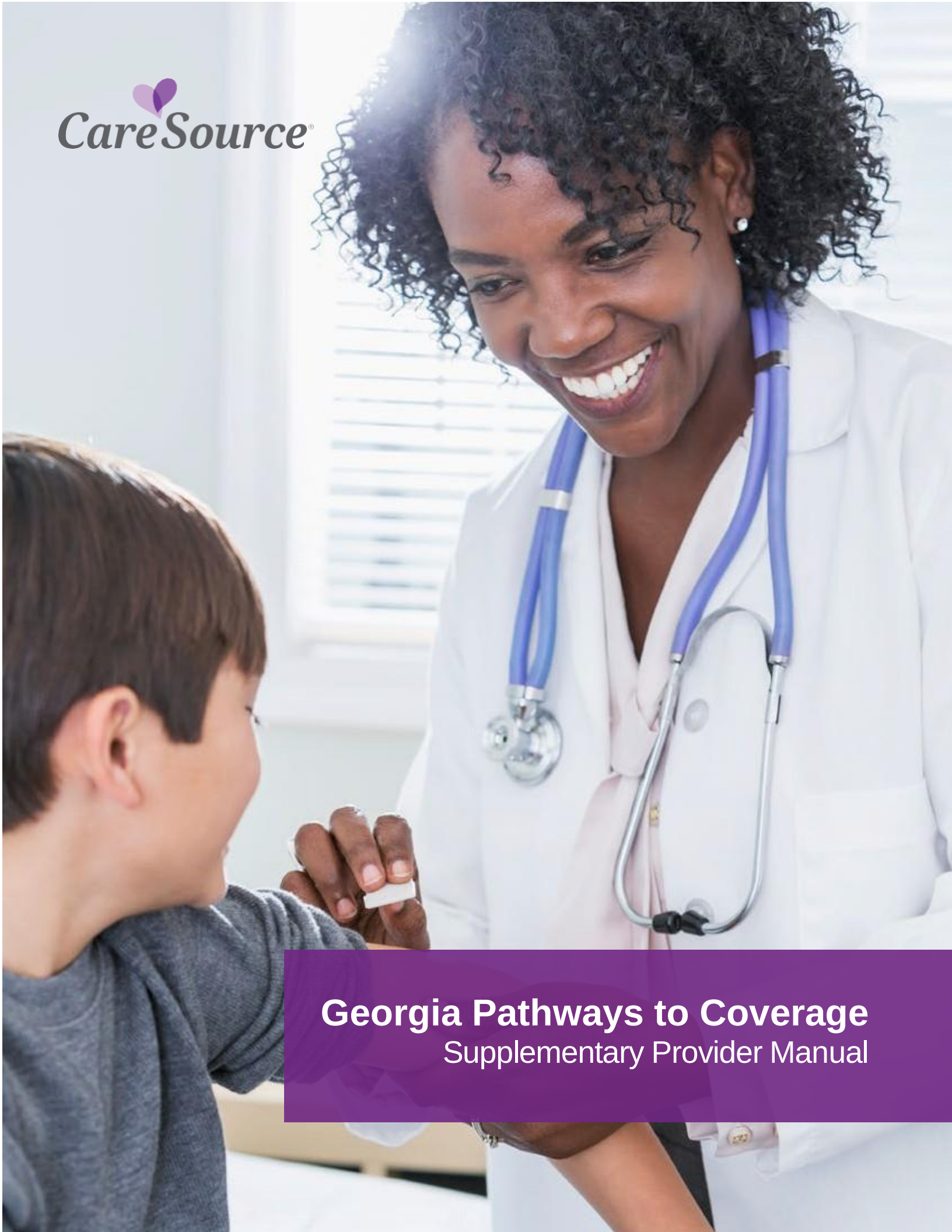
CareSource



Georgia Pathways to Coverage

Supplementary Provider Manual

OVERVIEW

This document is a supplement to the CareSource Georgia Medicaid Provider Manual. Providers should still check the CareSource Georgia Medicaid Provider Manual for information on how to work with our plan. You can also call Provider Services at 1-855-202-1058.

Georgia Pathways to Coverage is a new program that will give low-income Georgians, who are not eligible for traditional Medicaid, a new opportunity to gain access to health care coverage. Georgia residents can apply for the program starting on July 1, 2023.

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

The Georgia Pathways to Coverage program will be implemented in several phases. CareSource will work to keep our providers informed with program updates as they become available. For more information, visit https://dch.georgia.gov/georgiapathways.

This content has been reviewed; however, changes and/or revisions occur frequently. Providers should check our website at **CareSource.com** for the most current version of this manual.

Provider Participation

If you already have a contract with CareSource to serve our Georgia Families® and Planning for Healthy Babies® members, you do not need a new contract to see Georgia Pathways to Coverage members. Georgia Pathways to Coverage members should be treated as any other Georgia Families member. Members will have an ID card that will indicate if they are part of the Georgia Pathways to Coverage program.

Eligibility Requirements

To be eligible for Georgia Pathways to Coverage, an individual must:

- Be a Georgia resident
- Be a U.S. citizen or legal resident
- Be at least 19 years old and between the ages of 19 and 64
- Be low-income, with a household income up to 100% FPL
- Prove that they are doing one or more qualifying activities for at least 80 hours per month
- Not be eligible for any other category of Medicaid
- Not be incarcerated
- Sign the Pathways Contract

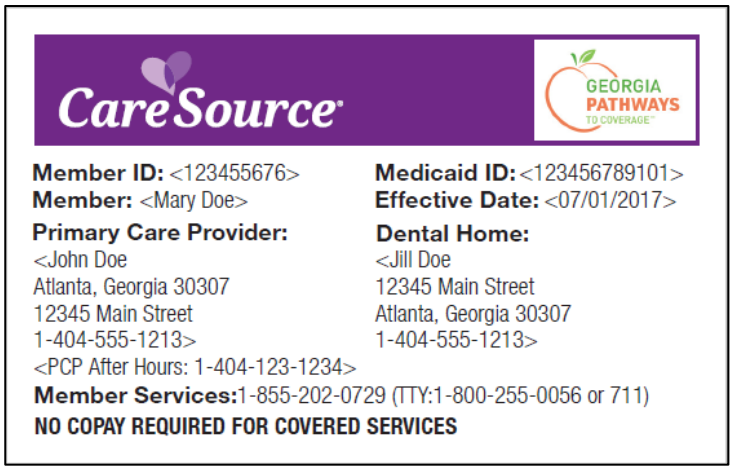
Verifying Eligibility

Providers may access the Provider Portal at **CareSource.com** > Login > Provider, selecting Georgia to verify member eligibility. After logging in to the Provider Portal, you can view member eligibility with:

- 24 months of history
- Date of service plus member name, date of birth, case number, Medicaid ID number or CareSource member ID number
- Multiple member look-up (up to 500)

You can also verify eligibility on the GAMMIS portal at http://www.mmis.georgia.gov or by calling CareSource's Provider Services at **1-855-202-1058** and using our interactive voice response system.

CareSource Pathways members use the following ID card:



Income Threshold

In order to qualify for Georgia Pathways to Coverage, an individual must be low-income, with a household income up to 100% FPL. Income is calculated using the Modified Adjusted Gross Income (MAGI methodology), which is currently used in the State to determine other classes of Medicaid. Dollar amounts for the federal poverty level are updated annually and available here.

Income Verification

An individual must provide documentation for verification of income at the time of application in order to determine if the individual meets the financial eligibility requirements for Pathways.

Income verification will be determined prior to enrollment by the State's eligibility system and is not determined by CareSource.

Enrollment with CareSource

Individuals identified as eligible for Georgia Pathways to Coverage will be assigned as follows:

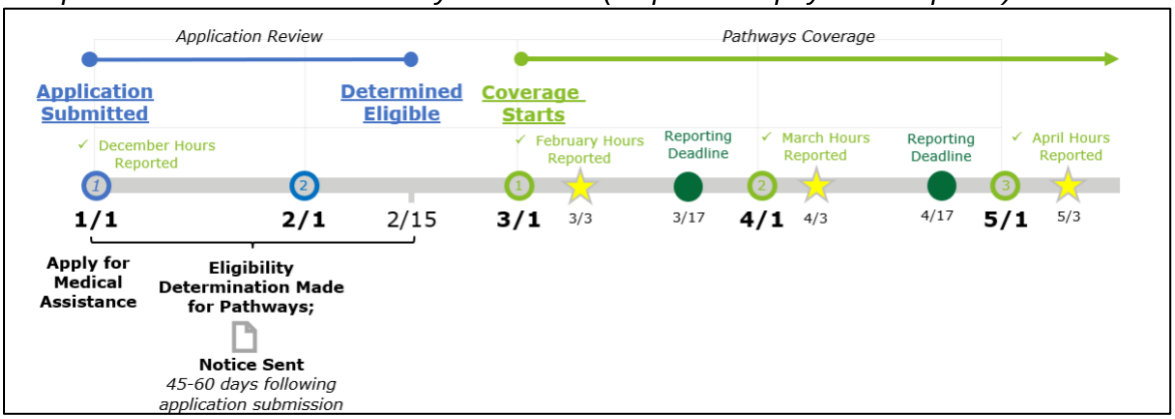
- Members who are new to Medicaid and enrolled in Pathways will be assigned using the current auto-enrollment methodology.
- Members who, at re-determination, move from traditional Medicaid to Pathways, will stay with their current CMO.

- Members who lost Medicaid Coverage and have come back to enroll in Pathways will be assigned using the current auto-enrollment methodology.

- The Department of Community Health (DCH) will follow its current process of allowing the individual up to 90 days after auto-assignment to change Care Management Organizations (CMOs).

- Coverage in Georgia Pathways to Coverage and the member's CMO enrollment is prospective only and begins the first day of the month following the determination of eligibility.

Example Timeline for New Pathways Members (no premium payment required)



Sample timeline for demonstration purposes only; actual months will vary

- No retroactive coverage or assistance in paying prior months' medical bills will be provided to individuals enrolling in Georgia Pathways to Coverage.

    - There are limited circumstances in which retroactive coverage is allowable, once a member is already enrolled in Georgia Pathways to Coverage.

        - If a member submits qualifying activities via mail, and the mail is postmarked by the 17th of the month, it is possible the form will be received and acted upon by DFCS after the 17th of the month.

            - Retroactive coverage will be allowable to reinstate the member if they were suspended or terminated, but properly postmarked mail was acted upon by DFCS after the suspension or termination.

            - If the reporting date is postmarked by the 17th and entered into Gateway, the system will gran retroactive eligibility for the month in which the member met the reporting requirement.

        - If a member appeals an adverse action, (i.e., suspension or termination), requests a hearing, and requests a continuation of benefits, retroactive coverage will be allowable via a manual override through the Gateway Worker Portal.

Qualifying Activities

In order to be eligible for Georgia Pathways to Coverage 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.

Qualifying activities include:

Qualifying Activity	Definition
Unsubsidized employment	Full- or part-time employment in the public or private sector that is not subsidized by a public program.
Subsidized private sector employment	Employment in the private sector for which the employer receives a subsidy from public funds to offset some or all of the wages and costs of employing an individual.
Subsidized public sector employment	Employment in the public sector for which the employer receives a subsidy from public funds to offset some or all of the wages and costs of employing an individual.
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.
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.

Vocational Educational Training	Organized educational programs that are directly related to the preparation of individuals for employment in current or emerging occupations. A full-time academic workload will meet the requirements for 80 hours of qualifying activities in the month. An individual with a current course-load between 6 and 11 credit hours will be granted 40 hours per month of a qualifying activity. An individual with a current course-load between 1 and 5 credit hours will be granted 20 hours per month of a qualifying activity. Participation in vocational educational training is limited to 12 months in a member's lifetime, unless a member is enrolled in vocational education for a highly sought-after trade through the Technical College System of Georgia High Demand Career Initiative. In this instance, vocational educational training may count as a qualifying activity for the duration of the vocational education program.

Qualifying Activity	Definition
Vocational Educational Training *(continued)*	***Technical College System of Georgia High Demand Career Initiative:*** High Demand Career Initiative (HDCI) was launched in 2014. The HDCI Occupations List has been compiled using a combination of labor market data, employer feedback, and collaboration with strategic partners. This list represents the occupations in each of Georgia's key industries that are in-demand, pay an above-average entry-level wage, and are considered strong options for pursuing a successful career in Georgia. These occupations are critical to the success of these industries and the health of Georgia's economy. For the latest HDCI Occupations List, access this webpage on the Technical College System of Georgia website.
Enrollment in an Institution of Higher Education	Enrolled in and earning course credit at a college, university, or other institution of higher learning. A full-time academic workload of at least 11.5 credit hours will meet the requirements for 80 hours of qualifying activities in the month. An individual with a current course-load between 5.50 and 11.49 credit hours will be granted 40 hours per month of a qualifying activity. An individual with a current course-load between 0.011 and 5.49 credit hours will be granted 20 hours per month of a qualifying activity. The student's workload may include any combination of courses, work, research, or special studies that the institution considers contributing to the individual's full-time status.

Enrollment and active engagement in the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation program	Enrolled in and compliant with the requirements of the GVRA Vocational Rehabilitation (VR) program. This 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.

Qualifying Activities Verification

An individual must provide one source of documentation for verification per qualifying activity reported. Documentation must verify hours reported for the most recent four weeks available within the eight weeks prior to application submission date.

Qualifying Activity	Verification Source
Employment	• Pay stubs • Written statement from source/employer • Gross earnings (if hourly pay is known) • Timesheet
Self-employment	• Signed Standardized Work/Participation Calendar from member indicating hours engaged *(Member may fill in a standardized worksheet template indicating total weekly hours worked per client/activity; OR submit a snapshot of their actual work calendar from the reporting month (e.g., Photo of ledger of appointments or screenshot of calendar with work activities)*
On-the-job training (OJT)	• Statement from supervisor sponsoring the OJT
Job Readiness	• Signed statement from Recognized Agency or Community Resource indicating hours engaged. *(Recognized agencies include: Georgia Department of Labor Career Center, Workforce Development Board, Georgia Vocational Rehabilitation Agency, Goodwill, and other agencies as authorized by the State)* • Signed statement from habilitation/rehabilitation institution verifying hours in last four weeks
Community Service	• Signed Standardized Work/Participation Calendar • Signed statement on organization letterhead from supervisor verifying hours

Vocational Educational Training	• Official course enrollment for the current semester from the Office of the Registrar • Copy of class schedule for the current semester • Enrollment status through an interface (if available and if the student has consented to have their enrollment information shared with the Department of Human Services)
Enrollment in an Institution of Higher Education	• Official course enrollment for the current semester from the Office of the Registrar • Copy of class schedule for the current semester • Enrollment status through an interface (if available and if the student has consented to have their enrollment information shared with the Department of Human Services)
Enrollment and active engagement in the GVRA Vocational Rehabilitation program	• Signed statement from GVRA dated within four weeks of Georgia Pathways to Coverage application submission by the individual • Enrollment letter dated within four weeks of Pathways application submission by the individual • Current active client status through GVRA interface (if available)

Maintaining Eligibility

To remain eligible for Medicaid coverage through Georgia Pathways to Coverage, an individual must report their hours monthly to the State; they may report their qualifying hours and activities through multiple channels:

- Gateway Customer Portal (CP): Members may attest to hours and activities for the past month and upload documentation (pdf, jpg, tiff, bmp, docx) through their CP account.
- Paper/Mail: Members may attest to hours and activities using a standard form template with attached documentation and mail it to a local DFCS office. Mail must be post-marked by the 17th of the month of reporting.
- In-Person: Members may attest to hours and activities and provide documentation at a local DFCS office. Documentation must be stamped upon receipt by the 17th of the month of reporting.
- Telephonic: Members may call to attest to their hours and activities but will need to submit supporting documentation via one of the other allowable channels by the 17th of the month of reporting.
- Mobile: Members may attest to hours and activities for the past month and upload documentation to their account.

Reporting of hours will include an individual's self-attestation of activity hours, accompanied by supporting documentation for verification. While the CMOs are not responsible for ensuring members maintain eligibility, they should understand how their members can maintain an

active status and encourage the following reporting activities.

- If a member does not report hours by the 3rd of the month, the member will receive a notice that their reporting is incomplete and they have until the 17th to report and provide documentation for verification.
- The late reporting deadline is the 17th of each month in order to maintain coverage for the following month.
- If a member does not report by 17th of the month, the member will receive a Suspension Notice and enter suspension the first of the following month. While in suspension, the member's claims and capitation payments are not paid, and the member is not covered.

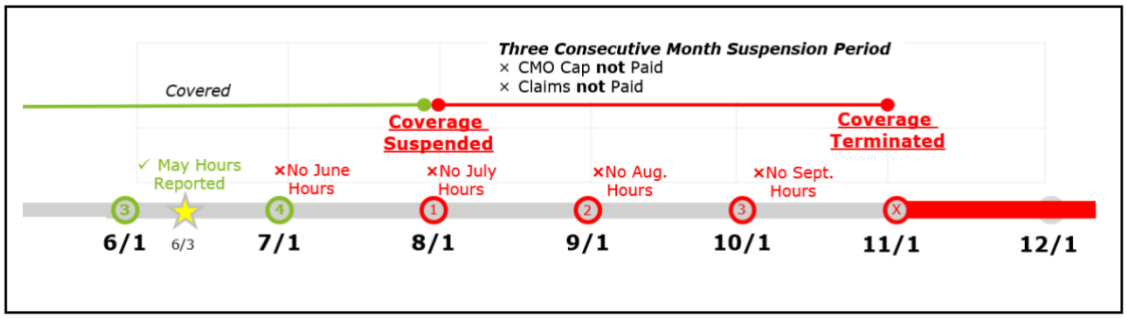
An individual with evidence of meeting the hours and activities threshold for six consecutive months will be exempt from the reporting requirement, except that they will have an affirmative responsibility to inform the State of any changes in circumstance. An individual who can provide evidence of meeting the monthly minimum of 80 hours of employment during the most recent six consecutive months prior to application will also be exempt from the ongoing reporting requirement, except that they will have an affirmative responsibility to inform the State of any changes in circumstance. All members must report their qualifying activities and provide documentation for verification at their annual redetermination.

Suspension

If an individual fails to report their monthly hours, they will be suspended from the program.

- The member will be instructed to report hours and activities for the previous month by the 3rd day of the current month.
- The late reporting deadline is the 17th of each month in order to maintain coverage for the following month.
- If a member does not report by the 17th of the month., the member will enter suspension the first of the following month.
- The member has 90 days from the start of suspension to report they are meeting the 80 hours of qualifying activities in order to be reinstated in Georgia Pathways to Coverage for prospective coverage starting the first day of the next month.
- If the member does not meet the qualifying hours within 90 days from the start of suspension, the member is terminated from Pathways and must reapply for coverage.
- A terminated member may reapply at any time following their termination.

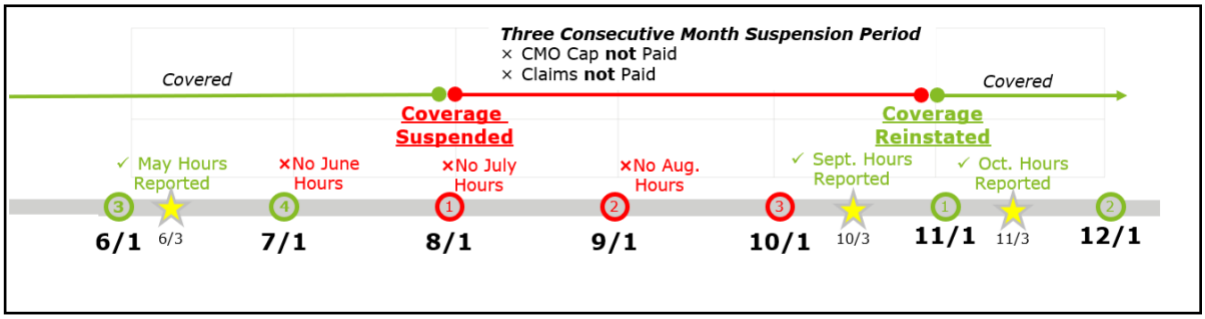
Example Timeline for Noncompliant Pathways Member



Sample timeline for demonstration purposes only; actual months will vary

- If the member reports meeting the Qualifying Hours and Activities threshold within the 90 days of suspension, coverage will be reinstated starting the first of the month following reporting.

Example Timeline for Noncompliant Pathways Member and Re-Engages



Sample timeline for demonstration purposes only; actual months will vary

Good Cause Exceptions

Pathways members may request a Good Cause Exception in a month when they did not meet the 80 hour qualifying activities requirement. Good Cause Exceptions are broadly defined as temporary circumstances that prevent or diminish a member's ability to fulfill the hours and activities threshold during the reporting period. There is a limit of 120 hours of Good Cause exception per certification year. Members may request a Good Cause Exception via several methods, including: 1) Gateway Customer Portal, 2) Paper/mail, 3) In person, or 4) Telephonic 5) Mobile. Good Cause Exception requests are processed by the State Agency and are not the responsibility of CareSource. Good Cause reporting is a function of the member to the State, and the CMO does not need to take action.

Overview of Good Cause Exceptions

- Members may request a Good Cause Exception when reporting hours and qualifying activities of up to 80 hours.

- If the Good Cause Exception is submitted timely, approved, and the Good-Cause hours allows the members to meet their 80-hour/month threshold, the member will not enter a suspension period in the month following non-compliance with hours and activities requirements.
- Good Cause Exceptions are broadly defined as temporary circumstances that prevent or diminish a member's ability to fulfill the hours and activities threshold during the reporting period.
- Members may only request a Good Cause Exception for the prior month of activities and hours.
- The timeline for reporting Good Cause Exceptions is the same as for reporting qualifying hours and activities.
- Members will be expected to make Good Cause Exception requests if they fail to meet the threshold of 80 hours in any given month while they are obligated to report their hours and activities monthly.
    - If a member who is no longer obligated to report their hours and activities monthly does not meet the threshold of 80 hours in any given month, they are obligated to submit a Good Cause Exception request. The member will be allowed up to 120 hours of Good Cause Exception hours per certification year even if no longer required to report monthly.
- Acceptable Good Cause Exceptions reasons and definitions are provided in the table below.

Good Cause	Definition for Georgia Pathways to Coverage
Family emergency or life event	The individual or a member of their immediate family was a victim of/ involved in domestic violence, divorce, legal proceeding, legal matter, or temporary incarceration during the reporting period; or the individual was confirmed to serve jury duty during the reporting period. *Immediate family means the individual's spouse, child, parent, brother and sister. Immediate family also includes any other person who resides in the individual's household and is recognized by law as a dependent of the individual.*
Birth, adoption, foster placement, or death of an immediate family member	A member of the individual's immediate family was born, was adopted, or died during the reporting period. The individual received a placement of a foster child in the home, including those in kinship during the reporting period.
Temporary illness/short term injury	The individual experienced a temporary illness or short-term injury that resulted in an inability to work, attend school, or perform other regular daily activities for over three consecutive calendar days during the reporting period.

Serious illness or hospitalization of member, or immediate family member	The individual or a member of the individual's immediate family was hospitalized or otherwise incapacitated during the reporting period due to illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility; or continuing treatment by a health care provider.
Natural or human-caused disaster	The individual was a victim of a natural or human-caused disaster, such as a flood, storm, earthquake, serious fire, industrial accident, shooting, act of terrorism, incidents of mass violence, or other declared incident of mass trauma during the reporting period.
Temporary homelessness	The individual was evicted from their home or became homeless during the reporting period.
COVID-19	The individual is unable to fulfill the hours and activities requirements because the individual was quarantining in response to having COVID-19 symptoms, a COVID-19 diagnosis, or exposure to COVID-19, or because of a closure of the place(s) related to COVID-19 where the individual was meeting the hours requirement. Note: The State may decide to remove this Good Cause Exception reason if warranted by the circumstances.
Other	Other Good Cause reason as defined and approved by the State.

Good Cause Exception Submission Requirements and Timeline

- In order to make a Good Cause Exception request, the member must complete four steps:
    - Select a reason for the Good Cause Exception from a list of pre-defined options, or select "other"
    - Provide a written explanation of the circumstance
    - Indicate the number of hours requested for Good Cause
    - Submit documentation to support the request
- At the time of submitting the request, the member attests that they were unable to fulfill their qualifying hours and activities due to the Good Cause reason that is selected.
- Members may make a Good Cause Exception request at the same time as reporting their qualifying hours and activities.
    - Example: If a member at the time of reporting April hours in May is reporting any amount under the threshold of 80 hours (including zero), they may submit a Good Cause request for the number of hours missing that month.
- If by the 3rd of the month a member does not report their hours or reports insufficient

hours (any amount less than 80), and does not submit a Good Cause Exception request by this date, then they will receive instructions on the Good Cause Exception request process in their Monthly Qualifying Activity Incomplete Notice.

Limitations

- Members may request a maximum of 120 hours of Good Cause Exceptions per certification year.
    - If the cumulative total of Good Cause hours requested in a single certification year reaches 120 hours, all subsequent requests will be denied.
    - Members will not be able to request a Good Cause Exception if they have reached the 120-hour maximum.

Required Verification for Good Cause Exceptions

- Acceptable documentation for Good Cause requests is defined as follows:

Good Cause Reason	Acceptable Verification Documentation
Family emergency or life event	• Client Statement with Collateral Contact • Clinician's Note • Court Papers/Legal Papers • Police Report/Domestic disturbance report • Jury Duty Selection Notice
Birth, adoption, foster placement, or death of an immediate family member	• Birth certificate • Birth announcement • Adoption papers • Obituary • Death certificate • Caregiver Placement Passport (for foster placement)
Temporary illness/short term injury	• Clinician's Note • Employer/Supervisor Statement
Serious illness or hospitalization of member or immediate family member	• Clinician's Note • Employer/Supervisor Statement
Natural or human-caused disaster	• Client Statement with Collateral Contact • State-issued executive order • Federally declared disaster • Property loss statement

Temporary homelessness	• Client Statement • Landlord letter • Lease document
COVID-19	• Client Statement with Collateral Contact • Clinician's Note • Employer/Supervisor Statement
Other	• Client Statement with Collateral Contact • TBD (circumstance reviewed and determined acceptable)

Premium Copayments, and MRA

No copays are required for Pathways Members.

Reasonable Accommodations and Modifications

The existing Reasonable Modifications provided today by the State to individuals with disabilities who apply for or are enrolled in Medical Assistance under the traditional Medicaid program will continue to be available for Georgia Pathways to Coverage applicants and members following established processes.

In addition, Reasonable Modifications unique to the Pathways qualifying activities and hours requirement will also be made available to individuals with disabilities. The definition of a disability used for Georgia Pathways to Coverage follows the ADA definition which states that an individual: (i) has a physical, mental or sensory impairment which substantially limits one or more major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment. This is different from the definition of disability used for ABD Medicaid.

Reasonable Modifications Available for Georgia Pathways to Coverage Applicants

Changes made by eligibility staff to the Georgia Pathways to Coverage Medicaid application rules, policies, or practices are considered Reasonable Modifications. This includes:

- Pending the Pathways application up to an additional 90 days to allow the applicant who indicates they have a disability to provide verification of engagement in a qualifying activity
- Pending the Pathways application up to an additional 90 days while the customer who indicates they have a disability and needs support to gain employment/engage in a qualifying activity is referred by DFCS to the Georgia Vocational Rehabilitation Program (GVRA)
    - If an individual is determined eligible and enrolled in services for GVRA:
        - Gateway automatically updates the Medical Assistance application to indicate enrollment in GVRA, which is a qualifying activity for Pathways.
            - If GVRA enrollment status is received manually, a worker will be able to update the case with GVRA enrollment information.

- Gateway will auto-approve the individual as eligible for Pathways and an approval notice will be sent.

- If an individual is NOT determined eligible for services with GVRA:
  - Gateway will authorize a denial for Pathways and a denial notice will be sent.
    - The denial notice will specify that an individual is not eligible for Pathways due to not meeting the hours and activities threshold and that the agency has been informed of their denial from GVRA.
  - The individual may reapply when they are compliant with the qualifying hours and activities eligibility criteria for Pathways.
  - The denial notice will include information regarding other workforce development resources, which is provided to all applicants who are denied for failure to meet the qualifying activities requirement.

Reasonable Modifications for Pathways Members

Changes made by eligibility staff to the Pathways Medicaid rules, policies, or practices for enrolled Pathways members are considered Reasonable Modifications.
This includes:

- Allowing a member to maintain coverage through Georgia Pathways to Coverage up to 90 days if they can no longer work/engage in a qualifying activity due to a disability while they are referred to and going through the intake process with GVRA

Enrollment in GVRA is not considered a Reasonable Modification as this is considered a qualifying activity for Georgia Pathways to Coverage.

Providing alternative reporting channels to report monthly compliance with qualifying hours and activities is not considered a Reasonable Modification as all Pathways members are able to report their monthly hours and activities via multiple channels including: Customer Portal, Mobile, Fax, Telephone, or Mail.

Reasonable Accommodations for Pathways Members

Reasonable Accommodations for Pathways only refers to accommodations made by an employer/institution and the individual with a disability to allow them to work or engage in an activity.

- Individuals must request accommodations directly from the employer/institution or through GVRA.
- DFCS staff do not collect verification of disabilities for an accommodation nor make determinations on the types of accommodations necessary for the Georgia Pathways to Coverage applicant/member to be able to engage in a qualifying activity.

The only circumstance in which DFCS needs to be informed about a Reasonable Accommodation made between the employer/institution and the Georgia Pathways to Coverage member is if the member has reduced work/engagement hours and will be unable to meet the minimum of 80 hours/month required for Pathways eligibility.

- In this circumstance, the member will report and provide verification of the accommodation by their employer/institution and the DFCS Specialized Unit will reduce their monthly minimum qualifying activities and hours requirement to maintain ongoing Pathways eligibility accordingly.

Services Covered by CareSource

Georgia Pathways covers all medically necessary care. Members should not be billed for these services.

What's covered by CareSource:

- Office visits – providers and specialists
- Inpatient and outpatient care
- ER visits
- Vision care
- Dental care
- Ambulance services
- Preventive care
- Helping you plan for having children
- Maternity care

Services Not Covered

CareSource will not pay for care or supplies you get if you don't follow the directions in this handbook. We do not pay for care that isn't covered by Medicaid. This includes:

- Abortions (except in the case of a reported rape, incest, or when medically necessary to save the life of the mother)
- Acupuncture (therapy with needles)
- All care or supplies that are not medically necessary
- Experimental services and procedures
- Infertility treatment for males or females, along with reversal of voluntary sterilizations
- Services/care you get in another country
- Alternative medicine
- Voluntary sterilization if under 21 years of age or not able to legally agree
- Plastic or cosmetic surgery that is not medically necessary

Benefits At-A-Glance

The following benefits at-a-glance lists the covered care and services for CareSource members. You can find out more at CareSource.com/Georgia or by calling Provider Services.

Office Visits

- Convenience Care Clinic inside of stores like CVS Minute Clinic®
- Federally Qualified Health Center (FQHC)
- Other Health Care Practitioners (Nurse, PA, Midwife)
- Podiatry (foot care)
- Primary Care Providers like Family Physicians, Pediatricians, OB-GYNs, and Nurse Practitioners
- Specialist (Podiatrist, Neurologist, Oncologist, etc.)
- Telehealth

Emergency Services

- Emergency Room (ER)
- Emergent Ambulance
- Urgent Care

Preventive Services/Screenings

- Abdominal Aortic Aneurysm Tests (AAA)
- Alcohol Misuse Screening and Counseling
- Blood Pressure Screening (Adults)
- Bone Mass Measurements
- Breast Cancer Screening (Mammogram)
- Breast Pumps
- Cardiovascular Disease Testing
- Cervical and Vaginal Cancer Screening (Pap test)
- Cholesterol Screening (Adults)
- Colorectal Cancer Screening (Adults)
- Depression Screening (Adults)

- Diabetes Screening
- Electrocardiogram (ECG/EKG)
- Hepatitis B Screening
- HIV Screening
- Immunizations (shots)
- Lung Cancer Screening
- Nutritional Counseling
- Obesity/BMI Screening & Dietary Counseling
- Physical Exams
- Prostate Screening
- STI/STD Screening & Counseling
- Tobacco/Smoking Screening & Counseling

Inpatient Facility/Services

- Inpatient Hospital (Maternity/Delivery, Rehab Therapy, Physician Services)*
- Long Term Acute Care (LTAC)*
- Skilled Nursing Care*

Outpatient Facility/Services

- Blood Services*√
- Chemotherapy Services/Radiation Therapy
- Clinical Trials
- Dialysis√
- Home Health*
- Observation Services
- Outpatient Facility Physician Services*
- Outpatient Hospital Surgery & Ambulatory Surgical Center*
- Outpatient Hospital Surgery*/Freestanding Birth Center Services
- Outpatient Hospital Rehab Therapy*
- Urinary Drug Testing (UDT)*

Mental Health Treatment

- Inpatient Substance Use*
- Inpatient Mental Health*
- Intensive Outpatient Program (IOP)*
- Mental Health Residential Treatment*
- Psychiatric Residential Treatment Facility (Only age 21 and younger)*
- Partial Hospitalization (PHP)*
- Outpatient Substance Use
- Outpatient Mental Health and Substance Abuse

Outpatient Surgery/Physician Service

- Abortion Surgery*
- Bariatric Surgery*
- Blepharoplasty Surgery*
- Cosmetic/Plastic Surgery*
- General Surgery*
- Reconstructive Surgery*
- Sterilization Surgery*
- Transplants*
- Gender Affirming Care*
- Vision Surgery*

Outpatient Diagnostic Services

- Imaging (CT/PET/MRI)* √
- Outpatient Laboratory/Professional Services*√
- X-Rays and Diagnostic Imaging/Portable X-Rays*√

Hospice Services

- Home
- Hospice/Respite Facility*

Home Health Services

- Certified Nurse Aide (Home Health Aides)*
- Durable Medical Equipment (DME)*
- Infusion Therapy
- Occupational Therapy*√
- Orthotics/Prosthetics*
- Oxygen*
- Physical Therapy*√
- Skilled Nursing*
- Home Based Sleep Studies
- Social Worker*
- Speech Therapy*√

Durable Medical Equipment & Supplies

- Enteral/Parenteral Nutrition & Supplies*
- Diabetic Supplies
- Incontinence Supplies
- Other DME (Ostomy bags, commodes, syringes)*
- Oxygen & Supplies*
- Cochlear Implants*
- Wheelchairs/Walkers*
- Wound Care*

Rehab Therapy Services

- Cardiac Rehab*
- Cognitive Therapy*
- Occupational Therapy*√
- Physical Therapy*√
- Post-Cochlear Implant Aural Therapy*
- Pulmonary Rehab*
- Speech Therapy*√

Habilitative Services

- Applied Behavior Analysis (ABA) Therapy*
- Clinical Therapeutic Intervention
- Mental/Behavioral Services
- Assertive Community Treatment*
- Therapy Services (Physical Therapy/Occupational Therapy/Speech Therapy)* √

Family Planning and Maternity Services

- Antepartum Care
- Birth Control (Pharmacy, Planned Parenthood, PCP/OB-GYN)
- Family Planning (Exams, STD/STI Screenings and Treatment)
- Lactation Classes
- Lamaze Classes
- Parent Education
- Home Visits
- Infertility Services (Diagnosis Only, Provider Visit, Labs)*
- Postpartum Care

Pharmacy

- Preferred Brand Drugs and Non-Preferred Drugs

Education/Training Services

- Asthma Education
- Diabetes Self-Management

Hearing Services

- Hearing Aids & Related Items (Ages 19 and 20)*
- Non-Routine Hearing Exams
- Routine Screenings (with EPSDT/Health Check)

Vision Services

- Vision Exam Screenings (Adults age 21 and up)
- Glasses/Frames (Adults age 21 and up)
- Contacts (Adults age 21 and up)*

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) ages 19 and 20 only

- Full Health and Developmental History Exam
- Nutritional Assessment
- Development/Behavioral Assessment
- Vision Screening
- Hearing Screening
- Dental Observation, Fluoride Varnish
- Lab tests and procedures
- Vaccinations
- Lead Screenings
- Health Education
- Telehealth Visits

Other Services

- Allergy Testing & Treatment
- Accidental Dental Services
- Inhalation Therapy
- Medical Nutrition Therapy
- Anesthesia Services
- Pain Management*
- Weight Loss*

Communicating with CareSource

CareSource communicates with our network providers through a variety of methods including phone, fax, mail, our website at **CareSource.com**, provider portals, newsletters, network notifications and in person through our provider orientation process.

Hours of Operation

Provider Services

Georgia Pathways to Coverage	Monday - Friday	7 a.m. to 7 p.m., excluding holidays

Member Services

CareSource24®	Available 24 hours a day, seven days a week, 365 days a year	
Georgia Pathways to Coverage	Monday - Friday	7 a.m. to 7 p.m., excluding holidays

Please visit **CareSource.com** > Members > Members Overview > Contact Us, selecting Georgia Medicaid, for the holiday schedule or contact Provider Services for more information.

Phone

To help us direct your call to the appropriate professional for assistance, you will be instructed to select the menu option that best fits your need. Please note that our menu options are subject to change. We also provide telephone-based self-service applications that allow you to verify member eligibility.

Provider Services	1-855-202-1058
CareSource Prior Authorization	1-855-202-1058
Georgia Medicaid Management Information System (GAMMIS) Centralized Prior Authorization	1-800-766-4456
Claim Inquiries	1-855-202-1058
Pharmacy	1-855-202-1058
Grievances & Appeals	1-855-202-1058
Member Services	1-855-202-0729
CareSource24® - Nurse Advice Line	1-844-206-5944

Fraud, Waste and Abuse Hotline	1-855-202-1058
TTY for the Hearing Impaired	1-800-255-0056 or 711

CareSource Provider Portal

Our secure online Provider Portal, located at **CareSource.com** > Login > Provider, selecting Georgia, allows 24/7/365 access to valuable information, self-service features, resources and tools. Simply enter your username and password (if already a registered user), or submit your information to become a registered user (see below). Assisting you is a top priority in order to achieve better health outcomes for our members.

If you are not registered with CareSource's Provider Portal, please follow these easy steps

1. Go to the Provider Portal, https://providerportal.caresource.com/GA, click the "Register Now" button and complete the three-step registration process. Please note: You will need your Tax ID number.
2. Click the Continue button.
3. Note the username and password you create so that you can access the portal's many helpful tools.
4. If you do not remember your username/password, please call Provider Services at **1-855-202-1058**.

GAMMIS Portal

The Georgia Medicaid Management Information System (GAMMIS) portal provides timely communications, data exchange and self-service tools for members and providers with both secure and public access areas. The GAMMIS system can process claims in real time, give claim status, verify eligibility, collect prior authorization requests and more.

The GAMMIS portal serves as the centralized portal for the submission of fee-for-service (FFS) authorization requests and authorization requests for certain services provided to Medicaid members enrolled in a CMO. Access the portal at www.mmis.georgia.gov.

Hewlett Packard Enterprise (HPE) is the fiscal agent for the Georgia Department of Community Health, which includes updating and maintaining the GAMMIS portal. HPE Customer Service Representatives may be reached at 1-800-766-4456 or by inquiring on the GAMMIS portal at www.mmis.georgia.gov.

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