RULES
OF
DEPARTMENT OF COMMUNITY HEALTH

CHAPTER 111-5-1
GEORGIA VOLUNTEER HEALTH CARE PROGRAM

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111-5-1-.01 Definitions.

The words used in these rules shall have the usual and customary meaning ascribed to them, unless otherwise defined or the context thereof shall clearly indicate the contrary.

As used in this Chapter, the term:

(1) "Adverse incident" means an incident of medical negligence, intentional misconduct, and any other act, neglect, or default of the Health Care Provider that caused or could have caused injury to or death of a patient including, but not limited to, those incidents that are required by state or federal law to be reported to any governmental agency or body, and occurrences that are reported to or reviewed by any health care facility peer review, risk management, quality assurance, credentials, or other similar committee.

(2) ~~(3)~~ "Commissioner" shall mean the Commissioner of the Department of Community Health.

(3) "Contract shall mean an agreement between the Department and a Health Care Provider wherein the Health Care Provider offers uncompensated Health Care to Patients. Payments made to a Health Care Provider from the Indigent Care Trust Fund created by O.C.G.A. § 31-8-192(1) shall not be considered compensation."

(4) ~~(2)~~ "Covered Services" shall mean those services that a Health Care Provider is able to perform competently and at the prevailing standard of care. It shall also mean and include all those services which he or she is allowed to perform under his or her professional license.

(5) ~~(4)~~ "DCH" or "Department" shall mean the Georgia Department of Community Health or its designees.

(6) ~~(5)~~ "DHR" shall ~~mean~~ the Georgia Department of Human Resources.

(7) ~~(6)~~ "Director" shall mean the individual designated by the Commissioner of the Department of Community Health who has supervisory oversight for Regional Volunteer Coordinators, as well as oversight for all aspects of the Program.

(8) ~~(7)~~ "DOAS" shall mean the Georgia Department of Administrative Services.

(9) ~~(8)~~ "Eligibility Records" shall mean any and all documents utilized to make a determination as to whether a person is eligible to participate in the Georgia Volunteer Health Care Program.

(10)~~(9)~~ "Emergency Care" shall mean health care that is provided for a condition of recent onset and sufficient severity including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate health care could result in:

(a) Placing the patient's health in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

(11) ~~(10)~~ "Experimental/clinically unproven procedures" shall mean the use of a service, supply, drug, or device not recognized as standard health care for the condition, disease, illness, or injury treated.

(12) ~~(11)~~ "Family" shall mean one or more persons living in one dwelling place who are related by parentage, marriage, law, or conception. For example, a pregnant woman and her unborn child or children are considered to be two (2) or more family members.

If the dwelling place includes more than one (1) family or more than one (1) unrelated individual, the poverty guidelines are applied separately to each family or unrelated individual and not to the dwelling place as a whole. A single adult, over 18, living with relatives is considered to be a separate family for income determination purposes. A full-time student, age 18-21, living at the dwelling place, shall be considered a family member. For purposes of this definition, a full-time student shall be registered for the minimum number of hours required to meet the accredited institution's full-time status.

(13) "Goods and Services shall include, but not be limited to, medical/dental supplies and equipment, in-kind and monetary contributions, or the actual hours a Volunteer dedicates to the Program."

(14) ~~(12)~~ "Gross Family Income" shall mean the sum of income available to a family at the time of application. Gross Family Income shall be based on all income or compensation earned or received in the last four (4) consecutive weeks. Income shall not include: Supplemental Security Income (SSI), income from trusts fully funded by SSI payments, Temporary Assistance to Needy Families (TANF), or any other governmental assistance. Generally, Gross Family Income shall include, but not be limited to, the following:

(a) Wages and salary;

(b) Child support;

(c) Alimony;

(d) Unemployment compensation;

(e) Worker's compensation;

(f) Retirement Income;

(g) Veteran's pension;

(h) Social Security;

(i) Pensions and annuities;

(j) Dividends and interest on savings, stocks, and bonds;

(k) Income from estates and trusts;

(l) Net rental income or royalties;

(m) Net income from self employment; and

(n) Other forms of compensation or financial contributions.

(15) ~~(13)~~ **"**Health Care" shall mean care, services, or supplies related to the health of an individual. Health Care includes, but is not limited to, the following: (i) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and (ii) the sale or dispensing of a drug, device, equipment, or other items in accordance with a prescription. "Health Care" shall include "Medical Care," "Dental Care," and/or "Emergency Care."

(16) ~~(14)~~ "Health Care Provider" shall mean:

(a) An ambulatory surgical center licensed under Article 1 of Chapter 7 of Title 31 of the Official Code of Georgia Annotated;

(b) A hospital or nursing home licensed under Article 1 of Chapter 7 of Title 31 of the Official Code of Georgia Annotated;

(c) A physician or physician assistant licensed under Article 2 of Chapter 34 of Title 43 of the Official Code of Georgia Annotated;

(d) An osteopathic physician or osteopathic physician assistant licensed under Article 2 of Chapter 34 of Title 43 of the Official Code of Georgia Annotated;

(e) A chiropractic physician licensed under Chapter 9 of Title 43 of the Official Code of Georgia Annotated;

(f) A podiatric physician licensed under Chapter 35 of Title 43 of the Official Code of Georgia Annotated;

(g) A physical therapist licensed under Chapter 33 of Title 43 of the Official Code of Georgia Annotated;

(h) A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under Chapter 26 of Title 43 of the Official Code of Georgia Annotated or any facility which employs nurses licensed or registered under Chapter 26 of Title 43 of the Official Code of Georgia Annotated to supply all or part of the care delivered under this article;

(i) A midwife certified under Chapter 26 of the Official Code of Georgia Annotated;

(j) A dentist or dental hygienist licensed under Chapter 11 of Title 43 of the Official Code of Georgia Annotated;

(k) A health maintenance organization certificated under Chapter 21 of Title 33 of the Official Code of Georgia Annotated;

(l) A professional association, professional corporation, limited liability company, limited liability partnership, or other entity which provides or has members which provide health care services;

(m) Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers non-surgical human medical treatment and which includes an office maintained by a provider;

(n) Any other health care professional, practitioner, provider, or facility under contract with the Department, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs (a) through (j) of this paragraph;

(o) Any nonprofit corporation qualified as exempt from federal income taxation under Section 501(c) of the Internal Revenue Code which delivers health care services provided by licensed professionals listed in this paragraph; or

(p) Any federally funded community health center, Volunteer Corporation, or volunteer health care provider that delivers health care services.

(17) ~~(15)~~ “Medicaid eligible” shall mean an individual eligible to receive services under the Medicaid Program, whether or not actually enrolled in the Medicaid Program.

(18) ~~(16)~~ “Patient Records” shall mean any and all documents, records, and items related to and arising out of an individual’s Health Care including, but not limited to, x-rays, laboratory tests results, examinations, nurse’s notes, physician’s notes, tests requested, and general notes.

(19) ~~(17)~~ “Net Family Income” shall mean Gross Family Income minus the standard work-related, child care, and child support deductions as used in determining presumptive eligibility for Medicaid expansion as designated by the Omnibus Budget Reconciliation Act of 1986.

(20) ~~(18)~~ "Program" shall mean the Georgia Volunteer Health Care Program.

(21) ~~(19)~~ "Patient" shall mean:

(a) A person who is Medicaid eligible in Georgia;

(b) A person who is without health or dental insurance;

(c) A person who has health or dental insurance that does not cover the injury, illness, or condition for which treatment is sought and whose family income does not exceed 200 percent of the federal poverty level as defined annually by the Federal Office of Management and Budget; or

(d) Any client or beneficiary of ~~A person who is a client of DCH~~ the Department or the Department of Human Resources ~~(DHR)~~ who voluntarily chooses to participate in a Program offered or approved by the Department ~~DCH~~ or the Department of Human Resources ~~DHR~~ and meets the Program eligibility guidelines of the department or the Department of Human Resources ~~either agency~~ whose family income does not exceed 200 percent of the federal poverty level as defined annually by the federal Office of Management and Budget.

(22) ~~(20)~~ "Referral" shall mean a request from the Department or a Volunteer for a Health Care Provider to evaluate and/or treat a Patient that has been deemed eligible to participate in the Program.

(23) ~~(21)~~ "Regional Volunteer Coordinator" shall mean an individual assigned to a specific region in the state of Georgia responsible for certain administrative and supervisory duties specifically related to the operations of the Program.

(24) ~~(22)~~ "Self-declaration" shall mean a statement of income, expenses, and family size made by the individual applying for the Program. Self-declaration does not include any documentation other than the signature of the person making the statement. The self-declaration statement shall include a signed acknowledgement that the statement is true at the time it is made and that the person making the statement understands that the Department may verify the statement.

(25) ~~(23)~~ "Verification" shall mean to confirm the accuracy of information through sources other than the self-declaratory statement of the individual originally supplying the information. Verification may be by telephone, in written form, or by face-to-face contact. Verification does not require written documentation to confirm an applicant's statement. Examples of verification include, but are not limited to:

(a) A statement from a state or federal agency which attests to the applicant's financial status;

(b) A statement from the applicant's or family member's employer;

(c) Pay stubs for four (4) consecutive weeks; or

(d) A statement from a source providing unearned income to the applicant or family unit.

(26) ~~(24)~~ “Volunteer” ~~shall~~ means any person who, of his or her own free will, ~~provides goods or services~~ and in support of or in assistance to the ~~Health Care Provider~~ Program of Health Care Services provided to any governmental contractor, provides goods or clerical services, computer services, or administrative support services with ~~no~~ or without monetary or material compensation. This term shall not include a health care provider.

Authority: O.C.G.A. § 31-8-192

SYNOPSIS

This regulation reflects those definitions necessary to implement the Health Share Volunteers in Medicine Act.

SUMMARY OF PROPOSED CHANGES

In response to public comment and HB 1224 becoming law, the following changes have been proposed:

A definition for the word “Contract” has been added at 111-5-1-.01(3) to reflect the meaning of a contractual agreement between the Department and the Health Care Provider pursuant to O.C.G.A. § 31-8-192(1).

A definition for “Goods and Services” has been added at 111-5-1-.01(13) to reference more specifically, but not exclusively, what item(s) and/or action(s) shall constitute a “Good” or a “Service” for purposes of these regulations.

An addition has been made to the end of the definition of “Patient” at 111-5-1-.01(21)(d) in order to clarify that a Patient’s family income must not exceed two hundred (200) percent of the federal poverty level as defined annually by the federal Office of Management and Budget and as required by the definition of “Low-income” as codified at O.C.G.A. § 31-8-192(5).

The definition of the word “Volunteer” has been revised in order to be consistent with the statutory definition of the word “Volunteer” pursuant to O.C.G.A. § 31-8-192(8).

Some definitions in 111-5-1-.01 have either been added or revised. Any numbers that have shifted as a result of such additions or revisions have been changed.

111-5-1-.02 Administration of the Program

(1) The Commissioner shall designate a Director to maintain overall oversight of the Program, responsible for the promotion, technical support, and standardization of the Program. The Director shall supervise Regional Volunteer Coordinators, as well as any other Department staff assigned to the Program.

(2) Each Regional Volunteer Coordinator shall be assigned to a specific geographic region of the state of Georgia, as defined by the Department. The Regional Volunteer Coordinator shall be tasked with the following responsibilities:

(a) Assists with recruiting Health Care Providers, negotiates Health Care Provider Contracts, and ensures appropriate license verification of the Health Care Provider upon initial entry into the Program and on an annual basis;

(b) Reviews the status of Health Care Provider corporations upon initial entry into the Program and on an annual basis;

(c) Monitors participating Health Care Providers through an administrative quality assurance Program to ensure compliance with the Program policies and procedures, as well as with compliance with these Rules;

(d) Monitors the Department's financial eligibility and referral process to ensure only eligible individuals participate in the Program and that eligibility determination and referral process is documented appropriately;

(e) Maintains a summary on a periodic basis, as defined by the Department, of the number of Volunteers, donated hours, and value of service rendered by Volunteers;

(f) Conducts training on record retention, HIPAA, financial eligibility and patient referral procedures, and other state and federal mandates that impact the Program, and

(g) Maintains a database documenting the participation of Health Care Providers and Volunteers participating in the Program.

Authority: O.C.G.A. §§ 31-8-193, 31-8-195

SYNOPSIS

This regulation authorizes the Department to establish the Georgia Volunteer Health Care Program and to utilize staff to maintain oversight for the Program in specified geographic regions of the state of Georgia.

SUMMARY OF PROPOSED CHANGES

There are no changes as a result of public comment and/or the passage of HB 1224.

111-5-1-.03 Health Care Provider Eligibility.

(1) The Department shall be authorized to contract with Health Care Providers to offer Health Care to Patients under what shall be formally known as the "Georgia Volunteer Health Care Program."

(2) In order to participate in the Program, a Health Care Provider shall comply with the following:

(a) Have and maintain, in good standing, the applicable Georgia health professional license and any other licenses, certificates, or permits that are required to practice their profession as a condition of participation in the Program as a Health Care Provider;

(b) Enter into a Ccontract with the Department to provide Health Care to Patients as delineated in Ga. Admin. Comp. Ch. 111-5-1-.08;

(c) Not be subject to probation or suspension or other limitation of the Health Care Provider's scope of practice by the applicable licensing board or intermediate sanctions by the Centers for Medicare and Medicaid Services or have Medicare or Medicaid violations;

(d) Submit to a credentialing process, as specified by the Department, to determine acceptability of participation;

(e) Provide services to Patients on both a walk-in and referral basis; and

(f) Participate in a quality assurance program as specified by the Department.

Authority: O.C.G.A. §§ 31-8-193, 50-21-22

SYNOPSIS

This regulation specifies that the Department may contract with certain health care providers to offer health care to certain low-income persons eligible to participate in the Program and sets forth the various requirements health care providers must comply with in order to provide such health care.

SUMMARY OF PROPOSED CHANGES

As a result of public comment, a cross reference has been added to the end of 111-5-1-.03(2)(b) in order to reference the contractual requirements for Health Care Providers participating in the Program as outlined in 111-5-1-.08. Additionally, necessary capitalization has been incorporated.

111-5-1-.04 Volunteers

(1) Health Care Providers shall recruit Volunteers to perform certain responsibilities to assist in providing Health Care to Patients. These responsibilities include, but are not limited to:

(a) Performing financial eligibility determinations and patient referrals if deemed by the Department to be a delegated responsibility to the Health Care Provider; and

(b) Providing other clerical, computer, and administrative support as required.

With regard to performing financial eligibility determinations and patient referrals, only those Volunteers specifically authorized and deemed appropriate by the Department shall perform such duties.

(2) Prior to a Health Care Provider's recruitment of a Volunteer, the Volunteer must participate in a screening and orientation process as specified by the Department. Additionally, the Volunteer and Department must execute a written agreement with provisions that address the following:

(a) Scope of work of the Volunteers;

(b) Responsibilities regarding documentation of donated hours contributed to Program activities;

(c) Acknowledgment and agreement to adhere to HIPAA and applicable federal and state confidentiality laws; and

(d) A statement that the Volunteer is considered a state employee or officer for purposes of sovereign immunity so long as he or she has acted within the scope of services defined in the agreement.

(3) The Department is authorized to utilize Volunteers to perform certain duties as the Department deems necessary so long as the Department executes a written agreement as described in Paragraph (2) of this Rule.

Authority: O.C.G.A. §§ 31-8-192, 31-8-195, 50-21-22, 50-21-25

SYNOPSIS

This regulation authorizes the Department and Health Care Providers to utilize the Services of volunteers on an occasional and/or regular-service basis. The regulation further highlights certain requirements that must be fulfilled prior to a volunteer's participation in the Program.

SUMMARY OF PROPOSED CHANGES

There are no changes as a result of public comment and/or the passage of HB 1224.

111-5-1-.05 Patient Selection and Referral.

(1) The Department shall be responsible for determining an applicant's financial eligibility and the patient referral process for participation in the Program. The Department may, in its discretion, delegate the responsibility for determining the applicant's financial eligibility and patient referral process to a Health Care Provider. In the event that the Department makes such a designation, the Health Care Provider shall make the financial eligibility determinations and patient referrals in accordance with Ga. Admin. Comp. Ch. 111-5-1-.06 and shall only utilize Volunteers in the manner prescribed in Ga. Admin. Comp. Ch. 111-5-1-.04 for making financial eligibility determinations and patient referrals.

(2) The Department shall be responsible for the referral of Patients to Health Care Providers except in those instances in which the Department has delegated the responsibility of determining financial eligibility and making patient referrals to the Health Care Provider as described in Paragraph 1 of this Rule. Health Care Providers shall be required to accept all referrals unless the Ceontract between the Department and the Health Care Provider(s) authorizes a specific limit on the number of Patients that may be referred to a Health Care Provider.

(3) Neither the Department nor its designees may refer a Patient to a Health Care Provider unless a determination has been made that the Patient is eligible to participate in the Program.

(4) If a Patient has been referred by the Department, neither the Health Care Provider nor the facility in which the Health Care is rendered shall be permitted to charge the Patient.

Authority: O.C.G.A. § 31-8-194

SYNOPSIS

This regulation details the Department's responsibility or its designee to make eligibility determinations and referrals of care to health care providers participating in the Program. Additionally, the regulation explicitly provides that a health care provider must accept all referrals from the Department except in those instances where both the Department and the health care provider have agreed to limit the number of referrals in the Contract between the two parties.

SUMMARY OF PROPOSED CHANGES

As a result of public comment, a new subsection has been added at 111-5-1-.05(4) to clarify that neither a Health Care Provider nor a facility rendering Health Care can charge a Patient referred by the Department for Health Care. Additionally, necessary correction(s) to capitalization has been made.

111-5-1-.06 Eligibility.

(1) In order to determine if an individual is eligible for participation in the Program ~~if the individual is not currently enrolled in Medicaid,~~ the Department shall be required to obtain a self-declaration of income and expenses from the individual on a form specified by the Department. Applicants must furnish income and expenses for the four (4) week period prior to the date of the application which shall include, but not be limited to, Eligibility Records regarding the Gross Family Income for the family unit, child care expenses, and child support payments. The Department may seek Verification to confirm that the applicant qualifies for participation in the Program**.** Such eligibility determinations shall be made for each and every encounter wherein the Patient seeks Health Care.

(2) The Department shall use Net Family Income to determine eligibility.

(3) If the Department determines that the applicant has intentionally omitted or failed to provide pertinent information and/or falsified or misrepresented information that the Department relied upon to determine eligibility, the Department shall terminate the applicant from participation in the Program, and the applicant will be considered ineligible for any further participation in the Program. Any challenge to the Department's determination shall be governed by O.C.G.A. Section 50-13-13 et seq. Despite such a termination, the Health Care Provider shall still be considered immune from liability and suit as set forth in Ga. Admin. Comp. Ch. 111-5-1-.11 as long as the Health Care Provider acted within the scope of services set forth in the Contract with the Department.

(4) An applicant who engages in conduct set forth in Paragraph 3 of this Rule may be, pursuant to O.C.G.A. Section 16-10-20, subject to, upon conviction, a fine of not more than $1,000 or by imprisonment for not less than one nor more than five years, or both.

Authority: O.C.G.A. §§ 31-8-192, 16-10-20

SYNOPSIS

This regulation defines the criteria that individuals must meet in order to qualify as a patient and receive health care from a health care provider in the Program. Additionally, the regulation details the methodology by which the Department makes a determination as to whether an individual qualifies for participation in the Program. Lastly, the regulation addresses consequences that may arise out of an individual providing false information or omitting information that the Department would rely upon in making an eligibility determination.

SUMMARY OF PROPOSED CHANGES

1. As a result of public comment, a sentence has been added to the end of 111-5-1-.06(1) clarifying that an eligibility determination will be made for each and every instance in which a Patient seeks Health Care.

2. The phrase “if the individual is not currently enrolled in Medicaid” has been deleted from the first sentence in 111-5-1-.06(1) inasmuch as it is unnecessary text.

3. Necessary correction(s) to capitalization has been made.

111-5-1-.07 Covered Services.

(1) Health Care Providers are restricted from performing Experimental/Clinically Unproven Procedures in connection with the Program. Health Care Providers shall only provide Covered Services as defined in Ga. Admin. Comp. Ch. 111-5-1-.01(4).

(2) In the event that a Health Care Provider performs an Experimental/Clinically Unproven Procedure, the provider's claim to sovereign immunity shall be deemed waived and the Contract between the Health Care Provider and the Department shall terminate immediately.

(3) The Department reserves the right to approve, through written protocols, all referrals for specialty care and hospitalization, with the exception of Emergency Care.

Authority: O.C.G.A. §§ 31-8-193; 31-8-200

SYNOPSIS

This regulation establishes that health care providers participating in the Program may not utilize experimental and clinically unproven procedures while treating patients. Additionally, the regulation highlights those services that the Department is authorized to approve.

SUMMARY OF PROPOSED CHANGES

There are no changes as a result of public comment and/or the passage of HB 1224.

Necessary correction(s) to capitalization has been made.

111-5-1-.08 Contracts

A Health Care Provider must, as set forth in Ga. Admin. Comp. Ch. 111-5-1-.03(2)(b), execute a Contract with the Department prior to delivering Health Care to Patients which shall include, but not be limited to, the following provisions:

(1) Access to Records

As governed by applicable state and federal laws, the Health Care Providers shall make all Patient Records and other documents related to the Health Care provided under the Program available to the Department and state and/or federal entities that are legally entitled to request and examine them.

~~The Health Care Provider shall make all Patient Records and any other documents related to the Health Care provided under the Program available for examination and audit by the DCH, DHR, DOAS, HHS, the State Attorney General, State Health Care Fraud Control Unit, applicable Georgia licensing boards, or other authorized state or federal personnel.~~

(2) Termination

The Department is authorized to terminate the Health Care Provider from participating in the Program for the following reasons:

(a) Failure of the Health Care Provider to perform responsibilities identified in the C~~c~~ontract within a time period prescribed by DCH after receipt of written notice of default by DCH.

(b) Convenience of DCH or the Health Care Provider, upon thirty (30) calendar days notice.

(c) The performance of an Experimental/Clinically Unproven procedure.

(d) Health Care Provider's failure to be deemed acceptable under a credentialing process wherein the termination shall be immediate.

(e) Suspension, probation, conditional restriction, debarment, or revocation of any license, certificate, or permit required for the Health Care Provider to perform the full scope of services pursuant to the terms and conditions of this Agreement.

(f) A determination by the appropriate department, agency, or board that the Health Care Provider has failed to provide Health Care in accordance with applicable standards of care.

(g~~f~~) The amendment or repeal of O.C.G.A. 31-8-190 et seq. wherein the Health Care Provider is not considered a state officer or employee for purposes of Article 2 of Chapter 21 of Title 50 of the Official Code of Georgia Annotated.

If termination occurs as a result of a reason delineated in 111-5-1-.08(2)(e) and/or 111-5-1-.08(2)(f), the Department reserves the right to reinstate the Health Care Provider if the determination upon which the termination is based is reversed.

(3) Adverse Incidents

(a) Health Care Providers must report to the Department within twenty-four (24) hours of such occurrence following the Adverse Incidents:

1. Any unanticipated Patient death not related to the natural course of the Patient's illness or underlying condition;

2. A rape, as defined pursuant to O.C.G.A. § 16-6-1, that occurs on the premise at which the Health Care is provided;

3. Any surgery on the wrong Patient or on the wrong body part of the Patient;

4. Any Patient injury which is unrelated to the Patient's illness or underlying condition and results in a permanent loss of limb or function;

5. Second or third degree burns involving twenty (20) percent or more of the body surface of an adult patient or fifteen (15) percent or more of the body surface of a child which burns were acquired by the Patient while in the care of the Health Care Provider;

6. Serious injury to a Patient resulting from the malfunction or intentional or accidental misuse of patient care equipment;

7. Any assault, committed pursuant to O.C.G.A. § 16-5-21 et seq. or any other applicable law, on a Patient, which results in an injury requiring treatment;

8. Discharge of an infant to the wrong family;

9. Any circumstances involving a patient under observation who cannot be located where circumstances reasonably indicate that the health, safety, or welfare of the Patient or others are at risk and the Patient has been missing for more than eight (8) hours; and

10. To the extent that the Health Care Provider determines that the following events caused a significant disruption to a Patient's care, labor strikes, walk-outs or sick-outs, or interruption of service.

The Adverse Incidents set forth in this Paragraph are not intended to be an exhaustive list.

(b) The Department shall report adverse incidents provided in Paragraph 3(a) of this Rule to the appropriate department, agency, or board for further action. Notwithstanding, the Department may conduct its own investigation and terminate the Health Care Provider if the Department deems such action necessary and appropriate.

(4) Patient Number Modifications

The Department and a Health Care Provider may mutually agree in writing to modify the number of Patients referred to the Health Care Provider.

Authority: O.C.G.A. §§ 31-8-193, 31-8-200, 50-18-72.

SYNOPSIS

This regulation sets forth specific provisions that must be reflected in the Contract between the Department and health care providers that are participating in the Program.

SUMMARY OF PROPOSED CHANGES

As a result of public comment, the following are proposed changes:

The paragraph under 111-5-1-.08(1) has been deleted in its entirety and replaced with language that indicates that Health Care Providers shall make Patient Records and any other relevant documentation available to governmental entities having a right to those records pursuant to any applicable state or federal laws.

The last paragraph under 111-5-1-.08(2) has been added with respect to terminations.

A citation to O.C.G.A. § 16-6-1 has been inserted into 111-5-1-.08(3)(a)(2), as that Code section defines rape under Georgia law.

A reference to O.C.G.A. § 16-5-21 et seq. has been inserted in 111-5-1-.08(3)(a)(7), as that Code section outlines the general elements of assault under Georgia law.

A fourth subsection entitled “Patient Number Modifications” has been added to the end of the section at 111-5-1-.08(4) stating that the number of Patients Health Care Providers agree to treat can be modified by Contract amendment.

Necessary correction(s) to capitalization has been made.

111-5-1-.09 Notice Requirements

(1) Each Health Care Provider, prior to providing Health Care, must provide written notice to each Patient, or to the Patient's legal representative, receipt of which must be acknowledged in writing on a form prescribed by the Department, that the Health Care Provider is an agent of the Department and that the exclusive remedy for injury or damage suffered as a result of any act or omission of the Health Care Provider is by commencement of an action pursuant to the provisions of Article 2 of Chapter 21 of Title 50 of the Official Code of Georgia Annotated.

(2) In the event that a Patient requires Emergency Care, the form referenced in Paragraph 1 of this Rule must either be signed by the Patient's legal representative, or if such person is unavailable, the Patient must receive and execute the acknowledgment within forty-eight (48) hours after the Patient has the mental capacity to consent to the Emergency Care. If the Patient or Patient's legal representative refuses to consent to the Emergency Care after such care has been provided, the Department may terminate the Patient's right to further participate in the Program.

Authority: O.C.G.A. §§ 31-8-194, 50-21-22; 50-21-25

SYNOPSIS

This regulation specifies that prior to receiving health care under the Program, a patient must acknowledge, in writing, that: (1) the health care provider offering the health care is considered to be a state officer or employer as long as the health care provider acted within the scope of services set forth in the Contract between the Department and the Health Care Provider, and that (2) the patient's sole legal remedy is set forth in Article 2 of Chapter 21 of Title 50 of the Official Code of Georgia Annotated. Additionally, the regulation addresses those legal remedies available to a patient if the health care provider acted outside of the scope of services set forth in the Contract between the Department and the health care provider.

SUMMARY OF PROPOSED CHANGES

There are no changes as a result of public comment and/or the passage of HB 1224.

111-5-1-.10 Patient Records

(1) Each Health Care Provider shall maintain a current and complete Patient Record of each Patient that receives Health Care.

(2) The Health Care Provider shall maintain a record retention system that enables the proper documentation, completion, and preservation of the Patient Records of Patients who receive Health Care under the Program.

(3) Health Care Providers shall retain Patient Records for a period of at least ten (10) years following the date of death or discharge. For pediatric patients, the records shall be retained for five (5) years after the Patient reaches the age of majority.

(4) Patient Records shall be available for inspection only by the Health Care Provider, his or her professional staff, the Patient, representatives of the Department acting in an official capacity, DHR, DOAS, Health and Human Services, the State Attorney General, State Health Care Fraud Control Unit, applicable licensing boards, or other persons authorized in writing by the Patient to have access to the Patient Records. Patient Records requested by the Department shall be produced in accordance with Ga. Admin. Comp. Ch. 111-5-1-.08(1) immediately for on-site review or sent to the Department by mail within fourteen (14) calendar days following a request.

(5) The Health Care Provider shall release copies of all or part of a Patient Record to the Patient or to others with the written consent of the Patient or the Patient's legal guardian and to parties when required by applicable state and/or federal law. The Health Care Provider may charge a reasonable fee for the copies produced as allowable under O.C.G.A. Section 31-33-2.

(6) The Patient Record for each Patient shall contain at a minimum:

(a) Patient identifying information (name, address, age, sex, marital status, emergency contact);

(b) Department financial eligibility and patient referral forms;

(c) Name of Health Care Provider(s);

(d) Patient allergies;

(e) Diagnosis of the Patient's condition;

(f) Reports from diagnostic testing;

(g) Physician orders;

~~(h) Long- and short-term patient care plans;~~

(h) ~~(i)~~ Documentation that the Patient has consented to the Health Care, as well as the signed acknowledgment required by Ga. Admin. Comp. Ch. 111-5-1-.09; and

(i) ~~(j)~~ Information justifying the treatment or procedure provided and a report of outcomes of treatment or procedures.

(7) All entries in the Patient Records shall be permanent, accurate, dated with the actual date of entry, and signed by the individual making the entry.

(8) Patient Records shall be completed within thirty (30) days after Health Care has been provided to the Patient.

(9) Health Care Providers must comply with the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 with respect to the handling of Patient Records, as well as with any other applicable federal and/or state laws and rules and regulations.

Authority: O.C.G.A. § 31-33-1., Health Insurance Portability and Accountability Act of 1996

SYNOPSIS

This regulation provides general guidance on the manner in which health care providers must maintain and disclose Patient Records of patients that have received health care under the Program. Additionally, this regulation explicitly details what information must be contained in each medical record.

SUMMARY OF PROPOSED CHANGES

As a result of public comment, a cross reference to 111-5-1-.08(1) has been inserted into 111-5-1-.10(4) inasmuch as the cross-referenced provision provides the guidance for access to Patient Records.

The text at 111-5-1-.10(6)(h) has been deleted inasmuch as the nature of the Health Care provided does not necessitate long and short term Patient care plans.

Any grammatical error(s) or necessary change(s) in capitalization have been made.

Any lettering changes as a result of additions or deletions have been made.

111-5-1-.11 Sovereign Immunity

(1) To the extent that a Health Care Provider has provided Health Care within the scope of services identified in the Contract between the Health Care Provider and the Department allowing the Health Care Provider to participate in the Program, the Health Care Provider shall be considered a state officer or employee, and therefore immune from liability and suit pursuant to O.C.G.A. Section 50-21-25.

(2) To the extent that a Volunteer has assisted a Health Care Provider, acting within the scope of services identified in the Contract between the Volunteer and the Department allowing the Volunteer to participate in the Program, the Volunteer shall be considered a state officer or employee and therefore shall be immune from liability and suit pursuant to O.C.G.A. Section 50-21-25.

(3) Notwithstanding the provisions of this Rule, Health Care Providers and Volunteers shall not be subject to any provisions of Georgia law with respect to state employment, collective bargaining, hours of work, rates of compensation, unemployment compensation, leave time, or employee benefits.

Authority: O.C.G.A. §§ 31-8-196, 50-21-22, 50-21-25

SYNOPSIS

For purposes of this regulation, health care providers and volunteers who provide Services under the Program shall be considered “state officers or employees.” Accordingly, health care providers and volunteers shall be granted immunity from suit and liability for all conduct that falls within the scope of services defined in the Contract between the Department of Community Health or its designee and a health care provider or volunteer.

Although health care providers and volunteers shall be considered “state officers or employees,” they shall not be afforded other state benefits and privileges.

SUMMARY OF PROPOSED CHANGES

There are no changes as a result of public comment and/or the passage of HB 1224.

Necessary correction(s) to capitalization has been made.

111-5-1-.12 Legal Actions

(1) In the event that a Patient suffers an injury as a result of the Health Care he or she has received from a Health Care Provider and desires to seek a legal remedy, he or she must comply with the provisions of O.C.G.A. Section 50-21-26.

(2) If at any time it is determined that a Health Care Provider caused an injury to a Patient by or through an act or omission that is outside of the scope of services defined in the Contract between the Department and the Health Care Provider, the Patient must seek his or her remedies under general tort law or any other applicable law.

Authority: O.C.G.A. §§ 31-8-194; 50-21-26

SYNOPSIS

This regulation outlines the process by which a patient who has received health care under the Program may pursue legal actions for injuries that may have arisen out of the health care offered by a health care provider. Additionally, the regulation provides guidance to patients regarding those injuries that arise out of a health care provider acting beyond the scope of services outlined in the health care provider's Contract with the Department.

SUMMARY OF PROPOSED CHANGES

There are no changes as a result of public comment and/or the passage of HB 1224.

Necessary correction(s) to capitalization has been made.

111-5-1-.13 Complaints.

(1) All complaints regarding a Health Care Provider and/or a Volunteer which do not contemplate formal legal action as described in Ga. Comp. Admin. Ch. 111-5-1-.12 must be submitted to the Department by certified mail or personal delivery. Complaints may involve, but are not restricted to, the following issues:

(a) Privacy and confidentiality violations; and

(b) Discrimination on the basis of race, color, age, sex, sexual orientation, marital status, religion, physical or mental disability, national origin, pregnancy, or any other protected bases with regard to the provision of Health Care.

(2) The complainant shall sign a sworn statement indicating the nature of the complaint, the date on which the event giving rise to the complaint occurred, the identity of the complainant, and witnesses, if any.

(3) Within thirty (30) days' receipt of the complaint, the Department shall conduct an informal investigation utilizing the facts submitted by the complainant, as well as any other independent, verifiable information available, and shall submit a written response to the complainant on its findings and recommendations.

Authority: O.C.G.A. § 31-8-200

SYNOPSIS

This regulation creates a mechanism by which Patients may submit complaints to the Department regarding matters that are not the basis for legal actions set forth under Ga. Admin. Comp. Ch. 111-5-1-.12.

SUMMARY OF PROPOSED CHANGES

There are no changes as a result of public comment and/or the passage of HB 1224.

111-5-1-.14 Department Reports.

(1) The Department shall submit, by January 1 of each year, an annual report with a reporting period of July 1 through June 30 of the preceding year, to the President of the Senate, the Speaker of the House of Representatives, the minority leaders of each house, and chairpersons of the House Health and Human Services Committee, and the Senate Health and Human Services Committee providing the following:

(a) The number of participating Health Care Providers in the Program;

(b) The number of referrals to each Health Care Provider;

(c) The number of Patient encounters;

(d) The value of the Health Care and Emergency Care rendered;

(e) The value of any grants and/or donation of Gg~~g~~oods and S~~s~~ervices received by the Health Care Provider, and utilized in providing Health Care to Patients;

(f) A report of all claims including the number and total of all claims pending and paid as reported to the Department by the DOAS;

(g) The costs associated with the defense of claims brought against providers as reported to the Department by the DOAS;

(2) The Department shall, on an annual basis, report to the DOAS the number and type of Health Care Providers that participated in the Program.

Authority: O.C.G.A. §§ 31-8-197, 31-8-198, 31-8-199

SYNOPSIS

This regulation mandates that the Department submit a report on the efficacy of access and treatment outcomes resulting from the health care provided to low-income persons under the Program to the President of the Senate, the Speaker of the House of Representatives, the minority leaders of each house, and the chairpersons of the House and Senate Health and Human Services Committees. Additionally, the regulation requires that the Department, on an annual basis, submit information on the number and type of health care providers that participate in the Program to the Department of Administrative Services.

SUMMARY OF PROPOSED CHANGES

There are no changes as a result of public comment and/or the passage of HB 1224.

Necessary correction(s) to capitalization has been made.