Georgia Health Law Developments

A Publication of the Health Law Section of the State Bar of Georgia

IN THIS ISSUE

HEALTH LAW SECTION

HEALTH LAW DEVELOPMENTS

MESSAGE FROM THE CHAIR

With all the changes in health care this year, your participation in our Section activities is important and appreciated. The Executive Committee has worked to prepare meaningful programs for our Section, and we hope that you have benefited from their efforts.

Our section has had a busy year, including planning and sponsoring ICLE seminars and other activities. In conjunction with the mid-year meetings, we had an informative presentation by Dr. Carla Denise Edwards, Chief of Staff of the Department of Community Health. Rod Meadows should be commended for once again chairing our annual Fundamentals seminar. Also, thanks to the Georgia Academy of Health Care Attorneys (GAHA) and Rob Keenan for helping plan our first joint event – an informative lecture by Grady Healthcare CEO Michael Young and Chairman Pete Correll, followed by facility tours.

We also appreciate the authors contributing to this newsletter: Stan Jones, Helen Sloat and April Morgan for providing the summary of the 2009 Georgia legislative session; Keith Mauriello, Amy Fouts, Joel Schuesller and Rob Stone, for their informative articles. Charlotte Combre did a great job leading our efforts in publishing this edition.

We look forward to seeing many of you at the Advanced Health Law seminar to be held October 9, 2009 in Atlanta. We have confirmed several speakers recognized as leaders in their field to address emerging topics in health care reform.

Please let us know if you have any ideas or suggestions to help us better serve you and our members. It has been an honor to serve as Chair this year, and I hope to see you on October 9th!

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The Gold Dome Report
Special Edition
2009 Georgia Legislative Session Health Care Issues

by Stanley S. Jones, Jr., Attorney, Helen L. Sloat, Legislative Consultant and
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While many called it tumultuous, Georgia's 2009 Legislative Session was relatively calm in terms of the numbers of bills which actually passed. Most lawmakers of course worried over the State's declining revenues in the wake of the poor national economy "Thorny" issues other than the budget also caused some diversion from permitting other legislative ideas to work their way through the system, such as Department of Transportation governance and funding; reorganization of the Department of Human Resources, especially in light of the huge difficulties with the State's mental health system; tax reforms, and sustainable funding for a true statewide trauma network.

A huge volume of bills affecting health care delivery, nursing education, physician licensure, trauma, health insurance, and non profit organizations were introduced. Most of these failed, and this report concentrates on the passed bills. It will summarize the successful relevant bills and accent the important issues that carry over.

Budget

While the Governor eventually proposed that hospitals and other providers receive 10% and 6% cuts, respectively, below the 2008 fiscal year rates, the General Assembly did *not* implement those proposed reductions. It used the increased Federal Medicaid rates to avoid these cuts. Unfortunately, the increases to hospital and physician rates proposed in the 2008 Session for fiscal year 2009 were postponed again, both for 2009 and 2010. So the 2008 hospital rate structure remains in place.

Additionally, no new taxes were imposed on hospitals or HMOs as initially proposed by Governor Perdue to fund the Medicaid and PeachCare budget shortfalls. These proposals never included a new increase in rates for providers, simply attempting to restore what had been proposed in 2008.

HB 228 – Department of Human Resources' Reorganization

As mentioned earlier, one of the largest issues facing the General Assembly was the proposed reorganization of the Department of Human Resources. Last Session, in the Certificate of Need legislation, some of the functions of the Office of Regulatory Services were moved over to the Department of Community Health, including the licensing of healthcare entities such as hospitals and home health agencies. Moreover, no increase was made on Georgia's tobacco tax (such as passage of HB 39 by Rep. Ron Stephens (R-Savannah) which would have increased tobacco taxes by $1.00) to deal with longer term revenue shortfalls and better health promotion and disease prevention. The increase in the federal tax on tobacco seemed to forestall an additional state fee.

Trauma care funding also did not achieve the desired result as many hospitals had hoped: only $23 million in State funds were included in the new year budget, less than the $58 million amount passed in 2008 for the fiscal year July 1, 2008 to June 30, 2009. Of course, the "Super Speeder" legislation was passed, with $12 million expected to be realized in the new fiscal year 2010, but it is not clear how much revenue will actually be received. This super speeder money is not "earmarked" for any special fund – it is to be deposited into the State's General Treasury and then must be appropriated to trauma funding each year.

The federal stimulus money comes to Georgia through many existing funding streams. The primary health care uses are an increase in the federal matching rate for Medicaid, noted above, rising from 64% to 75%. This change will total nearly $1.5 billion over three fiscal years, but it was not used to raise provider rates or eligibility levels – it merely filled a budget hole from expected increases in beneficiaries. Most of the reduction in state funds realized from matching dollars at the higher rates are being spent on non health care programs. The stimulus package does contain electronic medical record development funds awarded to applicants who can be states or other organizations.

More detailed budget comments are at the end of this paper.

In consideration of this year's legislation, HB 228, which takes effect on July 1, 2009, a compromise was reached leaving in the reconstituted Department of Human Services the Divisions of Aging, Family and Children's Services and Child Support. A newly created Department of Behavioral Health and Developmental Disabilities goes into effect on July 1, incorporating the Divisions of Mental Health/Developmental Disabilities/Addictive Diseases from DHR into this new Department. Additionally, the legislation moved the Division

of Public Health to the Department of Community Health with a separate Director overseeing its functions under the tutelage of an Advisory Council on Public Health, all of whom will all be appointed by the Governor. There is also a newly designated State Health Officer appointed by the Governor. As of the date of this writing, Dr. Rhonda Medows, Commission or DCH, has also announced that she will be the designated state health officer. HB 354, which proposed moving the Division of Aging out of DHR, failed to pass and remained in the House Human Relations and Aging Committee where it will be eligible next Session.

Trauma

As noted, only the super speeder bill passed, a $200 fine for exceeding the speed limit by 20 miles per hour or more. The proceeds are appropriated to trauma funding, and some additional state dollars were appropriated, a total of $23 million, as mentioned above. No proposal at this point widens the trauma network to include a larger number of hospitals. The amount of appropriated money is less than half of the state fiscal year 2009 amount. The following bills were proposed and remain active, but in a political climate that still opposes all tax increases.

- **HB 160**, by Rep. Jim Cole (R-Forsyth), creates an additional fine for *"super speeders"* who violate posted speed limits on Georgia roads and highways in O.C.G.A. § 40-6-189. A $200 fine (in addition to other fines or penalties imposed by any local jurisdiction or the department) will be imposed on any driver who is convicted of driving at speeds of 85 miles per hour or more on any road or highway or 75 miles per hour or more on any two-lane road or highway. Fees collected under this provision are to be deposited in the State's general fund with the intent that the monies will be used to fund a trauma care system. There are other increases in fines and fees made in Title 40 such as reinstatement fees for driver's licenses (one example is the increase of the fee from $35 to $100 for a driver's license reinstated after being suspended for the failure to respond to a citation).

- **HB 480**, by Rep. Harry Geisinger (R-Roswell), failed. It was "tabled" in the Senate. It proposed in O.C.G.A. § 40-2-25.1 a flat fee of not more than $1,500 for vehicle transfers broken into two portions (State of $720 or no more than 3.36% of the fair market value of the vehicle and local in the amount of $780 or no more than 3.64% of the fair market value of the vehicle) with the State's portion of the fee to be used for trauma care funding. Georgia Municipal Association and Association of County Commissioners of Georgia both had reservations about this change in their funding.

- **HR 139**, by Rep. Harry Geisinger (R-Roswell), remained in House Ways and Means Committee. It would propose a Constitutional Amendment to "authorize the General Assembly by general law to provide for the imposition and collection of charges to telephone subscribers in this state for the specific purpose of funding any and all costs or any portion of the costs of providing trauma services by public and private hospitals and medical facilities in this state that maintain trauma centers." It would amend Article III, Section IX, at Paragraph VI.

- **HR 162**, by Rep. Fran Millar (R-Dunwoody), remained in the House Ways and Means Committee. It would amend the Constitution at Article VII, Section I, Paragraph II so as to provide that the revenue from the State ad valorem tax would be dedicated for the purpose of funding trauma care.

- **HR 370**, by Rep. Burke Day (R-Tybee Island), remained in the House Ways and Means Committee. It was an attempt to amend the Constitution to provide that the General Assembly may provide by law for the creation and funding of the Georgia Trauma Care Trust Fund by amending Article III, Section IX, Paragraph VI.

- **SB 156**, by Sen. Cecil Staton (R-Macon), failed after the House postponed action on April 1, 2009. It proposed extensive revisions to the law governing the Georgia Trauma Care Network Commission and how it would establish funding priorities. It also proposed to establish a State Office of EMS/Trauma and proposed to take the State ad valorem tax levy and deposit those monies into the Georgia Trauma Trust Fund. This Bill will be viable in 2010.

- **SB 179**, by Sen. Bill Jackson (R-Appling), remained in the Senate Health and Human Services Committee. It proposed addressing the funding priorities of the Georgia Trauma Care Network Commission. It is viable in 2010.

- **SR 277**, by Sen. Greg Goggans (R-Douglas), cleared the House Ways and Means Committee and then stalled. It would have amended the State's Constitution at Article III, Section IX, Paragraph VI to impose a $10.00 trauma charge on certain passenger motor vehicle registrations for the purpose of funding trauma care and to provide for a trauma trust fund.

The remainder of this report summarizes bills that passed relevant to health care providers or insurers.

It is relatively selective, but covers issues that affect health care entities as businesses or employers. The subject matter of each bill is in *italics* to make the descriptions easier to use. There are comments about carry over bills to the 2010 Session at the end of the paper.

Education

- **HB 300**, by Rep. Joe Wilkinson (R-Atlanta), passed and on May 5, 2009 became **Act No. 165**. It requires the Departments of Education and Human Resources (probably now the Department of Community Health's Division of Public Health) to work together so that if a local board of education provides information on immunizations, infectious diseases, medications, or other school health issues to parents/guardians of students in grades six through 12, then information it must also provide information about *meningococcal meningitis disease* and its vaccine must also be included (how disease is transmitted and its symptoms, sources for additional information, etc.). It takes effect on July 1, 2009.

Health

Senate Bills:

- **SB 8**, by Sen. Jack Murphy (R-Cumming), passed and permits students to possess and *self-administer auto-injectable epinephrine* in O.C.G.A. § 20-2-776. It became **Act No. 10** on April 21, 2009 and takes effect on July 1, 2009.

- **SB 38**, by Sen. Seth Harp (R-Midland), was signed on May 4, 2009 into law as **Act No. 103**. It amends Chapter 16 of Title 45 to clarify that the Georgia Bureau of Investigations has jurisdiction over the post-mortem examination or autopsy on persons whose death occurs on certain State property and permits a medical examiner the ability to provide to approved canine instructors or schools bodily fluids or human blood for the purposes of training canine service dogs in recovery and rescue of persons. These changes take effect on July 1, 2009.

- **SB 104**, by Sen. John Wiles (R-Marietta), passed and became **Act No. 341** on May 11, 2009. It amends the current law relating to cosmetic laser practitioners and *"assistant laser practitioners"* now permitting a licensed practical nurse to be among those individuals of who can apply for this licensing in O.C.G.A. § 43-34-244. It further amends the supervision requirements of these services provided by assistant laser practitioners requiring "on-site" rather than "direct" supervision of a senior laser practitioner. It amends O.C.G.A. § 43-34-248 the requirements of a consulting physician for any facility providing cosmetic laser services other than hair removal using lasers or pulsed light devices. O.C.G.A. § 43-34-249 is amended addressing the written consent and notice requirements to be provided to patients. The composition of the Advisory Board is amended, requiring at least one Georgia-licensed physician with expertise in the biologic behavior of the skin. The provisions would take effect *only* if the licensing is funded through appropriations. Many of this Bill's provisions are incorporated into HB 509 which also passed and those revisions to the cosmetic licensure law take effect only when funded.

- **SB 133**, by Sen. Lee Hawkins (R-Gainesville), passed and was signed into law on May 4, 2009 as **Act No. 105**. It permits an expansion of *Georgia's "'Health Share' Volunteers in Medicine Act"* by permitting registered professional nurses and physicians who provide services in safety net free clinics, the Health Share Program, to be compensated and to be granted sovereign immunity in O.C.G.A. § 31-8-195.1. It takes effect on July 1, 2009.

- **SB 159**, by Sen. Johnny Grant (R-Milledgeville), passed. It creates the *"Hemophilia Advisory Board Act"* in O.C.G.A. § 31-1-10 which is to report its findings and recommendations to the General Assembly and Governor. After the first year, the director of the Division of Public Health, in consultation with the Commissioner of Insurance, is to make a report to the Governor and the General Assembly on the status of implementing the recommendations. Governor Perdue **vetoed** this Bill on May 11, 2009 as **Veto No. 10** noting that the legislation could "create unnecessary litigation and usurp the role of expert testimony properly qualified by the General Assembly's adoption of the *Daubert* standard in O.C.G.A. § 24-9-67.1." He will issue an executive order establishing an advisory board.

- **SB 165**, a Bill by Sen. Greg Goggans (R-Douglas), passed and will permit the Department of Community Health to *verify income data and information* with the Department of Revenue for those individuals applying for either *Medicaid or PeachCare for Kids Program benefits* in O.C.G.A. § 49-4-146.1(j) and O.C.G.A. § 49-5-273(o) respectively. The Department of Revenue would then notify the Department of Community Health if an individual exceeds the income level thresholds for these programs. Implementation of this Bill could generate a larger number of uninsured persons. Governor

Perdue signed this Bill as **Act No. 20** on April 21, 2009; its provisions take effect on January 1, 2010.

House Bills:

- **HB 49**, by Rep. Mickey Channell (R-Greensboro), was signed as **Act No. 27** on April 21, 2009. It expands the *powers and duties of the Georgia Board for Physician Workforce* in O.C.G.A. § 49-10-3 so that it may apply for grants and to solicit and accept donations, gifts, and contributions from any source to study or engage one or more contractors to study issues relevant to medical education or implement initiatives designed to enhance Georgia's medical education infrastructure and to meet physician workforce needs in the State. It takes effect on July 1, 2009.

- **HB 59**, by Rep. Larry O'Neal (R-Bonaire), passed and was signed into law on April 21, 2009 as **Act No. 28**. It codifies in O.C.G.A. § 48-8-3 (47) an Executive Order from August 2008 *exempting dangerous drugs and controlled substances* which are distributed by physicians, dentists, clinics, and hospitals that are lawfully dispensed samples or as a part of a clinical trial *from sales and use taxes*. This Bill's revisions in O.C.G.A. § 48-8-18 became effective upon signature; the remaining portion takes effect on July 1, 2009.

- **HB 60**, by Rep. Mike Jacobs (R-Atlanta), passed. It amends O.C.G.A. § 43-10A-7(b) so that "no person exempt from the *licensing requirements* of such Code section shall hold himself or herself out as being licensed to practice *professional counseling, social work, or marriage and family therapy* or use any term or other indicia implying that he or she is licensed to practice professional counseling, social work, or marriage and family therapy or any combination thereof." Governor Perdue issued a signing statement on this Bill on May 11, 2009 indicating that he would work with the "legislative sponsor of HB 60 on any legislative revisions that may be needed in the 2010 Session of the General Assembly" as he still had concerns that a licensed professional, not necessarily a licensed professional counselor, social worker, or marriage and family therapist, might not accurately indicate their "licensed" profession. For instance, the professional might be a licensed psychologist, specializing in marriage and family therapy. It became **Act No. 342** on May 11, 2009, taking effect July 1, 2009.

- **HB 64**, by Rep. Chuck Sims (R-Ambrose), passed. It requires in O.C.G.A. § 31-10-15 that a *funeral director file a death certificate* within 72 hours of assuming custody of a body. It adds in (c)(2) that in a Governor-declared state of an emergency in the event of an influenza pandemic, "any registered professional nurse employed by a long-term care facility, advanced practice nurse, physician's assistant, registered nurse employed by a home health agency, or nursing supervisor employed by a hospital shall be authorized to complete and sign the death certificate, provided that such person has access to the medical history of the case, such person views the deceased at or after death, the death is due to natural causes, and an inquiry is not required under Article 2 of Chapter 16 of Title 45, the 'Georgia Death Investigation Act.'" Also, the law governing "coroners" is amended at O.C.G.A. § 45-16-22 adding a new subparagraph (f.1): "When death occurs in a hospital as a direct result and consequence of acts or events taking place in a county other than the one in which such death occurs, the *hospital shall* immediately notify the coroner or the county medical examiner of the county in which the acts or events resulting in the death occurred." Governor Perdue signed this legislation into law on April 21, 2009 as **Act No. 29**, and it takes effect on July 1, 2009.

- **HB 68**, by Rep. Chuck Sims (R-Ambrose), passed. It amends Chapter 18 of Title 43 concerning the *location of a crematory limiting it to 1,000 feet of a lot in a residential subdivision* in O.C.G.A. § 43-18-72. It further establishes in O.C.G.A. § 43-18-73 that the "authorizing agent" has the responsibility for the cremated remains' disposition. It added in O.C.G.A. § 31-21-7 language regarding *"pre-need" funeral contracts and who has the right to control the disposition of the remains of a deceased person*; the location, manner, and conditions of disposition; and arrangements for funeral goods and services to be provided. This Bill became **Act No. 68** on April 30, 2009, taking effect on July 1, 2009.

- **HB 69**, by Rep. Sean Jerguson (R-Woodstock), dealt with *Do Not Resuscitate Orders* in nursing home situations and it passed. It amends O.C.G.A. § 31-39-4(c), relating to an order not to resuscitate, to provide for an attending physician to issue an order not to resuscitate to a candidate for non-resuscitation *without* concurrence by another physician under certain conditions. Governor Perdue signed this legislation as **Act No. 69** on April 30, 2009. It takes effect on July 1, 2009.

- **HB 93**, by Rep. Barbara Sims (R-Augusta), passed. *Georgia Medical Center Authority* is created in Chapter 15 of Title 20, whose purpose is: "(1) The provision of life sciences industry research and

development and manufacturing facilities and programs based in the State of Georgia; (2) The commercialization of biomedical and biotechnical research results; (3) The promotion of closer ties between academic institutions of the state and the biomedical industry so as to capitalize on present and future state intellectual resources; (4) The facilitation of the development of a life sciences industrial cluster in the State of Georgia; and (5) The advancement of local and state economic growth." This modification provides authorization for the Authority to take partial and joint ownership interests in real property, to create nonprofit subsidiaries, to create investment or revolving loan funds using bond money as seed funds, and to invest in equity investments managed by third-party managers. Governor Perdue signed this Bill into law on April 30, 2009 as **Act No. 72**. The legislation takes effect on July 1, 2009.

- **HB 217**, by Rep. Jimmy Pruett (R-Eastman) for Governor Perdue as one of his Floor Leaders, passed and addresses the issues in *administering the flu vaccine.* It permits actively practicing physicians to prescribe for a group of patients, through the entry of protocol agreements with both pharmacists and nurses, to authorize the administration of the influenza vaccine in O.C.G.A. § 43-34-26.4. Information must be retained on the patient's name; name of person administering the vaccine; information on the vaccine (such as the manufacturer and dose); where the vaccine was given; etc. There are registration requirements for the administering of these vaccines and patients must remain under observation for 15 minutes subsequent to administration of the influenza vaccine. A delegating physician *cannot* enter into an influenza vaccine protocol agreement with more than ten pharmacists or nurses, or combination thereof, at any one time; *provided, however,* and notwithstanding the geographic limitations provided in subsections (b) and (c) of this Code section, a delegating physician may enter into an influenza vaccine protocol agreement with more than ten pharmacists or nurses, or any combination thereof, at any one time *so long as the pharmacists or nurses are in the same public health district* as established in O.C.G.A. § 31-3-15, *and are employees or agents of the same corporate entity*. There are prohibitions established whereby no pharmacist or nurse can delegate his or her authority a protocol agreement to some other personnel. Language is included so that no influenza vaccine protocol agreement can permit a pharmacist or nurse to administer an influenza vaccine to any child under the age of 13 without an individual prescription from a physician; additionally, the consent of the child's parent or legal guardian is a condition precedent to the administration of an influenza vaccine to a child under the age of 18. Additionally, language was added at the request of the Georgia Hospital Association to address its members' concerns that hospitals be able to administer the influenza virus and pneumoccocal disease to inpatients. Hospitals would be required to follow the guidelines of the Centers for Disease Control and Prevention pursuant to standing orders approved by the facility's hospital medical staff. These changes were inserted into the law passed in 2007 on this issue at O.C.G.A. § 31-7-18. The Bill was signed as **Act No. 53** on April 28, 2009. It takes effect upon signature of the Governor.

- **HB 368**, by Rep. Ron Stephens (R-Savannah), passed and is the *annual update* to Georgia's *dangerous drug law* in Chapter 13 of Title 16. Governor Perdue signed this Bill on April 21, 2009 as **Act No. 43**, taking effect upon the Governor's signature.

- **HB 457**, by Rep. Allen Peake (R-Macon), passed. The initiative in Chapter 5 of Title 30 was pushed by a group of Alzheimer's advocates in an effort to strengthen Georgia's law governing what is considered a *criminal offense against a disabled individual*. Visitors and other persons who abuse patients in nursing home or other institutional settings are included in the criminal statutes. This Bill was signed into law on May 5, 2009 as **Act No. 147** and takes effect on July 1, 2009.

- **HB 464**, by Rep. Barbara Reece (D-Menlo), passed. It amends Chapter 5 of Title 42 and the definition of a *"chronic illness"* requiring that an inmate help defray costs paid by the State or county for medical treatment, *including* medication (except for a pregnancy or chronic illness). There are also limits to the reimbursement which correctional institutions pay to a hospital authority or hospital not under contract with the Georgia Department of Corrections as of July 1, 2009 to the applicable Medicaid rate for such services in O.C.G.A. § 42-5-2(c). Governor Perdue signed this initiative as **Act No. 48** on April 21, 2009, and this Bill became effective on that date.

- **HB 475**, by Rep. Sharon Cooper (R-Marietta), passed. Governor Perdue signed this Bill as **Act No. 60** on April 29, 2009. It revises Chapter 26 of Title 43 relating to the requirements for *nursing education programs and the requirements for licensure* as an advanced practice registered nurse, registered professional nurse, or licensed practical nurse. It allows graduates of out of state and in state technical colleges to satisfy the RN education requirements. It also amends the requirements of a nontraditional

nursing education program for registered professional nurses and licensed professional nurses, such as the Excelsior mid-career internet and correspondence training programs. It requires preceptorships for those individuals in these nontraditional nursing education programs. Advocates thought that the changes may increase the supply of RNs in Georgia. These changes took effect upon signature. *Other* nurse education bills failed, including HB 526, HB 610, SB 45, SB 49 and HR 532.

- **HB 509**, the *modernization of the Medical Practice Act* in Title 43 regulating physicians, acupuncturists, physician assistants, cancer and glaucoma treatment, respiratory care practice, clinical perfusionists, orthotics and prosthetics, and cosmetic laser services by the newly named State Board of Medical Examiners, passed. The Bill was signed into law on May 11, 2009 as **Act No. 243**. Its provisions take effect on July 1, 2009 (with exception to Section 1, which must be funded through an Appropriations Act prior to taking effect). It does not appear to affect nurses, physical therapists, occupational therapists or home health aides to a significant degree. It, however, does loosen on- site supervision by doctors of medical assistants in office settings. The initiative also adds language for the Polysomnography Act ("Sleep Labs" previously included in HB 675 and SB 252 which both *failed* to pass) at O.C.G.A. § 43-34-45.

- **HB 667**, by Rep. Stephen Allison (R-Blairsville), was signed as **Act No. 142** on May 5, 2009. It amends O.C.G.A. § 31-7-402 pertaining to the *expert and consultant fees paid concerning a not-for-profit hospital acquisition.* Currently, a cap of $50,000 is placed on these fees which are paid to the Attorney General. Under the revision, there is no "cap" and the "actual and reasonable cost and expense incurred in connection with the retention of the experts or consultants is to be paid directly to such experts and consultants by the parties in such proportionate amounts as the parties may agree or as determined by the Attorney General within 30 days of notice from the Attorney General of these costs. These changes took effect upon the Governor's signature.

Insurance

House Bills:

- **HB 80**, the Bill by Rep. Howard Maxwell (R-Dallas), passed and amends O.C.G.A. § 33-24-6(a)(5) and *reduces the numbers of employees required for group insurance coverage from 100 to two employees.* Governor Perdue signed this Bill as **Act No. 115** on May 4, 2009. This change takes effect on July 1, 2009.

- **HB 410**, by Rep. Tom Knox (R-Cumming), became **Act No. 128** on May 4, 2009. It amends O.C.G.A. § 33-8-4(c) concerning computation of *insurance premium taxes* so that insurers will be exempt from otherwise applicable State premium taxes as provided for in O.C.G.A. § 33-8-4(a) on premiums paid by Georgia residents for *high deductible health plans* as defined by Section 223 of the Internal Revenue Code (rather than sold/maintained in conjunction with an Health Savings Account). It adds in O.C.G.A. § 33-8-8.1(a.1) that life insurance companies which sell high deductible health plans do not have to pay local insurance premium taxes with this portion of the Bill taking effect on January 1, 2010. Other revisions were made to O.C.G.A. § 33-8-8.2(a.1) clarifying that life insurers will be exempt from the local computation of insurance premium taxes will be paid on premiums paid by Georgia residents for high deductible health plans as defined by Section 223 of the Internal Revenue Code (rather than sold/maintained in conjunction with an Health Savings Account). Another clarifying change was made in O.C.G.A. § 48-7-27(a)(13.1) permitting a deduction of 100% from income taxes owed for the amount of premium paid for a high deductible health plan. Finally, it addresses O.C.G.A. § 48-7-29.13 relating to tax credits for qualified health insurance expenses. All other portions of this legislation took effect on May 4, 2009 and apply to tax years beginning on and after January 1, 2009.

Senate Bills:

- **SB 63**, by Sen. Ralph Hudgens (R-Hull), passed and amends O.C.G.A. § 33-50-2(b) which *exempts any plan or arrangement established or maintained by two or more accredited independent nonproprietary institutions of higher education*, with assets of more than $100 million, located in Georgia from the licensure requirements relating to *multiple employer self-insured health plans*. Governor Perdue signed this Bill on May 5, 2009 as **Act No. 146**; it takes effect on July 1, 2009.

- **SB 94**, by Sen. Judson Hill (R-Marietta), passed and will permit *individuals who have been laid off* by small employers – those with 20 or fewer employees who are not covered by COBRA -- to *continue their employer-sponsored health insurance* for themselves and their dependents for nine (9) months. Federal stimulus funds will pay 65% of the premium for this extension. Current law permits continuation of coverage for three months and this period will remain

after the stimulus package subsidy of the state continuation benefit expires. The final bill *deleted* extension of dependent coverage to age 25 for dependents who are not full time students. Sen. Hill also added language to Code Section 33-51-7, previously included in SB 105, making clear that the Commissioner of Insurance is authorized to allow *health reimbursement arrangement ("HRAs") only plans*, that encourage employer financial support of health insurance or health related expenses recognized under the rules of the federal Internal Revenue Service, for sale in connection with or packaged with individual health insurance policies otherwise approved by the Commissioner. These HRAs which are not sold in connection with or packaged with individual health insurance policies are not to be considered insurance under Title 33. Additionally, individual insurance policies offered or funded through HRAs are not to be considered employer-sponsored or group coverage. Governor Perdue signed this legislation as **Act No. 154** on May 5, 2009 and it took effect upon signature of the Governor.

- **SB 123**, a Bill by Sen. Lee Hawkins (R-Gainesville), passed but was later **vetoed**. It would have *regulated and licensed pharmacy benefit managers* through a new Chapter 64 in Title 33. The Bill defines the term, "pharmacy benefits management" to mean "the service provided to a health plan or covered entity, directly or through another entity, including the procurement of prescription drugs to be dispensed to patients, or the administration or management of prescription drug benefits, including but not limited to any of the following: (A) Mail service pharmacy; (B) Claims processing, retail network management, or payment of claims to pharmacies for dispensing prescription drugs; (C) Clinical or other formulary or preferred drug list development or management; (D) Negotiation or administration of rebates, discounts, payment differentials, or other incentives for the inclusion of particular prescription drugs; (E) Patient compliance, therapeutic intervention, or generic substitution programs; and (F) Disease management." The Legislation requires an entity operating as a pharmacy benefits manager to obtain an annual license with the initial cost of this license of $500 through the Department of Insurance. A bond requirement of $100,000 is also required for maintenance of this license. The Bill does exempt in O.C.G.A. § 33-64-2(l) the following: "A pharmacy benefits manager operating as a line of business or affiliate of a health insurer, health care center, hospital service corporation, medical service corporation, or fraternal benefit society licensed in this state or of any affiliate of such health insurer, health care center, hospital service corporation, medical service corporation, or fraternal benefit society shall not be required to obtain a license pursuant to this chapter. Governor Perdue **vetoed** this Bill as **Veto No. 9** on May 11, 2009 indicating that pharmacy benefit managers have kept insurance premiums lower for individuals with commercial health insurance. He agreed that "cost-reduction methods employed by the pharmacy benefits managers, however, have not gone without significant and troubling criticism." He has agreed to work on an administrative solution, addressing issues giving rise to SB 123.

Public Benefits and Immigration Policies

- **HB 2**, the Bill by Rep. Tom Rice (R-Duluth), passed. It makes several changes in Titles 13, 32, 42, and 50 with the goal to *screen individuals' citizenship prior to the use of public funds*. The Bill specifically requires in O.C.G.A. § 13-10-91(a) that "every public employer, including, but not limited to, every municipality and county, shall register and participate in the federal work authorization program to verify employment eligibility of all newly hired employees. Upon federal authorization, a public employer shall permanently post the employer's federally issued user identification number and date of authorization, as established by the agreement for authorization, on the employer's website; provided, however, that if a local public employer does not maintain a website, then the identification number and date of authorization shall be published annually in the official legal organ for the county." It further defines "public benefit" in O.C.G.A. § 50-36-1(a)(3)(A) as "a state or local public benefit or state administered federal public benefit as defined in 8 U.S.C. Sections 1611 and 1621; a benefit identified by the federal government under the federal Systematic Alien Verification for Entitlements (SAVE) program; and any authorization, renewal, recognition, or registration of such benefit. The benefits listed on the Attorney General's report required by subparagraph (B) of this paragraph shall also be considered public benefits for purposes of this Code Section." It goes further in (B) of that same Code Section to require that on August 1 of each year that the State's Attorney General prepare "a detailed report indicating any 'state public benefit' and 'local public benefit' that may be offered in this state that is covered by the definitions in 8 U.S.C. Sections 1611 and 1621 and whether such benefit is subject to SAVE verification." This report must include the "name of the benefit and name the agency or political subdivision providing the benefit." This Bill became **Act No. 339** on May 11, 2009 and took effect upon the Governor's signature.

- **SB 20**, by Sen. Chip Pearson (R-Dawsonville), passed and *prohibits immigration sanctuary policies by local governmental entities* in O.C.G.A. § 36-80-23. A "sanctuary policy" is defined as any "regulation, rule, policy, or practice adopted by a local governing body which prohibits or restricts local officials or employees from communicating or cooperating with federal officials or law enforcement officers with regard to reporting immigration status information while such local official or employee is acting within the scope of his or official duties." This Bill became **Act No. 152** on May 5, 2009, taking effect upon signature of the Governor.

Taxation

- **HB 438**, by Rep. O'Neal (R-Bonaire), makes changes to Chapter 7 of Title 48 providing for the *comprehensive revision of the income tax credits for qualified jobs, investment, investment property, and projects*. It passed. Governor Perdue signed this Bill on May 5, 2009 as **Act No. 172**; it became effective upon his approval and will apply to all tax years beginning on and after January 1, 2009. Several new terms are defined such as "business enterprise," "eligible full-time employee," "payroll maintenance requirement," "payroll requirement," "qualified investment property," "qualified investment property requirement," "qualified project," and "recapture period." If approved, the business can receive a tax credit for taxes imposed equal to $5,250 annually per new eligible full-time employee job for five years beginning with the year in which the job is created through year five. This credit cannot exceed the tax liability of the business. It is limited to no more than 3,300 new full-time employee jobs created by any one project.

Workers' Compensation

- **HB 330**, by Rep. Mike Coan (R-Lawrenceville), passed and became **Act No. 40** on April 21, 2009. The Advisory Group to the State Board of Workers' Compensation and representatives of businesses worked on this Bill. It is a series of *updates to Georgia's Workers' Compensation Law* in Chapter 9 of Title 34, including:
  - Amends O.C.G.A. 34-9-102(f) concerning the *decisions of the administrative law judge and the dissemination of those decisions to counsel and parties* and clarifies that notice to counsel of record constitutes service of notice to the party, if a copy of the decision was sent to the address of record of said party. Similar language concerning "notice" is added in O.C.G.A. § 34-9-103 when an appeal is involved. Additionally, it states that the compensation award becomes *final* in 20 days after the issuance of the notice of the award (rather than currently, which is unless an appeal is filed).
  - Amends O.C.G.A. § 34-9-121, relating to *compensation for injury outside of State*: "(b)(1) Any employer from another state engaged in the construction industry within this state with a workers' compensation insurance policy issued under the laws of such other state so as to cover that employer's employees while in this state shall be in compliance with subsection (a) of this Code section if: (A) Such other state recognizes the extraterritorial provisions of Code Section 34-9-242; and (B) Such other state recognizes and gives effect within such state to workers' compensation policies issued to employers of this state. (2) Nothing in this subsection shall be construed to void any insurance coverage."
  - Amends O.C.G.A. § 34-9-207 providing that an *employee's waiver of confidentiality includes past medical history with respect to any condition or complaint related to the condition for which the employee claims compensation.*

- **SB 76**, by Sen. Ralph Hudgens (R-Hull), became **Act No. 15** on April 21, 2009. It amends Chapter 9 of Title 34 regarding workers' compensation insurance and Chapter 9 of Title 33 regarding to references of this cost:
  - "Reserves" O.C.G.A. § 34-9-135, concerning disclosure of costs by insurer
  - Deletes references to O.C.G.A. § 34-9-135 in O.C.G.A. § 33-9-21(a)(2) and O.C.G.A. § 33-9-40.1(b)

  The provisions take effect on July 1, 2009.

Study Committees

- **SR 257**, by Sen. Don Thomas (R-Dalton), was adopted by both the House and Senate and became **Act No. 95** on April 30, 2009. The Resolution creates the sixteen-member *"Alzheimer's Disease and Other Dementias Task Force."* This Task Force is required to make a final report on or before June 30, 2010. There are specific points to be studied for recommendations: "(1) Surveillance of persons with Alzheimer's disease for purposes of having proper estimates of the number of Georgians with Alzheimer's disease; (2) Safety and well-being of persons with Alzheimer's disease (e.g., driving assessment and emergency placement for persons who are found or abandoned); (3) Dementia care practice recommendations to ensure quality care in

long-term settings; (4) Future need for dementia related services as well as funding for programs for individuals with dementias, including those with younger-onset; and (5) Implementation of the following action steps to improve public health surveillance: (A) Add the Communicable Disease Center's optional module on caregiving, including questions about memory and other cognitive problems of the care recipient to Georgia's 2009 Behavioral Risk Factors Surveillance System; (B) Add the additional questions on memory and thinking to Georgia's 2009 Behavioral Risk Factors Surveillance System; (C) Plan for simple and cross-tabular analysis of the data generated in this state and for its wide public dissemination; and (D) Add the module on memory and other cognitive problems that is being developed by the Communicable Disease Center's expert panel to Georgia's 2010 Behavioral Risk Factors Surveillance System."

- **SR 263**, by Sen. Renee Unterman (R-Buford), was adopted. The Resolution recognized the benefits of public health programs in Georgia's local communities and urged the President and United States Congress to provide support to strengthen Georgia's *public health infrastructure*.

- **SR 300**, by Sen. Greg Goggans (R-Douglas), was adopted by the Senate. It mirrors HR 316 by Rep. Mickey Channell as mentioned above. The Resolution urges and requests the Department of Community Health to work in conjunction with statewide medical organizations representing pediatric physicians to obtain or prepare and disseminate written materials, at appropriate literacy levels, containing information about the possible complications, proper care, and support for pre-term infants.

- **SR 328**, by Sen. Jeff Mullis (R-Chickamauga), was adopted by the Senate. It acknowledged "a paramount right to life and the need for the protection of innocent human life at every stage of life."

- **SR 334**, by Sen. Judson Hill (R-Marietta) creates a third-year *Senate Study on Health Care Transformation*. This proposal was adopted and is the third year that such "study" has been conducted. The "joint" Study Resolution on this issue failed (SR 331 see above).

- **SR 476**, by Sen. Greg Goggans (R-Douglas), was adopted. It creates the *Senate Study Committee for Advance Directives, Assessment, Planning and Oversight.* This Committee would be composed of five Senate Members.

- **SR 506**, by Sen. Renee Unterman (R-Buford), was adopted. It creates the *Senate Study Committee on Mental Health Continuum Care*.

- **SR 628**, by Sen. Ralph Hudgens (R-Hull), creates a *Senate Study Committee on Health Care Provider Rental Network Contract Arrangements*. This proposal was adopted.

- **SR 664** creates a *Senate Study Committee on the Patient Centered Medical Home* by Sen. Don Thomas, M.D. (R-Dalton) and was adopted. This Committee will be appointed by the Lieutenant Governor.

- **SR 665**, by Sen. Don Thomas (R-Dalton), was adopted. It creates the *Senate Administration of Dental Benefits for Medicaid and PeachCare Study Committee* looking at the number of Georgia children not being served by Medicaid and PeachCare; the adequacy of the dental network of providers; payments to the care management organizations for their services; and any financial implications of transferring the administration to a single administrator model. The Senate Bill proposing the use of a single administrator of dental benefits for Medicaid and PeachCare, SB 146, failed, remaining in the Senate Health and Human Services Committee.

Budget Detail

Department of Human Resources

Adult Addictive Diseases Services

- Reduction of $61,117 in State funds from the contract with BHL for Georgia Crisis and Access Line
- Reduction of $350,000 in State funds for Hope House, Inc. (The Highland West location) for the expansion of substance abuse and outpatient behavioral health services
- Reduction of $417,000 in State funds from various contracts
- Reduction of approximately $1.3 million in State funds from core and specialty services

Adult Mental Health Services

- Reduction of $130,000 in State funds for Employee Mentoring, an internship program for people with mental illness working with MH/DD/AD
- Reduction of $240,00 in State funds by *not* initiating the Central Navigation Website

- Restoration of $91,676 proposed cut to BHL contract for the Georgia Crisis and Access Line
- Reduction of $1,673,065 of State funds for various service contracts
- Recognition of $13,539,260 federal funds from additional Federal Medical Assistance Percentage funds from the American Recovery and Reinvestment Act of 2009
- Transfer of $200,000 from the Injury Prevention Program for suicide prevention activities from the Division of Public Health to the new Department
- Language is added that the purpose of the appropriation is to provide evaluation, treatment, crisis stabilization, and residential services to facilitate rehabilitation and recovery for adults with mental illnesses. *No funds shall be used to privatize the State owned mental health hospitals prior to the appointment of a director of the new Department of Behavioral Health and Developmental Disabilities.* This language according to the Governor's statement on signing HB 119 is "intent language considered non-binding." "The General Assembly seeks to instruct the department as to the operation of the Direct Care and Support Services program. This language dictates a matter controlled by general law and is therefore null and void."

Child and Adolescent Addictive Diseases

- Reduction of $1 million in State funds from third-party administrators providing non-medically necessary services to support maintenance of children in the community
- Reduction of $1.18 million in State funds to eliminate funds for parolee outpatient services
- Reduction of $40,745 in contract with BHL for the Georgia Crisis and Access Line
- Reduction of $551,986 in State funds for child and adolescent substance abuse core services

Child and Adolescent Mental Health Services

- Reduction of $1.7 million in State funds and utilize other agency funds for the transition of consumers from four state-operated community homes to community private placements
- Reduction of $1 million in State funds by cancelling the planned expansion of summer recreational programs for youth with serious emotional disturbances
- Deferral of $3 million in State funds for the projected Medicaid rate increases for the rehab option
- Reduction of $100,000 in State funds for various contracts
- Reduction of $61,117 in State funds for the BHL contract for the Georgia Crisis and Access Line
- Reduction of $2.4 million in State funds and utilize other agency funds for the transition of child and adolescent residential services
- Reduction of $4 million in State funds and utilize other agency funds for the transition of child and adolescent services in the Outdoor Therapeutic Program
- Recognize $8,776,359 in Federal Medical Assistance Percentage funds from the American Recovery and Reinvestment Act of 2009
- Transfer $200,000 in State funds from the Injury Prevention program for suicide prevention activities to the new Department from the Division of Public Health in DHR

Department of Community Health

Aged, Blind and Disabled Medicaid and Low-Income Medicaid Programs

- An approximate $1.6 million increase in State funds for 100 Independent Care Waiver Program ("ICWP") slots for the Money Follows the Person ("MFP") grant for developmentally disabled adults.
- The stimulus package federal matching rate was recognized, moving Georgia to higher Medicaid matching rate of nearly 75%.

PeachCare for Kids

- Federal matching rate was increased to 75.54% in FY 2010.

Emergency Preparedness/Trauma System Improvement

- $23 million in State funds were added for the Georgia Trauma Network Commission – a combination of new funds and proceeds from a new super speeder fine.

CARRY OVER ISSUES

Bills introduced in the first year of our Biennial legislative Session carry over to the second year of each Session. They revert back to the Speaker and Lietenant Governor and are reassigned to Committee the first day of each Session. It is possible for a committee assignment to change, but Committee changes typically do not occur.

The interesting health care and related issues that can be expected next year include:

- Continued intense discussion of how to govern and fund the trauma network, as reflected in the Trauma section of the highlights section.

- Reintroduction of the hospital and HMO tax to fund budget shortfalls in Medicaid and generally. This effort could occur, though not likely, in a Special Session of the General Assembly this summer, perhaps as early as August.

- Continuing consideration of an increase in the tobacco tax for fund health care, though this is not very likely after the increase in the federal fees on tobacco.

- Tighter controls of the Medicaid care management organizations as they grant and deny approvals for services to kids under the EPSDT programs, particularly for the therapies for disabled children – physical, occupational and speech therapy.

- The permission for psychiatric advanced directives so that patients suffering from mental illnesses can record their preferred medicines and treatment choices in situations where they cannot give consents on their own.

- Multiple managed care issues, such as limitations as to generic drug substitutions, regulation of rental networks for providers so that providers know which insurers are using discounts already granted.

- Mandated treatment for autism, with preference for the newer techniques using intense behavior modification techniques.

- Additional tort reform tightening on the defendant's side.

- Continuing discussion, particularly in the Senate, on use of stem cell embryos for research and other value issues relating to abortion.

- Health care transformation ideas from the Gingrich Health Care Transformation Task Force that focus on high deductible plans, savings accounts issues at the state level, encouragement of prevention activities.

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We will be happy to answer questions on these issues at the numbers below. We also publish a longer Gold Dome Report on the Firm website at www.nelsonmullins.com. You can reach any of us at 404 322 6000 or email at Helen.sloat@nelsonmullins.com, April.Morgan@nelsonmullins.com or Stan.Jones@nelsonmullins.com. Any bill can be easily accessed in its entirety under Georgia General Assembly on the internet.

Necessary Legal Revisions Have Arrived For Hospitals – Administering Influenza And Pneumococcal Vaccines Pursuant To Standing Orders

by Keith A. Mauriello
Arnall Golden Gregory LLP

While certain business sectors and political camps found this past Georgia legislative session to end in disappointment, those in the hospital industry achieved a notable success with regard to the administration of influenza and pneumococcal vaccines pursuant to standing orders. The General Assembly passed House Bill 217 which, among things, amended O.C.G.A. § 31-7-18 so that hospitals are now permitted to offer and administer influenza and pneumococcal vaccines to all patients pursuant to standing orders. This legislation finally provides hospitals the clarity needed under Georgia law.

BACKGROUND

- **Federal Law**

In October 2002, based on recommendations from certain advisory committees and organizations regarding the

facilitation of influenza and pneumococcal vaccinations, the Centers for Medicare & Medicaid Services ("CMS") decided to remove the Federal barrier to the physician's order requirement for influenza and pneumococcal vaccinations from the conditions of participation for Medicare and Medicaid participating hospitals, long-term care facilities and home health agencies. See 67 Fed. Reg. 61,808 (Oct. 2, 2002).

Specific to hospitals, CMS changed the relevant condition of participation found at 42 C.F.R. § 482.23(c)(2) to allow for influenza and pneumococcal vaccines to be administered per physician-approved hospital policy. The regulation was revised to read as follows:

> All orders for drugs and biologicals must be in writing and signed by the practitioner or practitioners responsible for the care of the patient as specified under § 482.12(c) with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications.

67 Fed. Reg. at 61,814 (emphasis added). According to CMS, this revision allows participating providers "to adopt strategies to increase influenza and pneumonia vaccination rates such as institution or physician-approved protocols i.e., standing orders, that do not require individually signed physician orders." CMS Letter from Director of Survey and Certification Group, Ref: S&C-03-02 (October 10, 2002).

In November 2006, in an effort to strengthen requirements regarding use of verbal orders, CMS further revised 42 C.F.R. § 482.23(c)(2) to read as follows:

> With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under Sec. 482.12(c).

See 71 Fed. Reg. 68,671, 68,678 & 68,694 (Nov. 27, 2006). As is apparent in comparing the 2002 text with the 2006 text, the language regarding the influenza and pneumococcal vaccines exception remained the same.

- **Georgia Law**

Prior to House Bill 217, Georgia law did not follow the Federal condition of participation referenced above. As a threshold point, both the Georgia Pharmacy Practice Act and Dangerous Drug Act require orders for dangerous drugs, which include influenza and pneumococcal vaccines, to be tied to a specific patient and his/her practitioner. See O.C.G.A. §§ 16-13-21(6.1), 16-13-71(473) & (743), 16-13-74(a), 26-4-5(35) & (36), 26-4-80(b). In effect, these Acts prohibit the use of non-patient-specific standing orders or blanket protocols for such vaccines in presumably all settings, including hospitals. Thus, for hospitals there was a need to develop an "exception" under law.

In 2008, the Georgia General Assembly adopted House Bill 1105 which, effective July 1, 2008, required hospitals to offer inpatients 65 years or older vaccinations for influenza and pneumococcal disease from October 1 to March 1 and permitted the vaccines to be administered pursuant to standing orders. Specifically, the Bill amended Article 1 of O.C.G.A. § 31-7 by adding new legislation (enacted as § 31-7-17, but later redesignated as § 31-7-18) stating:

> Annually between October 1 through March 1, prior to discharging any inpatient who is 65 years of age or older, a hospital shall offer the inpatient vaccinations for the influenza virus and pneumococcal disease, unless contraindicated and contingent on availability of such vaccine, in accordance with any applicable rules and regulations of the department. The vaccinations may be administered pursuant to a standing order that has been approved by the hospital's medical staff. A hospital or health care provider acting in good faith and in accordance with generally accepted health care standards applicable to such hospital or health care provider shall not be subject to administrative, civil, or criminal liability or to discipline for unprofessional conduct for complying with the requirements of this Code section.

O.C.G.A. § 31-7-18 (2008).

The statute, however, was quite limited in its application particularly in comparison to the CMS regulation. It restricted the time period in which hospitals could offer such vaccinations to five months (rather than year round) and only covered inpatients 65 years or older. It was clearly drafted with a specific focus in mind and did not take into account other patients or circumstances where a standing order for influenza and pneumococcal vaccines would be beneficial.

While House Bill 1105 was a step in the right direction, it did not go far enough as hospitals that were using standing orders for influenza and pneumococcal vaccines, beyond what was provided in House Bill 1105, were potentially exposed to some degree of risk.

GEORGIA HOUSE BILL 217

House Bill 217 amended O.C.G.A. § 31-7-18 to provide the necessary legal "exception" so that hospitals are no longer technically restricted in offering and administering influenza and pneumococcal vaccines to all patients pursuant to standing orders. The revised statute removed the time period limitation and now not only permits hospitals to offer all patients such vaccinations pursuant to a standing order but also allows them to provide all of their health care workers any vaccination, test or prophylactic measure pursuant to a standing order. Specifically, the revised statute, which became effective April 28, 2009, now reads as follows:

> (a) Prior to discharging any inpatient who is 65 years of age or older, a hospital shall offer the inpatient vaccinations for the influenza virus and pneumococcal disease in accordance with the recommendations of the Centers for Disease Control and Prevention and any applicable rules and regulations of the department, unless contraindicated and contingent on availability of such vaccine. A hospital may offer other patients such vaccinations in accordance with the recommendations of the Centers for Disease Control and Prevention and any applicable rules and regulations of the department. The vaccinations may be administered pursuant to a standing order that has been approved by the hospital's medical staff.
>
> (b) A hospital may offer to its health care workers any vaccination, test, or prophylactic measure required or recommended by, and in accordance with, the recommendations of the Centers for Disease Control and Prevention pursuant to standing orders approved by the hospital's medical staff to ensure the safety of employees, patients, visitors, and contractors.
>
> (c) A hospital or health care provider acting in good faith and in accordance with generally accepted health care standards applicable to such hospital or health care provider shall not be subject to administrative, civil, or criminal liability or to discipline for unprofessional conduct for complying with the requirements of this Code section.
>
> (d) Nothing in this Code section shall restrict or limit the use of standing orders in hospitals for any other lawful purpose.

O.C.G.A. § 31-7-18 (2009) (emphasis added).[1]

CONCLUSION

Although there have been concerns and uncertainty under Georgia law for some time, the Georgia legislature finally passed the necessary changes to provide clarity to hospitals in administering influenza and pneumococcal vaccines pursuant to standing orders. It is quite possible this issue may present itself in other provider settings, but at least for now hospitals can rest assured that administering such vaccines under a standing order is explicitly recognized under Georgia law.

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Mr. Mauriello is an associate with Arnall Golden Gregory LLP and is a member of the Healthcare Practice Team. His practice focuses on healthcare matters and involves representing all types of healthcare providers including hospitals, nursing homes, assisted living facilities, hospices, home health agencies, and physicians. He represents and advises providers in matters ranging from operations, regulatory compliance, Medicare and Medicaid reimbursement, certificate of need, change of ownership and civil monetary penalty defense. Mr. Mauriello has been recognized as a Georgia "Super Lawyer - Rising Star" for his work in Healthcare Law in Atlanta Magazine.

[1] Of course, this issue is not just relevant to hospitals as there have been concerns regarding limitations in the law for other provider types. Indeed, House Bill 217 also tackles this issue relating to pharmacists and nurses by adding a new code section at O.C.G.A. § 43-34-26.4.

An Ounce Of Prevention Is Worth A Pound Of Cure – How To Prepare For The Medicaid Integrity Contractors

by Amy Fouts
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INTRODUCTION

The government's ability to review health care providers' claims, both from the federal and state level, has increased exponentially over recent years. Indeed, the number of acronyms out there waiting to audit providers can seem overwhelming. Providers may face audits from a number of entities, including but not limited to: Program Safeguard Contractors (PSCs), Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Zone Program Integrity Contractor (ZPICs), Comprehensive Error Rate Testing (CERTs), the Office of Inspector General (OIG), and now the government has thrown another program, the Medicaid Integrity Contractors (MICs) into the mix. This paper focuses on the Medicaid Integrity Contractors, one of the auditing programs Medicaid providers are likely to encounter in upcoming years.

OVERVIEW OF THE MEDICAID INTEGRITY CONTRACTORS

The Medicaid Integrity Program (MIP) was created by the Deficit Reduction Act of 2005.[2] The MIP is the first comprehensive Federal initiative to prevent and reduce provider fraud, waste, and abuse in the Medicaid program. Indeed, Congress appropriated $5 million in funding during 2006, $50 million in both 2007 and 2008, and $75 million in 2009 and in each year thereafter for this program.[3] The Centers for Medicare and Medicaid Services (CMS) has several broad responsibilities under the MIP:

- To review the actions of individuals or entities furnishing items or services to a State plan to determine whether fraud, waste, or abuse has occurred, or is likely to occur;
- To audit claims for payment for items or services furnished, or administrative services rendered, under a State plan;
- Identification of overpayments to individuals or entities receiving Federal funds under this title; and
- Provide education of providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and quality of care.[4]

Although each State is primarily responsible for combating fraud in the Medicaid program, CMS provides technical assistance, guidance and oversight in these efforts.

The MIC Program was launched in April 2008, with activities to be conducted in 14 States throughout CMS Regions three and four.[5] The MICs are divided into three separate categories with varying responsibilities: the Review MICs, Audit MICs and Education MICs.

Review MICs:

- Analyze claims data to identify potential vulnerabilities;
- Provide leads/target audits to the Audit MICs; and
- Use data-driven approaches to focus efforts on aberrant billing practices.

Audit MICs:

- Conduct post-payment audits of Medicaid providers;
- Perform combination field audits and desk reviews; and
- Identify overpayments.

Education MICs:

- Develop training materials and awareness campaigns; and
- Highlight value of education in preventing fraud and abuse.

[2] Deficit Reduction Act of 2005, Pub. L. 109–171, 120 Stat. 4.
[3] *Id.*

[4] *Id.*

[5] Region 3: Washington, D.C., Delaware, Maryland, Pennsylvania, West Virginia, Virginia.
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

The MIC program, while similar to CMS's Recovery Audit Contractor Program, has several distinctions. First, the MICs are not paid based on a contingency fee basis. Further, while the selection of providers to be audited will be determined by the MIC, the audit process will be a joint effort between the MIC and the state. The MIC will provide draft audit reports to the state for the state's review once the MIC has completed the audit but before providing such reports to providers. MICs are responsible for audits in several states, yet payment policies differ from state to state. Thus, the practice of permitting states to review draft audit reports allows states to identify instances in which the MIC may have misinterpreted state guidelines or policy. Once any necessary corrections have been made to the report based on the state's input, the MIC will provide the draft audit report to the providers. Similar to the RAC rebuttal process, providers may submit additional documentation to demonstrate that a service was appropriately billed and that an overpayment did not occur.

After the audit process is finalized, the state has 60 days to return the overpayment amount to CMS. The state may then choose to recoup that amount from the provider. Appeal processes are determined by the rights afforded in each state. Therefore, filing deadlines for appeals are also determined on a state-by-state basis and may be much shorter than the 120-day Medicare deadline.

MIP officials expect auditors to perform 200 provider audits per month once they are up and running. Unfortunately for providers who provide services to Medicaid beneficiaries, this means that it is not a question of whether you will be audited, but rather, when.

PREPARING FOR A MIC AUDIT

The old adage "an ounce of prevention is worth a pound of cure" applies as much to auditing as it does to the practice of medicine. MICs were created to recoup monies and providers large and small should take steps to prepare for these audits to prevent costly denials and appeals. Of course, not every facility or provider is going to have the manpower or financial means to audit every claim that may be reviewed by the MIC. There are small steps and preventive measures, however, that providers can implement to minimize risk and ensure that they are ready if (or likely, when) the MIC shows up on your doorstep.

Appoint an audit coordinator and task force – There should be one individual responsible for responding to and coordinating with the MIC. Large hospital systems may want to consider alerting the MIC of this individual and request that any correspondence be sent directly to the audit coordinator. There have been several instances where letter requests are sent to different individuals at the same facility and these requests go unnoticed until it is too late to respond.

Providers should also designate a core team to coordinate audit activities. This group may include compliance, finance, revenue cycle management, medical records, case management, coding and clinical. The audit team should meet regularly to track and oversee audits and ensure all departments are up-to-date on current "hot" audit areas.

Conduct a Risk Assessment – Providers should conduct an overall risk assessment of their billing to determine potential risk areas. This should be followed-up with regular audits of known target areas. Providers should keep up with target areas from past and current audits being conducted by the MICs. Additionally, the Department of Health and Human Services Office of Inspector General (OIG) publishes its annual work plan, which contains areas (including Medicaid) that each provider should review.

Develop a work plan – It is important to have a plan mapped out of how to respond to requests made by the MIC. For example:

- How will the various departments be notified of a request?
- Who will gather and copy the requested documents? Please note that, unlike the RACs, MICs do not reimburse providers for the costs related to copying and submitting medical records. Additionally, MICs are not limited in the number of records they may request.
- Who will be responsible for reviewing the documents to ensure that all documentation is included?
- Should the records be reviewed by clinical staff or an outside consultant?
- Who is responsible for tracking deadlines? For some states, providers have as little as ten days to copy and provide records to the MIC.

Many decisions need to be made well in advance of receiving a request from the MIC. Providers that wait until they receive a request for records are often left facing tough deadlines and are less likely to include all relevant documentation necessary to support a claim.

Develop a tracking system – It is imperative that each facility establish and maintain an adequate tracking and calendaring system. Providers must make sure they keep track of what has been requested, what has been sent (with proof that it was sent), and keep up with the resolution of each encounter requested by the MIC. Importantly, the failure to send requested documents within the timeframe may result in an automatic denial of those claims and a demand for overpayment amounts.

Education – Provide comprehensive education to audit team members and all impacted departments and

workforce members about the audit process and work flow. Further, after identifying any potential risk areas, make sure that all affected departments and individuals are appropriately trained on the matter.

Corrective Action – If errors are identified through self-auditing, disclose the errors to mitigate damages and prevent a review. If possible, pay the claim directly to the state. Providers should establish a mechanism for correcting and providing education on such matters. These areas should be monitored and audited in the future to ensure compliance.

CONCLUSION

The elimination of fraud, waste and abuse in Federally funded healthcare programs is a top priority. The government has many weapons in its arsenal to combat fraud, waste and abuse, and is now rolling out various programs, including the MIC program, to assist in these efforts. Therefore, providers need to be aware of how these programs work and be proactive in taking preventive measures to minimize risk and be ready when one of the audit programs knocks on their door.

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Georgia DCH HITT Advisory Board Update

by Joel Schuessler
DeKalb Medical

As a member of the Board, and in what I hope is the first of regular of updates, I want to first introduce the members of the Health Law Section to the Georgia Department of Community Health (DCH) Health Information Technology and Transparency Advisory Board (the Board). On October 17, 2006, Governor Sonny Perdue issued an executive order creating the Board. The stated purpose of the Board is to advise DCH on establishing a statewide strategy that will (1) encourage the empowerment of health care consumers by granting full access to health care information so that they are fully informed when making health decisions and (2) improve patient safety and health care quality. The Board is to accomplish this purpose by (1) providing leadership for a coordinated effort across the state to achieve health information exchange; (2) encouraging the use of electronic health records that recognize interoperability standards as identified by the Secretary of the U.S. Department of Health and Human Services; (3) promoting marketplace transparency within the health care industry and communities through the offering of accurate information to the consumer of health care regarding the cost and quality of health care; and (4) maintaining the security and privacy of patient information. The initial Board sunset on June 31, 2008, at which point, Dr. Rhonda Medows, DCH Commissioner reconstituted the Board on July 1, 2008. The current Board is composed of a broad spectrum of stakeholders in the health care system. Board members include physicians, representatives of hospitals, pharmacies, insurers and managed care organizations, representatives from Georgia government agencies, consumer advocates and health information technology experts.

Since its inception, the Board has been involved with DCH's Office of Health Information Technology and Transparency (HITT) in its implementation of health information technology initiatives through out the state in a variety of ways. The Board has provided guidance to DCH in its issuance of grants to a number of health care providers throughout the state to develop and implement health information exchanges. The Board receives frequent updates from the grantees on their progress and lessons learned in working to implement health information exchanges. Several members of the Board served as speakers on the privacy and security of electronic health/medical records through DCH's involvement with the national Health Information Security and Privacy Collaborative. Most recently, the Board has received updates and information on DCH's recently launched transparency website, georgiahealthinfo.gov. The transparency website provides Georgia consumers with a variety of cost and educational resources to make informed

decisions about their health care choices. DCH representatives also provide the Board with frequent updates about the status of health information technology within DCH, including in progress and planned projects and initiatives. I encourage the members of the Health Law Section to visit the website of DCH's Office of HITT where they can find more information about the Board and DCH's health information technology plans and activities.

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The Georgia Medicaid Care Management Organizations Act (HB 1234) One Year After Implementation

by Rob Stone
Alston & Bird LLP

Passage of the Medicaid Care Management Organizations Act in May 2008 was generally hailed by medical professionals and providers as a step forward in protecting their rights and clarifying the basic administrative process of Medicaid managed care in Georgia. It has been just over one year since the CMO Act went into effect and while it has improved provider-CMO interactions in a number of areas, it also had several unanticipated effects that the provider community, the Department of Community Health ("DCH") and the CMOs have been forced to address. This article will review several of these areas and provide an update about progress made over the last year.

Summary of the Act

Because the CMO program was initially implemented in 2006 by the Governor without any contemporaneous statutory action, the State Legislature had not had an opportunity to weigh in on how Medicaid managed care should operate in the state until passage of the CMO Act. As a result of several DCH-sponsored studies and numerous provider complaints, state Senator Mickey Channel and others worked to identify key areas where regulatory oversight was lacking and address them in the Act.

The final Act included the following major provisions:[6]

- Definition: For the first time, the Act provided a statutory definition of Care Management Organizations, and re-iterated their status as HMOs, subject to other pre-existing statutory regimes such as the HMO Act.
- Payment Provisions: The Act added specific payment provisions in the following areas:
  - Emergency Services
  - Coverage of Newborns
  - Verification of Eligibility Procedures
- Provider Enrollment: Each CMO is required to allow licensed dentists who are subject to certain loan forgiveness programs and operating in high-need areas to contract with the CMO as a provider.
- Provider Websites: Each CMO is required to maintain a website that allows for electronic claims submission and adjudication and also includes a searchable list of contracted providers.
- Standardization of Timeframes: Each CMO must utilize the same timeframes for claims process and adjudication, including appeals, as DCH uses in its fee-for-service program.
- Appeals & Complaints: The Act addressed provider concerns in several areas related to appeals and complaints, including:
  - Special remedies for critical access hospitals;
  - A provision allowing providers that have contract or payment disputes with a CMO to

[6] The CMO Act is located at O.C.G.A. § 33-21A-1 to 33-21A-12. It is also often referred to as House Bill 1234 or HB 1234.

either seek arbitration or review by a DCH Administrative Law Judge, at the provider's option;

- A new interest provision of 20% per annum applied to initially denied or underpaid claims that are eventually determined or agreed to have been owed; and
- A requirement that providers be allowed to consolidate similar claims on appeal, which allows smaller claims to be bundled and resolved in a more efficient and economic manner than individual appeals.

Implementation Issues

Effective Date of the Act

The CMO bill states that it would go into effect when approved by the Governor or allowed to become law without signature.[7] Governor Perdue signed the Bill on May 13, 2008.[8] Nevertheless, multiple publications and provider alerts released by the CMOs and DCH in the summer and fall of 2008 listed the effective date as July 1, 2008.[9] While this is the default date under Georgia law that bills become effective if they are not affirmatively signed by the Governor, that was not the case here. As a result, the Act went into effect on May 13, 2008.

Considering that a number of the Act's provisions involve specific payment obligations and procedures, the actual effective date could prove to be a live issue for a number of provider claims or appeals. Given the implementation language in the original Bill and the Governor's signing date of May 13, 2008, providers should view the often-repeated effective date of July 1, 2008 with significant skepticism.

Timeframe Standardization Resulting in Shortened Appeal Deadlines

The CMO Act states:

> 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.[10]

The intent of this provision was two-fold: (1) to standardize applicable timeframes and consequently decrease providers' administrative costs in tracking multiple timeframes for different Medicaid payors and (2) ensure that CMOs could not implement overly restrictive deadlines on providers' claims submissions and appeals. Unfortunately, the DCH timeframes for filing appeals were actually shorter than most of the CMO allowed timeframes in their provider agreements. DCH required providers to submit appeals within 30 days from the date of the initial determination while CMOs previously allowed anywhere from 45 to 90 days. As a result, the Act has inadvertently led to the CMOs tightening their appeal deadlines.

The simplest remedy for this unanticipated result would be for DCH to extend its appeal deadline, thereby triggering a statutorily required revision by the CMOs as well. But DCH has thus far been reluctant to make such a change. Any other fix will require a change to the statute, which is obviously much more difficult and not likely to occur in the near future. Until and unless DCH changes its deadline, providers are forced to take what comfort they can from the fact that while the appeal timeline is shorter, it is uniform across all Medicaid payors.

Recoupment from Providers When Commercial Insurance Coverage Is Present

The CMO Act states that if a provider complies with the proper verification procedures for determining an individual's eligibility (i.e. use of the Georgia Health Partnership portal), but those procedures indicate the wrong party as the payor (i.e. the portal shows that DCH is the payor but it is actually one of the CMOs), then the payor who was indicated on the portal (called the "responsible health organization") is required make a payment to the provider.

[7] See section 3 of HB 1234, available at, http://www.legis.ga.gov/legis/2007_08/pdf/hb1234.pdf.

[8] See Press Release, Governor Perdue Signs CMO Reform Bill, available at: http://gov.georgia.gov/00/press/detail/0,2668,78006749_112654855_113442959,00.html.

[9] See http://www.pshpgeorgia.com/2008/12/11/important-notice-house-bill-1234/ ;

https://www1.amerigroupcorp.com/providers/providerposts/documents/2008/CMAP-5307-Claim%20Timelines-GA-06.18.08.pdf

http://georgia.wellcare.com/WCAssets/georgia/assets/GA_HB1234ProviderFAQs.pdf

[10] O.C.G.A. § 33-21A-7(f).

That payor may then pursue recovery from the proper payor, but may not seek to recover from the provider.[11]

This provision seeks to ensure that the risks from a sometimes error-prone eligibility verification system are not borne by providers who comply with the proper procedures, but by the payors themselves. Prior to passage of the CMO Act, providers had reported problems with the accuracy of verification procedures, sometimes resulting in a beneficiary's status changing after initial verification was obtained. This resulted in a denial of payment (either because the patient was not actually eligible as shown or because the provider failed to obtain pre-authorization from the proper payor because they could not identify who the proper payor was at the time of the service). There were also complaints of different payors referring a provider back and forth, with neither payor taking responsibility for the patient's care, in spite of what the portal or other verification procedures indicated.

Based on one CMO FAQ, as well as anecdotal provider reports, at least one of the CMOs took the position that this section of the CMO Act was superseded by the federal Medicaid secondary payor laws, at least as related to commercial payors. As a result, the CMO said that if a provider determined through the Act's verification procedure that the CMO was the proper payor, submitted a bill to the CMO and received payment, and the CMO later determined that the patient was covered by a commercial payor, the CMO would seek to recoup the payment from the provider, in direct contradiction to the requirements and protections of the CMO Act. The CMO's FAQ stated:

> Q: [The CMO] is requesting an overpayment and stating that the member has primary coverage through a commercial carrier like United, Aetna, CIGNA, or Blue Cross but I verified coverage as directed and within 72 hours prior to performing services. Do I owe the refund?
>
> A: Under federal law a Medicaid plan is considered the payor of last resort so if a member has other insurance that coverage will always supersede the Medicaid plan. You must repay the overpayment ***regardless of state law*** and then may file a claim with the primary carrier. We suggest submitting the claim as an appeal and show your Medicaid EOP as proof of timely filing.[12]

According to provider reports, DCH has intervened and clarified the proper interpretation of applicable law. DCH reportedly informed the CMO that both federal and state law are consistent on this point, and that it was improper for the CMO to seek recovery from the provider. Without this intervention from DCH, this protection provided by the Act could have been seriously undermined by the CMO's interpretation.

Reconciling New Interest Provision with the Prompt Pay Statute

The CMO Act includes an interest provision requiring CMOs to pay providers interest at the rate of 20% per annum on all claims that are initially denied or underpaid but eventually agreed or determined to have been owed by the CMO. The amount of interest due is calculated from 15 days after the date the claim was submitted.[13]

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[11] This section of the Act states:

> If a provider submits a claim to a responsible health organization for services rendered within 72 hours after the provider verifies the eligibility of the patient with that responsible health organization, the responsible health organization shall reimburse the provider in an amount 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 resolving the provider's claim, if the responsible health organization made payment for a patient for whom it was not responsible, then the responsible health organization may pursue a cause of action against ***any person who was responsible for payment*** of the services at the time they were provided but may not recover any payment made to the provider.

O.C.G.A. § 33-21A-9(a) (emphasis added).

[12] http://georgia.wellcare.com/WCAssets/georgia/assets/GA_HB1234ProviderFAQs.pdf (emphasis added).

[13] Section 33-21A-7(c) of the Act states:

> 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 20 percent per annum, calculated from 15 days after the

A pre-existing statutory provision (the "prompt pay" statute) also requires insurers, including licensed HMOs, either to pay or deny complete or so-called "clean claims" within 15 days of receipt. If the claim is denied, in whole or in part, the insurer is required to provide a written explanation to the provider.[14] The CMO Act appears to envision these two provisions existing side-by-side, as it states that CMOs "shall pay all interest required to be paid under [the CMO Act] or [the prompt payment statute] automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment."

Not surprisingly, the interplay between these two interest provisions has resulted in differing points of view and interpretations by several CMOs. One CMO has taken the position that submission of a clean claim is a prerequisite for the clock to start running on either interest provision, in spite of CMO Act's penalty provision making no such reference.[15]

Another has drawn a distinction between interest for clean claims (paid at 18% per annum) and interest related to "root cause issues where claims [were] processed incorrectly," (paid 20% per annum).[16] As of this writing, the author is unaware of any guidance from DCH on application of these two interest provisions in the event that they are both arguably implicated by a CMO's actions. In the absence of guidance from DCH, providers and CMOs are left to interpret the statutes and resolve any differences that might arise on a case-by-case basis.

Summary

Overall, medical professionals and providers welcomed the requirements included in the CMO Act and DCH and the CMOs have worked diligently to implement them. In fact, Myers and Stauffer, LLC an auditing company hired by DCH to investigate and document provider complaints about the CMOs, indicated in its final report dated July 17, 2008, that "many provisions of [the CMO Act] appear to address the observations, findings and recommendations included in this report."[17] Nevertheless, as the accounts in this article demonstrate, there remain a number of issues and potential issues to be addressed. While this is not surprising, considering the complexities of the Medicaid managed care system, it will require continued effort and communication to resolve these issues and fulfill the intentions behind the CMO Act.

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> date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment. All interest payments shall be accurately identified on the associated remittance advice submitted by the care management organization to the provider. A care management organization shall not be responsible for the penalty described in this subsection if the health care provider submits a claim containing a material omission or inaccuracy in any of the data elements required for a complete standard health care claim form as prescribed under 45 C.F.R. Part 162 for electronic claims, a CMS Form 1500 for nonelectronic claims, or any claim prescribed by the Department of Community Health.

[14] See O.C.G.A. § 33-24-59.5.

[15] See "The Medicaid Care Management Organization Act (Georgia House Bill 1234), Frequently Asked Questions, June 30, 2008 ("The timeline for processing [unclean] claims starts over from the date of receipt of the corrected claim or additional information. WellCare has 15 business days from the date of receipt to process the claim and pay interest on any unpaid balance.") available at, http://georgia.wellcare.com/WCAssets/georgia/assets/GA_HB1234ProviderFAQs.pdf

[16] Medicaid Webinar Notes 7-9-08, available at, http://hometownhealth.wikispaces/Medicaid+Look+Up.

[17] See Myers & Stauffer Comparative Analysis, Final Draft, July 17, 2008, available at, http://dch.georgia.gov/vgn/images/portal/cit_1210/34/0/118307357GAFamCMOFinalPoliciesProcCompar071708.pdf.

MESSAGE FROM THE EDITOR – CALL FOR AUTHORS

The Health Law Section of the State Bar of Georgia is pleased to provide a publication for its members to address current topics of interest. We encourage you to send us summaries of recent cases, legislation, and agency activities that may be of interest to health law attorneys who practice in Georgia and the Southeast. Suitable short feature articles on timely topics may also be accepted for publication. Please address inquiries, submissions, and suggestions to:

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