

Senate Bill 140

By: Senators Williams of the 19th and Cagle of the 49th

A BILL TO BE ENTITLED
AN ACT

1 To amend Article 2 of Chapter 20A of Title 33 of the Official Code of Georgia Annotated,
2 relating to the patient's right to independent review, so as to revise and add definitions; to
3 change references to conform to revised and new terms; to amend Article 7 of Chapter 4 of
4 Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally,
5 so as to strike Code Section 49-4-156, which is reserved, and inserting a new Code Section
6 49-4-156 to provide that certain requirements shall not apply to health maintenance
7 organizations which contract with the department of community health; to amend Article 13
8 of Chapter 5 of Title 49 of the Official Code of Georgia Annotated, relating to PeachCare for
9 Kids, so as to provide for a definition; to provide for a reduction in the maximum income
10 limit in the discretion of the board of community health; to change certain provisions relating
11 to services, copayments, enrollment, and contracting of services; to provide for related
12 matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

13 BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

14 **SECTION 1.**

15 Article 2 of Chapter 20A of Title 33 of the Official Code of Georgia Annotated, relating to
16 the patient's right to independent review, is amended by striking such article in its entirety
17 and inserting in lieu thereof a new Article 2 to read as follows:

18 "ARTICLE 2

19 33-20A-30.

20 This article shall be known and may be cited as the 'Patient's Right to Independent Review
21 Act.'

22 33-20A-31.

23 As used in this article:

1 (1) 'Department' means the Department of Community Health established under Chapter
 2 5A of Title 31.

3 (2) 'Eligible enrollee' means a person who:

4 (A) Is an enrollee or an eligible dependent of an enrollee of a managed care plan or
 5 was an enrollee or an eligible dependent of an enrollee of such plan at the time of the
 6 request for treatment; ~~and~~

7 (B) Seeks a treatment which reasonably appears to be a covered service or benefit
 8 under the enrollee's evidence of coverage; provided, however, that this subparagraph
 9 shall not apply if the notice from a managed care plan of the outcome of the grievance
 10 procedure was that a treatment is experimental; and

11 (C) Is not a Medicaid care management member.

12 ~~(2)~~(3) 'Grievance procedure' means the grievance procedure established pursuant to Code
 13 Section 33-20A-5.

14 ~~(3)~~(4) 'Independent review organization' means any organization certified as such by the
 15 planning agency department under Code Section 33-20A-39.

16 (5) 'Medicaid care management member' means a recipient of medical assistance, as that
 17 term is defined in paragraph (7) of Code Section 49-4-141, and shall also include a child
 18 receiving health care benefits pursuant to Article 13 of Chapter 5 of Title 49.

19 ~~(4)~~(6) 'Medical and scientific evidence' means:

20 (A) Peer reviewed scientific studies published in or accepted for publication by
 21 medical journals that meet nationally recognized requirements for scientific
 22 manuscripts and that submit most of their published articles for review by experts who
 23 are not part of the editorial staff;

24 (B) Peer reviewed literature, biomedical compendia, and other medical literature that
 25 meet the criteria of the National Institutes of Health's National Library of Medicine for
 26 indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS
 27 data base or Health Services Technology Assessment Research (HSTAR);

28 (C) Medical journals recognized by the United States secretary of health and human
 29 services, under Section 1861(t)(2) of the Social Security Act;

30 (D) The following standard reference compendia: the American Hospital Formulary
 31 Service-Drug Information, the American Medical Association Drug Evaluation, the
 32 American Dental Association Accepted Dental Therapeutics, and the United States
 33 Pharmacopoeia-Drug Information; or

34 (E) Findings, studies, or research conducted by or under the auspices of federal
 35 government agencies and nationally recognized federal research institutes including the
 36 Federal Agency for Health Care Policy and Research, National Institutes of Health,
 37 National Cancer Institute, National Academy of Sciences, the Centers for Medicare and

1 Medicaid Services, and any national board recognized by the National Institutes of
2 Health for the purpose of evaluating the medical value of health services.

3 ~~(5)~~(7) 'Medical necessity,' 'medically necessary care,' or 'medically necessary and
4 appropriate' means care based upon generally accepted medical practices in light of
5 conditions at the time of treatment which is:

6 (A) Appropriate and consistent with the diagnosis and the omission of which could
7 adversely affect or fail to improve the eligible enrollee's condition;

8 (B) Compatible with the standards of acceptable medical practice in the United States;

9 (C) Provided in a safe and appropriate setting given the nature of the diagnosis and the
10 severity of the symptoms;

11 (D) Not provided solely for the convenience of the eligible enrollee or the convenience
12 of the health care provider or hospital; and

13 (E) Not primarily custodial care, unless custodial care is a covered service or benefit
14 under the eligible enrollee's evidence of coverage.

15 ~~(6) 'Planning agency' means the Health Planning Agency established under Chapter 6 of
16 Title 31 or its successor agency.~~

17 ~~(7)~~(8) 'Treatment' means a medical service, diagnosis, procedure, therapy, drug, or
18 device.

19 ~~(8)~~(9) Any term defined in Code Section 33-20A-3 shall have the meaning provided for
20 that term in Code Section 33-20A-3 except that 'enrollee' shall include the enrollee's
21 eligible dependents.

22 33-20A-32.

23 An eligible enrollee shall be entitled to appeal to an independent review organization when:

24 (1) The eligible enrollee has received notice of an adverse outcome pursuant to a
25 grievance procedure or the managed care entity has not complied with the requirements
26 of Code Section 33-20A-5 with regard to such procedure; or

27 (2) A managed care entity determines that a proposed treatment is excluded as
28 experimental under the managed care plan, and all of the following criteria are met:

29 (A) The eligible enrollee has a terminal condition that, according to the treating
30 physician, has a substantial probability of causing death within two years from the date
31 of the request for independent review or the eligible enrollee's ability to regain or
32 maintain maximum function, as determined by the treating physician, would be
33 impaired by withholding the experimental treatment;

34 (B) After exhaustion of standard treatment as provided by the evidence of coverage or
35 a finding that such treatment would be of substantially lesser or of no benefit, the
36 eligible enrollee's treating physician certifies that the eligible enrollee has a condition

1 for which standard treatment would not be medically indicated for the eligible enrollee
2 or for which there is no standard treatment available under the evidence of coverage of
3 the eligible enrollee more beneficial than the treatment proposed;

4 (C) The eligible enrollee's treating physician has recommended and certified in writing
5 treatment which is likely to be more beneficial to the eligible enrollee than any
6 available standard treatment;

7 (D) The eligible enrollee has requested a treatment as to which the eligible enrollee's
8 treating physician, who is a licensed, board certified or board eligible physician
9 qualified to practice in the area of medicine appropriate to treat the eligible enrollee's
10 condition, has certified in writing that scientifically valid studies using accepted
11 protocols, such as control group or double-blind testing, published in peer reviewed
12 literature, demonstrate that the proposed treatment is likely to be more beneficial for the
13 eligible enrollee than available standard treatment; and

14 (E) A specific treatment recommended would otherwise be included within the eligible
15 enrollee's certificate of coverage, except for the determination by the managed care
16 entity that such treatment is experimental for a particular condition.

17 33-20A-33.

18 Except where required pursuant to Code Section 51-1-49, a proposed treatment must
19 require the expenditure of a minimum of \$500.00 to qualify for independent review.

20 33-20A-34.

21 (a) The parent or guardian of a minor who is an eligible enrollee may act on behalf of the
22 minor in requesting independent review. The legal guardian or representative of an
23 incapacitated eligible enrollee shall be authorized to act on behalf of the eligible enrollee
24 in requesting independent review. Except as provided in Code Section 51-1-49,
25 independent review may not be requested by persons other than the eligible enrollee or a
26 person acting on behalf of the eligible enrollee as provided in this Code section.

27 (b) A managed care entity shall be required to pay the full cost of applying for and
28 obtaining the independent review.

29 (c) The eligible enrollee and the managed care entity shall cooperate with the independent
30 review organization to provide the information and documentation, including executing
31 necessary releases for medical records, which are necessary for the independent review
32 organization to make a determination of the claim.

1 33-20A-35.

2 (a) In the event that the outcome of the grievance procedure under Code Section 33-20A-5
3 is adverse to the eligible enrollee, the managed care entity shall include with the written
4 notice of the outcome of the grievance procedure a statement specifying that any request
5 for independent review must be made to the ~~planning agency~~ department on forms
6 developed by the ~~planning agency~~ department, and such forms shall be included with the
7 notification. Such statement shall be in simple, clear language in boldface type which is
8 larger and bolder than any other typeface which is in the notice and in at least 14 point
9 typeface.

10 (b) An eligible enrollee must submit the written request for independent review to the
11 ~~planning agency~~ department. Instructions on how to request independent review shall be
12 given to all eligible enrollees with the written notice required under this Code section
13 together with instructions in simple, clear language as to what information, documentation,
14 and procedure are required for independent review.

15 (c) Upon receipt of a completed form requesting independent review as required by
16 subsection (a) of this Code section, the ~~planning agency~~ department shall notify the eligible
17 enrollee of receipt and assign the request to an independent review organization on a
18 rotating basis according to the date the request is received.

19 (d) Upon assigning a request for independent review to an independent review
20 organization, the ~~planning agency~~ department shall provide written notification of the name
21 and address of the assigned organization to both the requesting eligible enrollee and the
22 managed care entity.

23 (e) No managed care entity may be certified by the Commissioner under Article 1 of this
24 chapter unless the entity agrees to pay the costs of independent review to the independent
25 review organization assigned by the ~~planning agency~~ department to conduct each review
26 involving such entity's eligible enrollees.

27 33-20A-36.

28 (a) Within three business days of receipt of notice from the ~~planning agency~~ department
29 of assignment of the application for determination to an independent review organization,
30 the managed care entity shall submit to that organization the following:

31 (1) Any information submitted to the managed care entity by the eligible enrollee in
32 support of the eligible enrollee's grievance procedure filing;

33 (2) A copy of the contract provisions or evidence of coverage of the managed care plan;
34 and

35 (3) Any other relevant documents or information used by the managed care entity in
36 determining the outcome of the eligible enrollee's grievance.

1 Upon request, the managed care entity shall provide a copy of all documents required by
2 this subsection, except for any proprietary or privileged information, to the eligible
3 enrollee. The eligible enrollee may provide the independent review organization with any
4 additional information the eligible enrollee deems relevant.

5 (b) The independent review organization shall request any additional information required
6 for the review from the managed care entity and the eligible enrollee within five business
7 days of receipt of the documentation required under this Code section. Any additional
8 information requested by the independent review organization shall be submitted within
9 five business days of receipt of the request, or an explanation of why the additional
10 information is not being submitted shall be provided.

11 (c) Additional information obtained from the eligible enrollee shall be transmitted to the
12 managed care entity, which may determine that such additional information justifies a
13 reconsideration of the outcome of the grievance procedure. A decision by the managed care
14 entity to cover fully the treatment in question upon reconsideration using such additional
15 information shall terminate independent review.

16 (d) The expert reviewer of the independent review organization shall make a determination
17 within 15 business days after expiration of all time limits set forth in this Code section, but
18 such time limits may be extended or shortened by mutual agreement between the eligible
19 enrollee and the managed care entity. The determination shall be in writing and state the
20 basis of the reviewer's decision. A copy of the decision shall be delivered to the managed
21 care entity, the eligible enrollee, and the planning agency department by at least first-class
22 mail.

23 (e) The independent review organization's decision shall be based upon a review of the
24 information and documentation submitted to it.

25 (f) Information required or authorized to be provided pursuant to this Code section may
26 be provided by facsimile transmission or other electronic transmission.

27 33-20A-37.

28 (a) A decision of the independent review organization in favor of the eligible enrollee shall
29 be final and binding on the managed care entity and the appropriate relief shall be provided
30 without delay. A managed care entity bound by such decision of an independent review
31 organization shall not be liable pursuant to Code Section 51-1-48 for abiding by such
32 decision. Nothing in this Code section shall relieve the managed care entity from liability
33 for damages proximately caused by its determination of the proposed treatment prior to
34 such decision.

35 (b) A determination by the independent review organization in favor of a managed care
36 entity shall create a rebuttable presumption in any subsequent action that the managed care

1 entity's prior determination was appropriate and shall constitute a medical record for
2 purposes of Code Section 24-7-8.

3 (c) In the event that, in the judgment of the treating health care provider, the health
4 condition of the enrollee is such that following the provisions of Code Section 33-20A-36
5 would jeopardize the life or health of the eligible enrollee or the eligible enrollee's ability
6 to regain maximum function, as determined by the treating health care provider, an
7 expedited review shall be available. The expedited review process shall encompass all
8 elements enumerated in Code Sections 33-20A-36 and 33-20A-40; provided, however, that
9 a decision by the expert reviewer shall be rendered within 72 hours after the expert
10 reviewer's receipt of all available requested documents.

11 33-20A-38.

12 Neither an independent review organization nor its employees, agents, or contractors shall
13 be liable for damages arising from determinations made pursuant to this article, unless an
14 act or omission thereof is made in bad faith or through gross negligence, constitutes fraud
15 or willful misconduct, or demonstrates malice, wantonness, oppression, or that entire want
16 of care which would raise the presumption of conscious indifference to the consequences.

17 33-20A-39.

18 (a) The ~~planning agency~~ department shall certify independent review organizations that
19 meet the requirements of this Code section and any regulations promulgated by the
20 ~~planning agency~~ department consistent with this article. The ~~planning agency~~ department
21 shall deem certified any independent review organization meeting standards developed for
22 this purpose by an independent national accrediting organization. To qualify for
23 certification, an independent review organization must show the following:

24 (1) Expert reviewers assigned by the independent review organization must be
25 physicians or other appropriate providers who meet the following minimum
26 requirements:

27 (A) Are expert in the treatment of the medical condition at issue and are
28 knowledgeable about the recommended treatment through actual clinical experience;

29 (B) Hold a nonrestricted license issued by a state of the United States and, for
30 physicians, a current certification by a recognized American medical specialty board
31 in the area or areas appropriate to the subject of review; and

32 (C) Have no history of disciplinary action or sanctions, including, but not limited to,
33 loss of staff privileges or participation restriction, taken or pending by any hospital,
34 government, or regulatory body;

1 (2) The independent review organization shall not be a subsidiary of, nor in any way
 2 owned or controlled by, a health plan, a trade association of health plans, a managed care
 3 entity, or a professional association of health care providers; and

4 (3) The independent review organization shall submit to the ~~planning agency~~ department
 5 the following information upon initial application for certification, and thereafter within
 6 30 days of any change to any of the following information:

7 (A) The names of all owners of more than 5 percent of any stock or options, if a
 8 publicly held organization;

9 (B) The names of all holders of bonds or notes in excess of \$100,000.00, if any;

10 (C) The names of all corporations and organizations that the independent review
 11 organization controls or is affiliated with, and the nature and extent of any ownership
 12 or control, including the affiliated organization's type of business; and

13 (D) The names of all directors, officers, and executives of the independent review
 14 organization, as well as a statement regarding any relationships the directors, officers,
 15 and executives may have with any health care service plan, disability insurer, managed
 16 care entity or organization, provider group, or board or committee.

17 (b) Neither the independent review organization nor any expert reviewer of the
 18 independent review organization may have any material professional, familial, or financial
 19 conflict of interest with any of the following:

20 (1) A managed care plan or entity being reviewed;

21 (2) Any officer, director, or management employee of a managed care plan which is
 22 being reviewed;

23 (3) The physician, the physician's medical group, health care provider, or the
 24 independent practice association proposing a treatment under review;

25 (4) The institution at which a proposed treatment would be provided;

26 (5) The eligible enrollee or the eligible enrollee's representative; or

27 (6) The development or manufacture of the treatment proposed for the eligible enrollee
 28 whose treatment is under review.

29 (c) As used in subsection (b) of this Code section, the term 'conflict of interest' shall not
 30 be interpreted to include a contract under which an academic medical center or other
 31 similar medical research center provides health care services to eligible enrollees of a
 32 managed care plan, except as subject to the requirement of paragraph (4) of subsection (b)
 33 of this Code section; affiliations which are limited to staff privileges at a health care
 34 facility; or an expert reviewer's participation as a contracting plan provider where the
 35 expert is affiliated with an academic medical center or other similar medical research center
 36 that is acting as an independent review organization under this article. An agreement to

1 provide independent review for an eligible enrollee or managed care entity is not a conflict
2 of interest under subsection (b) of this Code section.

3 (d) The independent review organization shall have a quality assurance mechanism in
4 place that ensures the timeliness and quality of the reviews, the qualifications and
5 independence of the experts, and the confidentiality of medical records and review
6 materials.

7 (e) The ~~planning agency~~ department shall provide upon the request of any interested
8 person a copy of all nonproprietary information filed with it pursuant to this article. The
9 ~~planning agency~~ department shall provide at least quarterly a current list of certified
10 independent review organizations to all managed care entities and to any interested
11 persons.

12 33-20A-40.

13 (a) For the purposes of this article, in making a determination as to whether a treatment is
14 medically necessary and appropriate, the expert reviewer shall use the definition provided
15 in paragraph ~~(5)~~(7) of Code Section 33-20A-31.

16 (b) For the purposes of this article, in making a determination as to whether a treatment
17 is experimental, the expert reviewer shall determine:

18 (1) Whether such treatment has been approved by the federal Food and Drug
19 Administration; or

20 (2) Whether medical and scientific evidence demonstrates that the expected benefits of
21 the proposed treatment would be greater than the benefits of any available standard
22 treatment and that the adverse risks of the proposed treatment will not be substantially
23 increased over those of standard treatments.

24 For either determination, the expert reviewer shall apply prudent professional practices and
25 shall assure that at least two documents of medical and scientific evidence support the
26 decision.

27 33-20A-41.

28 The ~~planning agency~~ department shall provide necessary rules and regulations for the
29 implementation and operation of this article.

30 33-20A-42.

31 Medicaid care management members shall, after first exhausting the grievance procedure
32 of the managed care plan providing health care benefits pursuant to Article 7 of Chapter
33 4 of Title 49 or Article 13 of Chapter 5 of Title 49, be afforded the fair hearing rights

1 provided pursuant to Code Section 49-4-153 or the state plan provided for in Article 13 of
 2 Chapter 5 of Title 49."

3 SECTION 2.

4 Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to
 5 medical assistance generally, is amended by striking Code Section 49-4-156, which is
 6 reserved, and inserting in lieu thereof a new Code Section 49-4-156 to read as follows:

7 "49-4-156.

8 ~~Reserved.~~ The provisions of Code Section 33-21-16 shall not apply to health maintenance
 9 organizations with respect to contracts entered into with the department for the furnishing
 10 of health care services to persons pursuant to this article."

11 SECTION 3.

12 Article 13 of Chapter 5 of Title 49 of the Official Code of Georgia Annotated, relating to
 13 PeachCare for Kids, is amended by striking Code Section 49-5-272, relating to definitions,
 14 and inserting in lieu thereof the following:

15 "49-5-272.

16 As used in this article, the term:

17 (1) 'Board' means the Board of Community Health.

18 (2) 'Department' means the Department of Community Health.

19 ~~(2)~~(3) 'Federal law' means Title XXI of the federal Social Security Act.

20 ~~(3)~~(4) 'Medicaid' means medical assistance provided under Article 7 of Chapter 4 of this
 21 title, the 'Georgia Medical Assistance Act of 1977.'

22 ~~(4)~~(5) 'PeachCare' or 'program' means the PeachCare for Kids Program created by Code
 23 Section 49-5-273."

24 SECTION 4.

25 Said article is further amended by striking Code Section 49-5-273, relating to the creation
 26 of PeachCare, availability, eligibility, payment of premiums, and enrollment, and inserting
 27 in lieu thereof the following:

28 "49-5-273.

29 (a) There is created the PeachCare for Kids Program to provide health care benefits for
 30 children in families with income below 235 percent of the federal poverty level. The board
 31 may establish the maximum income limit in a lesser amount when the department has
 32 reason to believe the cost of enrollment or services may exceed the availability of funding.
 33 Children from birth through 18 years of age in families with family incomes below 235
 34 percent of the federal poverty level or the maximum income limit established by the board,

1 whichever is lower, and who are not eligible for medical assistance under Medicaid shall
2 be eligible for the program, to be administered by the department pursuant to federal law
3 and subject to availability of funding.

4 (b) No entitlement to benefits for the children covered under the program or this article
5 shall be created by the program, nor shall this article or any rules or regulations adopted
6 pursuant to this article be interpreted to entitle any person to receive any health services or
7 insurance available under this program. The program shall be established subject to the
8 availability of funds specifically appropriated by the General Assembly for this purpose
9 and federal matching funds as set forth in federal law. The department shall operate the
10 program consistent with administrative efficiency and the best interests of children.

11 (c) The program shall offer substantially the same health care services available to children
12 under Georgia's Medicaid plan, as determined by the department, but coverage for such
13 services shall not be provided by an expansion of eligibility for medical assistance under
14 Medicaid. However, the program shall exclude nonemergency transportation and targeted
15 case management services. The department shall utilize appropriate medical management
16 and utilization control procedures necessary to manage care effectively and shall
17 prospectively limit enrollment in the program and modify the health care services benefits
18 when the department has reason to believe the cost of such enrollment or services may
19 exceed the availability of funding.

20 (d) The department may require copayments for services consistent with federal law;
21 provided, however, that no copayment shall be charged for preventive services and no
22 copayments or premiums shall be charged for any child under six years of age except when
23 authorized by the board. Preventive services include but are not limited to medically
24 necessary maintenance medication and monitoring for chronic conditions such as asthma
25 and diabetes.

26 (e) The department shall require payment of premiums for participation in the program.
27 The premiums shall not exceed the amounts permitted under Section 1916(b)(1) of the
28 Social Security Act or federal law.

29 (f) The department may provide for presumptive eligibility for all applicant children as
30 allowed by federal law and in a manner consistent with the provisions of this article.

31 (g) The department shall provide for outreach for the purpose of enrolling children in the
32 program. Applications shall be accepted by mail or in person. All necessary and
33 appropriate steps shall be taken to achieve administrative cost efficiency, reduce
34 administrative barriers to application for and receipt of services under the program, verify
35 eligibility for the program and enforce eligibility standards, and ensure that enrollment in
36 the program does not substitute for coverage under a group health insurance plan.

1 (h) Any health care provider who is enrolled in the Medicaid program shall be deemed to
2 be enrolled in the program.

3 (i) The department shall file a Title XXI plan to carry out the program with the United
4 States Department of Health and Human Services Centers for Medicare and Medicaid
5 Services ~~by June 1, 1998~~. The department shall have the authority and flexibility to make
6 such decisions as are necessary to secure approval of that plan consistent with this article.
7 The department shall provide a copy of the plan to the General Assembly. The department
8 shall operate this program consistent with federal law.

9 (j) The department shall publish an annual report, copies of which shall be provided to the
10 Governor and the General Assembly, setting forth the number of participants in the
11 program, the health services provided, the amount of money paid to providers, and other
12 pertinent information with respect to the administration of the program.

13 (k) All state agencies shall cooperate with the department and its designated agents by
14 providing requested information to assist in the administration of the program.

15 (l) The department, through the Department of Administrative Services or any other
16 appropriate entity, may contract for any or all of the following: the collection of premiums,
17 processing of applications, verification of eligibility, outreach, data services, and
18 evaluation, if such contracting achieves administrative or service cost efficiency. The
19 department, and other state agencies as appropriate, shall provide necessary information
20 to any entity which has contracted with the department for services related to the
21 administration of the program upon request. For purposes of compliance with Code Section
22 34-8-125, a request by any entity which has contracted with the department for services
23 related to the administration of the program shall be deemed to be a request by a
24 responsible official of the department and considered to be a request by the department.

25 (m) Nothing in this article shall be interpreted in a manner so as to preclude the department
26 from contracting with licensed health maintenance organizations (HMO) or provider
27 sponsored health care corporations (PSHCC) for coverage of program services and eligible
28 children ~~in a metropolitan statistical area~~; provided, however, that such contracts shall
29 require payment of premiums and copayments in a manner consistent with this article. The
30 department may ~~not~~ require enrollment in a health maintenance organization (HMO) or
31 provider sponsored health care corporation (PSHCC) as a condition of receiving coverage
32 under the program.

33 (n) There shall be created a separate budget unit 'C' and a separate appropriation in the
34 department for the purpose of carrying out the provisions of this article.

35 (o) The Department of Education and local boards of education shall cooperate with and
36 provide assistance to the department and its designated agents for the purposes of
37 identifying and enrolling eligible children in the program."

1 **SECTION 5.**

2 This Act shall become effective upon its approval by the Governor or upon its becoming law
3 without such approval.

4 **SECTION 6.**

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