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State/Territory Name: Georgia

State Plan Amendment (SPA) #: GA-17-0023

This file contains the following documents in the order listed:

The complete final approved title XXI state plan for Georgia consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below.

Link to state title XXI state plans and amendments: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

SEP 1 4 2017

Ms. Sheila Alexander
Program Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Ms. Alexander:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number GA-17-0023 submitted on August 15, 2017 has been approved. This SPA has a retroactive effective date of July 1, 2017.

Through this SPA, Georgia updates Section 12.2 of the CHIP state plan to describe the review process for health services matters and the State Fair Hearing process. After receiving an adverse benefit determination, a parent or Authorized Representative can file a request for an appeal to the Care Management Organization (CMO). If the CMO upholds the adverse benefit determination, the parent or Authorized Representative may request a State Fair Hearing.

Your title XXI project officer is Ms. Cassie Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Lagorio's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and to Ms. Shantrina Roberts, Acting Associate Regional Administrator (ARA) in our Atlanta Regional Office. Ms. Roberts's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

We look forward to continuing to work with you and your staff.

Sincerely,

/ Anne Marie Costello /

Anne Marie Costello
Director

cc: Shantrina Roberts, Acting ARA, CMS Region IV

State Plan Amendment 21
Effective Date: July 1, 2017

Section of SPA to be amended:

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Health Services Matters

12.2 Please describe the review process for health services matters that complies with 42 CFR 457.1120.

~~Upon denial of covered benefits, a parent will notify the Care Management Organization if the parent believes that the service should be covered. The information provided by the parent in the phone call will initiate a review. The contracted CMO will research the situation, including reviewing the medical policy, the claims system and any documentation submitted by the physician, if applicable. The CMO will ensure that all reviews are conducted by a health care professional with appropriate clinical expertise, as determined by DCH, in treating the Member's Condition. If the initial review does not result in a change in the decision to deny a service, the parent will be notified of the reason the denial was upheld. If the parent would like additional reconsideration of the decision, the parent may submit a request in writing to the PeachCare for Kids, to be reviewed by DCH management staff, including the policy director of the service area and the Chief of the Division of Medicaid Services or his designee. If this decision of this review is maintain the denial of service, a letter will be sent to the parent detailing the reason for denial. If the parent elects to dispute the decision, the parent will have the option of having the decision reviewed by the Formal Appeals Committee for the State Health Benefit Plan. The decision of the Formal Appeals Committee will be the final recourse available to the member. In reference to the Formal Appeals level, the State assures:~~

- ~~Enrollees receive timely written notice of any determinations that include the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.~~
- ~~Enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, termination of health services, failure to approve, or provide payment for health services in a timely~~

~~manner. The independent review is available at the Formal Appeals level.~~

- ~~Decisions are written when reviewed by the CMO, DCH and the Formal Appeals Committee.~~
- ~~Enrollees have the opportunity to represent themselves or have representatives in the process at the Formal Appeals level.~~
- ~~Enrollees have the opportunity to timely review of their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, members will be notified of the timeframes for the appeals process once an appeal is filed with the Formal Appeals Committee.~~
- ~~Enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or in writing.~~
- ~~Reviews that are not expedited due to an enrollee's medical condition will be completed within 90 calendar days of the date a request is made consistent with 42 CFR §457.1160(b)(1).~~
- ~~Reviews that are expedited due to an enrollee's medical condition are completed within 72 hours of the receipt of the request consistent with 42 CFR §457.1160(b)(2).~~

~~Consistent with 42 CFR §457.1130(c), DCH and its Agents are not required to provide an opportunity for review of medical or eligibility matters 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 without regard to their individual circumstances.~~

Health Services Matters

12.2 Please 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 of adverse benefit determination will meet the requirements of 457.1140, and 457.1150. 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 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. 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.

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.

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 the ability to withdraw their request via any of the modalities available for requesting a fair hearing. Telephonic withdrawals will be recorded, and must include the appellant's statement and telephonic signature. The state will ensure that written confirmation of the request to withdraw the appeal 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 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 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.