	GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES MEDICAID POLICY MANUAL			
	Chapter:	**2100**	**Effective Date:**	**July 2023**
	Policy Title:	**Pathways**		
	Policy Number:	**2195**	**Previous Policy Update:**	**N/A**

REQUIREMENTS

Georgia designed and submitted its Pathways Section 1115 Demonstration waiver to CMS on December 23, 2019. The goal of this class of assistance (COA) is to create an opportunity for Georgians ages 19 through 64 with household incomes up to 95% of the FPL after 5% income disregard, who are not otherwise eligible for Medicaid, to gain access to affordable, quality healthcare until their income meets or exceeds 100% of the FPL, and they have access to affordable health insurance through the individual market or employer-sponsored insurance. Pathways will go into effect on July 1, 2023, and is a MAGI COA.

BASIC CONSIDERATIONS

Basic Eligibility Criteria

A/Rs must meet the following basic eligibility requirements:

- **Age** – Must be an adult age 19 through 64. Refer to Section 2255, Age (Family Medicaid).
- **Citizenship/Immigration Status/Identity** – A/R must be a U.S. citizen or meet immigration eligibility requirements. Refer to Section 2215, Citizenship/Immigration Status.
- **Enumeration** – A/R must furnish, apply for, or agree to apply for a Social Security Number (SSN) for each member, unless Good Cause for SSN is established, is penalized. Refer to Section 2220, Enumeration.
    - **Tax Filer and Non-Tax Filer Status** – A/Rs expected to be included on the next tax return filed are potentially eligible to receive MAGI Medicaid. A/Rs that meet non-tax filer criteria are potentially eligible to receive MAGI Medicaid. Refer to Section 2245, Filer Status/Specified Relative Relationship.

BASIC CONSIDERATIONS (cont.)

Basic Eligibility Criteria (cont.)

- **Residency** - AU members must be residents of Georgia and not incarcerated in a public institution. Refer to Section 2225, Residency.
- **Third Party Liability Requirements** – The A/R is required to provide information regarding any Third-Party Liability (TPL) available to any Potential Pathways member. The A/R must assign his/her TPL rights to DCH, unless Good Cause for TPL exists. Refer to Section 2230, Third Party Liability.
- Potential Pathways Member is not eligible for any other Medicaid class of assistance (Family or ABD).

NOTE: For Pathways COA, Application for Other Benefits is not a requirement. A/R should be notified of potential benefits if applicable.

Prospective Eligibility - Coverage in Pathways is prospective only and begins with the first day of enrollment in either a Medicaid Care Management Organization (CMO) or the Pathways Health Insurance Premium Payment (HIPP) program. A/Rs subject to premium payments must make their initial premium payment before they are enrolled in Pathways. A/Rs not subject to premium payments will begin coverage on the first of the month following the A/R's eligibility determination.

NOTE: There are no retroactive months or Hospital Presumptive Eligibility (HPE) for this COA. There is also no Emergency Medical Assistance (EMA) eligibility for Pathways.

Financial Eligibility Criteria

A/R must have income within the following limit:

- **Modified Adjusted Gross Income (MAGI)** - The total taxable net income of the AU must be equal to or less than the MAGI income limit of the AU size. For Pathways the household income can be up to 100% of the FPL, which includes a 5% of the FPL income disregard. After the 5% disregard and all applicable 1040 and Pre-tax deductions the A/R income must be equal to or less than 95% of the FPL. Refer to Appendix A2, Financial Limits for Family Medicaid.

Prospective budgeting is used in determining eligibility for the application month and the ongoing benefit period. Data sources and/or active related programs verification is used prior to requesting verification.

Modified Adjusted Gross Income (MAGI) financial methodologies are used to calculate the monthly MAGI income used for the BG. Pre-Tax deductions and 1040 deductions are given. Refer to Section 2669, MAGI Budgeting.

BASIC CONSIDERATIONS (cont.)

Non-Financial Eligibility Criteria

- **Qualifying Activities** - In order to be eligible for Pathways at application, an A/R 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:

  - Unsubsidized employment, including self-employment
  - Subsidized private sector employment
  - Subsidized public sector employment
  - On-the-job training
  - Job readiness
  - Community service
  - Vocational educational training
  - Enrollment in an institution of higher education
  - Enrollment and active engagement in the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation program

- **Maintaining Eligibility** – To remain eligible for Medicaid coverage through Pathways, an A/R must report their hours monthly. Reporting of hours will include an A/R's self-attestation of activity hours, accompanied by supporting documentation for verification. If an A/R fails to report their monthly hours, they will be suspended from the program unless they have a Good Cause Exception.

An A/R 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 a responsibility to report any changes in circumstance. An A/R who can provide evidence of meeting the hours and activities threshold for the six months prior to applying for Medical Assistance will also be exempt from the monthly reporting requirement, except that they will have an affirmative responsibility to inform the State of any changes in circumstance.

For more information regarding reporting requirements - Refer to Section 2256, Qualifying Activities Reporting

Pathways Health Insurance Premium Payment (HIPP) Program – A/Rs with access to Employer Sponsored Insurance (ESI) must enroll in the Pathways HIPP program if it is determined to be cost-effective for the State.

- **Cost-effectiveness** is defined as a savings of $1.00 or more per year for the State. It takes in to account the cost to the State paying the A/R's cost-sharing obligations, including premiums, for the employer's insurance compared to the cost of paying Medicaid capitation rates. Cost-effectiveness will be determined by the Third-Party Liability (TPL) vendor using their proprietary formulas and processes.

BASIC CONSIDERATIONS (cont.)

Pathways Health Insurance Premium Payment (HIPP) Program (cont.)

If the A/R is determined eligible for Pathways but is determined not to be cost-effective to enroll in ESI, the A/R will receive an approval notice from Gateway for Pathways and be enrolled into a CMO.

- **HIPP Referral Process** An A/R who reports having access to or reports being currently enrolled in ESI at application will be referred to the TPL vendor Health Management Systems (HMS) for an ESI cost-effectiveness determination if they are identified as potentially eligible for Pathways. The A/R will receive a notice informing them of this referral.

  The eligibility determinations for Pathways and for ESI cost-effectiveness will occur concurrently in order to remain within the 45-day standard of promptness requirement for eligibility determination. Gateway will determine eligibility for Pathways while the TPL vendor will determine cost-effectiveness for ESI.

  If the A/R is determined eligible for Pathways and is determined cost-effective to enroll in ESI, the A/R will receive an approval notice from Gateway outlining requirements for ongoing participation and next steps for enrollment with the TPL vendor.

NOTE: A/Rs enrolled in the Pathways HIPP program will have their ESI premium payments and cost-sharing obligations (including copayments & deductibles) made on their behalf by the State. **The Pathways HIPP program is not effective until Phase 2 implementation, scheduled January 1, 2024.**

Member Rewards Account – All A/Rs enrolled in Pathways, except those participating in the Pathways HIPP program, will have access to a Member Rewards Account (MRA or account). Premium payments will be deposited into the account. Additionally, A/Rs will have the opportunity to earn dollars by engaging in healthy behaviors. Funds in the account will be available to pay copayments as well as to pay for additional services not covered by Medicaid, such as vision or dental services.

NOTE: MRA program will not be effective until Phase 3 implementation, scheduled July 1, 2024.

Premium Payment and Tobacco Use Surcharges – A/Rs with income between 50% and 100% of the FPL and not enrolled in the Pathways HIPP program will be required to pay monthly premiums. Monthly premium payments are due by the 3rd of the month in order to maintain eligibility. The final deadline for a late premium payment is the 17th of the month. The monthly amount for A/Rs with income from 50% up to 85% is $7.00 and the monthly amount for A/Rs with income from 85% up to 100% is $11.00. A/Rs that currently consume tobacco or tobacco products on a regular basis will be subject to a tobacco surcharge.

BASIC CONSIDERATIONS (cont.)

Premium Payment and Tobacco Use Surcharges (cont.)

A/Rs who have income less than 50% FPL or are enrolled in the Pathways HIPP program are exempt from the premium requirement. A/Rs enrolled in and for 2 months after graduation from the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant program are waived from the premium requirement.

Premiums will be deposited monthly into the Members Rewards Account (MRA).

Premium Payments at Renewal - If a member is required to pay premiums in their current certification period, their premium is due on the 3rd of the last calendar month of their certification period (with a final deadline of the 17th of the month) in order to be eligible for the following month.

Members who are newly required to pay premiums as a result of a change in income determined at the renewal process will have a one-month waiver from premium payment.

During redetermination, A/R's income will be verified in order to determine eligibility for a new certification year. If at redetermination the member's income has increased or decreased, the State will evaluate whether the member's premium contribution amount should be adjusted for the following certification year.

If the A/R's income at redetermination is between 50% and up to 100% of the FPL, the member must pay the premium for the first month of the new certification period as a condition of eligibility. If the A/R was not required to pay premiums in the prior certification year, but now has an income between 50% and up to 100% of the FPL, then they will be required to pay premiums in the new certification year. They will be notified of this change in the Redetermination Approval Notice.

NOTE: For these members, a one-month waiver for premium payment will be given to provide the member with sufficient time to receive information about the new obligation and allow for continuous coverage.

The timeline for payment of the new premium amount depends on whether the change is negative or positive for the member.

- If positive (decrease or elimination of elimination of premium), the new premium amount is owed starting in the first month of the new certification period.

- If negative (increase of new requirement to pay premium), the new premium amount is owed starting in the first of the month following expiration of timely notice or at the start of the second month, whichever

BASIC CONSIDERATIONS (cont.)

Premium Payment and Tobacco Use Surcharges (cont.)

is later. This will provide the member with sufficient time to receive information about the new amount and adjust payment accordingly.

NOTE: Premium Payments will not be required until Phase 3 implementation, scheduled July 1, 2024.

Copayments – Copayments will be required for all A/Rs enrolled in Pathways regardless of their income, except for A/Rs enrolled in the Pathways HIPP program.

NOTE: Pathways copayments will not be required until Phase 3 implementation, scheduled July 1, 2024.

Pathways Contract – In order to be enrolled in Pathways, an A/R identified as potentially eligible must sign a contract with the State indicating their awareness of the terms of coverage, agreeing to comply with the premium payment (if applicable) and qualifying activities reporting requirement, that they may be subject to random and periodic audits, and awareness that their employer may be contacted to gather additional information on their ESI plan (if applicable).

NOTE: Pathways contract must be signed by the A/R for whom it is intended or an authorized representative they have given permission to act on their behalf. A Pathways contract must be received for each A/R who would like to be evaluated for Pathways COA.

Pathways Renewal- If the renewal is completed and submitted timely, the member will continue to be covered under Pathways until the renewal is processed, as long as they continue to meet their monthly qualifying activities requirement and premium payment (if applicable). For more information regarding the renewal process for Pathways please refer to Section 2706, Renewals.

NOTE: Pathways renewal process will be implemented in Phase 2, scheduled for January 2024.

Changes

All Pathways members are required to report a change in circumstance to the State which may impact their continued eligibility for the program within 10 days. During all reported changes, Pathways members will be evaluated to determine potential eligibility for all Medicaid classes of assistance other than Pathways.

In addition to reporting changes required by MAGI-Medicaid classes of assistance, Pathways members are required to report changes in:

BASIC CONSIDERATIONS (cont.)

Changes (cont.)

- Participation in qualifying activities that would impact their eligibility for the program (e.g., reduction of hours engaged below 80-hour threshold, withdrawal from full-time enrollment in an institution of higher education, etc.)

- Employer access to ESI (e.g., gain of access to ESI that was not indicated in the Medical Assistance application)

  For Changes in Qualifying Hours and Activities refer to Section 2256, Qualifying Activity Report.

- **Failure to Report a Change-** If the State is made aware that a member failed to report a change that makes them ineligible for Pathways or any other COA, the member will be terminated effective the first day following the month timely notice expires.

A/Rs who are terminated for failure to report a change in circumstance will receive a notice that their coverage will be terminated along with information on appeals.

If it is discovered that a member has intentionally defrauded the State, the current process for referral, investigation and fraud resolution will be followed.

- **Transition from Another COA to Pathways at Change-** Existing Medicaid A/Rs age 18 or older will have the opportunity to be evaluated for Pathways when reporting a change and signing the Pathways Contract. If eligible and approved for Pathways, coverage will begin prospectively on the first of the month following authorization of the approval. A/Rs will receive a one-month waiver for premium payment (if premium payment is required) to allow for continuous coverage.

- **Targeted Advance Notice** - Gateway will identify A/Rs currently enrolled in other classes of assistance who are coming to a known termination date (due to age) and who are under 120% of the FPL and include a Targeted Advance Notice with their Change/Termination Notice. The Targeted Advance Notice will include information such as the Pathways program overview, and information on submitting a change or new application and reporting qualifying activities for consideration of coverage through Pathways.

OTHER CONSIDERATIONS

Pathways and Care Management Organizations – A/Rs enrolled in Pathways will be automatically assigned into a Care Management Organization (CMO), except A/Rs who are enrolled in ESI and determined to be cost-effective. A/Rs will have 90 days after auto-assignments to change CMOs.

Pathways Manual Audit Process - As part of ongoing operations for Pathways, auditing of enrolled members will be conducted to verify compliance with the qualifying hours and activities requirement. All Pathways members assigned to a CMO or enrolled in ESI claimed through a spouse or family member will be subject to program audits. Upon approval in Pathways, the eligibility approval notice is generated which contains language to inform the A/R of the requirement to comply with random and periodic audits to maintain coverage under Pathways.

Enrolled Pathways members within the following three categories are subject to audit:

1. Members who are required to report monthly and who have reported hours and activities.

2. Members who have completed six months of consecutive reporting and who are exempt or waived from reporting hours and activities.

3. Members who have submitted Good Cause Exception request.

NOTE: Pathways members who are enrolled in the Pathways Health Insurance Premium Payment (HIPP) program are not required to report qualifying hours and activities monthly unless the Pathways member Employer-Sponsored Insurance (ESI) is claimed through a spouse or family member. As such, they are not subject to the qualifying hours and activities compliance audit.

The Pathways Program eligibility audit process will consist of third party and/or collateral verification of the qualifying hours and activity documents submitted by the member for the most recent month available within the case. Third party verification may be obtained via work number or computer matches. Collateral contact may be made verbally by telephone or, in writing. Additionally, members who are exempt from monthly reporting are expected to have certain forms of documentation available to show their continued engagement in qualifying activity or activities. If audited, the member will need to provide documents to verify compliance with qualifying hours and activities.

OTHER CONSIDERATIONS (cont.)

Applying for Pathways – A/Rs can apply for Pathways through the following methods:

- Online through the Customer Portal at www.gateway.ga.gov
- By calling 1-877-423-4746
- In-person at a Division of Family and Children Services (DFCS) office
- By paper application