GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

PUBLIC NOTICE OF PROPOSED RULE CHANGES

Pursuant to the Georgia Administrative Procedures Act, Official Code of Georgia (O.C.G.A.) § 50-13-1, et seq., the Georgia Department of Community Health is required to provide public notice of its intent to adopt, amend, or repeal certain rules other than interpretative rules or general statements of policy. Accordingly, the Department hereby provides notice of its intent to transfer and repeal the **Rules and Regulations for Health Maintenance Organizations, from Rules & Regs., R. 290-5-37 to new Chapter 111-8-29.** These changes are being proposed pursuant to the authority granted to the Department in O.C.G.A. §§ 33-21A-12 and 49-4-1. An exact copy of the revised rules and a synopsis of the revisions are attached to this public notice.

NOTICE OF PUBLIC HEARING

An opportunity for public comment will be held on September 15, 2020 at 11:00 a.m. via WebEx audio. There will be no in-person attendance at the Department of Community Health. The WebEx event number is **127 479 8191** and the event password is "**Public**". Follow these instructions to join the event:

1. Copy the following link to a browser: https://dchevents.webex.com/dchevents/onstage/g.php?MTID=eeccf042a0bb0c49a7f267e1afba66398

2. Click "Join Now".

Oral comments may be limited to ten (10) minutes per person. Individuals who are disabled and require assistance to participate during this meeting should contact the Office of General Counsel at (404) 657-7195 at least three (3) business days prior to the meeting.

Individuals wishing to comment in writing on any of the proposed changes should do so on or before September 18, 2020. Due to reduced physical staffing at the 2 Peachtree St. location in an attempt to limit the amount of exposure to COVID-19, DCH encourages written public comments submitted in accordance with O.C.G.A. 50-13-4(a)(2) to be submitted via e-mail to the following e-mail address: **PublicComment@dch.ga.gov**.

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Any comments not able to be submitted via e-mail may be submitted via regular mail to the following address:

Attention: Mary Peterkin
Office of General Counsel
Georgia Department of Community Health
2 Peachtree Street, NW, 40th Floor
Atlanta, GA 30303

Comments from written and public testimony will be provided to the Board of Community Health prior to October 8, 2020. The Board will vote on the proposed changes on October 8, 2020.

NOTICE IS HEREBY GIVEN THIS 13th DAY OF AUGUST, 2020

Frank W. Berry, Commissioner

RULES OF

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

HEALTHCARE FACILITY REGULATION DIVISION

REPEAL CHAPTER 290-5-37

AND

REPLACE WITH NEW CHAPTER 111-8-29

RULES AND REGULATIONS FOR HEALTH MAINTENANCE ORGANIZATIONS

SYNOPSIS OF REVISED RULES

STATEMENT OF PURPOSE:

The Department of Community Health proposes to repeal the Rules and Regulations for Health Maintenance Organizations under Chapter 290-5-37 and publish amended Health Maintenance Organizations Rules under Chapter number 111-8-29. This change is necessary to reflect that the Health Maintenance Organizations are subject to regulation by the Department of Community Health rather than the Department of Human Resources, which has since been renamed as the Department of Human Services. These rules are being proposed pursuant to the authority granted to the Department of Community Health in O.C.G.A. §§ 31-2-4, 31-2-5, and 33-21-1 *et seq*.

MAIN FEATURES OF THE PROPOSED RULE:

The proposed Rules and Regulations for Health Maintenance Organizations, Chapter 111-8-29, update the existing rules by replacing the Chapter number, replacing the name of the Department, and correcting rule numbering and grammatical errors. The proposed Rules and Regulations for Health Maintenance Organizations, Chapter 111-8-29, do not change any substantive provisions of the existing rule.

RULES OF
GEORGIA DEPARTMENT OF ~~HUMAN SERVICES~~ COMMUNITY HEALTH
DIVISION OF ~~PUBLIC HEALTH~~ HEALTHCARE FACILITY REGULATION

CHAPTER ~~290-5-37~~ 111-8-29

RULES AND REGULATIONS FOR HEALTH MAINTENANCE ORGANIZATIONS

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Rule ~~290-5-37~~ 111-8-29-.01 Introduction and Purpose

(1) The Department of ~~Human Resources~~ Community Health is authorized by the Georgia Health Maintenance Organization Act of 1979, Ga. Laws of 1979, p. 1148, et seq., (Ga. Insurance Code Chapter 56-36) to promulgate rules and regulations necessary to establish and control the standards of health care which any Health Maintenance Organization (HMO)created under that Act shall be required to maintain. Before the Insurance Commissioner may issue a Certificate of Authority to operate an HMO, the Commissioner of the Department of ~~Human Resources~~ Community Health must certify to the Insurance Commissioner that the standards of health care are met by the applicant HMO.

(2) The purpose of these rules and regulations is to establish the standards of health care which will be required by the Department of ~~Human Resources~~ Community Health of HMOs. Minimum parameters of operation for the clinical staff and management of HMOs and components thereof will also be set. In recognition that HMOs are intended to be a cost effective alternative for the

delivery of health care services, the Department is supportive of efforts to assure their availability to all citizens. It is the intent of the Department to assist the growth and development of HMO programs in Georgia and to aid in providing technical assistance needed for their efficient and effective utilization.

(3) HMOs are subject to review by the ~~State Health Planning and Development Agency~~ Office of Health Planning, pursuant to the Georgia Certificate of Need Law and 1122 of the Social Security amendment (where applicable). Evidence of completion of this review shall be Submitted to the Department of ~~Human Resources~~ Community Health as a documentation requirement during the Certificate of Authority process.

(4) Copies of these rules and regulations shall be available within the HMO, and employees shall be fully informed and instructed with reference to their requirements.

Authority: Ga. L. 1964, pp. 499,507, 523; Ga. L. 1979, p. 1148 et seq.; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.02. Definitions

Unless a different meaning is required or given in the context, the following terms as used in these rules and regulations shall have the meaning hereinafter respectively ascribed to them:

(a) "Basic Health Care Services" means healthcare services which an enrolled population might reasonably require in order to be maintained in good health, including as a minimum but not restricted to, preventive care, emergency care, inpatient hospital and physician care, and outpatient medical services;

(b) "Commissioner" means the Commissioner of the Georgia Department of ~~Human Resources~~ Community Health or his designee;

(c) "Complaint" means a written expression of concern by an enrollee or provider regarding the provision of health care services by the HMO or a condition in the operation of an HMO which affects an enrollee or provider to such an extent as to be viewed by such as deserving of formal redress;

(d) "Department" means the Georgia Department of ~~Human Resources~~ Community Health (~~DHR~~ DCH);

(e) "Enrollee" means an individual person who is enrolled in a health benefits plan;

(f) "Governing Body" means the person or persons, natural or corporate, in which the ultimate responsibility, authority and accountability for the conduct of the HMO is vested;

(g) "Health Benefits Plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services and at least part of such arrangement consists of arranging for or the provision of health care services, as distinguished from an arrangement which provides only for indemnification against the cost of such services, on a prepaid basis through insurance or otherwise;

(h) "Health Care Services" means any services included in the furnishing to any individual of medical or dental care, or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury;

(i) "Health Education" means the provision of health information and the use of educational techniques to modify an individual's or family's knowledge and/or behavior to achieve and maintain optimum physical and mental health and to prevent illness, injury, chronicity, or unnecessary disability;

(j) "Health Maintenance Organization" or "HMO" means any legal entity subject to the provisions of the Georgia Health Maintenance Organization Act;

(k) "Health Professional" means those professionals engaged in the delivery of health services who are currently licensed to practice in the State of Georgia, or provide services authorized under an institutional license, or are certified, or practice under authority consistent with Georgia laws;

(l) "In-Area" means the geographical area defined by the health maintenance organization as its service area in which it provides health services to its enrollees directly through its own resources or through arrangements with other providers in the area;

(m) "Insurance Commissioner" means the Insurance Commissioner of the State of Georgia or his designee;

(n) "Medical Audit" means the retrospective examination and evaluation of the documentation of clinical application of medical knowledge as revealed inpatient health records for the purposes of education, accountability, and quality assurance;

(o) "Out-of-Area" means that area outside of the geographical area defined by the health maintenance organization as its service area;

(p) "Physician" means an individual who is currently licensed to practice medicine, surgery, or osteopathy in the State of Georgia, under the Georgia Medical Practice Act, Chapter 84-9, Georgia Laws Ann.;

(q) "Primary Care Physician" means the physician responsible for the management of medical care and coordination of health care services of an enrollee;

(r) "Provider" means any physician, hospital, or other person or facility which is licensed or otherwise authorized in this State to furnish health care services;

(s) "Peer Review" means professional evaluation by currently licensed professional persons in the same category as those being reviewed, of the performance of individuals in the medical and related health care fields for the purpose of achieving and maintaining high standards of care and professional practice;

(t) "Person" means any individual, institution, partnership, association, corporation, the State, or any municipalities or subdivision thereof, or any other entity whether organized for profit or not;

(u) "Quality Assurance Program" means the planned systematic medical and/or management actions which assure consistent rendering of high quality health care services through the use of monitoring and evaluation techniques;

(v) "Service Area" means the defined geographical area (i.e., boundaries of political subdivisions, census tracts, Area Planning

and Development Commissions or Health System's Agencies, etc.) in which HMO services are available and readily accessible to enrollees;

(w) "Subscriber" means an enrollee who has entered into a contractual relationship for the provision of/or arrangement of health care services from an HMO for himself and/or his dependents;

(x) "Supplemental Health Services" means those health services offered in addition to "Basic Health Care Services."

Authority: Ga. L. 1964, pp. 499,507, 523; Ga. L. 1979. p. 1148 et seq.; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.03 Basic Health Care Services

An HMO shall provide or arrange for the provision of basic health care services to its enrollees as needed and without limitations as to time, cost, type of service, or waiting period, e.g. maternity benefits, except as otherwise provided for in these rules and regulations. Provided, however, that such persons or institutions shall not be required to provide or receive services which conflict with their religious belief or moral objection. Exemptions claimed under this provision must be fully disclosed in the health benefits plan. Upon the determination of necessity, the HMO shall be responsible for medically necessary emergency care 24-hours per day, seven days per week, during the time of an existing contract. The HMO is responsible to provide or arrange for the provision of nonemergency care during reasonable and customary working hours and days. An HMO must provide the basic health care services listed herein and may not provide less service, nor may the HMO withhold a basic health care service because of an enrollee's known or unknown health condition. An HMO may provide one or more health benefits plans which exceed the basic health care services by including one or more supplemental health services. The basic health care services are:

(a) Preventive Care Services (including family planning services and services for the detection of asymptomatic diseases). The following services will be provided on a periodic basis, as specified in the plan:

1. The full range of family planning services;

2. Services for infertility;

3. Preventive eye/ear examinations by a physician, optometrist, or other qualified health professional to determine the need for correction, for children through age seventeen (17). The cost of corrective appliances and/or artificial aids shall not be included as a basic service unless otherwise specified in the health benefits plan;

4. Pediatric and adult immunizations in accordance with the Immunization Program of the Georgia Department of ~~Human Resources~~ Public Health;

5. Periodic health examinations with appropriate protocols for specific age and sex groups, which may include pelvic and breast examinations and pap smears for women and other special diagnostic and screening procedures for enrollees considered to be at risk for specific disease states (e.g., obesity, hypertension, diabetes, glaucoma, cardiovascular disorders, lung diseases, cancer, sickle cell disease, etc.);

6. Well-child care services aimed at preventing problems and promoting the well-being of the child according to an established schedule of examinations and services planned for early detection and treatment of disorders for the promotion of healthy growth and development(e.g., health assessments, nutrition counseling, immunizations, screening, health education, etc.); and

7. Health education activities (including nutritional education and counseling).Health education activities shall state in writing the targeted population, purposes and techniques to be utilized in the program and the evaluation of results.

(b) Emergency Care.

1. Medically necessary emergency care service is medical care rendered by affiliated or non-affiliated providers, whether in or out of the service area, under unforeseen conditions requiring services necessary for the repair of accidental injury, relief of acute pain and/or infection, protection of the person's health, or the amelioration of illness which, if not immediately diagnosed and treated, would result in physical or mental

impairment or loss of life. Outpatient and inpatient in-area medically necessary emergency health services shall be available 24-hours a day, seven days a week. Emergency health services shall include in-area ambulance services to the nearest facility designated by the HMO plan. The HMO shall have a plan for coverage of out-of-area emergencies-; the plan shall cover ambulance service. An HMO associated physician or other delegated health professional shall authorize the use of nonemergency ambulance services.

2. Medically necessary emergency services shall include psychiatric emergency care provided in an emergency room. Such care shall not be considered among the limited short-term outpatient mental health visits.

3. Emergency care related to alcohol use and abuse shall include:

   (i) immediate medical evaluation and care;

   (ii) medical management of intoxicated persons until they are no longer incapacitated by the effects of alcohol-; and/or

   (iii) initiation of other appropriate health services needed for continuity of care.

4. Emergency care related to drug abuse and addiction shall include treatment for overdose and adverse reactions to psychotropic substances such as barbiturates, amphetamines, hallucinogens (including marijuana), tranquilizers and narcotics.

(c) Outpatient Medical Services and Inpatient Hospital Services.

1. Outpatient medical services shall include diagnostic or treatment services or both for patients who are ambulatory and may be provided in a non-hospital-based health care facility or in a hospital.

2. Inpatient hospital services shall include, but not be limited to room (private, if determined medically necessary by the physician) and board, general nursing care, meals and special diets when medically necessary, use of operating room and

related facilities, intensive care unit and services, x-ray, laboratory and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, special duty nursing when medically necessary, physical therapy, respiratory therapy, radiation therapy, administration of whole blood and blood products (or components) and derivatives, other diagnostic therapeutic and rehabilitative services as needed, and coordinated discharge planning including the planning of such continuing care as may be necessary both medically and as a means of preventing possible early rehospitalization.

3. Outpatient medical services and inpatient hospital services shall include appropriate short-term rehabilitative services. The HMO must clearly define and make known its policy to enrollees.

4. Prenatal, intrapartum and postnatal maternity care shall be covered. This shall include complications of pregnancy of the mother and care with respect to the newborn child from the moment of birth; and necessary care and treatment of illness, injury, and congenital defects of the infant.

5. Medically necessary plastic surgery shall be provided as needed for the purpose of improving function by anatomic alterations. The HMO has flexibility to determine a policy for elective plastic surgery and must clearly define and make known its policy to enrollees.

6. Prescribed drug(s) and/or injection(s) maybe provided to an enrollee at the time of outpatient care as a basic healthcare service. The HMO must clearly define and make known its policy to enrollees.

7. Experimental procedures or biomedical clinical research investigations undertaken by the HMO or by health professionals associated with the HMO which involve HMO enrollees must comply with all current Federal and State regulations, especially with regard to informed patient consent, peer review, and the rights of human subjects.

8. The HMO shall provide outpatient evaluative and crisis intervention mental health services. These basic mental health

services may be provided through lesser or longer time periods if enrollees are equitably assured the equivalency of twenty full 50-55 minute session visits per enrollee per year. Modifications of the standard therapeutic full session shall be fully and fairly disclosed to enrollees of the HMO.

9. Diagnosis and medical treatment for the abuse of or addiction to alcohol and drugs includes detoxification on either an outpatient or inpatient basis, whichever is medically determined to be appropriate, in addition to treatment for other medical conditions.

10. Alcohol and drug referral services may be for either medical or for nonmedical ancillary services. Medical services shall be a part of basic health services; nonmedical ancillary services need not be a part of basic health services.

11. Diagnostic laboratory and diagnostic and therapeutic radiology services shall include, but are not to be limited to clinical and anatomic pathology, and diagnostic radiology, including special procedures, therapeutic radiology, nuclear medicine, electrocardiography, electroencephalography, and other generally accepted diagnostic and therapeutic technology. Laboratory and diagnostic radiology services necessary for the care and management of a condition of an enrollee shall be readily accessible.

12. Home health services are services which are provided at an enrollee's home by health care personnel, as prescribed or directed by the primary care physician. Home health services may include such rehabilitative therapy as medical social services and home health aide services. Homemaker services are not a required basic health service.

(d) Physician Care. Physician services (including consultant and referral services by a physician) shall be provided by or at the direction of a currently licensed physician.

1. Consultant services are defined as those services requiring the skills of a physician or other licensed health professional who by training and experience has acquired or demonstrated proficiency in specialized clinical areas. Coordination of patient

care shall continue to be the responsibility of the primary care physician associated with the HMO.

2. Referral services are defined as those health and medical services provided directly to an enrollee by another health professional or health agency. Referrals shall be authorized and coordinated through the enrollee's primary care physician.

Authority: Ga. L. 1964, pp. 499.507, 523; Ga. L. 1979, p. 1148 et seq.; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.04 Supplemental Health Services

(1) An HMO may provide or arrange for the provision of supplemental health services for which the enrollee has contracted and for which the required health manpower is available.

(2) An HMO must define the level and scope of each supplemental benefit to be offered, i.e., covered days of care, number of visits, or other specific units of service to be offered. Health service facilities, type of health professionals and range of specific services, and the capabilities made available under each benefit, shall be fully disclosed to enrollees and kept current and updated.

Authority: Ga. L. 1964, pp. 499,507, 523; Ga. L. 1979, p. 1148 et seq.; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.05. Health Services Information System

(1) The HMO and/or its providers shall establish and maintain an organized health services information system for the collection, processing, maintenance, storage and retrieval of information concerning health services received by HMO enrollees.

(2) An individual record shall be maintained within the system for each enrollee to include the following minimum data:

(a) Identification - name; address; identifying number; enrollment date; age and birthdate; sex; marital status; occupation; and telephone number;

(b) An initial health evaluation including a chronological record of past medical history, drug use profile, personal and social

history, family history and results of physical examinations, including laboratory and x-ray reports;

(c) A health care plan which identifies enrollee problem(s) and need(s) and the service(s) that will be provided for the enrollee's health maintenance, including revisions as indicated;

(d) The chief complaint and purpose of each visit; clinical diagnosis or impression; studies ordered; treatment given; disposition, recommendations, and instruction to patient; and a progress note for each follow-up visit;

(e) Copies of all consultation and/or referral requests and responses from other health care providers within and without of the organization, which shall be entered into the health record within 14 calendar days following the completion of services by the provider; and

(f) Other records, such as laboratory, x-ray and other test reports, vision/hearing records, immunization records, prenatal/postnatal records, copies of discharge summaries from inpatient health facilities, etc.

(3) The system shall be kept current and available to staff or agencies authorized to use the system.

(4) Health services information shall be retained for a period of six years after the last patient encounter for adults, and for six years after a minor reaches the age of majority. This information may be retained as originals, microfilms, or other usable forms and shall afford a basis for complete audit of professional information. If the HMO dissolves or changes ownership, the plan for retention shall be placed into effect and the Department shall be advised of the disposition and/or location of said records.

(5) Sufficient space and equipment for record processing, storage and retrieval shall be provided.

(6) Policies and procedures shall be written and implemented to assure organization and continuous maintenance of the health services information system.

Authority: Ga. L. 1964, pp. 499, 507, 523; Ga. L. 1979, p. 1148 et seq.; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.06. Confidentiality of Medical Information

Any data or information pertaining to the diagnosis, treatment, or health of any enrollee obtained from such person or from any provider by any HMO shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of these regulations ; or upon the express consent of the enrollee ;or pursuant to statute or court order for the production of evidence or the discovery thereof or in the event of claim or litigation between such person and the HMO wherein such data or information is pertinent. An HMO shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the HMO is entitled to claim.

Authority: Ga. L. 1979, pp. 1148, 1171, 1172; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.07. Quality Assurance

(1) Program Planning and Evaluation. The HMO shall have a formal organized plan for an ongoing quality assurance program. The purpose of the quality assurance plan is to assure that the quality of health care services is continually monitored, reviewed and evaluated for appropriate resource utilization, cost containment, and improvement of healthcare delivery. The written plan shall be approved by the governing body and implemented under the direction of the medical director of the HMO or the medical group. At a minimum, the plan shall include:

(a) The role and responsibilities of the medical director-;

(b) An organizational structure created for the purpose of monitoring, reviewing, and evaluating the quality of health care services provided and appropriate resource utilization and cost containment-;

(c) Mechanisms to collect data; identify problem areas and make recommendations for changes or improvements-; develop plans for correction of identified problems; and follow-up;

(d) Arrangements for routine reporting of results of quality assurance program activities to the governing body and administration;

(e) Provision for maintenance of minutes and records of quality assurance program activities; and

(f) A peer review process which will evaluate and document the internal quality assurance program and the professional standards and practices of the providers, and services provided.

(2) Accessibility and Availability of Services.

(a) Basic health care services and supplemental health services for which enrollees have contracted shall be accessible (capable of being reached) to each enrollee and shall be readily available (present or ready for immediate use), within the defined service area of the HMO.

(b) An HMO shall provide or arrange for regular and reasonable hours during which an enrollee may receive services. An orderly system for scheduling services to enrollees is required and shall take into account the immediacy of the need for service.

(c) The HMO shall have a physician available or arrange for physician services to be available at all times to provide diagnostic and treatment services. The HMO shall assure that every enrollee seen for a medical complaint is evaluated by a physician or other qualified health professional pursuant to Georgia law. Each enrollee shall have the opportunity to select his primary care physician from among those available at the HMO.

(d) Medically necessary emergency services shall be available and accessible within the service area 24-hours a day, seven days a week.

(e) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assume that all services offered by the HMO will be accessible without delays

detrimental to~~t~~ the health of the enrollees. The HMO shall demonstrate an adequate ratio of primary care physicians to enrollees.

(f) The HMO shall provide for the availability and accessibility to services of medical specialists as determined to be medically necessary for the enrollee.

(g) Each HMO shall have a procedure for monitoring and evaluating availability and accessibility of its services, including a system for addressing problems that develop.

(3) Continuity of Care.

(a) Each provider shall establish and maintain an individual health record on each enrollee served, which shall contain information relating to the health care of that enrollee. These records shall be available to accommodate the flow of pertinent information to and from primary care physicians, as needed to assure continuity of care.

(b) The HMO shall offer counseling in dealing with the physical, emotional, and economic impact of illness and disability through services such as pre- and post-hospitalization planning, referral to services provided through community health, social and welfare agencies for family counseling, home health services, mental health services, health education, etc.

(4) Personnel.

(a) All HMO personnel and providers of services shall be currently licensed to perform the services they provide, when such services require licensure or registration under applicable State laws.

(b) The HMO shall assure that there is a sufficient number of health professionals to meet the needs of its enrollees. The specialty mix of licensed physicians shall be consistent with the projected health needs of the enrolled population. Emphasis shall be placed on having an adequate number of primary health care physicians.

(c) The HMO shall arrange for programs of continuing education for its staff and providers, either internally or by external organizations or agencies, to maintain and update skills and to assure quality of health care services.

(d) The HMO shall maintain an individual personnel folder on each employee and/or provider. This file shall include all personal information concerning the employee and/or provider, including applications and qualifications for employment. The employee's and/or provider's current license or registration number shall be included, if applicable.

(5) Facilities and Equipment.

(a) All facilities and equipment used for and in the delivery of services which are required to be licensed and/or certified by law, shall be so licensed and/or certified. This includes but is not necessarily limited to hospitals, nursing and intermediate care homes, clinical laboratories, pharmacies, psychiatric hospitals, and state- operated facilities.

(b) Providers shall have a functional, sanitary, and comfortable environment for patients, personnel, and the public. At all times the privacy and dignity of patients will be upheld.

(c) There shall be an adequate amount of space for services provided and disabilities treated, including waiting and reception areas, staff space, examining rooms, treatment areas, and storage.

Authority: Ga. L. 1964, pp. 499,507, 523; Ga. L. 1979, p. 1148 et seq.; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.08. Policies and Procedures of the HMO

The HMO shall have written policies and procedures governing the provision of services which are based on the stated objectives of the HMO. Policies and procedures shall be approved by the governing body and reviewed and updated at least annually. All policies/procedures shall be available for review by staff, enrollees, and providers. Policies and procedures shall include the following subjects:

(a) Administrative Policies:

1. Advisory Panels. Enrollees shall be afforded an opportunity to participate in health care matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decision, or through the use of other mechanisms;

2. Complaint System. The HMO shall establish and maintain a complaint system approved by the Insurance Commissioner after consultation with the Commissioner;

3. Annual Report. The HMO shall annually, on/or before the first day of March, file with the Insurance Commissioner's Office an annual statement as of December 31st of the preceding year which has been certified by at least two principal officers of said HMO. This report shall include summary information and statistics relating to the quality of health care, cost of operations, the pattern of utilization of services, availability and accessibility to services, use of the complaint system, and such other matters as may be required by the Commissioner;

4. Separation of Medical Decisions. The HMO plan shall be able to demonstrate through its quality assurance program and utilization review process that medical decisions are not hindered by fiscal and administrative management;

5. Service Area. The HMO shall maintain a current, explicit, definition of its service area and a statement of any restrictions or limitations on out-of-area health care.

(b) Policies Related to Professional Services:

1. Physician Services. The enrollee shall have a choice of any of the primary care physicians under contract to the HMO subject to availability;

2. Other Services. A system shall be established for referral, consultant, and other services not directly provided by the HMO to ensure continuity and availability of care;

3. Inpatient Admission and Discharge Policies. The HMO shall have policies and procedures for inpatient health facility utilization and utilization review.

Authority: Ga. L. 1964, pp. 499,507, 523 ; Ga. L. 1979, pp. 1148, 1153, 1157, 1159, 1160, 1161; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.09. Statistical Information

(1) The HMO shall develop, compile, evaluate, and report statistics to the Department as requested relating to the cost of its operations, the pattern of utilization of its services, and the availability and accessibility of its services. The HMO shall provide the Department with full access to all operational and statistical data to enable the Department to verify the HMO's compliance.

(2) The annual statistical report shall contain the following information and shall be made on forms to be provided by the Commissioner. (Federally qualified HMO's may substitute for this annual statistical report, a copy of their four (4) most recent quarterly reports under the National Data Reporting Requirements).

(a) Enrollee statistics:

1. Number of employer contracts and total number of enrollees served by the contracts;

2. Number of subscriber contracts and total number of enrollees served by the contracts;

3. Number of enrollees at the beginning of the reporting year, and number of enrollees at the end of the reporting year, additions during the reporting year, losses during the reporting year;

4. Number of Medicaid and Medicare enrollees.

(b) Provider contracts:

1. Number by type of provider (i.e. physician, dentist, hospital, etc.)-;

2. Additions during the year;

3. Number of terminations during the year.

(c) Utilization, availability, accessibility, and cost data on the following:

1. Inpatient services;

2. Ambulatory care;

3. Preventive health care services.

(d) Other relevant information as determined by the Commissioner.

Authority: Ga. L. 1964. pp. 499, 507. 523; Ga. L. 1979. pp. 1153, 1159, 1160, 1161; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.10. Examinations

(1) The HMO shall be available at all reasonable and/or scheduled operating hours for observation and examination by properly identified representatives of the Department. These examinations shall pertain to all matters relating to the quality of healthcare services of the HMO and all providers with whom such HMO has contracts, agreements, or other arrangements pursuant to its health benefits plan, as often as the Commissioner shall deem it necessary for the protection of the interests of the people of the State, but not less than once every five years. Such examinations may include any accounts, records, documents and files in the possession or control of the HMO, its officers, employees, representatives and providers, which relate to the subject of the examination. An HMO shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the HMO is entitled to claim.

(2) The administrator or his representative shall accompany the Department representative on all tours of inspection and shall sign the completed checklist.

(3) Each HMO shall be periodically inspected to determine whether it is continuing to meet these requirements or is making satisfactory progress on approved plans of correction.

Authority: Ga. L. 1964. pp. 499, 505, 507, 523; Ga. L. 1979, pp. 1148, 1164, 1165; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.11. Regulatory Process

Upon certification to the Insurance Commissioner's Office that the HMO does not meet the requirements of Section 56-3603(1) (b) of the HMO Act of Georgia; or the HMO is unable to fulfill its obligations to furnish health care services as required under its health benefits plan(s); or the HMO has violated any provision of the rules and regulations of the Department, the HMO shall be subject to the regulatory process as prescribed by the HMO Act of Georgia.

Authority: Ga. L. 1979, pp. 1148, 1166, 1167, 1168; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.12. Enforcement

(1) Informal Procedure. If the Commissioner shall for any reason have cause to believe that any violation of these rules and regulations or of the Georgia Laws governing HMO's has occurred or is threatened, the Commissioner may give notice to the HMO and to its representatives, or to other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of ascertaining the facts relating to each suspected violation. In the event it appears that any violation has occurred or is threatened, the conferees may determine an adequate and effective means of correcting or preventing such violation. The proceedings under this subsection may be conducted in the manner deemed appropriate by the Commissioner under the particular circumstances.

(2) Formal Regulatory Process. In the event the Department does not choose to use the informal procedure set out above, or if an HMO does not correct or prevent the alleged violations as required by the Commissioner when the Department finds an HMO does not meet the requirements of these regulations or an HMO is unable to fulfill its obligations to furnish health care services as required under its health benefits plan, the Department shall so certify to the Insurance Commissioner for enforcement proceeding by that Department.

Authority: Ga. L. 1979. pp. 1170, 1171; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.13. Applicability of Regulations

These regulations are applicable only to HMO's and the services provided therein, and do not modify or revoke any of the provisions of other published rules of ~~DHR~~ DCH.

Authority: Ga. L. 1964, p. 499 et seq; Ga. L. 1979, p. 1148 et seq.; O.C.G.A. § 33-21-1 et seq.

Rule ~~290-5-37~~ 111-8-29-.14. Severability

In the event that any rule, sentence, clause or phrase of any of these rules and regulations may be construed by any court of competent jurisdiction to be invalid, illegal, unconstitutional, or otherwise unenforceable, such determination or adjudication shall in no manner affect the remaining rules or portions thereof and such remaining rules or portions thereof shall remain of full force and effect, as if such rule or portions thereof so determined, declared or adjudged invalid or unconstitutional were not originally a part hereof. It is the intent of the Board of ~~Human Resources~~ Community Health to establish rules and regulations that are constitutional and enforceable so as to safeguard the health and well-being of the people of the State.

Authority: Ga. L. 1979, p.1172; O.C.G.A. § 33-21-1 et seq.