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State/Territory Name: Georgia

State Plan Amendment (SPA) #: GA-24-0037

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

February 28, 2024

Stefanie Ashlaw
Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Stefanie Ashlaw:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) GA-24-0037, submitted on February 2, 2024, has been approved. This SPA has an effective date of July 1, 2023.

Through this SPA, Georgia updates its process for health services matters reviews to be consistent with the state's managed care appeals process and for the state's CHIP review process to demonstrate compliance with requirements at 42 CFR §§ 457.1120 – 457.1180.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (443) 934-2064. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan Effective Date: September 1, 1998

Implementation Date: November 1, 1998

SPA number: GA-24-0037

Purpose of SPA: Update Section 12.2, Health Services Matters, to align with Section **3.9** Grievances and Appeals of the State Plan and to demonstrate compliance with 42 CFR 457.1120.

Proposed effective date: 07/01/2023

Proposed implementation date: 07/01/2023

1.4-TC Tribal Consultation. (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The State of Georgia has no recognized Tribes and therefore no Tribal Consultation is necessary.

Section 9.10- Estimated impact on Budget:

There is no impact on the States Budget as a result of this State Plan Amendment.

12.2 Health Services Matters- Describe the review process for health services matters that complies with 42 CFR 457.1120.

~~Upon receiving an adverse benefit determination as described in 42 CFR 457.1130(b), a parent or Authorized Representative (A/R) may notify the Care Management Organization (CMO) if the parent believes that the service should be covered. The notice requirements of 457of adverse benefit determination will meet the.1140, and 457.1150.~~

The State assures that each Care Management Organization (CMO) has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. Upon receiving an adverse benefit determination, a parent, or Authorized Representative (A/R) may notify the CMO if the parent believes that the service should be covered. The notice of adverse benefit determination will meet the requirements of 457.1260(c).

~~The parent or A/R has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the CMO. An appeal request may be submitted by phone, in writing, by fax or email. An oral appeal may be submitted, but must be followed by a written, signed appeal.~~

The parent or A/R may file a grievance with their CMO at any time. The parent or A/R has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the CMO. An appeal request may be submitted either orally or in writing. The CMO will send written notification of receipt of an Appeal request within ten (10) business days. The CMO will research all aspects of the case including reviewing medical policy, the claims system and any documentation submitted by the physician. The CMO will assure that all reviews are conducted by a health care professional who was not involved in any prior review of the decision, and who has appropriate clinical expertise, as determined by DCH, in treating the member's condition, as provided in 457.1150. The parent and or their A/R have the right to provide documentation or explanation of the member's medical need for consideration during the Appeal.

A parent or A/R may request an expedited appeal of an adverse benefit determination for certain health care services and treatment. Expedited Appeals may be filed by phone, ~~in writing, by fax or email.~~ or in writing. ~~-~~Appeals will be expedited when the provider indicates, or the CMO determines that following the standard timeframe could seriously harm the participants life, health or ability attain, maintain, or regain maximum function.

The CMO will notify the member of the Appeal decision within thirty (30) days from the day the Appeal is received, and 72 hours when there is an expedited Appeal. If an Appeal request for benefits is approved, the CMO will provide the member, their doctor, or the ordering health partner with the appropriate notice. If the CMO upholds the adverse benefit determination, the member will be notified in a final adverse determination notice. This notice will be in writing and will include all information regarding the member's right to request ~~a fair hearing, and instructions on how to file a fair hearing~~

~~request.~~ an Independent Medical Review and instructions on how to request the review in accordance with 42 CFR 457.1260(e)(1) and (4).

~~Georgia State Fair Hearing~~

~~The parent or A/R may request a State Fair Hearing after receiving notice under 457.1130(b) that the adverse benefit determination is upheld. The State Fair Hearing request must be made within 120 calendar days of the date on the appeal decision. A provider may not ask for a State Fair Hearing, unless he or she is acting as your Authorized Representative and/or has written consent.~~

~~The Office of State Administrative Hearings will notify the member of the time, place, and date of the hearing. Both the member or A/R and CMO can be present at the hearing. Each will be allowed to present their case to the Administrative Law Judge. The decision of the Administrative Law Judge will be provided in writing and will be final. There will be no further recourse for the member or CMO.~~

All Children's Health Insurance Program (CHIP) Independent Medical Review requests must be made through the Department of Community Health, Medical Assistance Plans. The State will send written notification of receipt of an Independent Medical Review request within ten (10) business days. The review is independent of both the State and CMO and is offered without any cost to the enrollee. The Department of Community Health will request all documentation from the CMO/Provider that was utilized to make their determination. The parent and or their A/R have the right to provide documentation or explanation of the member's medical need for consideration during the Review with the Independent Medical Review Committee. The Independent Medical Review Committee will provide their determination within 90 days from the time a review is requested for a standard review in accordance with (42 CFR 457.1160(b)(1)), and 72 hours from the time a review is requested for an expedited review in accordance with (42 CFR 457.1160(b)(2)). The Committee has the right to request any additional information if needed to provide an appropriate determination. The State may extend the 72-hour time frame by up to 14 days if the enrollee requests an extension.

If the Independent Medical Review Committee upholds the adverse benefit determination, the member will be notified in an adverse benefit determination notice. If an Independent Medical Review request for benefits is overturned by the Independent Medical Review Committee, the Department of Community Health will provide the member, their provider, and the CMO with the appropriate notice. This notice will be in writing.

This review is the final recourse regarding the denial.

In reference to the Review process for Health Service Matters, the state also assures:

- The parent or A/R can request an extension of the time frame to resolve a standard or expedited Appeal up to fourteen (14) calendar days. The CMO may also request up to fourteen (14) additional days to resolve a standard or expedited Appeal, however the CMO must provide the Department of Community Health (DCH) evidence that the delay is necessary, if requested by DCH. The CMO must notify the member, in writing, immediately when they request an extension and include the reason for the extension, and the date that a decision must be made.

- ~~According to 431.223(a),~~ The state will allow individuals who have requested ~~a fair hearing~~ an Independent Medical Review the ability to withdraw their request via any of the modalities available for requesting ~~a fair hearing~~ an Independent Medical Review. Telephonic withdrawals ~~will be recorded and must include the appellant's statement and telephonic signature.~~ Telephonic withdrawals of an Independent Medical Review may be submitted, but must be followed by a written, signed withdrawal. The state will ensure that written confirmation of the request to withdraw the ~~appeal~~ Independent Medical Review is sent within 5 days of the date of receipt of withdrawal request.

- The state will ensure that CMO's will meet the requirements of handling grievances per 42 CFR 438.406, which requires that members be given reasonable assistance in completing forms and taking other procedural steps related to an appeal.

- Consistent with 42 CFR 457.1130(c), The State is not required to provide an opportunity for ~~appeal~~ an Independent Medical Review of a matter if the sole basis for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.