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Provider Manual Addendum

Georgia Pathways to Coverage

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GEORGIA PATHWAYS TO COVERAGE℠

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Provider Manual Addendum
Georgia Pathways to Coverage

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Updates and Changes

This provider manual, as part of your provider agreement and related addendums, may be updated at any time and is subject to change. The most up-to-date version is available online at **https://providers.amerigroup.com/GA**. To request a free, printed copy of this manual, call Provider Services at **800-454-3730**.

If there is an inconsistency between information contained in this manual and the agreement between you or your facility and Amerigroup Community Care the agreement governs. In the event of a material change to the information contained in this manual, we will make all reasonable efforts to notify you through web-posted newsletters, provider bulletins and other communications. In such cases, the most recently published information supersedes all previous information and is considered the current directive.

This manual is not intended to be a complete statement of all policies and procedures. We may publish other policies and procedures not included in this manual on our website or in specially targeted communications, including but not limited to bulletins and newsletters.

Introduction

Amerigroup Community Care is contracted with the Georgia Department of Community Health (DCH) to serve individuals eligible for Georgia Pathways to Coverage. Georgia Pathways to Coverage, or Pathways, is a Medicaid program for Georgians ages 19-64 who meet the eligibility requirements and otherwise would not qualify for traditional Medicaid.

Georgia Pathways members are eligible to receive the **same Medicaid benefits** as other eligible groups, with the exception of Non-Emergency Medical Transportation (NEMT). However, Georgia Pathways member ages 19 and 20 who are receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services may access NEMT as part of their benefits.

Implementation of the Georgia Pathways program will:

- Improve the health of low-income Georgians by increasing their access to affordable healthcare coverage
- Promote member transition to commercial health insurance
- Empower members to become active participants and consumers of their healthcare
- Support member enrollment in employer-sponsored insurance
- Promote employment and/or engagement in employment-related activities

Eligibility

Georgia Pathways is for individuals who meet the following criteria:

- Live in Georgia.
- Be a U.S. citizen or legal resident.
- Be between the ages of 19 and 64.
- Have a household income of up to 100% of the Federal Poverty Level (FPL).
- Prove that they are doing at least 80 hours of qualifying activities for per month.
- Not qualify for any other type of Medicaid.
- Not be incarcerated in a public institution.

The Division of Family and Children's Services (DFCS) will manage the eligibility and verification of qualifying activities for Georgia Pathways members. In order to be eligible for Georgia Pathways at application, an individual must demonstrate that they are currently engaged in at least 80 hours per month of a qualifying activity or combination of activities.

To remain eligible for Medicaid coverage through Georgia Pathways, it is expected that an individual completes at least 80 hours of qualifying activities per month, though there is no requirement to report and upload proof of qualifying activity completion monthly. Qualifying activities will only be verified at initial application, annual renewal, and when an individual reports a change.

You should verify a member's status by inquiring online via the Georgia Medicaid Management Information System (GAMMIS) at **mmis.georgia.gov**. Online support is also available for provider inquiries at **https://provider.amerigroup.com/GA,** or you can call Provider Services at **800-454-3730**, Monday to Friday, 7 a.m. to 7 p.m.

Qualifying Activities

Qualifying Activities include:

Qualifying Activity	Definition
Employment	Full-or-part-time employment in the public or private sector, including self-employment.
On-the-job training	Training in the public or private sector that is given to a paid employee while he or she is engaged in productive work, and

	that provides knowledge and skills essential to the full and adequate performance of the job
Job Readiness	Activities directly related to the preparation for employment, including life-skills training, GED class time, resume building, and habilitation or rehabilitation activities, including substance use disorder treatment; rehabilitation activities must be determined to be necessary and documented by a qualified medical professional
Job Readiness - Skilled Nursing Facility and Job Readiness-Hospital Stay	An inpatient hospital stay/short-term skilled nursing facility (SNF) stay is considered a habilitation or rehabilitation activity under job readiness only at initial application. For each day of an inpatient hospital stay/SNF stay, an applicant may claim 4 hours towards their monthly Qualifying Activities requirement.
Community service	Structured programs and embedded activities in which the member performs work for the direct benefit of the community under the auspices of public or nonprofit organizations; approved community service programs are limited to projects that serve a useful community purpose in fields such as health, social service, environmental protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and childcare
Community Service - Relative caregiving	This is when an individual is providing relative caregiving services, also known as Structured Family Caregiving, within the Elderly Disabled Waiver Program (EDWP), Community Care Service Program (CCSP), or Service Options Using Resources in a Community Environment (SOURCE). If you are providing care with two or more providers, please enter a qualifying activity record for each provider.
Vocational education training	Organized educational programs that prepare individuals for employment in current or emerging occupations. Course hour requirements for vocational education training shall be determined by the Department of Community Health (DCH).
Enrollment in an institution of higher education	Enrolled in and earning course credit at a college, university, or other institution of higher learning. Current college course-load credit hours will be granted qualifying activity hours as follows: • At least 11.5 credit hours will count as 80 hours per month • Between 5.50 and 11.49 credit hours will count as 40 hours per month • Between 0.01 and 5.49 credit hours will count as 20 hours per month

Enrollment and active engagement in the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation program	Enrolled in and compliant with the requirements of the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation (VR) program; includes individuals who have been newly accepted into the GVRA VR program and whose Individualized Plan for Employment (IPE) is under development, or those compliant with the terms of their IPE once finalized; both satisfy the requirements for 80 hours of qualifying activities in the month
SNAP Works Program	Compliance with the eligibility requirements to receive Supplemental Nutrition Assistance Program (SNAP) benefits under the Work Program/Able-Bodied Adults Without Dependents (ABAWD) program. An individual enrolled in this program may only meet the Pathways qualifying activity requirement if they are completing a work activity.
Parent or Legal Guardian of a child under six (6)	Parents and legal guardians who are primarily responsible for the daily care and well-being of a child younger than six years of age. The child under six must be currently enrolled in the Medicaid program or must be on the Medicaid application also applying for Medicaid with the adult seeking Pathways coverage.

For information regarding verification sources, visit the DCH website at **www.gateway.ga.gov**. Georgia Pathways to Coverage: **pathways.georgia.gov**

Enrollment

Enrollment Procedures

Mandatory enrollment in a care management organization (CMO) is required for all eligible recipients. During the initial 90 days following the member's effective date of enrollment, the enrollee may disenroll from one CMO to move to another without cause. The 90-day time period applies to the enrollee's initial period of enrollment and to any subsequent enrollment periods when the enrollee enrolls in a new CMO. A member may request disenrollment from a CMO for cause at any time. The following situations constitute cause for disenrollment by the member:

- The CMO does not provide the covered services that the member seeks because of moral or religious objections.
- The member needs related services to be performed at the same time, and not all related services are available within the network; the member's provider or another provider has determined that receiving services separately would subject the member to unnecessary risk.
- The member requests to be assigned to the same CMO as family members.

- The member's Medicaid eligibility category changes to a category ineligible for the Georgia Families or Georgia Families 360°SM program, and/or the member otherwise becomes ineligible to participate in the program.
- DCH or its agents shall determine, per 42 CFR 438.56(d)(2), that poor quality of care, lack of access to covered services, or lack of provider experience in dealing with the member's health care needs warrant disenrollment.

Members are excluded from the program if they are:

- Receiving Medicare.
- Part of a federally recognized Indian tribe.
- Receiving Supplemental Security Income (SSI).
- Medicaid children enrolled in the Children's Medical Services program administered by the Georgia Department of Public Health.
- Enrolled in the Georgia Pediatric Program (GAPP).
- Enrolled under group health plans in which the DCH provides payment of premiums, deductibles, coinsurance, and other cost sharing pursuant to section 1906 of the Social Security Act.
- Enrolled in a hospice category of aid.
- Enrolled in a nursing home category aid.
- Enrolled in a Community-Based Alternative for Youth (CBAY) program.

Coverage in Pathways is **retroactive**, with the coverage effective date being the first of the month in which the customer applies. New members will be retroactively covered through Fee-for-Service (FFS); members will transition to coverage under a CMO two days following their eligibility determination.

- No assistance in paying prior months' medical bills will be provided to individuals enrolling in Pathways

Members' Rights

Georgia Pathways participants have a right to:

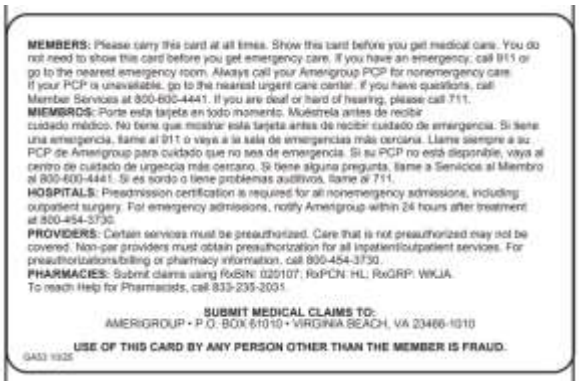
- Receive information about the Georgia Pathways program.
- Be treated with respect and due consideration for dignity and privacy.
- Have all records, medical and personal information, remain confidential.
- Participate in decisions regarding medical services.
- Request and receive a copy of medical records pursuant to 45 CFR 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR 164.524 and 164.526.
- Receive demonstration-related services in accordance with 42 CFR 438.206 through 438.210, as appropriate.

- Freely exercise their rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way the Pathway's participant is treated.

Covered Benefits, Services, and Member Identification Cards

Georgia Pathways to Coverage

ID card sample for Georgia Pathways members ages 19 to 20 receiving EPSDT services:



ID card sample for Georgia Pathways members ages 21 to 64:

Georgia Pathways Health Care Benefits

The following list shows the health care services and benefits that Georgia Pathways covers:

Covered services	Additional information
Abortions	• Abortions are covered services if a provider certifies that the abortion is medically necessary to save the life of the mother or if the pregnancy is the result of rape or incest. • Amerigroup covers treatment of medical complications occurring as a result of an elective abortion or treatments for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies. • Please note: Abortions or abortion-related services performed for family planning purposes are not a covered benefit.

Covered services	Additional information
Clinic services	FQHCs and RHCs will provide covered services, including preventive, diagnostic, therapeutic, rehabilitative, or palliative services in the service region.
Court-ordered services	Medically necessary court-ordered services are a covered benefit if an evaluation is ordered by a state or federal court.
Durable medical equipment (DME)	Medically necessary DME is a covered benefit.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services	A covered benefit for Georgia Pathways members ages 19 to 20.
Emergency and post-stabilization services	Emergency and medically necessary post-stabilization services do not require a referral. An emergency medical condition is a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could result in the following: • Serious jeopardy to the physical or mental health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) • Serious impairment to bodily functions • Serious dysfunction of any bodily organ or part • Serious harm to self or others due to an alcohol or drug abuse emergency • Injury to self or bodily harm to others
Family planning services and supplies	Coverage of family planning services and supplies includes: • Education and counseling necessary to make informed choices and understand contraceptive methods • Initial and annual complete physical examinations, including pelvic and breast exams • Lab and pharmacy • Follow-up, brief and comprehensive visits • Contraceptive supplies and follow-up care • Diagnosis and treatment of sexually transmitted diseases • Infertility assessment
Home Health services	The following services are not covered: • Social services • Chore services

Covered services	Additional information
	• Meals On Wheels • Audiology services
Hospice	Medically necessary hospice care is covered for members certified as being terminally ill and having a life expectancy of six months or less.

Covered services	Additional information

Hysterectomies/ sterilizations	**Hysterectomy** is a covered benefit for members age 21 and older at the time of consent only if:
	• The member is mentally competent.
	• The member is not institutionalized in a correctional facility/mental hospital or rehabilitative facility.
	• The member is informed verbally and in writing that the hysterectomy will render the member permanently incapable of reproducing. This is not applicable if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy.
	• The member has signed and dated the Georgia Families *Sterilization Request Consent* form (located in **Appendix A — Forms**) prior to the procedure.
	
	Hysterectomy is not a covered benefit if:
	• It is performed solely for the purpose of rendering the member permanently incapable of reproducing and if performed for the purpose of cancer prophylaxis.
	• There is more than one purpose for performing the hysterectomy, but the primary purpose was to render the member permanently incapable of reproducing.
	
	Sterilizations are a covered service for members age 21 and older at time of consent only if:
	• The member is mentally competent.
	• The member is not institutionalized in a correctional facility/mental hospital or rehabilitative facility.
	• The member voluntarily gives informed consent, including executing an *Informed Consent for Voluntarily Sterilization* form (located in **Appendix A — Forms**).
	• The consent is executed at least 30 days prior to the sterilization, but not more than 180 days between the date of informed consent and the date of sterilization, except at the time of a premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery if:
	  ○ At least 72 hours have passed since the informed consent for sterilization was signed.
	  ○ In the case of premature delivery, the informed consent is given at least 30 calendar days before the expected date of delivery. (The expected date of delivery must be on the consent form.)

Covered services	Additional information
	Interpreter services are available if needed. Call Amerigroup Provider Services at **800-454-3730**.
Inpatient hospital services	Inpatient hospital services are a covered benefit in general acute care and rehabilitation hospitals.
Inpatient mental health/substance abuse services	Inpatient mental health and substance use services are covered in general acute care hospitals with psychiatric units and free-standing psychiatric facilities.
Laboratory and X-ray services	All laboratory and X-ray services ordered, prescribed, and directed or performed within the scope of the license of a practitioner. The following services are covered: • Portable X-ray services • Services or procedures referred to another testing facility • Services provided by a state or public laboratory (see list in **Appendix A — Forms**) • Services performed by a facility that is Clinical Laboratory Improvement Amendments (CLIA)-certified or a waiver of a certificate of registration (**https://www.cms.gov/Regulations-andGuidance/Legislation/CLIA/Downloads/AOList.pdf**)
Nurse practitioner	A nurse practitioner certified (NP-C) is a registered professional nurse who is licensed by the state of Georgia and meets the advanced educational and clinical practice requirements beyond the two or four years of basic nursing education required for all registered nurses.
Oral surgery	Oral surgery services are a covered benefit if medically necessary.
Organ transplants	Medically necessary transplant services that are not experimental or investigational are covered. Heart, lung, and heart/lung transplants are not covered benefits for members age 21 and older.
Outpatient hospital services	Outpatient hospital services that are preventive, diagnostic, therapeutic, rehabilitative, or palliative are covered benefits.
Outpatient mental health/substance abuse services	• Outpatient mental health and substance abuse services are covered through community service boards (CSBs), community mental health providers designated as CORE or Intensive Family Intervention (IFI), and private practitioners. • Members may self-refer to a network provider for mental health or substance abuse visits. • Partial hospitalization and intensive outpatient treatment — Refer to the **Precertification and Notification Coverage Guidelines** section of this manual for more information. • Psychological testing — Refer to the **Precertification and Notification Coverage Guidelines** section of this manual for more information.

Covered services	Additional information
	• Community mental health rehabilitation services are covered — Refer to the **Precertification and Notification Coverage Guidelines** section of this manual for more information.
Physical/ occupational therapy, speech-language pathology, and audiology services	Covered for: • All Medicaid and Georgia Families 360°$_{SM}$ members • PeachCare for Kids members age 0-18 • All members older than age 21 for restorative care • Children's Intervention Services that are covered include audiology, nursing, nutrition services provided by licensed dietitians, occupational therapy, physical therapy, counseling provided by clinical social workers, and speech-language pathology when performed by a participating provider.
Physician services	All symptomatic visits to physicians or physician extenders within the scope of their licenses — including services while admitted in the hospital, in an outpatient hospital department, in a clinic setting, or in a physician's office — are covered benefits.
Podiatric services	Podiatric services are not a covered benefit for flatfoot, subluxation, routine foot care, supportive devices, and vitamin B-12 injections.
Prescription drugs	Prescription drugs must be prescribed by a member's primary care physician, specialist, consultant physician, dental provider, or other lawful prescriber. Excluded drug categories are those permitted under *Section 1927(d)* of the *Social Security Act*. Refer to the *Preferred Drug List* (*PDL*) for mandatory generic requirements, prior authorization (PA), step therapy, medical exception process, and quantity limits. The *PDL* may be found at **provider.amerigroup.com/georgia-provider/resources/pharmacy-information**. Over-the-counter (OTC) medications specified in the Georgia Medicaid plan and included in the *PDL* are covered under the outpatient Pharmacy benefit if ordered by a physician with a valid prescription. An in-network pharmacy must be used for prescription and OTC drug coverage.
Private-duty nursing services	Private-duty nursing services are a covered benefit if medically necessary.
Prosthetic and orthotic services	The following orthotic and prosthetic services are covered benefits for members under 21 years of age: • Orthopedic shoes and support devices for the feet that are not an integral part of a leg brace, except diabetic shoes • Hearing aids and accessories
Skilled nursing facility services	Long-term nursing facility stays over 30 days are not covered.

Covered services	Additional information
Swing-bed services	Swing beds are defined as hospital beds that can be used for either nursing facility or hospital acute levels of care on an as-needed basis. Swing-bed services are a covered benefit if rendered in an inpatient hospital setting for eligible Medicaid recipients as medically necessary.
Women's health specialists	Female members may self-refer to an in-network women's health specialist for annual exams and routine health services (including a Pap smear and a mammogram). Refer to the **Precertification and Notification Coverage Guidelines** section of this manual for more information.

Selection of a PCP

Amerigroup encourages enrollees to select a PCP who provides preventive and primary medical care, as well as coordination of all medically necessary specialty services. Members are encouraged to make an appointment with their PCP within 90 calendar days of their effective date of enrollment

Claims

For complete details about Amerigroup claim processes and procedures, refer to our Medicaid provider manual.

Cost-sharing information

Copays

All Pathways members enrolled in a health plan will be required to pay copayment amounts at point of service, in alignment with other classes of assistance as reflected in the State's Medicaid Plan. Pathways members who are unable to pay their copayment cannot be denied care for a covered service.

There are no copays for Pathways members under 21.

Service	Amount
Inpatient Hospitalization	$12.50 for entire stay
Outpatient Hospital Visit	$3.00 per visit
Non-Emergency Use of the ED	$3.00
Primary Care	$0.00
Specialist	$2.00
Durable Medical Equipment	$3.00; $1.00 for rentals and supplies
Pharmacy (preferred drugs)	$0.50
Pharmacy (non-preferred drugs)	$10.00 or less: $0.50 $10.01 to $25.00: $1.00 $25.01 to $50.00: $2.00 $50.01 or more: $3.00

Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies, and procedures that come together in a system, agency, or among professionals, enabling them to work effectively in cross-cultural situations. Cultural competency practices help an individual to:

- Acknowledge the importance of culture and language.
- Embrace cultural strengths with people and communities.
- Assess cross-cultural relations.
- Understand cultural and linguistic differences.
- Strive to expand cultural knowledge.

The quality of the patient-provider interaction has a profound impact on the ability of patients to communicate symptoms to their provider and to adhere to recommended treatment. Some of the reasons that justify the need for cultural competence in health care at the provider level include:

- The perception of illness and disease, and their causes, vary by culture.
- Belief systems related to health, healing, and wellness are very diverse.
- Culture influences help-seeking behaviors and attitudes toward health care providers.
- Individual preferences affect traditional and nontraditional approaches to health care.
- Health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system.

Cultural barriers between the provider and member or Georgia Pathways participant can impact many areas, including:

- The member's or Georgia Pathways participant's level of comfort with the practitioner and fear of what they might find upon examination.
- A different understanding on the part of the consumer of the U.S. health care system.
- A fear of rejection of personal health beliefs.
- The member's or Georgia Pathways participant's expectation of the health care provider and of the treatment.

To be culturally competent, Amerigroup expects providers serving members or Georgia Pathways participants within this geographic location to demonstrate the following competencies:

Cultural awareness needed:

- The ability to recognize the cultural factors (norms, values, communication patterns, and world views) which shape personal and professional behavior
- The ability to modify one's own behavioral style to respond to the needs of others while maintaining a professional level of respect and objectivity

Knowledge needed:

- Culture plays a crucial role in the formation of health or illness beliefs.
- Different cultures have different attitudes about seeking help.
- Feelings about disclosure can be unique to culture.
- There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups.
- Verbal and nonverbal language, speech patterns, and communication styles vary in cultural and ethnic groups.
- Resources, such as formally trained interpreters, should be offered and used on behalf of various cultural and ethnic groups.

Historical factors affect various cultural and ethnic groups. Healing practices and the role of belief systems play a crucial part in the treatment of various cultures and ethnic groups.

Skills needed:

- The ability to know the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of all cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and understanding of others' needs, values, and preferred means of meeting needs
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to specify consistency of actions
- The ability to recognize the importance of time and the use of group process to develop and enhance cross-cultural knowledge and understanding
- The ability to withhold judgment, action, or speech in the absence of information about a person's culture
- The ability to listen with respect
- The ability to formulate culturally competent treatment plans
- The ability to use culturally appropriate community resources
- The ability to know when and how to use interpreters and to understand the limitations of using interpreters
- The ability to treat each person uniquely
- The ability to recognize racial and ethnic differences and know when to respond to culturally based cues
- The ability to seek out information when you do not know
- The ability to use agency resources
- The capacity to respond with flexibility to a range of possible solutions
- The ability to accept ethnic differences between people and understand how these differences affect the treatment process
- A willingness to work with clients of various ethnic groups

The cultural competency plan is available at **https://providers.amerigroup.com/GA**.
To request a printed copy of the cultural competency plan, call Provider Services at **800-454-3730**.

For additional information about benefits and services, see your Amerigroup provider manual. If you have any questions about anything in this document, please don't hesitate to call us at **800-454-3730**. We are always interested in hearing from you. Please contact us with ideas or suggestions of how we can improve our service so that you can focus on your patients.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