
51 investing other moneys in the state treasury. Contributions and transfers to the trust fund
52 pursuant to Code Sections 31-8-153 and 31-8-153.1 shall not be deposited into the
53 segregated account.

54 31-8-179.3.

55 (a) Each hospital shall be assessed a provider fee, assessed uniformly upon all hospitals,
56 in the amount of the lesser of 1.6 percent of the net patient revenue of the hospital or the
57 maximum amount that may be assessed pursuant to the percentage limitation of the first
58 prong of the test for an indirect guarantee set out in 42 C.F.R. Section 433.68(f)(3)(i).

59 (b) The provider fee shall be paid quarterly by each hospital to the department. The
60 assessment shall be based on the most recent completed annual financial report prepared
61 by the department. Payment of the provider fee shall be due no later than the thirtieth day
62 following the end of each calendar quarter; the first payment shall be due on September 1,
63 2009, and the final payment of the first year shall be due no later than May 31, 2010.

64 31-8-179.4.

65 (a) The department shall collect the provider fees imposed pursuant to Code Section
66 31-8-179.3. No less than 90 percent of revenues raised pursuant to this article shall be
67 deposited into the segregated account. Such funds shall be dedicated and used for the sole
68 purpose of obtaining federal financial participation for medical assistance payments to
69 providers on behalf of Medicaid recipients pursuant to Article 7 of Chapter 4 of Title 49.
70 Up to 10 percent of revenues raised pursuant to this article may be deposited into the
71 general treasury with the intent that such funds be used for trauma care.

72 (b) The department shall prepare and distribute a form upon which each hospital shall
73 submit information to comply with this article.

74 (c) Each hospital shall keep and preserve for a period of three years such books and
75 records as may be necessary to determine the amount for which it is liable under this
76 article. The department shall have the authority to inspect and copy the records of a
77 hospital for purposes of auditing the calculation of the provider fee. All information
78 obtained by the department pursuant to this article shall be confidential and shall not
79 constitute a public record.

80 (d) In the event the department determines that a hospital has underpaid or overpaid the
81 provider fee, the department shall notify the hospital of the balance of the provider fee or
82 refund that is due. Such payment or refund shall be due within 30 days of the department's
83 notice.

84 (e) Any hospital that fails to pay the provider fee pursuant to this article within the time
85 required by this article shall pay, in addition to the outstanding provider fee, a 6 percent
86 penalty for each month or fraction thereof that the payment is overdue. If a provider fee
87 has not been received by the department by the last day of the month, the department shall
88 withhold an amount equal to the provider fee and penalty owed from any medical
89 assistance payment due such hospital under the Medicaid program. The provider fee levied
90 by this article shall constitute a debt due the state and may be collected by civil action and
91 the filing of tax liens in addition to such methods provided for in this article. Any penalty
92 that accrues pursuant to this subsection shall be credited to the segregated account.

93 (f) The Governor may suspend the collection of the provider fees, or any part thereof,
94 imposed pursuant to this article due the state until no later than the meeting of the next

95 General Assembly, but the Governor shall not otherwise interfere with the collection of
 96 such fees.

97 31-8-179.5.

98 (a) Notwithstanding any other provision of this chapter, the General Assembly is
 99 authorized to appropriate as state funds to the department for use in any fiscal year all
 100 revenues dedicated and deposited into the segregated account. Such appropriations shall
 101 be made for the sole purpose of obtaining federal financial participation for medical
 102 assistance payments to providers on behalf of Medicaid recipients pursuant to Article 7 of
 103 Chapter 4 of Title 49. Any appropriation from the segregated account for any purpose
 104 other than such medical assistance payments shall be void.

105 (b) Revenues appropriated to the department pursuant to this Code section shall be used
 106 to match federal funds that are available for the purpose for which such trust funds have
 107 been appropriated.

108 (c) Appropriations from the segregated account to the department shall not lapse to the
 109 general fund at the end of the fiscal year.

110 31-8-179.6.

111 The department shall report annually to the General Assembly on its use of revenues
 112 deposited into the segregated account and appropriated to the department pursuant to this
 113 article.

114 31-8-179.7.

115 Except where inconsistent with this article, the provisions of Article 7 of Chapter 4 of Title
 116 49, the 'Georgia Medical Assistance Act of 1977,' shall apply to the department in carrying
 117 out the purposes of this article."

118 **SECTION 2.**

119 Said chapter is further amended in Code Section 31-8-171, relating to definitions relative to
 120 quality assessment fees on care management organizations, by revising paragraph (1) as
 121 follows:

122 "(1) 'Care management organization' means an entity granted a certificate of authority
 123 under Chapter 21 of Title 33 ~~of the Official Code of Georgia Annotated, an entity~~
 124 offering an accident and sickness policy as defined in Code Section 33-29-1, and an
 125 entity operating as a preferred provider pursuant to Chapter 30 of Title 33 and which
 126 meets the definition found in 42 U.S.C. Sec. 1396b(w)(7)(A)(viii) as it now exists or as
 127 it may be amended in the future exists on July 1, 2009; provided however, that the term

128 shall not include a health benefit policy as defined in paragraph (1.1) of Code Section
129 33-1-2."

130 **SECTION 3.**

131 Said chapter is further amended in Code Section 31-8-173, relating to the assessment,
132 calculation, and payment of quality assessment fees on care management organizations, by
133 revising subsection (a) as follows:

134 "(a) Each care management organization shall be assessed a quality assessment fee, in an
135 amount to be determined by the department based on anticipated revenue estimates
136 included in the state budget report, with respect to its gross direct premiums. The quality
137 assessment fee shall be assessed uniformly upon all care management organizations. The
138 aggregate quality assessment fees imposed under this article shall not exceed the lesser of
139 1.6 percent of the gross direct premium of the care management organization or the
140 maximum amount that may be assessed pursuant to 42 C.F.R. Section 433.68(f)(3)(I). The
141 Governor may suspend the collection of the quality assessment fees, or any part thereof,
142 imposed pursuant to this article due the state until no later than the meeting of the next
143 General Assembly, but the Governor shall not otherwise interfere with the collection of
144 such fees."

145 **SECTION 4.**

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

148 **SECTION 5.**

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