House Bill 695

By: Representatives Carson of the 46th, Bennett of the 94th, and Epps of the 144th

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to public assistance, so as to provide for reimbursement for Medicaid providers; to provide for notice of policy changes in the Medicaid program; to provide for repayment of certain funds; to establish the Council on Care Management Organization and Medicaid Oversight; to provide for its composition and duties; to revise provisions relating to therapy services under Medicaid for children with disabilities; to provide for requirements relating to the Children's Intervention Services Program; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to public assistance, is amended in Article 7, relating to medical assistance generally, by adding new Code sections to read as follows:

"49-4-158.

Providers of medical assistance who deliver approved medical assistance services under contracts with a care management organization shall be reimbursed at a rate not less than that received by providers of medical assistance to recipients enrolled in the fee-for-service aged, blind, and disabled Medicaid program.

49-4-159.

Whenever the department makes a change in any policy that is not subject to Chapter 13 of Title 50, the 'Georgia Administrative Procedure Act,' whether substantive or procedural, that affects the level or availability of reimbursement to a provider of medical assistance, such policy shall become effective only after the department has posted at least 30 days' notice of the change in a manner typically used by the department to inform providers of medical assistance under the Medicaid program. This Code section shall apply to the

department's provider notices, provider manuals, and fee schedules published by the department or its successor and any other such similar notices or policies.

49-4-159.1.

(a) Whenever the department has wrongfully withheld or retroactively recouped funds due to a provider of medical assistance, such funds shall be repaid to such provider by the department within three months of the determination that such funds are due to be repaid.

(b) In legal actions regarding reimbursement for medical assistance in which a provider of medical assistance has prevailed, the department may be held liable for attorney's fees.

49-4-159.2.

(a) There is established the Council on Care Management Organization and Medicaid Oversight which shall advise the commissioner on the planning and implementation of medical assistance services provided through care management organizations and their subcontractors or other contractors or vendors of the department which are not care management organizations on such matters as:

(1) Assuring access to services;

(2) Creation and implementation of an intermediary or ombudsman to the department for recipients and providers of medical assistance;

(3) Enforcement of provisions of contracts between the department and a care management organization;

(4) Maintenance of a sufficient network of providers of medical assistance;

(5) Credentialing of providers of medical assistance; and

(6) Ensuring payment to providers of medical assistance for the delivery of approved medical assistance services.

(b) The council shall be composed of eight members as follows: the chairpersons of the House Committee on Health and Human Services and the Senate Health and Human Services Committee; one additional member of the House Committee on Health and Human Services and the Senate Health and Human Services Committee, who is a member of the minority party caucus, to be appointed by the Speaker of the House of Representatives and the Lieutenant Governor, respectively; two providers of medical assistance under the low income Medicaid program, one of each to be appointed by the Speaker of the House of Representatives and the Lieutenant Governor, and one of whom shall be a credentialed provider in the Children's Intervention Services program; and two consumers, one of each to be appointed by the Speaker of the House of Representatives

and the Lieutenant Governor, one of whom shall be a recipient or the parent of a recipient receiving services under the low income Medicaid program.

(c) The chairpersons of the House Committee on Health and Human Services and the Senate Health and Human Services Committee shall serve as cochairpersons of the council.

(d) The council shall meet as often as necessary, but no less than three times annually if the department is entering into contracts with one or more new care management organizations, if an existing care management organization enters into a contract with a new subcontractor, or if the department initiates a major change in the Medicaid program; otherwise, it shall meet no less than twice annually.

(e) The council shall annually report on its activities and progress to the General Assembly on or before December 1 of each year."

SECTION 2.

Said chapter is further amended by revising Code Section 49-4-169.1, relating to definitions relative to therapy services for children with disabilities, as follows:

"49-4-169.1.

As used in this article, the term:

(1) 'CIS Program' means the Children's Intervention Services program within the EPSDT Program.

~~(1)~~(2) 'Correct or ameliorate' means to improve or maintain a child's health in the best condition possible, compensate for a health problem, prevent it from worsening, prevent the development of additional health problems, or improve or maintain a child's overall health, even if treatment or services will not cure the recipient's overall health.

~~(2)~~(3) 'Department' means the Department of Community Health.

(4) 'Discipline' means occupational therapy, speech therapy, or physical therapy.

~~(3)~~(5) 'EPSDT Program' means the federal Medicaid Early Periodic Screening, Diagnostic, and Treatment Program contained at 42 U.S.C.A. Sections 1396a and 1396d.

~~(4)~~(6) 'Medically necessary services' means services or treatments that are prescribed by a physician or other licensed practitioner, and which, pursuant to the EPSDT Program or the CIS Program, diagnose or correct or ameliorate defects, physical and mental illnesses, and health conditions, whether or not such services are in the state plan.

(7) 'Plan of care' means the written service plan signed and dated by the physician ordering the therapy services as well as the plan of care developed by the provider of therapy services for approval of therapy services under the CIS program.

~~(5)~~(8) 'Therapy services' means occupational therapy, speech therapy, physical therapy, or other services provided pursuant to the EPSDT Program or the CIS Program to an

eligible Medicaid beneficiary 21 years of age or younger and which are recommended as medically necessary by a physician."

SECTION 3.

Said chapter is further amended in Code Section 49-4-169.2, relating to services and treatment for categorically needy and medically fragile children, as follows:

"49-4-169.2.

(a) All persons who are 21 years of age or younger who are eligible for services under the EPSDT Program or the CIS Program shall receive therapy services in accordance with the provisions of this article~~, whether they are categorically needy children enrolled in the low income Medicaid program or medically fragile children enrolled in the aged, blind, and disabled Medicaid program~~.

(b) The department and the care management organizations with which it contracts shall at all times enroll and maintain in their provider network a sufficient number of pediatric providers of therapy services of each discipline who are actively filing claims for therapy services to meet the needs of recipients in the EPSDT Program and CIS Program in all areas of this state.

(c) Approval of enrollment of providers by the care management organizations shall be effective as of the date of the application for enrollment."

SECTION 4.

Said chapter is further amended in Code Section 49-4-169.3, relating to requirements relating to administrative prior approval for services and appeals, as follows:

"49-4-169.3.

(a) The department shall develop and implement for itself, the care management organizations with which it ~~enters into~~ contracts, and its utilization review vendors consistent requirements, paperwork, and procedures for utilization review and prior approval of physical, occupational, or speech language pathologist services prescribed for children. Approval of therapy services shall be based on the individual needs of the child for whom approval is sought by a provider, without limitation as to any diagnosis of such child and shall also meet the following conditions:

(1) If prescribed as medically necessary and consistent with a plan of care, prior ~~Prior~~ approval for therapy services for chronic conditions shall be for a period of ~~up to~~ six months with a frequency and session duration that is ~~as~~ consistent with the needs of the individual recipient; and

(2) If prescribed as medically necessary and consistent with a plan of care, approval for a requested type of therapy service shall not be denied on the sole basis that the requested

service is experimental or ineffective if the requesting therapy service provider provides sufficient documentation that the requested service is medically necessary and submits credible evidence that such therapy service has been shown to be an accepted and effective treatment for other patients with similar conditions to those exhibited by the recipient for whom the request for services is made. The fact that a therapy service is reimbursed by at least one payor under the low income Medicaid program; the aged, blind, and disabled Medicaid program; the EPSDT Program; or the CIS Program or its equivalent in other states shall be a factor in considering whether such therapy is considered accepted, experimental, or ineffective; provided, however, that this paragraph shall not require the department or the care management organizations with which it contracts to reimburse the provider at a rate in excess of the prevailing rate for the specific therapy service or processing code for which therapy service is being requested.

(b) A decision by the department, a care management organization, or utilization review vendor to grant prior approval for therapy services shall be binding on another care management organization, a utilization review vendor, or the department for the frequency and duration of the approval, so long as the request is by a provider of the same discipline; provided, further, that a provider of the same discipline, regardless of whether he or she submitted the request for the approved therapy services, may deliver such services to the recipient according to the terms and conditions of the prior approval and plan of care.

~~(b)~~(c) The department, its utilization review vendors, or the care management organizations with which it contracts shall give notice to affected Medicaid recipients with a copy to the provider who submitted the prior approval request of the following information in cases where prior approval is denied:

(1) The medical procedure or service for which such entity is refusing to grant prior approval or is reducing the frequency, scale, or duration of the medical procedure or service being requested;

(2) Any additional information needed from the recipient's medical provider which could change the decision of such entity; and

(3) The specific reason used by the entity to determine that the procedure is not medically necessary to treat or will not correct or ameliorate the condition of ~~to~~ the Medicaid recipient, including facts pertinent to the individual case.

~~(c)~~(d) Notwithstanding any other provision of law, the department, its utilization review vendors, or its care management organizations shall grant prior approval for requests for therapy services when the recipient is eligible for Medicaid services and the services prescribed are medically necessary.

~~(d)~~(e)(1) In cases where prior approval is required under this article, ~~it shall be decided with reasonable promptness, not to exceed 15 business days, and~~ the department, its

utilization review vendors, or its care management organizations and their vendors or subcontractors shall decide requests for therapy services with reasonable promptness, not to exceed five business days beginning on the date that the request for prior approval is received by the department, its utilization review vendors, or its care management organizations or their vendors or subcontractors and prior approval may not be denied until it has been evaluated under guidelines established by the EPSDT Program or the CIS Program. If the department, its utilization review vendors, or its care management organization or their vendors or subcontractors deny a request for prior approval, such denial shall be transmitted electronically to the provider who requested it.

(2) In cases when prior approval for therapy services is revoked or is reduced in frequency or duration, the therapy service provider shall have the right to challenge the decision in writing, which may be transmitted electronically to the entity making the decision, and such entity shall make a decision on the challenge within three business days of the electronic transmission of the request for challenge. If no decision is transmitted to the therapy services provider in such three-day period, such provider may institute an appeal of the decision.

~~(e)~~(f)(1) Prescriptions and prior approval for services shall be ~~for general areas of treatment, treatment goals, or ranges of specific treatments or processing codes~~ by discipline. When establishing treatment coverage guidelines, the department shall promulgate rules, regulations, and policies taking into consideration and utilizing when appropriate the guidelines established by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

(2) Clinical coverage criteria or guidelines, including restrictions such as location of service and prohibitions on multiple services on the same day or at the same time, shall not be the sole determinant used by the department, its utilization vendors, or its care management organizations to limit either approval of therapy services under the EPSDT Program or CIS Program, the EPSDT standards, or ~~its~~ the definition of medically necessary ~~definition~~ in this article. Any such restrictions shall be waived under the EPSDT Program or CIS Program or this article if the prescribed services are medically necessary as defined in this article.

~~(f)~~(g) Nothing in this article shall be construed to prohibit the department, its utilization review vendors, or its care management organizations from performing utilization reviews of the diagnosis or treatment of a child receiving therapy services pursuant to the EPSDT Program or the CIS Program, the amount, duration, or scope or the actual performance or delivery of such services by providers, so long as such utilization review is consistent with the provisions of this article and does not unreasonably deny or unreasonably delay the provision of medically necessary services to the recipient.

~~(g)~~(h) Nothing in this article shall be deemed to prohibit or restrict the department, its utilization review vendors, or its care management organizations from denying claims or prosecuting or pursuing beneficiaries or providers who submit false or fraudulent prescriptions, forms required to implement this article, or claims for services or whose eligibility as a beneficiary or a participating provider has been based on intentionally false information.″

SECTION 5.

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