Georgia

Georgia - HB 1013

Sponsor: Representative David Ralston (R)

Actions:
03/14/2022 Referred to Senate Health and Human Services Committee
03/08/2022 Passed House
03/02/2022 Hearing Held; Substituted; Passed Committee
02/23/2022 Hearing Held
02/16/2022 Hearing Held
01/26/2022 Introduced; Referred to House Health and Human Services Committee

Summary: Summary for Behavioral Health/Telehealth

This measure requires each health benefit plan to provide coverage for behavioral and mental health services in accordance with the Mental Health Parity and Addiction Act of 2008.

This measure applies to healthcare providers and insurers.

This measure establishes reporting requirements for behavioral healthcare services in the state.

This measure allows for a health care entity to receive same-day reimbursement for a patient to see more than one provider in a day.

This measure requires the same scope of coverage for mental healthcare services as other medical services for each eligible individual in the state.

This measure includes telehealth services in the scope of practice for behavioral healthcare services.

This measure creates the Behavioral Health Care Database to monitor staffing requirements in healthcare facilities. This measure establishes licensing requirements for behavioral healthcare facilities.

This measure creates an outpatient mental healthcare advisory council and establishes procedures for outpatient care.

This measure does not state an overall effective date.

This measure defines "Mental health or substance use disorder" as a mental health condition or substance use disorder included under any of the diagnostic categories listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the World Health Organization's International Classification of Diseases, in effect as of July 1, 2022, or as the Commissioner may further define such term by rule and regulation.

Summary for Medicaid Provisions

These measures require mental health coverage parity by Medicaid managed care organizations.

This measure is applicable to Medicaid managed care organizations (MCOs.)

This measure requires state healthcare entities, including MCOs to provide parity coverage for mental health conditions. It also introduces reporting requirements and a complaint database hosted by the state. Finally, it requires an 85% medical loss ratio consistent with federal regulation for care management organizations.

This measure requires the Office created within the Health Strategy and Coordination department to create a comprehensive formulary for mental health and substance use disorders services no later than December 1, 2022.

This measure provides prescription drug coverage under the Medicaid program for an adult that has been diagnosed with schizophrenia or a different delusion disorder if: (1) the patient has unsuccessfully been treated with a preferred or generic drug within the past year; or (2) the patient has previously been prescribed and approved for the nonpreferred prescribed drug.

These provisions are largely effective January 1, 2023, though some reporting aggregate provisions applied to the state kick in later.

Summary for PBMs

This measure amends the state's insurance code and provides a definition for Nonquantitative treatment limitation. (pg 5.)

This section is applicable to pharmacy benefit managers and health insurers.

This measure defines Nonquantitative treatment limitation to mean limitations that are not expressed numerically but limit the scope or duration of benefits for treatment. NQTLs include, but are not limited to the following:

1. Medical management standards limiting or excluding benefits based on whether the treatment is medically necessary or whether the treatment is experimental or investigative

2. Formulary design for prescription drugs

3. For plans with multiple network tiers, network tier design

4. Standards for provider admission to participate in a network, including reimbursement rates

5. Plan methods for determining usual, customary, and reasonable charges

6. Step Therapy protocol

7. Exclusions based on failure to complete a course of treatment

8. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan

9. Standards for providing access to out-of-network providers

10. Limitations on inpatient services for situations when the participant is a threat to himself or herself or others

11. Experimental treatment limitations

12. Network adequacy

13. Provider reimbursement rates, including rates of reimbursement for mental health or substance use services in primary care.

Bill Links 3/2/2022 Version
1/26/2022 Version

Georgia - HB 1403

Sponsor: Representative Clint Crowe (R)

Actions: 03/09/2022 Hearing Held
02/22/2022 Referred to the House Special Committee on Access to Quality Health Care
02/17/2022 Introduced

Summary: Summary for 2/17/2022 Version

This measure extends certificate of need requirements for acute care facilities.

This measure establishes that an acute care hospital established on or after July 1, 2022, in a rural county that *no longer* meets certain provisions relating to patients, revenue, participation in Medicare and Medicaid, and operating authority, shall continue to meet certificate of need requirements for as long as the hospital continues to operate.

Bill Links 2/17/2022 Version

Georgia - HB 1547

Sponsor: Representative Matt Hatchett (R)

Actions: 03/09/2022 Introduced; Referred to the House Special Committee On Access to Quality Health Care

Summary: Summary for 3/9/2022 Version

This measure creates exemptions for health care facilities from certificates of need and creates a mental wellness program for uninsured individuals.

Under the measure, a single-specialty ambulatory surgical center is replaced by a "physician-owned surgical center", which is defined as an ambulatory surgical center where surgery is performed in the offices of an individual private physician or single group practice of private physicians if such surgery is performed in a facility that is owned, operated, and utilized by such physicians.

Any facility offering ambulatory surgery must provide uncompensated indigent and charity care in an amount equal to 5% of its gross revenue, removing other requirements previously emplaced on these facilities. Noncompliance with this requirement will result in a monetary penalty in the amount of the difference between the percentage required to perform charitable works and those actually provided.

The Department of Health cannot require a holder of a certificate of need to provide uncompensated indigent or charity care that exceeds 5% of an applicant's adjusted gross revenues. Penalties of less than the required amount will result in percentage fines of the facility's adjusted gross revenues.

This measure lays out revenue amounts that can result in the revocation of a certificate of need.

New perinatal services must provide uncompensated indigent or charity care that exceeds 5% of its adjusted gross revenue. Noncompliance with this requirement will result in a monetary penalty in the amount of the difference between the percentage required to perform charitable works and those actually provided.

This measure requires that on or after January 1, 2023, Medicaid shall reimburse the cost for any eligible individual being treated at a hospital located in a rural county.

The measure allows the Department to withhold all or any portion of any state grants or funds from a hospital authority that fails to make or file its annual report, adopt or file an annual budget, prepare and file a community benefit report or a report relating to member ownership of assets or stocks, conduct and file an annual audit, register annually with the Department of Community Affairs, or one or more of these requirements. Community benefit reports as required must be prepared and published by any corporate that operates, leases, or otherwise contracts with the hospital authority for the operation, lease, or management of the hospital authority or its assets. Medicaid and Medicare costs are not considered community benefits for this report.

The measure allows hospital authority to provide reasonable reserves for improvement of its facilities provided that the cash reserves do not exceed an amount equal to 12 months' operating costs.

Hospitals and hospital authorities that possess ownership or interest in any captive insurance company outside the US are not eligible to received funds from the Department for Medicaid services and costs.

The measure establishes a state-funded program for mental health assistance for indigent persons. Eligible individuals will be uninsured individuals who are not eligible for Medicaid, Medicare, or PeachCare for Kids, and meet income requirements. The program must provide coverage for mental illnesses, developmental disabilities, and addictive diseases. Enrollees will be required to reimburse the state.

Community service boards must ensure that disability services are prioritized for uninsured consumers and Medicaid recipients over insured consumers.

The measure removes the exemption of a certificate of need for home health agencies that extend or initiate services in a new service area unless authorized and determined to be needed by the Department.

This measure does not state an effective date.

Bill Links 3/9/2022 Version

Georgia - HB 49

Sponsor: Representative Shelly Hutchinson

Actions:
03/31/2021 Legislature adjourned
01/27/2021 Introduced; Referred to Insurance Committee
12/16/2020 Prefiled

Summary: Summary for 12/16/2020 Version

This measure, cited as the "Mental Health Parity Act," amends the Official Code of Georgia Annotated to mandate behavioral health coverage parity.

This measure is applicable to health insurers in Georgia.

This measure provides that a healthcare plan that covers prescription drugs is prohibited from excluding coverage for any FDA approved forms of medication-assisted treatment for the treatment of any mental disorder or substance use disorder. The measure also states that a healthcare plan that provides both medical and surgical prescription drug benefits and mental disorder or substance use disorder drug benefits, is required to place all medications approved by the FDA for mental disorders or substance use disorders on the lowest cost tier of the drug formulary the plan maintains. A healthcare plan is prohibited from imposing step therapy or prior authorization requirements before authorizing coverage for a prescription drug approved by the FDA for the treatment of mental disorders or substance use disorders.

Additionally, this measure provides that a healthcare plan is prohibited from imposing a nonquantitative treatment limitation (NQTL) with respect to a mental disorder or substance use disorder. For any utilization review for the treatment of a mental or substance use disorder, the clinical review criteria must be the most updated published representations of the American Society of Addiction Medicine. No other criteria may be used.

An insurer is required to submit an annual report to the Department, by March 1 of each year, beginning with March 1, 2022, containing the following information:

1. The frequency in which the plan required prior authorization for all treatment and services for mental and substance use disorder benefits for the previous year;
2. A description of the process used to develop or select the medical necessity criteria for mental or substance use disorder benefits;

3. Identification of all NQTLs that are applied to both mental and substance use disorder benefits;
4. The results of an analysis that demonstrates that for the medical necessity criteria and for each NQTL identified, the processes, strategies, evidentiary standards, or other factors used to apply the criteria;
5. The rates and reasons for the denial of claims for inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs, and emergency care substance use disorder services during the previous calendar year compared to the rates of and reasons for denial of claims in those same classifications of benefits for medical and surgical services during the previous calendar year;
6. A certification signed by the plan's CEO and CMO that states the plan has completed a comprehensive review or the administrative practices for the prior year;
7. Any other information requested by the Commissioner to clarify data provided.

The Department of Insurance is required to, by June 1, 2022, and June 1 of every year after, deliver a report to the House and Senate Insurance Committees.

This measure defines 'care management organization' means an entity that is organized for the purpose of providing or arranging healthcare, which has been granted a certificate of authority by the Commissioner of Insurance as a health maintenance organization pursuant to Chapter 21 of Title 33, and which has entered into a contract with the Department of Community Health to provide or arrange healthcare services on a prepaid, capitated basis to members.

In regards to care management organizations, this measure requires a healthcare plan to submit to the Department of Community Health, by March 1, 2022, and every March 1 after, the following information:

1. The frequency in which the plan required prior authorization for all treatment and services for mental and substance use disorder benefits for the previous year;
2. A description of the process used to develop or select the medical necessity criteria for mental or substance use disorder benefits;
3. Identification of all NQTLs that are applied to both mental and substance use disorder benefits;
4. The results of an analysis that demonstrates that for the medical necessity criteria and for each NQTL identified, the processes, strategies, evidentiary standards, or other factors used to apply the criteria;
5. The rates and reasons for the denial of claims for inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs, and emergency care substance use disorder services during the previous calendar year compared to the rates of and reasons for denial of claims in those same classifications of benefits for medical and surgical services during the previous calendar year;
6. A certification signed by the plan's CEO and CMO that states the plan has completed a comprehensive review or the administrative practices for the prior year;
7. Any other information requested by the Department as needed to clarify data.

The Department is required to enforce all applicable provisions of the federal Mental Health Parity and Addiction Equity Act of 2008.

This measure does not provide an effective date.

Bill Links 12/16/2020 Version