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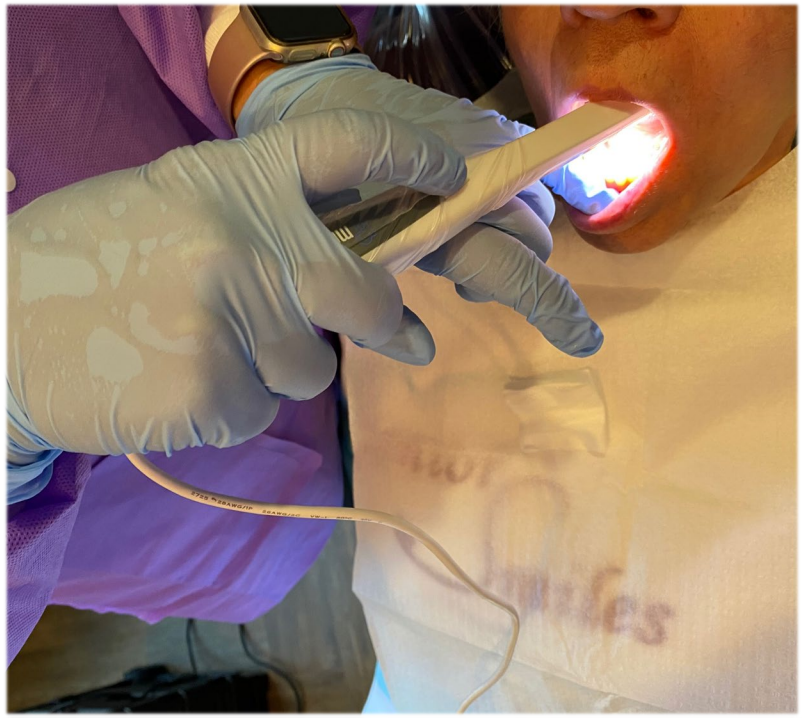
INFORMATION SUBMITTED BY

THE GEORGIA DENTAL HYGIENISTS ASSOCIATION



TELEDENTISTRY UNDER THE UMBRELLA OF TELEHEALTH

Types of Teledentistry

Synchronous, or "live"
Care delivered in real time. A dentist communicates with patients and other providers for exams and consultations via video or audio technology. Synchronous teledentistry is often provided when a patient is unable to come into the office or when providers consult with one another.

Asynchronous, or "store-and-forward"
Care that is not delivered in real time. A provider at a distant site captures diagnostic information, uploads and sends it to another provider, who reviews it at a later date. Asynchronous care is often provided at school-based clinics, long-term care facilities, and other sites outside the traditional dental office.

TELEDENTISTRY

Issues:

- 159 counties in Georgia; 126 HPSA
- 23 counties have no dental services
- Underserved populations

Solutions

- Remote Dental teams under General Supervision:
- Authorizing DDS
  - RDH (remote)
  - DA
- Teledentistry

Mobile Services

- Portable dental equipment
- Mobile Van
- Teledentistry system
  - Laptop
  - Intra-oral camera
  - Hand-held x-ray unit

TELEDENTISTRY

Teledentistry Equipment requirements/portability

- Laptop
- Secure software
- Cable
- Intraoral camera

Handheld portable x-ray unit (less than 5 lbs)

- Lead aprons

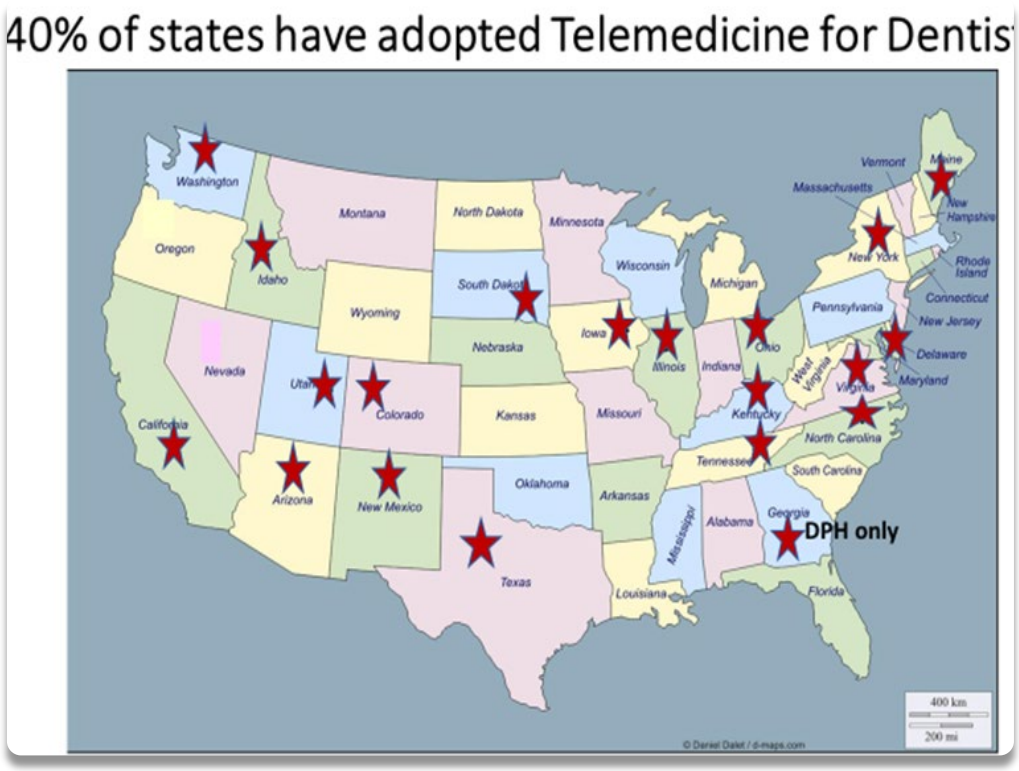
www.Mouthwatch.com

https://www.dhpsupply.com/item/570-ARIFP0151/NOMAD-Pro-2-Handheld-X-Ray/

Teledentistry

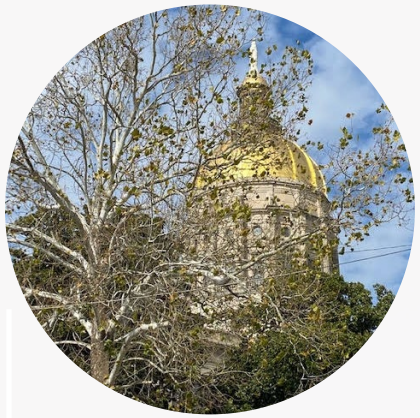
- **Benefits**
  - Expand dental teams into the community
    - Improve access to care for patients
  - Improve the oral hygiene of patients
  - Be more affordable than in-office dentistry
  - Align with today's patients' needs for modern forms of communication
  - Make in-office appointment times more accessible to patients who really need them
  - Provide the same level of care to patients as in-office visits
  - Integrate dental-medical healthcare

TELEDENTISTRY



- **States with Teledentistry regulations**
  - **AZ, CA, CO, DE, ID, IL, IO, KY, ME, NM, NY, NC, OH, SD, TN, TX, UT, VA, WA, GA (DPH only)**
- **Georgia:**
  - **Telemedicine is accessible in all 159 counties**
  - **In 2020, the GBOD approved the use of synchronous Teledentistry based on Governor Kemp's Executive Order; this order expired on March 31, 2022**
  - **Use of Teledentistry is no longer permitted in GA**
  - **Legislative action is required to establish regulations for Teledentistry to increase resources in GA of healthcare providers**

THANK YOU



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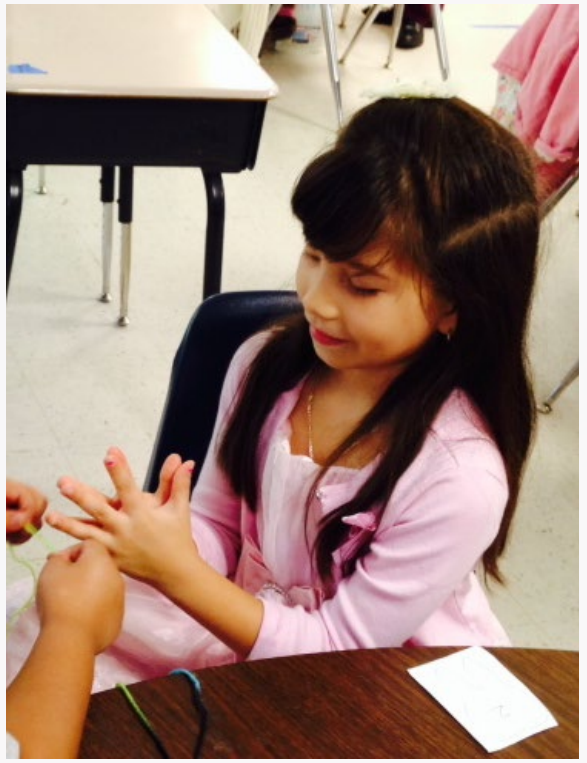


Teledentistry

In 2017, the GA legislature authorized Georgia supervising dentists to allow their dental hygienists to provide preventive dental services in alternative dental settings, such as long-term care facilities, school-based clinics, and other safety-net settings without first requiring an exam by a dentist.

Dental hygienists working in these non-traditional practice settings act as the doctor's "eyes" by providing an in-depth assessment of the patient prior to beginning care because their extensive training allows them to "see and identify" oral conditions that point the doctor to immediate and future dental needs the patient may have.

In many states where the supervising dentist is not physically present in the treatment facility such as the safety-net setting, assessed patient information may be sent remotely to the dentist. This is known as Telehealth for Dentistry, or Teledentistry, and may take several forms, such as photos, or two-way audio, visual, or other electronic communications.

All applications used in teledentistry aim to bring about efficiency, provide access to underserved populations, improve quality of care and reduce oral disease burden. However, in Georgia, no rules or legislation have ever been passed to authorize GA supervising dentists to send or receive remote communication.

Yet Georgia has been engaging with telemedicine for more than 20 years. It is available in all 159 counties and has become one of the most widely accepted solutions to increasing access to care across the state.

The 2017 final report of Georgia's Health Care Reform Task Force (January 2018), declared "the state needs new models of health care delivery, which are more flexible, less capital-intensive, and take advantage of new technologies to deliver care in a timely and efficient manner." The expansion of teledentistry provides one solution toward achieving that goal.

The American Dental Association (ADA) resolution on teledentistry suggests that this model of delivery of care can provide easier access to dental care for nursing home residents or those who live in rural areas without a dentist, thus enhancing early detection of disease as teledentistry provides the patient consultation and treatment planning with the dentist without the patient having to travel.

According to the American Teledentistry Association, teledentistry is proven to:

- Improve the dental hygiene of patients.
- Be more affordable than in-office dentistry.
- Align with today's patients' needs for modern forms of communication.
- Improve access to care for patients.
- Reduce the amount of time employees spend away from the office.
- Make in-office appointment times more accessible to patients who really need them.
- Provide the same level of care to patients as in-office visits.

GEORGIA COUNCIL ON AGING

COALITION OF ADVOCATES CO-AGE FOR GEORGIA'S ELDERLY

Telehealth for Dentistry

Dental hygienists working in non-traditional practice settings under general supervision assess the patient prior to beginning care. Their comprehensive education allows them to "see and identify" oral conditions that point the doctor to immediate and future dental needs the patient may have.

Telehealth for Dentistry, also known as Teledentistry, is a live two-way interaction between the doctor and the dental hygienist with a patient. Teledentistry can take several forms, such as real-time two-way audio/visual telecommunication or electronic communications and facilities assessment.

- Teledentistry has been shown to bring about efficiency, provide access to underserved populations, and improve quality of care to reduce the oral disease burden.
- Oral concerns and/or findings may be sent remotely to the dentist for evaluation when the dentist is not physically present during a patient assessment.
- Georgia has no laws to authorize a Georgia supervising dentist to send or receive remote communication even though the state has engaged with telemedicine for over 20 years.
- The American Dental Association (ADA) policy on teledentistry states that this model of delivery of care can provide easier access to dental care for nursing home residents or those who live in rural areas without a dentist.

CO-AGE supports the efforts of the Georgia Dental Hygienists Association to pass legislation allowing dental hygienists to serve individuals in external settings under the general supervision of a dentist. The Georgia Board of Dentistry permitted the temporary use of teledentistry through May 13th, 2020 in emergencies when dental offices were not open. This measure proved that teledentistry can bring about efficiency, provide access to underserved populations, and improve quality of care to reduce the oral disease burden.

ADA Policy on Teledentistry
https://www.ada.org/about/governance/current-policies/ada-policy-on-teledentistry

Teledentistry refers to the use of telehealth systems and methodologies in dentistry. Telehealth refers to a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery.

Teledentistry can include patient care and education delivery using, but not limited to, the following modalities:

Synchronous (live video): Live, two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology.

Asynchronous (store and forward): Transmission of recorded health information (for example, radiographs, photographs, video, digital impressions and photomicrographs of patients) through a secure electronic communications system to a practitioner, who uses the information to evaluate a patient's condition or render a service outside of a real-time or live interaction.

Remote patient monitoring (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in care and related support of care.

Mobile health (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDA).

General Considerations: While in-person (face to face) direct examination has been historically the most direct way to provide care, advances in technology have expanded the options for dentists to communicate with patients and with remotely located licensed dental team members. The ADA believes that examinations performed using teledentistry can be an effective way to extend the reach of dental professionals, increasing access to care by reducing the effect of distance barriers to care. Teledentistry has the capability to expand the reach of a dental home to provide needed dental care to a population within reasonable geographic distances and varied locations where the services are rendered.

In order to achieve this goal, services delivered via teledentistry must be consistent with how they would be delivered in-person. Examinations and subsequent interventions performed using teledentistry must be based on the same level of information that would be available in an in-person environment, and it is the legal responsibility of the dentist to ensure that all records collected are sufficient for the dentist to make a diagnosis and treatment plan. The treatment of patients who receive services via teledentistry must be properly documented and should include providing the patient with a summary of services. A dentist who uses teledentistry shall have adequate knowledge of the nature and availability of local dental resources to provide appropriate follow-up care to a patient following a teledentistry encounter. A dentist shall refer a

patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in case of emergency.

As the care provided is equivalent to in person care, insurer reimbursement of services provided must be made at the same rate that it would be made for the services when provided in person, including reimbursement for the teledentistry codes as appropriate.

Patients' Rights: Dental patients whose care is rendered or coordinated using teledentistry modalities have the right to expect:

That any dentist delivering, directing or supervising services using teledentistry technologies will be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's dental board.

Access to the licensure and board certification qualifications of the oral health care practitioner who is providing the care in advance of the visit.

That the delivery of services through teledentistry technologies will follow evidence-based practice guidelines, to the degree they are available, as a means of ensuring patient safety, quality of care and positive health outcomes.

That they will be informed about the identity of the providers collecting or evaluating their information or providing treatment, and of any costs they will be responsible for in advance of the delivery of services.

That relevant patient information will be collected prior to performing services using teledentistry technologies and methods including medical, dental, and social history, and other relevant demographic and personal information.

That the provision of services using teledentistry technologies will be properly documented and the records and documentation collected will be provided to the patient upon request.

That services provided using teledentistry technologies and methods include care coordination as a part of a dental home and that the patient's records be made available to any entity that is serving as the patient's dental home.

That the patient will be actively involved in treatment decisions, will be able to choose how they receive a covered service, including considerations for urgency, convenience and satisfaction and without such penalties as higher deductibles, co-payments or coinsurance relative to that of in-person services.

That the dentist shall determine the delivery of services using teledentistry technologies and all services are performed in accordance with applicable laws and regulations addressing the privacy and security of patients' private health information.

Quality of Care: The dentist is responsible for, and retains the authority for ensuring, the safety and quality of services provided to patients using teledentistry technologies and methods. Services delivered via teledentistry should be consistent with in-person services, and the delivery

of services utilizing these modalities must abide by laws addressing privacy and security of a patient's dental/medical information.

Supervision of Allied Dental Personnel: The extent of the supervision of allied dental personnel should conform to the applicable dental practice act in the state where the patient receives services and where the dentist is licensed. The dentist should be knowledgeable regarding the competence and qualifications of the allied personnel utilized, and should have the capability of immediately contacting both the allied dental personnel providing service and the patient receiving services. All services delivered by allied dental personnel should be consistent with the ADA Comprehensive Statement on Allied Dental Personnel.

Licensure: Dentists and allied dental personnel who deliver services through teledentistry modalities must be licensed or credentialed in accordance with the laws of the state in which the patient receives service. The delivery of services via teledentistry must comply with the state's scope of practice laws, regulations or rules. Teledentistry cannot be used to expand the scope of practice or change permissible duties of dental auxiliaries. The American Dental Association opposes a single national federalized system of dental licensure for the purposes of teledentistry.

Reimbursement: Dental benefit plans and all other third-party payers, in both public (e.g. Medicaid) and private programs, shall provide coverage for services using teledentistry technologies and methods (synchronous or asynchronous) delivered to a covered person to the same extent that the services would be covered if they were provided through in-person encounters. Coverage for services delivered via teledentistry modalities will be at the same levels as those provided for services provided through in-person encounters and not be limited or restricted based on the technology used or the location of either the patient or the provider as long as the health care provider is licensed in the state where the patient receives service.

Technical Considerations: Dentists are encouraged to consider conformance with applicable data exchange standards to facilitate delivery of services via teledentistry modalities. These include, but are not limited to, Digital Imaging and Communications in Medicine (DICOM) standards when selecting and using imaging systems, X12/HL7 for the exchange of information and ICD-9/10-CM/SNOMED/SNODENT for documentation consistency.

Policy updated in 2020.

DPH Telemedicine

Georgia's Telemedicine Services

Georgia's Department of Public Health (DPH) has established a telemedicine network that is recognized as one of the most robust and comprehensive public health telemedicine networks in the nation and a best-practices model of care.

Georgia Department of Public Health

Network Overview

Technology is rapidly improving patient access to care in Georgia:

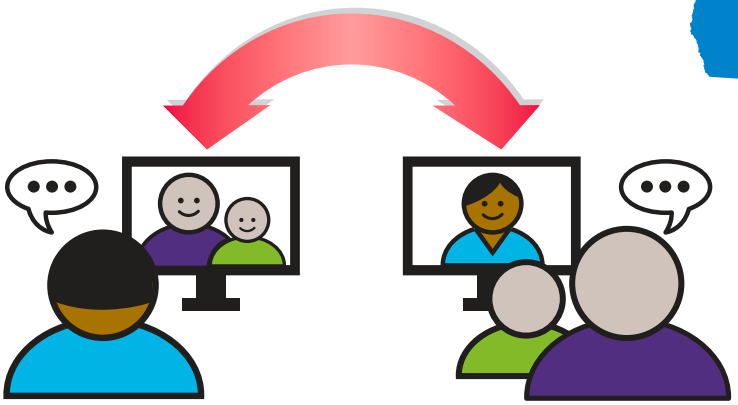
- Telemedicine increases efficiency, extends scope of practice, improves health outcomes, reduces healthcare costs, and enables greater healthcare equality across the state.
- The DPH network connects county health departments and specialty clinics with each other and to other collaborative partners and providers.

The network is a hybrid model comprised of on-premise and internet-based technologies, allowing us to scale the network, as needed.

More than **400** endpoints

Serving all **159** counties

Ours is the only Public Health lead network of its kind in the nation.



REAL TIME, SYNCHRONOUS VIDEO CONFERENCING

Some counties utilize the network for video conferencing and training, while others use it to exponentially expand their healthcare infrastructure.

Telemedicine services include:

- Community Paramedicine
- Individualized Nutrition Education
- High Risk Obstetrics
- Genetics
- Breastfeeding Education
- Emergency Preparedness & Response
- Epidemiology Remote Patient Monitoring
- Distant Learning Education
- Pediatric Dental Care
- Infectious Diseases
- Concussion Care
- Workforce Development
- Diabetes
- Asthma/Allergy
- Audiology

...and more.

Funding for the network comes from **federal, state, county**, and **grant** funds.

Improved Diagnosis and Treatment Time

Telemedicine is helping individuals across Georgia access specialty care closer to home.

$2.3 million

Amount DPH receives in legislative appropriation

to pay for the circuits and infrastructure for all 159 counties, allowing DPH to carry out its mission **to reduce health care access gaps** in vulnerable populations and populations at risk.

Network utilization tracking

affords DPH the opportunity to charge utilization fees by program to users/ providers via an established cost allocation plan.

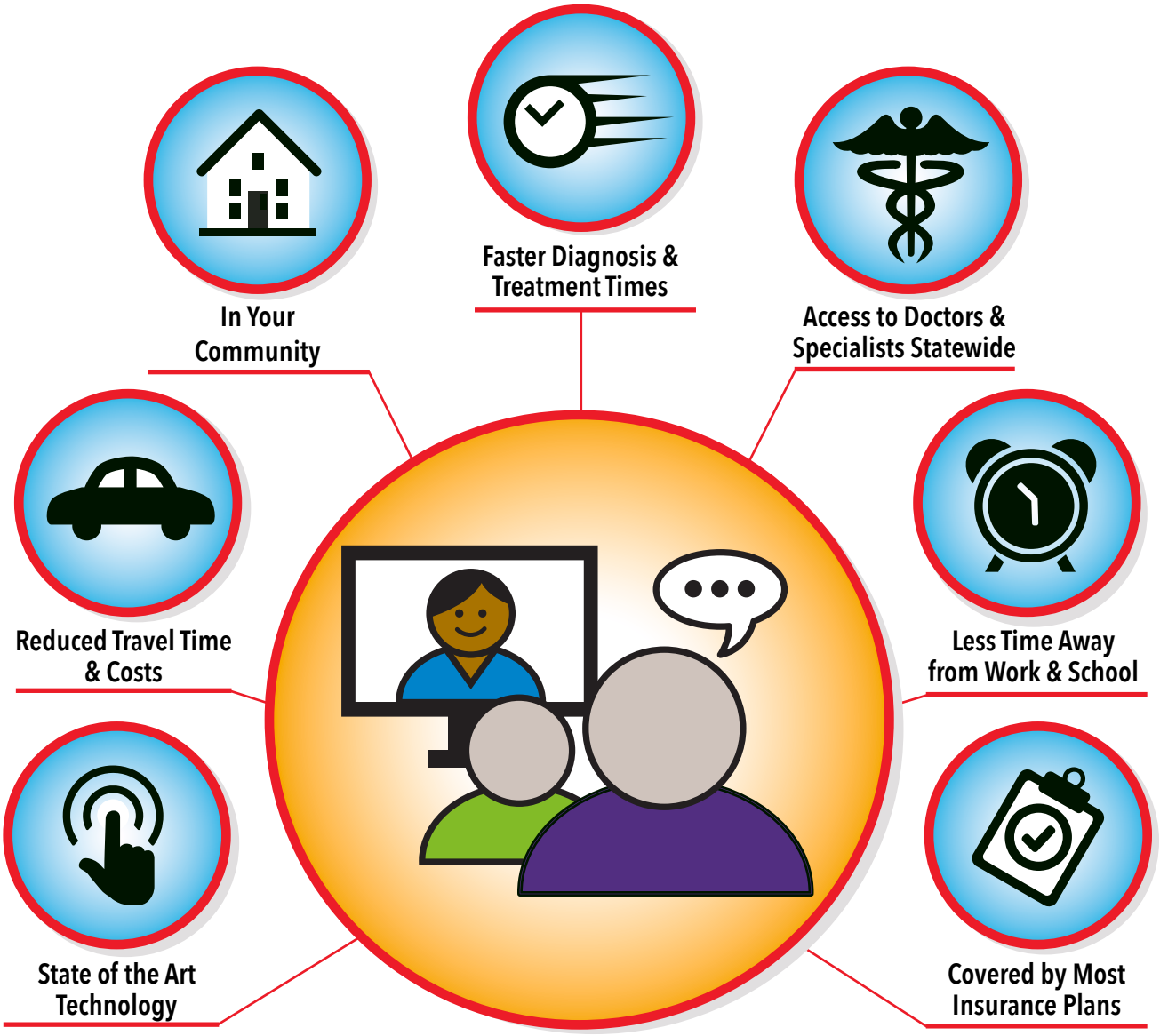
Additional funding sources are continuously explored and pursued to support and sustain the network.

We Protect Lives.

Georgia Department of Public Health

Georgia's Telemedicine Network

Quality Medical Care Where & When You Need It



Benefits to You!

>> Convenient locations across the state. <<

Sites include community hospitals, health departments, schools, WIC clinics and doctor's offices

To learn more visit https://dph.georgia.gov/office-telehealth-telemedicine or call 404-657-2305

We Protect Lives.

Telehealth Guidance

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

July 1, 2021

Policy Revisions Record Telehealth Guidance

2021

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
Jan. 1, 2019	Page 6	Clarification verbiage added in Coverage section in # 1.	M	N/A
Jan. 1, 2018		Revised CPT Code description	M	N/A
Oct. 1 2018		Added Audiology Codes and language related to Behavioral Health Services (Telemental Health)	A	N/A
April 1, 2019		Added other forms of Telehealth and respective regulations and codes pertaining thereof	A	N/A
July 1, 2019		Added Telehealth/Telehealth services for Autism Spectrum Disorders, Physicians,	A	
July 1, 2019		Online Prescribing	D	
July 1, 2019		Physician Services	A	
July 1, 2019		Community Behavioral Health and Rehabilitation	M	
January 1, 2020		Addition of Asynchronous service definition	M	Y Article 1 of Chapter 24 of Title 33 O.C.G.A.
January 1, 2020		License to practice medicine obtained through the Inter-state Compact will be issued by the State's Medical Composite Board.	A	Y Article 1 of Chapter 24 of Title 33 O.C.G.A.
April 1, 2020		Clarification of Telemedicine Codes as it relates to Public Health Emergency	A	

January 1, 2021		Change document to reflect new fiscal intermediary from DXE Technology to Gainwell Technologies	M	
July 1 2021		Deleted WellCare from Telemedicine Guidance	D	
July 1 2021		Added GA Families Appendix	A	

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Program Overview

The Department of Community Health (DCH) Telehealth and Telehealth policies are slated to improve and increase access and efficiency to health care services by enabling medical services to be delivered via telehealth methods in Georgia. Telehealth services are not an expansion of Georgia Medicaid covered services but, an option for the delivery of covered services. Telehealth will allow DCH to meet the needs of members and providers, while complying with all applicable Federal and State statutes and regulations. The quality of health care services delivered must be maintained regardless of the mode of delivery.

Telehealth is the use of medical information exchange from one site to another via electronic communications to improve patient's health status. It is the use of two-way, real time interactive communication equipment to exchange the patient information from one site to another via an electronic communication system. This includes audio and video communications equipment. Closely associated with telehealth is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Telehealth is the use of telecommunications technologies for clinical care (telehealth), patient teachings and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

The intent of our telehealth services policy is to improve access to essential healthcare services that may not otherwise be available for Medicaid eligible members. Telehealth is not a separate medical specialty. Products and services related to telehealth are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. When an enrolled provider, determines that medical care can be provided via electronic communication with no loss in the quality or efficacy of the member's care, telehealth services can be performed.

An interactive telecommunications system is required as a condition of payment. The originating site's system, at a minimum, must have the capability of allowing the distant site provider to visually examine the patient's entire body including body orifices (such as ear canals, nose, and throat). Depending upon an enrolled provider's specialty and scope of practice, the distant provider should also have the **capability** to hear heart tones and lung sounds clearly (using stethoscope) if medically necessary and currently within the provider's scope of practice. The telecommunication system must be secure and adequate to protect the confidentiality and integrity of the information transmitted.

Medicaid covered services are provided via telehealth for eligible members when the service is medically necessary, the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the member's needs.

Service Definitions

Asynchronous or "Store and Forward": Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous communication does not include telephone calls, images transmitted via fax machines and text messages without visualization of the patient (electronic mail)

The sending of x-rays, computerized tomography scans, or magnetic resonance images are common store and forward applications. The original image may be recorded or forwarded in digital or analog format and may include video 'clips' such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

Distant Site The telehealth site where the practitioner/provider is legally allowed to practice in Georgia while providing health care services.

Practitioners at the distant site may furnish and receive payment for covered telehealth services provided that such services are acting within the scope of practice of such health care practitioner or professional, within the guidelines of applicable Medicaid policy for service rendered and in accordance with the provisions of the Georgia State Code Section 43-34-31.

Originating Site For members receiving Telehealth or Telehealth services the originating site is the location where the member will receive services through a telecommunications system.

Telehealth is a broad definition of remote healthcare that does not always involve clinical services. Telehealth can be used in telecommunications technologies for patient education, home health, professional health education and training, administrative and program planning, and other diverse aspects of a health care delivery system.

Telehealth Involves the use of two-way, real time interactive communication equipment to exchange medical/clinical information between a healthcare practitioner and the member from one site to another via a secure electronic communication system. This includes audio and video communications equipment designed to facilitate delivery of healthcare services in a face-to-face interactive, though distant, engagement.

TeleMental Health is a term defined by Ga. Comp. R. & Regs. R. 135-11-01. and is applicable only to Licensed Social Workers, Professional Counselors and Marriage & Family Therapists when either 1) practicing telehealth as defined above, or 2) providing telephonic intervention when allowable via DCH/DBHDD guidelines). Per this rule and regulation, there are specific practice guidelines and mandatory training pertaining to what is identified as TeleMental Health. Providers shall adhere to these rules and regulations when TeleMental Health is provided by one of these named practitioners.

Synchronous services that are occurring in "real-time", as demonstrable in two-way consult between a member in concert with their practitioner/provider and another practitioner/provider at a distant site.

Security and Confidentiality:

In compliance with all applicable Federal and State statutes and regulations, providers of the CBHRS program are permitted to incorporate usage of Telehealth for certain services they provide. The goal for enabling telehealth methods is to improve and increase access and efficiency of behavioral health service delivery to Georgia Medicaid members. Appropriate use of Telehealth shall always consider its secure and confidential use. Special considerations in the use of electronic-facilitated treatment must include informed consent of the individual served, authorization through the process of Individualized Recovery Plans, educational components in assessment and service delivery which indicates ongoing agreement with the treatment method and under what circumstances electronic communications may and may not be used.

Telehealth Services must be HIPAA compliant and in accordance with Safety and Privacy regulations. All transactions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmitted information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver. All interactive video telecommunications must comply with HIPAA patient privacy regulations at the site where the member is located, the site where the consulting provider is located and in the transmission process. All communications must be on a secure network in compliance with HIPAA Encryption (Encryption is the conversion of plaintext into cipher text using a key to make the conversion) and Redundancy requirements.

Telehealth- Interstate Medical Licensure Compact

DCH is committed to providing all our stakeholders with the safest environment possible as well as access to qualified healthcare providers. The *Interstate Medical Licensure Compact (ILMC)* offers an expedited licensing process for physicians that are interested in practicing medicine in the state of Georgia yet are licensed within another state. The Compact was created with the goal of expanding access to health care, especially to those in rural and underserved areas of the state, and to facilitate the use of telehealth technologies in the delivery of health care.

Licensure Requirements

The Georgia Composite Medical Board is authorized to administer the compact in this state. Under the compact, physicians must meet certain requirements, including: possess a full and unrestricted license to practice medicine in a Compact state; possess specialty certification or be in possession of a time unlimited specialty certificate; have no discipline on any state medical license; have no discipline related to controlled substance; not be under investigation by any licensing or law enforcement agency; have passed the USMLE or COMLEX within three attempts; and have successfully completed a graduate medical education (GME) program.

License to practice medicine obtained through this compact will be issued by the State's Medical Composite Board.

A physician will apply for expedited licensure by designating a member state as the state of principal licensure and select Georgia to which the medical license is desired. The state of principal licensure will then verify the physician's eligibility and provide credential information to the Interstate Commission. The Commission will then collect the applicable fees and transmit the physician's information and licensure fees to the additional states. Upon receipt in the additional states, the physician will be granted a license.

Additional information will be housed with the Georgia Composite Medical Board.

Billing and payment for professional services furnished via telehealth

Submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service. The GT modifier is required as applicable and or the use of POS 02 will indicate Telehealth services. The GQ modifier is still required as applicable. By coding and billing with the covered telehealth procedure code, you are certifying that the member was present at an eligible originating site when you furnished the telehealth service. Telehealth services provided by the Distant Site providers must also bill with the appropriate CPT and/or HCPS code with the POS code 02 for timely payment.

Billing and payment for the originating site facility fee

Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014 with a payment of $20.52. Hospitals are eligible to receive reimbursement for a facility fee for telehealth when operating as the originating site. Claims must be submitted with revenue code 780 (telehealth) and type of bill 131. There is no separate reimbursement for telehealth serves when performed during an inpatient stay, outpatient clinic or emergency room visit or outpatient surgery, as these are all-inclusive payments.

Coverage Requirements

To provide coverage of medically necessary services provided using telecommunication systems the following requirements must be met:

1. The referring provider must be enrolled in GA Medicaid and comply with policy and procedures as outlined in applicable Georgia Medicaid manuals.
2. The member must be present and participating in the visit.
3. The referring health care practitioner must obtain written consent from the eligible Georgia Medicaid member prior to rendering service. The consent must state that the member agrees to participate in the telehealth-based service. Copies of this form (refer to Appendix A) should be in the medical record of both the originating and distant site providers. The consent form must include a description of the risks, benefits and consequences of telehealth and be included in the member's medical record. Providers may utilize a consent form other than the one attached to this guide; however, it must, at a minimum, contain the same requirements, standards and information listed on the member consent form in Appendix A.
4. The referring provider must be the member's attending physician, practitioner, or provider in charge of their care. The request must be documented in the member's record. The physician or practitioner providing the referral must provide pertinent medical information and/or records to the distant site provider via a secure transmission. Notwithstanding the foregoing, referrals for evaluation of physical, mental, or sexual abuse may be made by an appropriate agency or group, including but not limited to, law enforcement or social services agencies.

5. The referring provider must be requesting the opinion, advice, or service of another provider for a specific medical problem, illness or injury.
6. The consulting provider must be an enrolled provider in Medicaid in the state of Georgia and must document all findings and recommendations in writing, in the format normally used for recording services in the member's medical records. Both the originating site and distant site must document and maintain the member's medical records. The report from the distant site provider may be faxed to the originating provider. Additionally, all electronic documentation must be available for review by the Georgia Department of Community Health, Medicaid Division, Division of Program Integrity, and all other applicable divisions of the department.
7. All telehealth activities must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA): Standards for Privacy of individual identifiable health information and all other applicable state and federal laws and regulations.
8. All services that require prior approval must be prior approved. The provider at the distant site must obtain prior approval when services require prior approval.
9. If the member is a minor child, a parent/guardian must present the child for telehealth services and sign the consent form unless otherwise exempted by state or federal law. The parent/guardian need not attend the telehealth session unless attendance is therapeutically appropriate.
10. The member retains the right to withdraw at any time.
11. All existing confidentiality protections and HIPAA guidelines apply.
12. The member has access to all transmitted medical information, except for live interactive video (if there is no stored data of the encounter).
13. There will be no dissemination of any member images or information to other entities without written consent from the member.

Documentation Requirements

The appropriate medical documentation must appear in the member's medical record to justify medical necessity for the level of service reimbursed. The record must reflect the level of service billed and must be legible. Documentation must be maintained at both the origination and distant sites to substantiate the services provided. Services must be clearly and separately identified in the member's medical record. Documentation must indicate the services were rendered via telehealth and the location of the originating and distant sites. All other Georgia Medicaid documentation guidelines apply to services rendered via telehealth. Examples include but are not limited to: chart notes, start and stop times, date of visits, provider's signature, service provider's credentials, signed member consent form, and physician findings, diagnosis, illness, prescribed treatment, and so forth.

Covered Telehealth Service Delivery Modalities

- Interactive audio and video telecommunications must be used, permitting real time communications between the distant site provider or practitioner and the member.

- All transactions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information.
- Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.
- All interactive video telecommunications must comply with HIPAA patient privacy regulations at the site where the member is located, the site where the consulting provider is located and in the transmission process.
- All communications must be on a secure network in compliance with HIPAA Encryption and Redundancy requirements. Encryption is the conversion of plaintext into cipher text using a key to make the conversion.

Non-covered Services Modalities

- Telephone conversations.
- Electronic mail messages.
- Facsimile.
- Services rendered via a webcam or internet-based technologies (i.e., Skype, Tango, etc.) that are not part of a secured network and do not meet HIPAA encryption compliance.
- Video cell phone interactions.
- The cost of telehealth equipment and transmission.
- Failed or unsuccessful transmissions.

Authorizations

This guidance is written in accordance with the following Federal and State rules and regulations in addition to current specific Department policy manuals.

- Georgia Secretary of States Rules and Regulations 135-11-01 TeleMental Health
- State Plan Amendment 15-0008 Telehealth and Telehealth Services
- State Plan Amendment 15-0012 Transportation Facility Sites
- State Plan Amendment, 17-0002 Community Behavioral Health Rehabilitation Services
- Part II Policies and Procedures for Federally Qualified Health Center Services and Rural Health Clinic Services Section 970
- Part II Policies and Procedures for Dentistry Services
- Part II Policies and Procedures for Children's Intervention School Services Section 602.5
- Part II Policies and Procedures for Community Behavioral Health and Rehabilitation Services Appendices G and O
- Part II Policies and Procedures Manual for Autism Spectrum Disorder (ASD) Services

The state understands that there may be areas within the above referenced documents that differ in use of terminology. Additionally, if this guidance is found to conflict with state, federal, regulatory, or scope of service guidance, please apply the more stringent guidance.

State's Response during State and National Emergencies

The guidance contained within this document relates to services rendered and billed during normal circumstances. In the event of an officially declared National or State emergency, guidance may be modified to address members and providers' needs. Providers are asked to refer to the most current Banner Messages, DCH website (dch.georgia.gov) and Providers Notices as to any policy updates.

Telehealth Reimbursement for Ambulance Providers

Telehealth Reimbursement for Ambulance Providers

Effective April 22, 2016, the Centers for Medicare & Medicaid Services (CMS) approved Georgia Department of Community Health (DCH), Medicaid Division State Plan Amendment (SPA) for Ambulance as telehealth sites. Emergency Ambulances may serve as a telehealth origination site and the ambulance may bill a separate origination site fee. Emergency Ambulance may not serve as a distant site. The following are the definitions for Telehealth Based Services:

A. Originating Sites (HCPCs 03014): Originating site means the location of an eligible Medicaid beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites are reimbursed at 84.645%of the 2012 Medicare fee schedule.

B. Distant Site Practitioners: Distant site means the site at which the physician or practitioner delivering the service is located at the time the service is provided via a telecommunications system. Distant Site Practitioners shall be reimbursed according to the same methodology as if the visit occurred in person. Ambulances are not authorized to provide distant site services.

Please review the information below to obtain a better understanding of what the telehealth billing entails. The prior approval requirements, non-covered, and covered services requirements have not changed. The Telehealth originating fee (03014) cannot be billed in combination with other rendered EMS services.

- Emergency ambulance transportation of more than 150 miles one way from an institution to an institution.

- Emergency transportation services certified by a physician as medically necessary, but not included as a covered service, may be covered for recipients under twenty-one years of age when such services are prior approved by the department.

- All ambulance transportation of more than 50 miles beyond the boundaries of the Georgia state line (out-of-state).

- Transportation that is not of an emergency nature, but the recipient requires services of an EMT and the life sustaining equipment provided in the emergency ambulance

All ambulance transportation by air ambulance except for recipients zero (0) to twelve (12) months of age who meet certain criteria listed in the policies and procedures manual.

Limitation: Emergency ambulance services are reimbursable only when medically necessary. The recipient's physical condition must prohibit use of any method of transportation except emergency for a trip to be covered.

Autism Spectrum Disorders (ASD) Services

Autism Spectrum Disorders (ASD) Services

Practitioners Eligibility to Provide Service

Practitioners of ASD services can use telehealth to assess, diagnose and provide therapies to patients.

As outlined in Part II-Chapter 600 "*Special Conditions of Participation"* a provider must:

Hold either a current and valid license to practice Medicine in Georgia, hold a current and valid license as a Psychologist as required under Georgia Code Chapter 39 as amended, or hold a current and valid Applied Behavior Analysis (ABA) Certification.

In addition to licensed Medicaid enrolled Physicians and Psychologists, Georgia Medicaid will enroll Board Certified Behavioral Analysts (BCBAs) as Qualified Health Care Professionals (QHCPs) to provide ASD treatment services. The BCBA must have a graduate-level certification in behavior analysis. Providers who are certified at the BCBA level are independent practitioners who provide behavior-analytic services. In addition, BCBAs supervise the work of Board-Certified Assistant Behavior Analysts (BCaBAs), and Registered Behavior Technicians (RBTs) who implement behavior-analytic interventions.

Attestation

New providers will submit the Attestation upon enrollment, and existing providers must also do so in order to provide adaptive behavior services. Both the lead QHCP and supervised QHCPs must cite any Degrees, Certifications, and/or Licenses, or other relevant credentials on the Attestation which is required to be on file with the Department. The Attestation must be updated and submitted to the Department within two (2) weeks of any change in staffing of QHCPs providing care. The Attestation may be downloaded, completed, and submitted by facsimile to the Attention of Georgia Department of Community Health (DCH) ABS Enrollment to 404-656-8366. The online Attestation is also available for electronic completion and online submission to GAMMIS. The online Attestation can be accessed via the GAMMIS web portal at:

https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FORMS/Attestation%20Form%20for%20Specialty%20Provider%20for%20Autism%20Services_revised_03_13_18%20%202018032217 4355.pdf

Please refer to Part II Policies and Procedures Manual for Autism Spectrum Disorder (ASD) Services for additional qualifications, requirements, and Facility Enrollments.

Member Eligibility

Services to treat Autism Spectrum Disorders (ASD), as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, include assessment and treatment provided to Medicaid beneficiaries in accordance with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit and according to medical necessity. Pursuant to 42 CFR 440.130(c), services must be recommended by a licensed physician or other licensed practitioner of the healing arts acting within their scope of practice under state law to prevent the progression of ASD, prolong life, and promote the physical and mental health of the individual.

Billing

Prior Authorization (PA) is required for all Medicaid-covered:

- Adaptive Behavior Services (ABS)
- Behavioral Assessment and
- Treatment Services

All services are to be billed with modifiers specific for practitioner level and service delivery setting/modality as outlined in the Part II Policies and Procedures Manual for Autism Spectrum Disorder (ASD).

Codes

The following codes can be used to provide ASD services

Table A

2019 Category I/III CPT Codes for Adaptive Behavior Services Description	2019 Procedure Code	Practitioner Level Modifier	Service Location	Unit	Rate
Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare profession's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	97151	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01
Behavior Identification Supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minutes	97152	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01
		U4	GT	15 min	20.30
		U5	GT	15 min	15.13
Behavior identification supporting assessment, each 15 minutes of technician' time face-to-face with a patient, requiring the following components: a) administered by the physician or other qualified healthcare professional who is on site; b) with the assistance of two or more technicians; c) for a patient who exhibits destructive	0362T	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01

behavior; d) completed in an environment that is customized to the patient's behavior		U4	GT	15 min	20.30
		U5	GT	15 min	15.13
Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes	97153	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01
		U4	GT	15 min	20.30
		U5	GT	15 min	15.13
Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15	97154	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01
		U4	GT	15 min	20.30
		U5	GT	15 min	15.13
Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	97155	U1	GT	15 min	58.21
		U2	GT	15 min	38.97
		U3	GT	15 min	30.01
Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	97156	U1	GT	15 min	21.90
		U2	GT	15 min	17.01
		U3	GT	15 min	13.21
Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	97157	U1	GT	15 min	25.34
		U2	GT	15 min	17.00
		U3	GT	15 min	13.21
Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients, each 15 minutes	97158	U1	GT	15 min	25.34
		U2	GT	15 min	14.00
		U3	GT	15 min	13.21
Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components:	0373T	U1	GT	15 min	58.21

- administered by the physician or other qualified healthcare professional who is on site;		U2	GT	15 min	38.97
- with the assistance of two or more technicians;		U3	GT	15 min	30.01
- for a patient who exhibits destructive behavior;		U4	GT	15 min	20.30
- completed in an environment that is customized, to the patient's behavior		U5	GT	15 min	15.13

"Out-of-Clinic" is billable for delivery of ASD services in any other location outside of the following:

(1) your agency/clinic (In-clinic)

(2) Telehealth

Table B

Practitioner Level Legend	***Level***
Physician, Psychiatrist	U1 - Level 1
Psychologist, BCBA-D	U2 - Level 2
BCBA	U3 - Level 3
BCaBA or Master's Level Behavior Analyst	U4 - Level 4
Registered Behavior Technician	U5 - Level 5

Community Behavioral Health and Rehabilitation Services

Community Behavioral Health and Rehabilitation Services

Purpose

Use of Telehealth for behavioral health services within the Community Behavioral Health and Rehabilitation Services (CBHRS) program.

Service Accessibility

Currently, the Departments of Community Health (DCH) and Behavioral Health and Developmental Disabilities (DBHDD) have authorized Telehealth to be used to provide some of the services in the CBHRS program. Providers may use Telehealth as a tool to provide direct interventions to individuals in the following circumstances:

- For some services, any member who consents may receive telehealth
- For some services, telehealth is allowed only for members who speak English as a second language, and telehealth will enable the member to engage with a practitioner who can deliver services in his/her preferred language (e.g. American Sign Language, etc.)(one-to-one via Telehealth versus interpreters).
- Telehealth is only allowed for certain CBHRS services and only two-way, real-time interactive audio and video communication as described in the Service Definitions section of this Guidance is allowable. ***Telehealth may not be used for any other Intervention.***
- For other specifics on Telehealth and its scope of use, see the DBHDD Provider Manual at: http://dbhdd.org/files/Provider-Manual-BH.pdf

Originating Site For CBHRS, members may be located at home, schools, and other community-based settings or at more traditional sites named in the Department of Community Health (DCH) Telehealth Guidance manual above.

Training

As outlined in the Rules and Regulations of the State of Georgia *Chapter 135-11-01 TeleMental Health* there are additional guidelines that establish minimum standards for the delivery of services by a licensed Professional Counselor, Social Worker, or Marriage and Family Therapist using technology-assisted media. Specific provisions can be found in the Georgia Rules and Regulations Department 135, Chapter 135-11-01 TeleMental Health.

Consent:

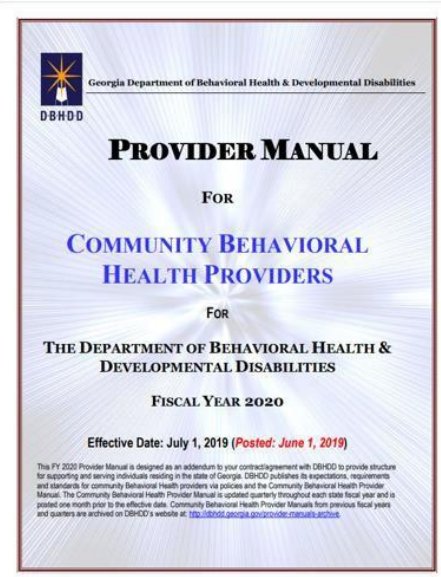
For CBHRS, the *Telehealth Member Consent Form* for each member is outlined in the Telehealth Guidance Document and must be utilized. Complete and detailed Guidance on Telehealth and Telehealth can be accessed by visiting https://www.mmis.georgia.gov/portal/; then clicking Provider Information, Provider Manuals and Telehealth Guidance.

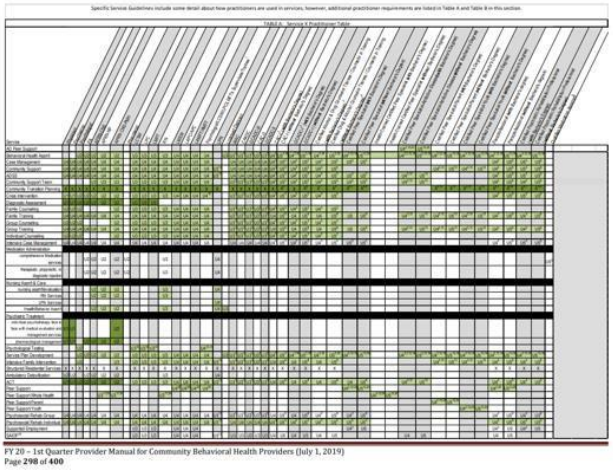
Service Delivery:

Currently, the Department of Behavioral Health and Developmental Disabilities (DBHDD) has authorized **Telehealth to be used to provide some of the services in the CBHRS program**. Practitioners may use Telehealth as a tool to provide direct interventions for

eligible individuals for some services. Additionally, for a subset of CBHRS services, individuals for whom English is not their first language (one-to-one via Telehealth versus interpreters) may access some services. For other specifics on Telehealth and its scope of use, see the DBHDD Provider Manual at: http://dbhdd.org/files/Provider-Manual-BH.pdf. Part I, Table A: Service X Practitioner Table. The table provides detailed instructions explanation for when and which type of practitioner can bill for Telehealth services. Within the table, Light green shading denotes services for which telehealth may be billed **only** if English is not the person's primary language. Dark green shading denotes services/practitioner types for which telehealth may be billed for any person (regardless of the person's primary language). Always reference the actual service guideline of interest for further guidance/clarification.

Image 1 and 2 (DBHDD Manual and table of practitioners eligible to provide telehealth services)





Billing & Reimbursement

Services that can be rendered via Telehealth are identified in Table C of the Telehealth guidance and Appendix C, Appendix M, and Appendix G of the Provider Manual for Community Behavioral Health Providers for The Department of Behavioral Health and Developmental Disabilities by procedure codes that include the 'GT' modifier. Please refer to these Tables and Appendices to determine which services can and cannot be provided via the telehealth option.

While some CBHRS services allow telephonic interactions, telephonic interventions do not qualify as telehealth defined herein.

Originating fees (as referenced in some of the other Georgia Medicaid programs) are not offered for telehealth when utilized in the CBHRS category of service. Telehealth costs are attributed to the services intervention rates.

Care Management Organizations may have specific billing requirements and practices which will be outlined in their unique agreements with providers. Georgia currently contracts with four (4) Care Management Organizations (Amerigroup, CareSource, and Peach State) for covered lives which includes physical health and behavioral health of all CMO members. All

four utilize the Georgia Partnership for Telehealth (GPT) to receive specialty and behavioral health care. With GPT services, the face-to-face video conferencing for visits with specialists, behavioral health providers and others whose offices are often in rural areas ensure better care with improved access. GPT has over 300 practitioners licensed in Georgia for behavioral health and physician health services.

Table C

Table C

Practitioner Types for CBHRS

Level 1	Physician, Psychiatrist
Level 2	Psychologist, Physician 's Assistant, Nurse Practitioner, Clinical Nurse Specialist, Pharmacist
Level 3	Registered Nurse, Licensed Dietician, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT)
Level 4	Licensed Practical Nurse (LPN); Licensed Associate Professional Counselor (LAPC); Licensed Master's Social Worker (LMSW); Licensed Associate Marriage and Family Therapist (LAMFT); Certified/Registered Addictions Counselors (e.g. CAC-I/II, CADC, CCADC, GCADC, MAC), Certified Peer Specialists, Trained Paraprofessionals and Certified Psychosocial Rehabilitation Professionals (CPRP) with bachelor's degrees or higher in the social sciences/helping professions
Level 5	Trained Paraprofessionals, Certified/Registered Addiction Counselors (CAC-I, RADT), Certified Peer Specialists, Certified Psychosocial Rehabilitation Professionals, and Qualified Medication Aides with at least a high school diploma/equivalent

Table D
Approved Codes for CBHR services

Service Description	*Procedure Code*	*Mod 1*	*Mod 2*	*Mod 3*	*Mod 4*	*Modifier Description (s)*	*Rate*	*Max Units*
Diagnostic Assessment	90791	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	116.90	2
Diagnostic Assessment	90791	GT	U3			Via interactive a/v telecom systems, Practitioner Level 3	90.03	2
Diagnostic Assessment	90792	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	174.63	2
Diagnostic Assessment	90792	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	116.90	2
Psychiatric Treatment (E&M- New Pt. 10 min)	99201 Discontinued as of 12/31/2020	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	38.81	1
Psychiatric Treatment (E&M- New Pt. 10 min)	99201 Discontinued as of 12/31/2020	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	25.98	1
Psychiatric Treatment (E&M- New Pt. 20 min)	99202	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	77.61	1
Psychiatric Treatment (E&M- New Pt. 20 min)	99202	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	51.96	1

Psychiatric Treatment (E&M- New Pt. 30 min)	99203	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	116.42	1
Psychiatric Treatment (E&M- New Pt. 30 min)	99003	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	77.94	1
Psychiatric Treatment (E&M- New Pt. 45 min)	99204	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	174.63	1
Psychiatric Treatment (E&M- New Pt. 45 min)	99204	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	116.90	1
Psychiatric Treatment (E&M- New Pt. 60 min)	99205	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	232.84	1
Psychiatric Treatment (E&M- New Pt. 60 min)	99205	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	155.88	1
Psychiatric Treatment (E&M Est. Pt. 5 min)	99211	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	19.40	1
Psychiatric Treatment (E&M Est. Pt. 5 min)	99211	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	12.99	1
Psychiatric Treatment (E&M Est. Pt. 10 min)	99212	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	38.81	1

Psychiatric Treatment (E&M Est. Pt. 10 min)	99212	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	25.98	1
Psychiatric Treatment (E&M Est. Pt. 15 min)	99213	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	58.21	1
Psychiatric Treatment (E&M Est. Pt. 15 min)	99213	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	38.97	1
Psychiatric Treatment (E&M Est. Pt. 25 min)	99214	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	97.02	1
Psychiatric Treatment (E&M Est. Pt. 25 min)	99214	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	64.95	1
Psychiatric Treatment (E&M Est. Pt. 40 min)	99215	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	155.23	1
Psychiatric Treatment (E&M Est. Pt. 40 min)	99215	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	103.92	1
Psychiatric Treatment Ind Psychotherapy y w E&M (+30 min add-on)	90833	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	97.02	1
Psychiatric Treatment Ind Psychotherapy y w E&M (+30 min add-on)	90833	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	64.95	1

Psychiatric Treatment Ind Psychotherapy w E&M (+45 min add-on)	90836	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	174.63	1
Psychiatric Treatment Ind Psychotherapy w E&M (+45 min add-on)	90836	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	116.90	1
Assertive Community Treatment	H0039	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	32.46	60
Assertive Community Treatment	H0039	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	32.46	60

Psychological Testing Codes/State Plan Amendment Codes

Service Description	Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Modifier Description	Rate	Unit of Service
BH Assessment & Service Plan Development	H0031	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	38.97	15 min
BH Assessment & Service Plan Development	H0031	GT	U3			Via interactive a/v telecom systems, Practitioner Level 3	30.01	15 min
BH Assessment & Service Plan Development	H0031	GT	U4			Via interactive a/v telecom systems, Practitioner Level 4	20.3	15 min
BH Assessment & Service Plan Development	H0031	GT	U5			Via interactive a/v telecom systems, Practitioner Level 5	15.13	15 min

BH Assessment & Service Plan Development	H0032	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	38.97	15 min
BH Assessment & Service Plan Development	H0032	GT	U3			Via interactive a/v telecom systems, Practitioner Level 3	30.01	15 min
BH Assessment & Service Plan Development	H0032	GT	U4			Via interactive a/v telecom systems, Practitioner Level 4	20.3	15 min
BH Assessment & Service Plan Development	H0032	GT	U5			Via interactive a/v telecom systems, Practitioner Level 5	15.13	15 min
Psychological Testing	96130	U2	GT			Via interactive a/v telecom systems, Practitioner Level 2	155.87	1 hour
Psychological Testing	96130	U3	GT			Via interactive a/v telecom systems, Practitioner Level 3	120.04	1 hour
Psychological Testing	96130	U4	GT			Via interactive a/v telecom systems, Practitioner Level 4	81.18	1 hour
Psychological Testing	96131	U2	GT			Via interactive a/v telecom systems, Practitioner Level 2	155.87	1 hour
Psychological Testing	96131	U3	GT			Via interactive a/v telecom systems, Practitioner Level 3	120.04	1 hour

Psychological Testing	96131	U4	GT			Via interactive a/v telecom systems, Practitioner Level 4	81.18	1 hour
Psychological Testing	96136	U2	GT			Via interactive a/v telecom systems, Practitioner Level 2	77.94	30 min
Psychological Testing	96137	U2	GT			Via interactive a/v telecom systems, Practitioner Level 2	77.94	30 min
Psychological Testing	96138	U3	GT			Via interactive a/v telecom systems, Practitioner Level 3	60.02	30 min
Psychological Testing	96138	U4	GT			Via interactive a/v telecom systems, Practitioner Level 4	40.59	30 min
Psychological Testing	96139	U3	GT			Via interactive a/v telecom systems, Practitioner Level 3	60.02	30 min
Psychological Testing	96139	U4	GT			Via interactive a/v telecom systems, Practitioner Level 4	40.59	30 min
Crisis Intervention	H2011	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	58.21	15 min
Crisis Intervention	H2011	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	38.97	15 min

Crisis Intervention	H2011	GT	U3			Via interactive a/v telecom systems, Practitioner Level 3	30.01	15 min
Crisis Intervention	H2011	GT	U4			Via interactive a/v telecom systems, Practitioner Level 4	20.3	15 min
Crisis Intervention	H2011	GT	U5			Via interactive a/v telecom systems, Practitioner Level 5	15.13	15 min
Crisis Intervention	90839	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	232.84	1 encounter
Crisis Intervention	90839	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	155.88	1 encounter
Crisis Intervention	90839	GT	U3			Via interactive a/v telecom systems, Practitioner Level 3	120.04	1 encounter
Crisis Intervention	90840	GT	U1			Via interactive a/v telecom systems, Practitioner Level 1	116.42	30 min
Crisis Intervention	90840	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	77.94	30 min
Crisis Intervention	90840	GT	U3			Via interactive a/v telecom systems, Practitioner Level 3	60.02	30 min
Nursing Services	T1001	GT	U2			Practitioner Level 2, In-Clinic	38.97	15 min

Nursing Services	T1001	GT	U3			Practitioner Level 3, In-Clinic	30.01	15 min
Nursing Services	T1001	GT	U4			Practitioner Level 4, In-Clinic	20.3	15 min
Nursing Services	T1002	GT	U2			Practitioner Level 2, In-Clinic	38.97	15 min
Nursing Services	T1002	GT	U3			Practitioner Level 3, In-Clinic	30.01	15 min
Nursing Services	T1003	GT	U4			Practitioner Level 4, In-Clinic	20.3	15 min
Nursing Services	96150	GT	U2			Practitioner Level 2, In-Clinic	38.97	15 min
Nursing Services	96150	GT	U3			Practitioner Level 3, In-Clinic	30.01	15 min
Nursing Services	96150	GT	U4			Practitioner Level 4, In-Clinic	20.3	15 min
Nursing Services	96151	GT	U2			Practitioner Level 2, In-Clinic	38.97	15 min
Nursing Services	96151	GT	U3			Practitioner Level 3, In-Clinic	30.01	15 min
Nursing Services	96151	GT	U4			Practitioner Level 4, In-Clinic	20.3	15 min
Community Support Individual	H2015	GT	U4			Practitioner Level 4, In-Clinic	20.3	15 min
Community Support Individual	H2015	GT	U5			Practitioner Level 5 In-Clinic	15.13	15 min
Psychosocial Rehabilitation (Individual)	H2017	GT	HE	U4	U6	Mental Health Program, Practitioner Level 5, In-Clinic	20.3	15 min
Psychosocial Rehabilitation (Individual)	H2017	GT	HE	U5	U6	Mental Health Program, Practitioner Level 4, In-Clinic	15.13	15 min
Addictive Disease Support Services	H2015	GT	HF	U4	U6	Substance Abuse Program, Level 4, In Clinic	20.3	15 min
Addictive Disease Support Services	H2015	GT	HF	U5	U6	Substance Abuse Program, Level 5, In Clinic	15.13	15 min

Individual Outpatient Services (=30 min)	90832	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	64.95	1 encounter
Individual Outpatient Services (=30 min)	90832	GT	U3			Via interactive a/v telecom systems, Practitioner Level 3	50.02	1 encounter
Individual Outpatient Services (=30 min)	90832	GT	U4			Via interactive a/v telecom systems, Practitioner Level 4	33.83	1 encounter
Individual Outpatient Services (=30 min)	90832	GT	U5			Via interactive a/v telecom systems, Practitioner Level 5	25.21	1 encounter
Individual Outpatient Services (=45 min)	90834	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	116.9	1 encounter
Individual Outpatient Services (=45 min)	90834	GT	U3			Via interactive a/v telecom systems, Practitioner Level 3	90.03	1 encounter
Individual Outpatient Services (=45 min)	90834	GT	U4			Via interactive a/v telecom systems, Practitioner Level 4	60.89	1 encounter
Individual Outpatient Services (=45 min)	90834	GT	U5			Via interactive a/v telecom systems, Practitioner Level 5	45.38	1 encounter
Individual Outpatient Services (=60 min)	90837	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	155.87	1 encounter

Individual Outpatient Services (=60 min)	90837	GT	U3			Via interactive a/v telecom systems, Practitioner Level 3	120.04	1 encounter
Individual Outpatient Services (=60 min)	90837	GT	U4			Via interactive a/v telecom systems, Practitioner Level 4	81.18	1 encounter
Individual Outpatient Services (=60 min)	90837	GT	U5			Via interactive a/v telecom systems, Practitioner Level 5	60.51	1 encounter
Family Outpatient Services	H0004	GT	HR	U2		Via interactive a/v telecom systems, With client present, Practitioner Level 2	38.97	15 min
Family Outpatient Services	H0004	GT	HR	U3		Via interactive a/v telecom systems, With client present, Practitioner Level 3	30.01	15 min
Family Outpatient Services	H0004	GT	HR	U4		Via interactive a/v telecom systems, With client present, Practitioner Level 4	20.3	15 min
Family Outpatient Services	H0004	GT	HR	U5		Via interactive a/v telecom systems, With client present, Practitioner Level 5	15.13	15 min
Family Outpatient Services	H0004	GT	HS	U2		Via interactive a/v telecom systems, Without client present, Practitioner Level 2	38.97	15 min

Family Outpatient Services	H0004	GT	HS	U3		Via interactive a/v telecom systems, Without client present, Practitioner Level 3	30.01	15 min
Family Outpatient Services	H0004	GT	HS	U4		Via interactive a/v telecom systems, Without client present, Practitioner Level 4	20.3	15 min
Family Outpatient Services	H0004	GT	HS	U5		Via interactive a/v telecom systems, Without client present, Practitioner Level 5	15.13	15 min
Family Outpatient Services	90846	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	38.97	15 min
Family Outpatient Services	90846	GT	U3			Via interactive a/v telecom systems, Practitioner Level 3	30.01	15 min
Family Outpatient Services	90846	GT	U4			Via interactive a/v telecom systems, Practitioner Level 4	20.3	15 min
Family Outpatient Services	90846	GT	U5			Via interactive a/v telecom systems, Practitioner Level 5	15.13	15 min
Family Outpatient Services	90847	GT	U2			Via interactive a/v telecom systems, Practitioner Level 2	38.97	15 min

Family Outpatient Services	90847	GT	U3			Via interactive a/v telecom systems, Practitioner Level 3	30.01	15 min
Peer Supports-Youth (Individual)	H0038	GT	HA	U4		Via interactive a/v telecom systems, Practitioner Level 4	20.3	15 min
Peer Supports-Youth (Individual)	H0038	GT	HA	U5		Via interactive a/v telecom systems, Practitioner Level 5	15.13	15 min
Family Outpatient Services	90847	GT	U4			Via interactive a/v telecom systems, Practitioner Level 4	20.3	15 min
Family Outpatient Services	90847	GT	U5			Via interactive a/v telecom systems, Practitioner Level 5	15.13	15 min
Family Outpatient Services	H2014	GT	HR	U4		Via interactive a/v telecom systems, With client present, Practitioner Level 4	20.3	15 min
Family Outpatient Services	H2014	GT	HR	U5		Via interactive a/v telecom systems, With client present, Practitioner Level 5	15.13	15 min
Family Outpatient Services	H2014	GT	HS	U4		Via interactive a/v telecom systems, Without client present, Practitioner Level 4	20.3	15 min

Family Outpatient Services	H2014	GT	HS	U5		Via interactive a/v telecom systems, Without client present, Practitioner Level 5	15.13	15 min
Peer Supports (Individual)	H0038	GT	HS	U4		Practitioner Level 4, In-Clinic	20.3	15 min
Peer Supports (Individual)	H0038	GT	HS	U5		Practitioner Level 5, In-Clinic	15.13	15 min
Peer Support Whole Health & Wellness	H0025	GT	U3			Practitioner Level 3, In-Clinic	30.01	15 min
Peer Support Whole Health & Wellness	H0025	GT	U4			Practitioner Level 4, In-Clinic	20.3	15 min
Peer Support Whole Health & Wellness	H0025	GT	U5			Practitioner Level 5, In-Clinic	15.13	15 min
Intensive Family Intervention	H0036	GT	U3			Practitioner Level 3, In-Clinic	30.01	15 min
Intensive Family Intervention	H0036	GT	U4			Practitioner Level 4, In-Clinic	22.14	15 min
Intensive Family Intervention	H0036	GT	U5			Practitioner Level 5, In-Clinic	16.5	15 min
Community Support Team	H0039	TN	GT	U3		Practitioner Level 3, In-Clinic	30.01	15 min
Community Support Team	H0039	TN	GT	U4		Practitioner Level 4, In-Clinic	20.3	15 min
Community Support Team	H0039	TN	GT	U5		Practitioner Level 5, In-Clinic	15.13	15 min
Intensive Case Management	T1016	GT	HK	U4		High Risk Population, Practitioner Level 5, out-of-Clinic	20.3	15 min
Intensive Case Management	T1016	GT	HK	U5		High Risk Population, Practitioner Level 5, out-of-Clinic	15.13	15 min

Case Management Services	T1016	GT	U4			Practitioner Level 5, Out-of Clinic	20.3	15 min
Case Management Services	T1016	GT	U5			Practitioner Level 5, Out-of Clinic	15.13	15 min

Teledentistry

Teledentistry

Teledentistry-is a combination of telecommunications and dentistry involving the exchange of clinical information and images over remote distances for dental consultation and treatment planning. The State allows for these services within the current Part II Policies and Procedures Manual for Dental Services.

Providers

Licensed Dentists
Licensed Dental Hygienist

Approved Codes for Reimbursement- These can only be used in the Public Health Setting as described within the Dentistry Policy manual.

Table E

Code	Service Description	Billing Note
D9995	Teledentistry – synchronous; real-time encounter	used to bill when there is a synchronous or real-time encounter instead of information that is stored and sent for review. Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.
D9996	Information store and forward to dentist for review	used by the Dental Hygienist when dental information is sent to a licensed Dentist for review via telehealth technology.
D9999	Teledentistry Exam	Teledentistry Exam used by the Dentist receiving the information and subsequently bills the Department D9999 for the exam and report.

Department of Public Health (DPH) Districts and Boards of Health Dental Hygienists shall only perform duties under this protocol at the facilities of the DPH District and Board of Health, at school-based prevention programs and other facilities approved by the Board of Dentistry and under the approval of the District Dentist or dentist approved by the District Dentist.

Telehealth within Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)

Telehealth within Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)

FQHCs and RHCs may serve as an originating site for telehealth services, which is the location of an eligible Medicare beneficiary or enrolled Medicaid member at the time the service being furnished via a telecommunications system occurs. FQHCs and RHCs that serve as an originating site for telehealth services are paid an originating site facility fee. FQHC's and RHC's are authorized to serve as a distant site for telehealth services and may bill the cost of the visit.

NOTE: FQHCs and RHCs cannot bill an originating site fee and distant site fee for telehealth services on the same encounter.

Telehealth and Dialysis Services

Telehealth and Dialysis Services

The Centers for Medicaid and Medicare Services (CMS) has added Dialysis Services to the list of services that can be provided under Telehealth.

The originating facility/site (Dialysis Facility) will bill with the revenue code and procedure codes listed below.

Table F

Revenue Code	Description	Procedure Code	Modifier
780	Telehealth General Classification	Q3014	GT

The distant site/physician providing the service via a telecommunications system will bill using Place of Service 02 to indicate Telehealth and the procedure codes below.

The term “distant site” means the site where the physician or practitioner providing the professional service, is located at the time the service is provided via a telecommunications system.

Table G

Code	Description	Modifier’s	Place of Service
90951	End Stage Renal Disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to- face physician visits per month	95, GT, or GQ	02
90952	End Stage Renal Disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to- face physician visits per month	95, GT, or GQ	02
90954	End Stage Renal Disease (ESRD) related services monthly, for patients two (2) - eleven (11) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to-face physician visits per month	95, GT, or GQ	02
90955	End Stage Renal Disease (ESRD) related services monthly, for patients two (2) -eleven (11) years of age to include monitoring for the	95, GT, or GQ	

	adequacy of nutrition, assessment of growth and development, and counseling of parents; with two (2) or three (3) face-to-face physician visits per month		
90957	End Stage Renal Disease (ESRD) related services monthly, for patients twelve (12) - nineteen (19) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four (4) or more face-to-face physician visits per month	95, GT, or GQ	02
90958	End Stage Renal Disease (ESRD) related services monthly, for patients twelve (12) - nineteen (19) years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with two (2) -three (3) face-to-face physician visits per month	95, GT, or GQ	02
90960	End Stage Renal Disease (ESRD) related services monthly, for patients twenty (20) years of age and older, with four (4) or more face-to-face physician visits per month	95, GT, or GQ	02
90961	End Stage Renal Disease (ESRD) related services monthly, for patients twenty (20) years of age and older, with two (2) - three (3) face-to-face physician visits per month	95, GT, or GQ	02
90963	Home dialysis services per month, patient younger than 2 years of age	95, GT, or GQ	02
90964	Home dialysis services per month, patient 2-11 years of age	95, GT, or GQ	02
90965	End Stage Renal Disease (ESRD) related services for home dialysis per full month; for patients twelve (12) - nineteen (19) years of age to include monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents	95, GT, or GQ	02
90966	Home dialysis services per month, patient 20 years of age or older	95, GT, or GQ	02

90967	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients younger than two (2) years of age	95, GT, or GQ	02
90968	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients two (2)- eleven (11) years of age	95, GT, or GQ	02
90969	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients twelve (12)-nineteen (19) years of age	95, GT, or GQ	02
90970	End Stage Renal Disease (ESRD) related services for dialysis (less than full month), per day; for patients twenty (20) years of age and older	95, GT, or GQ	02

Nursing Facility Specialized Services

Nursing Facility Specialized Services

Though not available in all areas of the State, Medicare-funded mental health services are currently provided to nursing home residents via telehealth, face-to-face visits by providers in the nursing home, and nursing home resident visits to psychiatric/mental health clinics/offices for those individuals able to travel outside the nursing facility.

NOTE: Though 440 codes allow for Medicaid members to have a variety of mental health professionals serve members in nursing facilities, please note that Medicare has more stringent requirements regarding these professionals to serve the Medicare eligible members in nursing facilities. (Please review the approved practitioner levels listed below [*Table C*]). When Nursing Facilities refer/coordinate Specialized Services for the PASRR approved resident, Nursing Facility staff should communicate to the Community Behavioral Health Service Provider (CBHSP), the DCH enrolled MH provider that the member is either dual eligible or Medicare Only

The NF and CBHS providers will communicate to arrange for the provision of specialized services to residents either in the nursing facility, via telehealth, or at the Community Behavioral Health location. The service location will be determined by the condition of the resident, ability to travel to the nearest clinic, and evaluation of both nursing facility and mental health staff regarding the most appropriate service delivery venue for the individual resident. If the nursing home resident can be assessed and treated in the outpatient clinic, NEMT transportation can be used to facilitate this visit. Those residents whose interest is best served by receiving mental health services in the nursing facility or in a nearby telehealth site can receive services in either of those locations, with the practitioner using out-of-clinic or telehealth procedure codes.

Table H

Level 1	Physician, Psychiatrist
Level 2	Psychologist, Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, Pharmacist
Level 3	Registered Nurse, Licensed Dietician, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT)
Level 4	Licensed Practical Nurse (LPN); Licensed Associate Professional Counselor (LAPC); Licensed Master's Social Worker (LMSW); Licensed Associate Marriage and Family Therapist (LAMFT); Certified/Registered Addictions Counselors (e.g. CAC-I/II, CADC, CCADC, GCADC, MAC), Certified Peer Specialists, Trained Paraprofessionals and Certified Psychosocial Rehabilitation Professionals (CPRP) with Bachelor's degrees or higher in the social sciences/helping professions
Level 5	Trained Paraprofessionals, Certified/Registered Addiction Counselors (CAC-I, RADT), Certified Peer Specialists, Certified Psychosocial Rehabilitation Professionals, and Qualified Medication Aides with at least a high school diploma/equivalent

PROCEDURE CODES: KEY:
Key: Code Modifiers used:
GT= Via interactive audio and video telecommunications systems
U1 = Practitioner Level 1 (see below for description of all practitioner levels)
U2 = Practitioner Level 2
U3 = Practitioner Level 3
U4 = Practitioner Level 4
U6 = In Clinic
U7 = Out-of-Clinic

For all procedures noted on the next page, practitioners must hold the license appropriate to the activity.

The following procedure codes may be used for service delivery and claims billing for specialized behavioral health services provided to nursing home residents: (Daily/Annual Max Units are effective 4/2013)

Table I

Description	**Procedure Code**	**Modifier**	**Service Group**	**Max Daily Units**	**Max Month Units**	**Max Year Units**
Psychiatric Diagnostic Assessment (session) Or Via Telehealth *Report with 90785 for interactive complexity when appropriate*	90791, 90792 (Formerly 90801, 90802) 90791, 90792	U2 U6, U2 U7 U3U6, U3U7 (Encounter) GT U1, GT U2, GTU3	10103	1 encounter	1	12
Psychiatric Treatment/Pharmacological Management (session) Or *Via Telehealth Report with add-on code for psychotherapy time*	Appropriate Evaluation and Management Code-see below (Formerly 90862)	U1 U6, U1 U7 U2 U6, U2 U7 GT U1, GT U2	10120	2	2	24

Evaluation and Management Codes						
Description	**Procedure Code**	**Modifier**	**Service Group**	**Max Daily Units**	**Max Month Units**	**Max Year Units**
E&M (New Pt - 10 min)	99201	U1 U6, U2 U6, U1 U7, U2 U7, GT U1, GT U2	10120	1	2	24
E&M (New Pt - 20 min)	99202					
E&M (New Pt - 30 min)	99203					
E&M (New Pt - 45 min)	99204					
E&M (New Pt - 60 min)	99205					
E&M (Estab Pt - 5 min)	99211					
E&M (Estab Pt - 10 min)	99212					
E&M (Estab Pt - 10 min)	99212					
E&M (Estab Pt - 15 min)	99213					
E&M (Estab Pt - 15 min)	99213					
E&M (Estab Pt - 25 min)	99214					
E&M (Estab Pt - 40 min)	99215					

Telehealth and School Based Settings

Telehealth and School Based Settings

School-Based Settings

Telehealth services provided in school-based settings also referred to as the Local Education Agencies (LEAs) can be provided upon enrollment into COS 600.
Telehealth benefits are allowed if all the following criteria are met:

- The provider is an authorized health-care provider enrolled in Georgia Medicaid
- The client is a child who is receiving the service in a primary or secondary school-based setting
- The parent or legal guardian of the client provides consent before the service is provided

Telehealth services provided in a school-based setting are also a benefit if the referring provider delegates provision of services to a nurse practitioner, clinical nurse specialist, physician assistant, or other licensed specialist as long as the above-mentioned providers are working within the scope of their professional license and within the scope of their delegation agreement with the provider.

Health Check Program

LEAs enrolled as Health Check providers to serve as telehealth originating sites only will be allowed to bill the telehealth originating site facility fee (procedure code Q3014). The LEA provider should report procedure code Q3014 along with the EP and GT modifiers, POS 03, and the appropriate ICD-10 diagnosis code(s). The diagnosis code(s) should be the same diagnosis code(s) listed on the distant site (rendering) provider's claim. The rendering provider serving as the telehealth distant site should report the E/M office visit code (992xx) along with the GT modifier (including any other applicable modifiers), the appropriate POS, and the ICD-10 diagnosis code(s). For the originating site (LEA) provider to receive reimbursement for procedure code Q3014, a corresponding paid history claim from the distant site provider must be found in GAMMIS. The distant site provider's claim billed for the same member, same date of service, with an E/M office visit code (992xx), the same ICD-10 diagnosis code(s) and the GT modifier, will confirm that a telehealth service was rendered. If no record of the E/M claim is found that aligns with the LEA provider's originating site claim, the originating site claim will suspend up to 30 days after submission in search of the E/M claim. If no record of an E/M claim is found within 30 days after submission of the LEA provider's originating site claim, reimbursement to the LEA provider will be denied. It is the responsibility of the LEA provider to contact the provider who rendered the distant site service to determine if the E/M visit was billed. The telehealth originating facility fee is reimbursed at the current DEFAULT rate.

Children's Intervention School Services (CISS)

Local Education Agencies (LEAs) may enroll in the Health Check Program (COS 600) to serve as telehealth originating sites only. The originating site is the actual location at which an eligible Medicaid member is receiving services via the telecommunications system. To enroll as a Health Check provider, the LEA will be required to submit a signed copy of the Attestation Form "For the Provision of Telehealth Services by Georgia's Local Education Agencies (LEAs)" which indicates that the LEA will comply with the telehealth requirements.

The Attestation Form is located on the MMIS web portal under the "Provider Information, Forms, Enrollment" tab. Please complete the form and fax it with the coversheet located under the

"Provider Information, Forms" tab to Gainwell Technologies Provider Enrollment at 1-866-483-1044. See section 603.21 in the CISS manual for claiming information.

LEAs can enroll in the Health Check Program (COS 600) to serve as telehealth originating sites only. As a Health Check provider, the LEA serving as a telehealth originating site will be allowed to bill only the telehealth originating site facility fee *Children's Intervention School Services VI-7 (procedure code Q3014).* The LEA should report procedure code Q3014 along with the EP and GT modifiers, Place of Service (POS) 03, and the appropriate ICD-10 diagnosis code(s). The diagnosis code(s) should be the same diagnosis code(s) listed on the distant site (rendering) provider's claim. The rendering provider serving as the telehealth distant site should report the evaluation and management (E/M) office visit code (992xx) along with the GT modifier (including any other applicable modifiers), the appropriate POS, and the ICD-10 diagnosis code(s). LEAs are reimbursed for procedure code Q3014 under the Health Check Program (COS 600). It is the responsibility of the LEA to contact the provider who rendered the distant site service to determine if the E/M visit was billed.

Speech Language Pathology Services

Speech Language Pathology Services involve the identification of children with speech and/or language disorders, diagnosis and appraisal of specific speech and/or language disorders, referral for medical and other professional attention necessary for the rehabilitation of speech and/or language disorders, provision of speech or language services for the prevention of communicative disorders. The speech language pathologist must bill for time spent in hands on activities or via telehealth services with the student. This includes time spent assisting the student with learning to use adaptive equipment and assistive technology.

Speech and Audiology Reimbursable Codes

Table J

Code	Service Description	Billing Note
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual.	Use POS 02
92521	Evaluation of Speech Fluency	Use POS 02
92522	Speech sound production evaluation	Use POS 02
92523	Speech sound production evaluation with language evaluation	Use POS 02
92524	Behavioral and qualitative analysis of voice and resonance	Use POS 02
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual. Two or more individuals	Use POS 02
97110	Therapeutic Exercise to Develop Strength, Endurance, range of motion, and flexibility, each 15 minutes	Use POS 02
97112	Therapeutic Procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes	Use POS 02

97161	Evaluation of physical therapy, typically 20 minutes	Use POS 02
97162	Evaluation of Physical Therapy, Typically 30 minutes	Use POS 02
97163	Evaluation of Physical Therapy, Typically 45 Minutes	Use POS 02
97164	Re-evaluation of Physical therapy, typically 20 minutes	Use POS 02
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes	Use POS 02
97532 DISCONTINUED Use code 97127	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact."	Use POS 02
97542	Wheelchair management, each 15 minutes	Use POS 02
97763	Management and/or training in use of orthotics (supports, braces, or splints) for arms, legs, and/or trunk, per 15 minutes	Use POS 02

97762 DISCONTINUED Use code 97763	Under Orthotic Management and Training and Prosthetic Training	Use POS 02
92567	Tympanometry (impedance testing)	Use POS 02
92568	Acoustic Reflex Testing	Use POS 02
92587	Distortion product evoked auditory test emissions	Use POS 02

Telehealth and Physician Services

Telehealth and Physician Services

The Department of Community Health's (DCH) Telehealth and Telehealth policies are slated to improve and increase access and efficiency to health care services by enabling medical services to be delivered via telehealth methods in Georgia. Telehealth services are not an expansion of Georgia Medicaid covered services; but, an option for the delivery of certain covered services. Telehealth will allow DCH to meet the needs of members and providers, while complying with all applicable federal and state statutes and regulations. The quality of health care services delivered must be maintained regardless of the mode of delivery.

Telehealth is the use of medical information exchange from one site to another via electronic communications to improve patients' health status. It is the use of two-way, real time interactive communication equipment to exchange the patient information from one site to another via an electronic communication system. This includes audio and video telecommunication equipment. Closely associated with telehealth is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Telehealth is the use of telecommunication technologies for clinical care (telehealth), patient teachings and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

The intent of our telehealth services policy is to improve access to essential healthcare services that may not otherwise be available for Medicaid eligible members. Telehealth is not a separate medical specialty. Products and services related to telehealth are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. When a provider, licensed in the state of Georgia, determines that medical care can be provided via electronic communication with no loss in the quality or efficacy of the member's care, telehealth services can be performed. The use of a telecommunications system may substitute for an in-person encounter for professional office visits, pharmacologic management, limited office psychiatric services, limited radiological services and a limited number of other physician fee schedule services.

An interactive telecommunications system is required as a condition of payment. The originating site's system, at a minimum, must have the capability of allowing the distant site provider to visually examine the patient's entire body including body orifices (such as ear canals, nose, and throat). The distant site provider should also have the capability to hear heart tones and lung sounds clearly (using a stethoscope) if medically necessary and currently within the provider's scope of practice. The telecommunication system must be secure and adequate to protect the confidentiality and integrity of the information transmitted.

Appendix A

Telehealth Member Consent Form

Prior to an initial telehealth service, the practitioner who delivers the service to a GA Medicaid Member shall ensure that the telehealth member consent form is provided to the member and signed. It should be delivered in a manner which the member can understand, using reasonable accommodations when necessary, that:

1. S/he retains the option to refuse the telehealth service at any time without affecting the right to future care or treatment and without risking the loss or withdraw of any program benefit to which the member would otherwise be entitled.
2. Available alternative options will be presented to the member (including in-person services).
3. The dissemination of any client identifiable images or information form the telehealth consultation to anyone, including researchers, will not occur without the written consent of the member.
4. S/he has the right to be informed of the parties who will be present at each end of the telehealth consultation and s/he has the right to exclude anyone from either site.
5. S/he has the right to see an appropriately trained staff or employee in- person immediately after the telehealth consultation if an urgent need arises.

Telehealth Member Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

GA MED ID#: _____

1. **PURPOSE**: The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with the following procedure(s) and/or service(s):

   _____
   _____

2. **NATURE OF TELEHEALTH CONSULT**: During the telehealth consultation:

   a. Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telehealth studio to aid in the video transmission.
   d. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

3. **MEDICAL INFORMATION & RECORDS**: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient- identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.

4. **CONFIDENTIALITY**: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth consultation, and all existing confidentiality protections under federal and Georgia state law apply to information disclosed during this telehealth consultation.

5. **RIGHTS:** You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

6. **DISPUTES**: You agree that any dispute arriving from the telehealth consult will be resolved in Georgia, and that Georgia law shall apply to all disputes.

7. **RISKS, CONSEQUENCES & BENEFITS**: You have been advised of all the potential risks, consequences, and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature: _____ Date: _____

If signed by someone other than the patient, indicate relationship: _____

Witness Signature: _____ Date: _____

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The three licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	CareSource 1-855-202-1058 www.caresource.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All three**

CMOs are State-wide.
The Department of Community Health has contracted with three CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.
Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.
The following categories of eligibility are included and excluded under Georgia Families:
Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)

876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged

237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged

411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com

Registering immunizations with GRITS:
If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.
Important tips for the provider to know/do when a member comes in:
Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.
You may also contact GAINWELL TECHNOLOGIES at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.
Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. GAINWELL TECHNOLOGIES will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.
Participating in a Georgia Families' health plan:
Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.
Billing the health plans for services provided:
For members who are in Georgia Families, you should file claims with the member's health plan.
If a claim is submitted to GAINWELL TECHNOLOGIES in error:
GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.
Credentialing
Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed. Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.
This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.
The CVO's one-source application process:

- •Saves time
- •Increases efficiency
- •Eliminates duplication of data needed for multiple CMOs
- •Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.
GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:
Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.
Billing the health plans for services provided:
For members who are in Georgia Families, you should file claims with the member's health plan.
If a claim is submitted to GAINWELL TECHNOLOGIES in error:
GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.
Receiving payment:
Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.
Health plans payment of clean claims:
Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	CareSource	Peach State Health Plan
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan

Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN #	GROUP #	Helpdesk

Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031
CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630
Peach State Health Plan	CVS	004336	MCAIDADV	RX5439	1-844-297-0513

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.
Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:

Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.
Will Medicaid cover prescriptions for members that the health plans do not?
No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.
Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929

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Teledentistry is One Solution to Increase Access to Care for Georgians

Georgia has a diverse population in its mix of rural and urban areas. Research demonstrates the need for increased access to healthcare with dental services being a top priority.

The Georgia Health Care Work Force Commission has been charged with discovering ways to best utilize provider resources to better meet the healthcare needs of our population. To this end, Teledentistry is indicated as one solution to address the issues at hand.

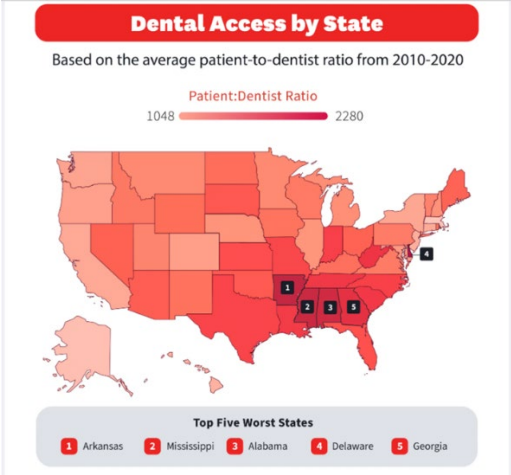
- According to the Health Resources and Services Administration (HRSA), as of July 2022, 136 of Georgia's 159 counties are considered Dental Health Professional Shortage Areas.
    - Data from the 2020 Dentist Workforce Report, published by the Georgia Board of Health Care Workforce, show that 21 of GA's 159 counties have no practicing dentists at all.

- Although GA has a number of low income or sliding scale dental clinics, according to the Ben Massell Dental Clinic, rising costs due to the pandemic and a smaller number of volunteers have increased wait times for services.
    - The Ben Massell dental clinic currently has a wait list of more than 2 years, while other dental clinics such as the Good Samaritan Health Center either haven't had an open an appointment in more than a year, or no longer accept new dental patients, such as the Rapha Clinic in Carroll County.
    - This has become a common theme among many GA clinics that provide care for GA's low-income residents.

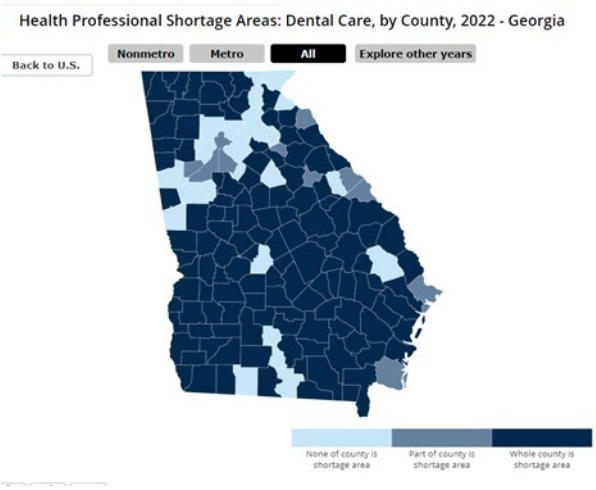
- A consequence of the extreme wait times for patients seeking dental care at these clinics is when care is unavailable, people will pursue treatment at a hospital emergency department (ED).

- Numerous published studies have identified the costly public health burden of residents seeking non-traumatic dental care (NTDC) at hospital EDs.
    - According to the American Dental Association (ADA) Health Policy Institute, every 15 seconds someone in the U.S. visits a hospital ED for dental conditions.
    - Data from the GA Department of Public Health, Office of Health Indicators for Planning (OHIP), Hospital and ER Visit statistical files (accessed October 20, 2021) show from 2016 through 2020, more than three hundred thousand (318,294) GA residents sought dental care at GA hospital EDs. Costs to the GA Medicaid Program, private payors and insurance companies were almost a half billion dollars, ($489,485,678).

- As of August 2022, GA was ranked the 5th worst state in the US for access to dental care.



- According to HRSA, as of July 2022, 136 of Georgia's 159 counties are considered a DHPSA (Dental Health Professional Shortage Area)



- Dental Deserts (August 2022): https://www.byte.com/community/resources/article/lack-of-dental-access/

Teledentistry under the umbrella of Telehealth will help increase access for GA underserved residents facing barriers to care by increasing communication with patients, triage patient needs, plan in-person visits more efficiently, and reduce costs associated with hospital ED visits.

Thank you for your consideration,

Pam Cushenan, RDH, MS, FSCDH
pcushenan@gdha.org
678-468-2535

Teledentistry in Georgia (2020):

Does Georgia allow for direct access to dental hygiene services?

In limited settings, qualified registered dental hygienists may perform screenings, oral prophylaxis, and application of sealants and fluoride under general supervision of a dentist. A law recently took effect on January 1, 2018 which authorizes a supervising dentist to allow his/her hygienist to work under general supervision but does not define how the supervising dentist must provide the authorization.

Can dental assistants help with teledentistry services?

Dental assistants and expanded function dental assistants may work only under the direct supervision of a dentist.

Does Georgia define "teledentistry"?

Not at this time.

Is it possible to be reimbursed for teledentistry services?

Georgia regulations require coverage of telemedicine services, subject to contract terms and conditions. Regulations require private payers to reimburse for live video. Georgia Medicaid lists dentists and dental hygienists as Eligible Distant Practitioners for live video reimbursement and lists store and forward transactions as a noncovered service.

Does Georgia provide a Parity Law regarding teledentistry?

Georgia has parity laws in place that allow coverage of telemedicine under private insurance and Medicaid.

Georgia Department of Public Health

Guidelines for Georgia Public Health Nurses Practicing in Telehealth/ Telemedicine

August 2019

ACKNOWLEDGEMENTS

The guidelines for telehealth/telemedicine nursing practices in Public Health settings were developed using the concepts of evidence-based practice and interdisciplinary collaboration. The telehealth/telemedicine workgroup formulated the guiding principles and core competencies with the overall goal to ensure safety and quality in providing telehealth/telemedicine public health services.

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GEORGIA DEPARTMENT OF PUBLIC HEALTH (DPH)
GUIDELINES FOR GEORGIA PUBLIC HEALTH NURSES PRACTICING IN TELEHEALTH/TELEMEDICINE

A. INTRODUCTION

Over the past decades, the use of telehealth technology to deliver health care from a distance has proven to be an effective way of overcoming certain barriers within the healthcare delivery systems. This is particularly true for communities located in rural and remote areas. In addition to its advantage of extending beyond geographical boundaries, telehealth/telemedicine can ease the gaps in providing essential and crucial care for those who are underserved, primarily because of a shortage of sub-specialty providers.

Telehealth technologies are evolving to provide both patients and healthcare professionals with real-time, interactive, data-rich health management systems that fully engage patients and/or guardians, and their interdisciplinary clinical care teams. These technologies offer a wide array of new opportunities for nurses nationwide. It provides great value to patients in remote locations and helps nurses in their everyday practice by offering an opportunity to expand their career choices. Telehealth/telemedicine makes it possible to share clinical skills and information. It has the potential to provide nurses the opportunity to play an important role in the development, deployment, and utilization of telemedicine and telehealth applications in delivering safe patient care.

Telehealth/telemedicine reduces health care costs by spreading limited resources to a large population over a broad geographic region. Georgia Public Health Nurses have played an important role assisting with the provision of services throughout the state. In 2012, Commissioner Brenda Fitzgerald, M.D., established an initiative to advance the use of telemedicine/telehealth technologies in health department and WIC (Women, Infants and Children) clinics.

Today, public health professionals are using telehealth technologies to enhance their productivity within the health care delivery systems. Telehealth technologies are changing the way public health does business. It brings people together, whether face-to-face, or whether they are across the state or around the globe. It brings experts to remote locations. It brings education and training to public health workers around the state, by providing strong lines of visual, graphical and multimedia communications.

B. PURPOSE

The purpose is to establish guidelines for Public Health Nursing staff to provide telehealth/telemedicine public health services to patients using videoconferencing equipment.

C. SCOPE OF PRACTICE FOR GEORGIA PUBLIC HEALTH NURSES

The scope of practice for a Public Health Nurse presenting for telehealth and/or telemedicine services is the same scope of practice for the Public Health Nurse providing non-telehealth or non-telemedicine services. The use of videoconferencing itself does not change the practice or patient care of a professional; it merely enables services to be performed with less travel for patients and/or providers.

D. GUIDING PRINCIPLES

1. **Quality**
   Commitment to quality of care by conducting periodic chart reviews and staff performance reviews.

2. **Advocacy**
   Assurance of patient advocacy by serving as a liaison between the patient and healthcare providers to ensure the highest quality of health care services are delivered.

3. **Rules and Regulations**
   Compliance with Health Information Portability and Accountability Act (HIPAA) rules and regulations by ensuring that all staff is trained regarding who is covered, what information is protected, and how protected information can be used and disclosed. Comply with all applicable rules and regulations of the Georgia Board of Nursing and the Georgia Composite Medical Board.

4. **Roles and Responsibilities**
   Assure clearly defined roles/responsibilities by developing specific protocols to be followed by staff providing telehealth/telemedicine services.

5. **Knowledge**
   Commitment to knowledge by providing ongoing educational opportunities that will enhance knowledge of current best practices.

E. DEFINITION OF TERMS

Distant site – The site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system (Center for Medicare and Medicaid Services [CMS], 2019).

Distance Learning – The incorporation of video and audio technologies, allowing participants to "attend" classes and training sessions that are being presented at a remote location. Distance learning systems are usually interactive and are a tool in the delivery of training and education to widely dispersed participants, or in instances in which the instructor cannot travel to the participant's site.

Encryption – A system of encoding electronic data where the information can only be retrieved and decoded by the person or computer system authorized to access it.

HIPAA – **Acronym** for Health Information Portability and Accountability Act. The HIPAA Privacy Rule protects the privacy of individually identifiable health information, the HIPAA Security Rule sets national standards for the security of electronic protected health information, and the confidentiality provisions of the Patient Safety Rule protect identifiable information being used to analyze patient safety events and improve patient safety (U.S. Department of Health and Human Services, 2017).

Medical Codes – **A** process of describing medical diagnoses and procedures using specific universal medical code numbers. States may select from a variety of Healthcare Common Procedure Coding System (HCPCS) codes (T1014 and Q3014), Current Procedural Terminology (CPT) codes and modifiers (GT, U1-UD) in order to identify, track and reimburse for telemedicine services (CMS, 2019).

Network – For this document, the referenced network is the Georgia Department of Public Health video conferencing platform, which is a HIPAA secured platform, managed internally by a dedicated team to provide real-time video connectivity.

Originating or Presenting site – Remote site where the patient is presented during a telemedicine encounter or where the professional requesting consultation with a specialist is located.

Peripheral Devices – **Any** device attached externally to a computer or video conferencing system (e.g., web camera, general exam camera, stethoscope, dermascope, otoscope, external microphone speaker; inter oral exam camera, etc.).

Telehealth and Telemedicine – The use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications (Health Resources and Service Administration [HRSA], 2019).

Telemedicine is not a separate medical specialty. Products and services related to telemedicine are often part of a larger investment by health care institutions in either information technology (IT) or the delivery of clinical care. Even in the reimbursement fee structure, there is usually no distinction made between services provided on site and those provided through telemedicine and often no separate coding is required for billing of remote services. Telemedicine encompasses different types of programs and services provided for the patient. Each component involves different providers and consumers.

Telenursing – The use of technology to provide nursing practice at a distance. May include synchronous, store and forward, and remote monitoring (Fronczek & Rouhana, 2018; Kumar & Snooks, 2011; Fairchild, Elfrink & Deickman, 2008).

Telemonitoring – The use of telehealth to remotely monitor a patients' health status. The information is reviewed by a health care provider in a setting separate from where the patient is located. This can be done synchronously or asynchronously. Data, such as weight, blood pressure, or glucose level, are captured via medical devices in the patient's home and then transmitted to a provider system via the Internet (Agboola & Kvedar, 2016).

Mobile Health (mHealth) – The use of internet and wireless devices to access health information and participate in online discussions (American Telemedicine Association, 2019).

Teledentistry – The use of communication technologies, electronic information, and imaging, including interactive videoconferencing and store and forward technologies, to provide dental care to a patient at a distance (American Teledentistry Association, 2019).

Synchronous (Live) – The use of a two-way interactive video connection between a patient and a care provider that allows for transmission of information in both directions at the same time () (American Telemedicine Association, 2019).

Store and Forward (Asynchronous) – The transmission of patient data, through technology, to a health practitioner using a device or software that records, stores, and send for the purpose of rendering a diagnosis or opinion (American Telemedicine Association, 2019).

Videoconferencing – Real-time transmission of digital video images between multiple locations.

F. BACKGROUND

Substantial growth in the use of technology in health care delivery has changed the landscape of where and how patients receive care. Digital communication technologies, internet expansion, and cloud-based platforms, which offer twenty-four-hour access to care, revolutionized data acquisition and transformed interactions among patients and healthcare providers (Weinstein, Krupinski & Doarn, 2018).

Although telenursing is not new, there are contextual differences that have emerged as health care needs are more complex. Access to care in remote areas remains challenging and innovative care that is patient-centered, cost effective, and ensures quality is in demand. While there are many terms that have been used interchangeably with telenursing, it has been defined as the use of technology to provide nursing practice at a distance. The scope of practice and use of the nursing process is unchanged in telenursing; it is the delivery medium that differs from traditional nursing practice (Fronczek & Rouhana, 2018; Barbosa, Dias da Silva, Araujo da Silva & Paes da Silva, 2016).

In a broader sense, telehealth denotes a range of providers who use telecommunications and information technology to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration (Health Resources and Service Administration, 2019). Telehealth has been studied in several populations and has been shown to improve outcomes and save costs (Souza-Junior, Mendes, Mazzo & Godoy, 2016; Radhakrishnan, Jacelon & Roche, 2012). Wade, Elliott, and Hiller (2012) purport that telehealth not only improves health outcomes and increases access to services for rural communities but also offers consumers of health services a choice of health care delivery and reduces adverse events.

The Department of Veteran Affairs (VA) has been known as innovators and early adopters of technology and has employed telehealth mode of care delivery for years to improve access, increase quality, and reduce cost of caring for veterans. Variability for access and use of VA services is influenced greatly by type of care within geographic regions. Veterans that live at a distance from VA facilities are less likely to access a myriad of specialized services than other Veterans (Adams et al., 2019).

One key strategy to addressing Veteran needs and improving access to high quality care was the expansion of VA's use of telehealth. Clinical videotape telemedicine (CVT) use within the Veteran Health Administration (VHA) is one such expansion that targeted Veterans living in rural communities. CVT use grew greater than 300 percent over a 6-year period with greatest utilization among rural Veterans. This form of technology provides Veterans real-time access to VHA care, inclusive of mental health care, and can be cost effective and lend to efficient remodeling of staffing structures (Adams et al., 2019).

The VA utilizes telehealth modalities for chronic and acute care management, to support self-care management where independence is a priority for veterans, and for multiple other clinical uses. In 2018 alone, one VA region experienced a burgeoning of

telehealth referrals by 232% with 81% of those receiving care via telehealth living in rural areas (Veazie, Bourne, Peterson & Anderson, 2019; Flaherty, Daniels, Luther, Haas & Kasckow, 2017).

According to the 2016 Veteran Profiles (National Center for Veteran Analysis and Statistics, 2018), Veterans are more likely to live in rural areas than the general population and may experience challenges living in rural settings as their health care needs can be complicated by combat related illness and injuries. Rural communities have a higher poverty rate, increased elderly populations, workforce shortages, residents with poorer health, and fewer health care infrastructures for the provision of Veteran-centric care (US Department of Veteran Affairs, Office of Research and Development, 2016).

Telehealth use in VA has been shown to decrease hospitalization frequency, length of stay, and may help reduce suicide risk in Veterans living with serious mental illness (Flaherty, Daniels, Luther, Haas & Kasckow, 2017). Other findings associated with telehealth use suggests comparable rates of patient satisfaction, cost and cost-effectiveness, and quality of life outcomes among patients attending in-person visits (Veazie, Bourne, Peterson & Anderson, 2019; Flaherty, Daniels, Luther, Haas & Kasckow, 2017).

G. RURAL COMMUNITIES AND TELEHEALTH/TELEMEDICINE

There are growing concerns relative to health disparities in rural communities where greater than 15% of Americans reside (Center for Disease Control and Prevention (CDC), 2017). When compared to urban communities, rural communities have higher risk of mortality associated with cancer, heart disease, obesity, stroke, chronic lower respiratory disease, unintentional injury and overall worse health outcomes. Many of these disparities are largely due to economics, poor access to care, fewer health care providers, lack of employment opportunities, and health behaviors such as smoking, binge drinking, and less physical activity. Depression, drug use and opioid misuse and overdose are exacerbated in rural areas due to a lack of access to mental health and substance abuse services (James et al., 2017; Borders, 2018;). These health disparities among rural communities underscore the need to develop comprehensive approaches for health promotion and disease prevention by public health. Implementing telehealth services in rural communities could help to bridge the gaps between healthcare services, healthcare providers, and those in need (James et al., 2017; Borders, 2018).

One-fifth of Georgia's population lives in rural areas. These 2.3 million rural residents are more likely to be uninsured or under-insured than their urban counterparts, mirroring other rural areas nationally with higher rates of diabetes, heart disease, obesity, and cancer (Georgia State Office of Rural Health, 2019). Rural Georgians have lower educational levels and higher poverty rates than Georgians living in urban areas. In 2017, the average per capita income among those living in rural areas in Georgia was $33,483 and the poverty rate was 20.3%, compared to an average per capita income of $44, 145 and poverty rate of 13.9% for those living in

urban areas in Georgia (United States Department of Agriculture Economic Research Services, 2019).

Georgia's 120 rural counties are medically underserved, with half the number of physicians of urban counties and significant shortages of nurses, nutritionists, and therapists (Economic Research Services, 2017; Georgia Rural Health Association, 2019). Many small hospitals in rural areas are facing financial challenges. One solution to this growing problem of access to care is the use of information and technology to link multi-level health providers with primary care practices to improve the overall quality of care and health care experiences of residents living in rural Georgia (Georgia Department of Community Health, 2019; Economic Research Services, 2017).

In using technology and developing telehealth models of care, there are unique challenges in rural communities that must be well thought out. Considering the health care workforce shortage in rural communities, many providers may have concerns about privacy and confidentiality violations found in smaller towns, insecure consistent funding for programs, and high up-front and operational costs. Patients residing in rural areas may share concerns regarding privacy and confidentiality. They may also face difficulties with lack of internet access and insurance coverage for telehealth services. Families living in rural areas indicate that financial constraints make it difficult to access needed services for their children with mental, behavioral or developmental conditions, and even describe their own mental health as poor. Many rural communities lack recreational amenities to support the built environment where children learn, play, and thrive (CDC, 2017). Families in rural areas are at greater risk for low health literacy when marginal educational levels exist. Other challenges to consider in developing health care strategies for rural families are a lack of access to pediatric providers and pediatric sub-specialties such as gastroenterology, pulmonary medicine, and psychiatry (Marcin, Shaikh & Steinhorn, 2016).

Despite many of the challenges confronting rural communities, telehealth/telemedicine provides an alternative to health care access and coordination of care for individuals and families living in remote areas. It offers care that extends beyond walls to improve health outcomes and reduce cost associated with hospitalizations (National Congress of American Indians, 2017).

H. EVOLUTION OF NURSING EDUCATION IN TELEHEALTH/TELEMEDICINE

The integration of technology in curriculums has become a priority among many health care disciplines as competencies in telehealth are expanding to meet the complex needs of patients (Tuckson, Edmunds & Hodgkins, 2017; Lee & Billings, 2016). There are no clear standards for education and development of healthcare providers for their evolving role in the era of technology advancement and many providers have not received formal training in telehealth modalities (Ali, Carlton & Ali, 2015; Hutcheson, 2001; Schlachta-Fairchild et al., 2010)

Schools of medicine have recognized knowledge gaps in the use of health-related technology among physicians and have adopted various forms of telehealth concepts into residency curriculums to ensure graduates are better prepared for job

market trends and new practice models (Saeed, Johnson, Bagga & Glass, 2017). Many health systems are responsive to knowledge gaps among clinicians relative to the use of technology in health care and are designing educational initiatives that extend beyond formal education as a solution-based approach to reduce access to care disparities.

In a recent study including 760 health care providers (nurses, physicians, psychologist, and social workers) at military sites and the VA, the effectiveness of a competency-based training program in the use of mobile health applications in behavioral health was evaluated. The education program focused on core competencies relative to knowledge acquisition of the mobile application use, integration of mobile technology in traditional practice environments, security and privacy issues, and ethical considerations. The findings of the study demonstrated a one-day interdisciplinary program was effective in leading to sustained increase in knowledge of the mobile technology and increase uptake in use among trainees (Armstrong, Ciulla, Edwards-Stewart, Hoyt & Bush, 2018). Thus, as academic programs move towards integration of technology in curriculums, health care systems and organizations will need to continue their educational efforts to address the knowledge gaps among health care providers to advance adoption of technology use in practice.

Education and development of nurses for telehealth have also been adapted to nursing practice in specific settings, and health care organizations are responsible for identifying and verifying competencies for their respective roles (ATA, 2008). In the case of nurses practicing in telehealth/telemedicine, specific competencies associated with nursing care delivery at a distance includes effective, proficient, appropriate and safe use of devices and technology that builds on existing nursing knowledge and expertise (Nagel & Penner, 2015). With the rapid speed of advancement of technology use in health care and value-based care influencing health system decisions, integrating telehealth concepts into schools of nursing are imperative.

While some schools of nursing are incorporating components of telehealth in simulation and clinical education, researchers have identified barriers to integrating telehealth in nursing curricula. These barriers include lack of trained faculty, saturated curriculums with no ability to expand content, inadequate educational time for telehealth delivery, cost of equipment, and complexity of hardware (Roney, Westrick, Acri, Aronson & Rebeschi, 2017; Ali, Carlton & Ali, 2015). To advance the integration of telehealth education in nursing curricula, it is imperative to address these barriers to keep pace with innovation in health care and emerging technology, and to conduct research to determine the impact on student learning (Ali, Carlton & Ali, 2015; Roney, Westrick, Acri, Aronson & Rebeschi, 2017).

I. BEST PRACTICES IN TELEHEALTH

The California Telehealth Resource Center (CTRC), a leading source of expertise and comprehensive knowledge in the development and operation of telemedicine and telehealth programs, published a National Compendium of Best Practices in Telehealth Services. This resource states that the initial step in development of a telehealth program is to assess and confirm readiness for telehealth

and complete a needs and environmental analysis. Performance of a formal assessment of readiness lends to early identification of potential problems and interventions while gaining support for the project.

Setting measurable goals and objectives will aid in staffing, equipment selection, performance evaluation, and prioritizing service delivery options. The goals for the telehealth program should also match the mission and strategic plan of the organization. In the planning of a telehealth system, it is critical to design and deploy health information exchange practices to ensure network privacy and security from the offset.

CTRC recommends identifying champions who are true change agents to lead and sustain the vision of the telehealth program. While growing champions is vital, it is important to know the geographic area and the community stakeholders and learn of their perceived challenges and concerns. Selection of the correct equipment for the telehealth program is essential for intended functionality and interoperability. However, being cognizant of the rapid speed of technology advancement is important, as applications require continuous upgrading and renewals. Planning for seamless integration requires designing activities that align with standard of practices and working methods. Developing a strong information technology workforce with a dedicated program manager are other essential elements in defining a best practice. Once the workforce is knowledgeable and familiar with operations, it is key to develop protocols, policies and procedures.

Once short and long-term goals are established, it is important to develop an evaluation and monitoring plan that allows for rapid development of quality improvement initiatives. During program implementation, a convenient and effective care environment reminiscent of a traditional care environment should be created. The designated telehealth room should be user friendly, well equipped with reliable and appropriate technology, be comfortable for patients and apply basic principles of room design for videoconferencing applications. Lastly, communication should occur regularly between the on-site and remote partners (clinicians, nursing staff, schedulers and other staff) to ensure that both ends of the telehealth link are satisfied with the program's management, administration, billing systems, IT support, problem resolution, coordination, and quality improvement (CTRC, n.d.).

J. SCOPE OF PRACTICE

The integration and expansion of technology in health care has broadened nursing practice beyond the traditional practice setting to reach patients who otherwise would not receive the care they need (Lorentz, 2008). In many areas, geographical health disparities and a demand to increase access to care have led to increased utilization of telehealth/telemedicine (Nagel & Penner, 2015). In the provision of care, nurses and other health care providers can access patients in remote and non-traditional settings (American Telemedicine Association, 2019) including patients with unique conditions who would otherwise not have access to a specialist

The American Nurses Association (ANA) first endorsed telenursing in 1999 as an official form of nursing practice. Telenursing meets the standards of nursing practice as

nurses follow the traditional nursing process and formulate care plans while using the telenursing platform (Fathi, Modin & Scott, 2017). Nurses assess, diagnose, plan, implement, and evaluate each patient as part of the nursing process and use decision support tools such as algorithms, protocols, and evidenced- based guidelines in their decision-making. The nursing process does not change when the method of delivery changes from the traditional in-person encounter to telenursing (Mataxen & Webb, 2019).

Telenursing is applied in numerous settings where the technology is used to provide health services and can be as effective as traditional nursing sites (Ali, Carlton & Ali, 2015). The range of nursing services using telehealth technology includes triage care, consultation, health advice, patient support, health education, care coordination, remote monitoring, videoconferencing, and computer–mediated communications (Nagel & Penner, 2015).

Nagel and Penner (2015) explain that nurses build on their education and training to develop new competencies for integrating technology into patient care. It is essential for nurses who provide care using telehealth technologies to not only be well-grounded in general nursing knowledge, theory, and practice competencies but also have additional expertise using technology (Nagel & Penner, 2015). Although nurses are seeing the patient via the virtual environment, they must identify clues from patients' tone of voice and facial expressions as part of their assessment and practice evidence-based nursing. Nurses working in telehealth must possess attributes such as strong verbal and written communication, active listening skills, and be skilled at posting questions to elicit information (Lorentz, 2008). Nursing practice involving telehealth technology also requires nurses to develop competency in relationship building, assessment, synthesizing and integrating multiple data sources, and clinical decision making (Fathi, Modin & Scott, 2017).

K. IMPLICATIONS FOR PRACTICE

Pressures to resolve issues related to confidentiality and privacy, licensure, scope of practice, interstate practice, liability coverage and reimbursement are commonly raised in discussions regarding telenursing (Ali, Carlton & Ali, 2015; Hutcheson, 2001; Schlachta-Fairchild et al., 2010). Restrictions for reimbursement from Medicaid and Medicare pose challenges for patients requiring diagnostic studies inclusive of imaging. Providers being reimbursed are required to be Medicaid providers, which may potentially limit participating specialists (Georgia Department of Community Health, 2015). Laws and policies regarding reimbursement for telehealth services in Georgia may be found at: https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies?jurisdiction=39&category=All&topic=All

Interstate practice and multistate compacts allows for practice in another state if the nurse abides by the laws of that state in which the patient is located (Brous, 2016). Information on applying for a multistate license in Georgia may be found at: http://sos.ga.gov/index.php/licensing/plb/45/nurse_licensure_compact

Malpractice coverage relative to nurses practicing in telehealth/telemedicine must

also be fully examined, inclusive of Advanced Practice Registered Nurses (APRNs) and their expanding role(s) in the healthcare delivery system. Issues associated with equipment failure, malfunction, inadequate preparation of users of equipment and medical errors that might ensue are other factors to consider (Brous, 2016; Glazer, 1999; Schlachta-Fairchild et al., 2010).

L. CORE COMPETENCIES AND STANDARDS FOR GEORGIA PUBLIC HEALTH NURSES

The Department of Public Health through the Office of Nursing has established practice guidelines and core competency standards for telehealth/telemedicine to help advance the science and to assure the uniform quality of service to patients throughout a broad geographic region. These guidelines are designed to serve as both an operational reference and an educational tool to aid in providing appropriate care for patients.

Georgia Public Health Nurses providing telehealth/telemedicine services shall:

I. be fully licensed and registered with the Georgia Board of Nursing.
II. be aware of credentialing requirements at their clinical site as well as the site where the patient is located, in compliance with regulatory and accrediting agencies
III. be knowledgeable of their locus of accountability, liability, ethical standards, documentation, record keeping and the other requirements that are specific to the telemedicine specialty area in which they practice
IV. be cognizant of the fact that when a provider-patient relationship has been established within the context of telemedicine encounter between the healthcare provider and the patient, whether interactive or store and forward, shall proceed accordingly with an evidence-based, best practice standard of care
V. have the necessary education, training/orientation, and ongoing continuing education/professional development to ensure they possess the necessary competencies for the safe provision of quality health services in their specialty area. Recommended approved professional development programs can be found at National School of Applied Telehealth (NSAT). NSAT Certification training includes Certified Telemedicine Clinical Presenter (CTCP) and Certified Telehealth Coordinator (CTC).

Georgia Department of Public Health through the Office of Nursing recommends that all presenting sites have at least one trained Telehealth Coordinator and at least 2 telehealth clinical presenters. Identified individuals will serve as resources, champions for change and a clinical support system for other Public Health Nurses that practice telehealth. Training for telehealth coordinators and telemedicine clinical presenters is available in person and/or virtually by your DPH Telehealth team. To request training, please contact the Telehealth team via email at dph-gphvn@dph.ga.gov.

Core competencies and Standards:

1. Clinical Standards for Georgia Public Health Nurses

   I. The Department of Public Health and Georgia Public Health Nurses shall be satisfied that health professionals providing care via telehealth are aware of their own professional discipline standards and code of ethics that governs their practice. These standards and code of ethics shall be upheld in telehealth practice.
   II. Georgia Public Health Nurses shall be guided by their professional governing body as well as any national existing clinical practice guidelines when practicing via telehealth. Any modifications to specialty-specific clinical practice standards for the telehealth setting shall ensure that clinical requirements specific to nursing practice standards are maintained.

2. Video Conferencing-Based Tele-presenting Practice Administrative Core Competencies/Standards

   The Public Health Nurse should be able to:

   i. Demonstrate knowledge of the existing scheduling procedures and policies within his/her Health District.
   ii. Verify and ensure that the evaluating provider who attends the virtual consultation is the scheduled, legitimate provider for the patient and is credentialed to provide the services being offered.
   iii. Identify the evaluating provider's clinical goals for the telehealth encounter; this should include the review of requested pre-consultation forms and diagnostic testing.
   iv. Establish and follow health district's procedure for contacting patients prior to the consultation to remind them of the appointment, give directions, and provide patient education.
   v. Implement a back-up plan that has been established by the nurse's Health District when/if there are technical problems.
   vi. Collaborate with the Health District and the remote provider to develop and implement patient protocols that are specific to each distant provider to ensure that patient information is readily available during the telehealth encounter.
   vii. Obtain a telemedicine consent form.
   viii. Demonstrate adherence to HIPAA regulations.
   ix. Adhere to state and federal regulations related to telepresenting and transfer of patient information electronically and all other record-keeping activities.
   x. Be knowledgeable about the location and operation of the state-district hub.
   xi. Evaluate and articulate outcomes and make suggestions for process improvement.
   xii. Collaborate with the remote providers in the development of patient

plan of care.

xiii. Demonstrate use of mobile telemedicine units (e.g., backpacks).

3. Clinical Core Competencies/Standards as the Public Health Nurse Presenter

The clinical aspects of the presenter role are both generalized as well as specific to the type of service that is being provided to the patient. The Public Health Nurse who functions as the presenter becomes the patient advocate to optimize the exchange of clinical information between the provider and patient.

a. Preparation of the Workstation

The Public Health Nurse should be able to:

i. Provide the evaluating provider with any available and necessary information regarding the patient (e.g., history and physical, radiographs, lab work, etc.), prior to the telehealth encounter.
ii. Understand and be able to implement contingency plans in an event of loss of connectivity (e.g., trouble shooting, rescheduling, referral etc.).
iii. Confirm with telehealth manager that all necessary equipment (including peripheral devices and supplies for the tele-encounter) are accessible and in good working condition in the examination room.
iv. Protect patient's personal identifiable health information
v. Assess and implement an appropriate plan for cultural, language, and/or disability issues as outlined by your Health Department.
vi. Demonstrate knowledge of the existing scheduling procedures and policies within his/her Health District.
vii. Verify and ensure that the evaluating provider who attends the virtual consultation is the scheduled, legitimate provider for the patient and is credentialed to provide the services being offered.
viii. Adhere to infection control principles/universal precautions.

b. Patient Education and Support

The Public Health Nurse Presenter shall:

i. Educate the patient/family and or guardian on what to expect during a telehealth encounter, this should include: the potential for an audio-video delay.
ii. Provide opportunities for questions and answers at every telehealth encounters.
iii. Introduce video-conferencing equipment to the patient, this should include identification of the microphone and camera locations.

iv. Anticipate and be able to accommodate exam requirements, including appropriately positioning and preparing of the patient for physical examination (e.g., gowning or uncovering body areas).
v. Introduce and make patient aware of all individuals in the room during the examination as well as those in the room at the remote site.
vi. Be alert and sensitive to nonverbal body language or any cultural barriers.
vii. Ensure the patient/family is comfortable with the tele-encounter and is aware of their right and ability to terminate a telehealth encounter at any time.

c. Knowledge and Skills

The Public Health Nurse Presenter shall:

i. Be knowledgeable and competent in health assessment skills, that is, have completed a Health Assessment course at a baccalaureate level as outlined by the Georgia Department of Public Health Clinical Competency Development Program.
ii. Be knowledgeable on how to turn on video-conferencing equipment, initiate and terminate a call, and identify resources to obtain technical assistance.
iii. Demonstrate knowledge and skills on how to operate the equipment and peripheral devices in the specialty area in which they practice. Equipment and peripheral devices include but are not limited to dental cameras, otoscope, ophthalmoscope, ECG monitoring, stethoscope, and spirometer.
iv. Be knowledgeable and demonstrate competency in health assessment skills for individuals across the lifespan.

d. Follow up post-telehealth encounter

The Public Health Nurse Presenter shall:

i. Review any instructions or information conveyed during the telehealth encounter by the remote evaluating provider after the session has concluded, as appropriate, based on the presenter's level of professional practice. Discussion should include; medication management, follow up tests or procedures that need to be done before the next visit.
ii. Provide patient, family and/or guardian with the evaluating provider's contact information, if needed for follow-up or emergency contact information during after-hours.
iii. Encourage and assist the patient, family and or guardian with directions to complete any evaluation forms after the telehealth encounter.

iv. Schedule follow-up appointments, treatments, etc., as ordered based on Health District's scheduling guidelines.
v. Provide the primary care physicians and/or other appropriate individuals involved in the patient's care coordination with necessary documentation from telehealth encounter and as requested by the patient.
vi. Document the telehealth encounter in the medical records and indicate where the patient's telehealth medical records will be filed.

M. CONCLUSION

Telehealth/telemedicine offers the potential to improve patient access to care and health outcomes in various settings with a myriad of telehealth applications. While proficient and safe use of technology is imperative, there is evidence to suggest that telehealth reduces travel time, increases nursing productivity, lends to cost savings, allows for providers to reach more patients in a timely manner, and may potentially impact the nursing shortage (Hutcheson, 2001; Lowie, 2012; ; Schlachta-Fairchild et al., 2010). Physicians and nurses can make better use of their time and education when telehealth technology is applied, particularly when traveling to rural communities and congested urban and metropolitan areas. Technological advances permit patients to access health care wherever they are and provides a platform to guide and monitor populations based on their need (Souza-Junior, Mendes, Mazzo & Godoy, 2016). Nursing practice in telehealth/telemedicine offers innovative approaches to patient care. These implications create opportunities specifically in public health settings and place nurses at the forefront of advancing technology use in health care delivery systems.

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Georgia Department of Public Health

O. APPENDIX A

Georgia Public Health Nurses Competency Form-Telehealth/Telemedicine

Facility/Health District: _____

Name: _____ Date Initiated: _____

Credentials and Job Title_____

Required competencies must be met regardless of trainee experience.

Trainer/Preceptor will sign each item of required competency when both trainer and trainee feel safe in allowing the trainee to perform each item without direct supervision.

Required Competencies: *Main categories and associated critical elements. (The trainee needs to prove they can perform those functions).*	**Verification:** *Method/comments* **D**: Demonstrated via simulator or direct care **V**: Verbalized via case studies, scenarios, etc.	Date Met	Trainee initials	Trainer Initials	**References** [Core competencies, scope of practice, regulatory, and standard operating procedures (SOP), practice manual].
Administrative Core Competencies ○ Demonstrate knowledge of existing scheduling procedure within the Health District. ○ Verify evaluating provider's credentials. ○ Obtain telemedicine consent form, if required. ○ Demonstrate adherence to HIPPA regulations. ○ Explain back up plan when there are technical problems.					Guidelines for Georgia Public Health Nurses Practicing in Telehealth/Telenursing/Telemedicine (2019).
Preparation of Workstation ○ Confirm that all equipment is in good working condition and is accessible. ○ Protect patient's personal identifiable health information. ○ Demonstrate Cultural competencies during the telehealth encounter. ○ Implement contingency plan in					Guidelines for Georgia Public Health Nurses Practicing in Telehealth/Telenursing/Telemedicine (2019). QA/QI for Public Health Nursing Practice manual (2019).

an event of loss connectivity. ○ Provide evaluating provider with any available health information (x-ray, lab work, H&P, etc.) prior to the telehealth encounter. ○ Adhere to Universal precautions.					Health District specific contingency plan Guidelines for standard Precautions and Blood borne Pathogens Occupational Exposure Control (2015). https://dph.georgia.gov/sites/dph.georgia.gov/files/DPH%20Guidelines%20for%20Standard%20Precautions%20and%20Bloodborne%20Pathogens.pdf
Patient Education and Support ○ Educate patient/family on what to expect during the encounter. ○ Provide opportunity for questions and answers at each encounter.					
Demonstrate knowledge and skills ○ Be knowledgeable and competent in health assessment skills. ○ Demonstrate knowledge and skills on how to operate the equipment and peripheral devices.					Clinical Competency Development Program for Public Health nurses. https://dph.georgia.gov/health-assessment District competency tools and/or preceptorship guide *(to be developed by each district).*
Follow up and post telehealth encounter ○ Schedules follow up appointment if required. ○ Review instructions with patient/family that was conveyed during the encounter. ○ Provide contact information for evaluating provider. ○ Provide after hours contact information. ○ Document the encounter in the medical records.					Health District specific SOP Health District specific SOP QA/QI for Public Health Nursing manual 2019.

INFORMATION SUBMITTED BY

THE HOME CARE ASSOCIATION OF AMERICA - GEORGIA CHAPTER

Home Care
Association of America
Georgia Chapter

October 24, 2022

Via Electronic Submission

Commissioner Caylee Noggle, Chair
Georgia Healthcare Workforce Commission
2 Peachtree Street, NW
Atlanta, Georgia 30303

Re: Georgia Healthcare Workforce Commission Public Comments

To: Commissioner Noggle

The Georgia Chapter of the Home Care Association of America (HCAOA) respectfully submits this public testimony to the Georgia Healthcare Workforce Commission on behalf of all providers of home and community-based services, and specifically the licensed private home care providers now serving elderly and disabled Georgians. The Georgia Chapter of the Home Care Association of America (HCAOA) represents almost two hundred licensed home care providers that go into the homes of thousands of Georgians each day. Our national headquarters is located in Washington, D. C. and represents more than 4,000 home care providers. We advocate at all levels of government for the services that our elderly and disabled need to remain active in their homes and communities. Further HCAOA details are available on our website located at www.hcaoa.org.

The HCAOA Georgia Chapter is pleased that the Governor appointed the Georgia Healthcare Workforce Commission to address the serious workforce issues that are impacting the delivery of care across all parts of the healthcare continuum. In following the meetings of the commission to-date, we are concerned that the caregiver workforce needs for long-term care services and supports has not been addressed in any detail. While we recognize that all the healthcare continuum has serious workforce needs, we do feel that it is important to widen the scope of the commission's work to include the long-term care of Georgia's elderly and disabled.

Late last year, a Kaiser Family Foundation study on care delivered in the home surveyed adults about their use of home and community-based services for care of their

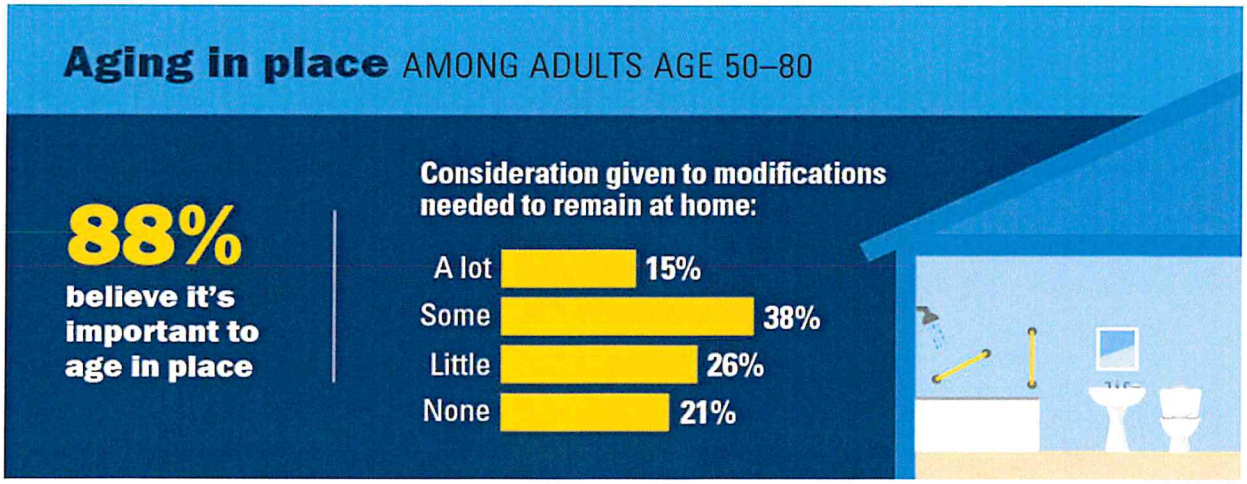
family members. Extrapolating that data to Georgia's current population (based on Georgia Data Analytics Center charts), care in the home is touching more than 1.8 million Georgians. While much of the care is provided by family and friends, the study estimates that as many as 415,000 Georgians are receiving paid care in their homes delivered by caregivers and/or nurses.

In presenting our public testimony, it is important to position home care within the long-term care providers that are currently licensed in Georgia:

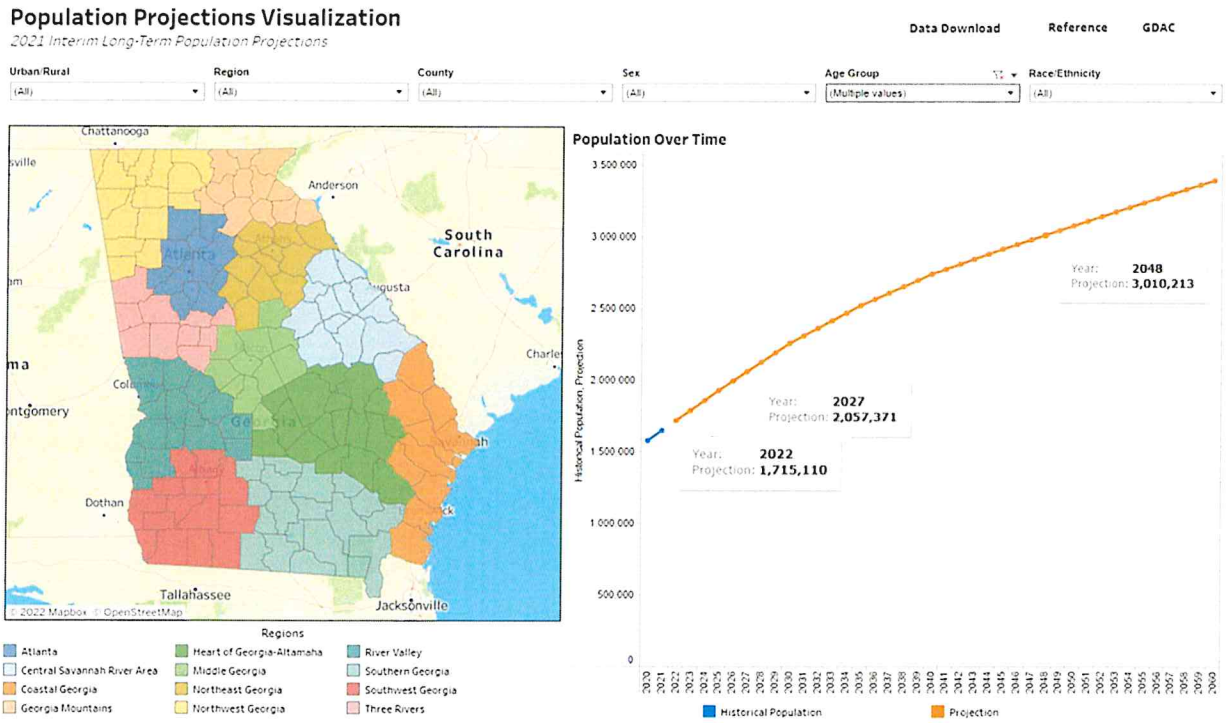
- Long-term care facilities total 83,687 licensed beds with an estimated occupancy in the 70,000-bed range. Licensed long-term care facilities include 1,372 personal care homes, 295 assisted living facilities, and 369 nursing homes.
- Hospice providers, including both in-home and facility hospice care, account for 280 licensed providers.
- Home health providers total 108 license holders, and provide short-term, in-home care after major healthcare events. Subsequently, in-home care is delivered as needed for a period that typically does not exceed 60 days.
- Private home care providers currently total 2,249 license holders and provide long-term care in the home that is typically delivered in hourly shifts for partial day and/or week coverage; and on occasion, up to 24/7 full-time care. Home care can be unskilled, skilled, or a combination of both depending on the individual care needs.

Each of these individual provider types are critical to the healthcare continuum and the long-term care needs of elderly and disabled Georgians. It is also important to note that these provider types share segments of the healthcare workforce, especially caregivers and nurses. As a result, changes in workplace job and reimbursement structures in one segment on the long-term care industry should also be considered throughout all providers. Currently, a wide range and methodology of reimbursement rates has created pay rate gaps approaching (and sometimes exceeding) $4.00 per hour.

Home care, and aging in place, is very important to seniors as a recent study by the University of Michigan noted. These national figures track the feedback history from the annual reports of Georgia's CCSP Medicaid waiver program.



In considering the entire healthcare workforce, and the workforce that delivers the long-term services and supports for our elderly and disabled population, the rapid growth of the senior population must be highlighted. In Georgia, the elderly population (>65 years of age) exceeded one (1) million in the early 2000's. Using the Georgia Data Analytics Center data, the elderly population is projected to double, reaching the two (2) million mark in 2027. Looking further ahead, the elderly population is projected to triple, reaching three (3) million Georgians in 2048. These trends cannot be ignored for their serious impact on the entire healthcare continuum, and especially the elderly and disabled Georgians that need to receive care in their homes and communities.

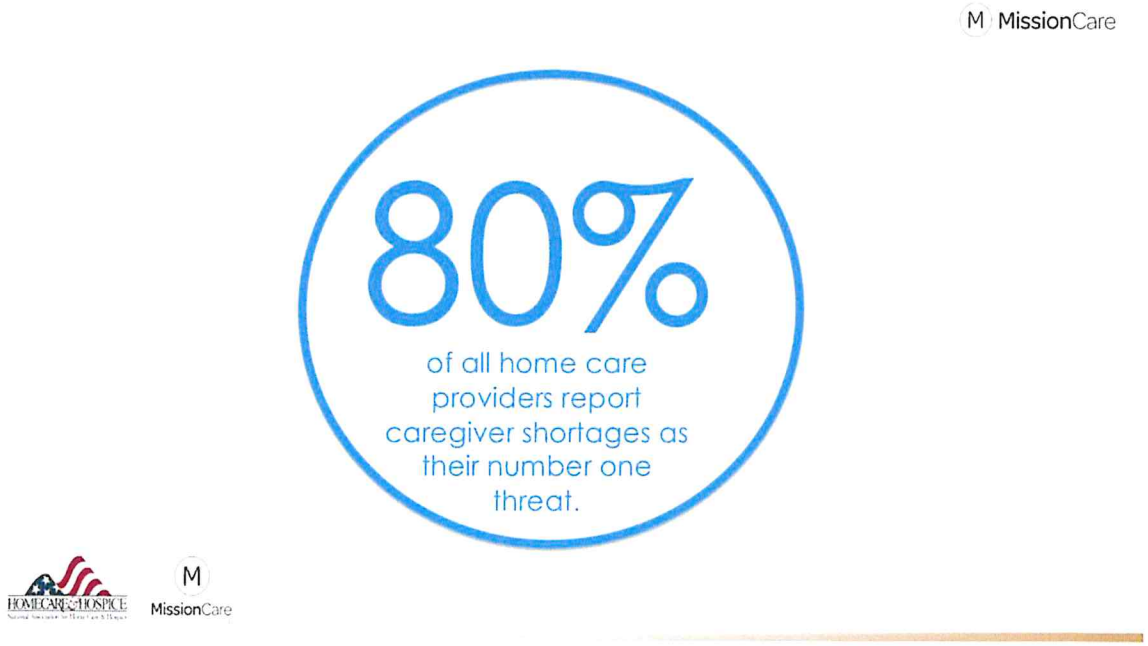


While the rapid increase of the senior population is concerning, it is important to consider the entire elderly and disabled population in Georgia that is dependent on care in their homes and communities. Using Georgia Data Analytics Center data, the current population is detailed as follow:

- Elderly & Disabled Population (2022) 2,687,241
- Percent of Total Population 24.6%
- Percent of Adult Population 32.1%

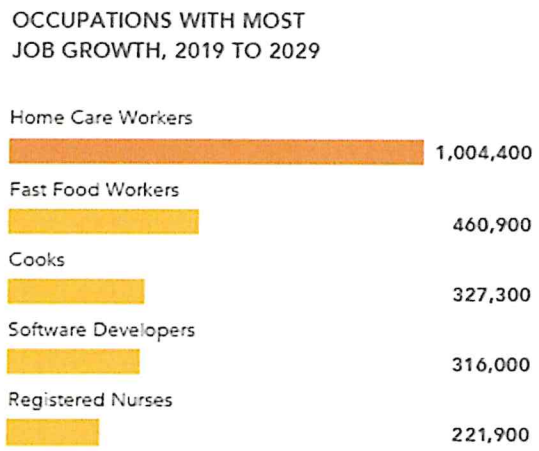
With almost one in three Georgia adults identifying as either elderly and/or disabled, and an estimated 415,000 Georgians already receiving paid care by a caregiver or nurse in their home, home care cannot be ignored as a critical segment of the healthcare continuum. Our industry's workforce issues are already interrupting the delivery of care to Georgians as a recent study with MissionCare highlights.

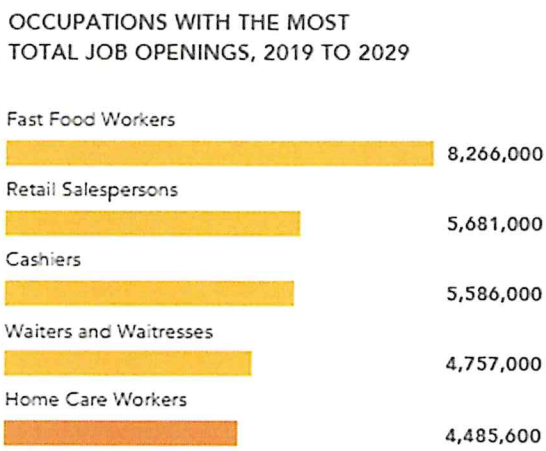
MissionCare, the parent company of myCNAjobs.com, is the largest job and candidate site for CNA's and caregivers in the US. Their trends are alarming.



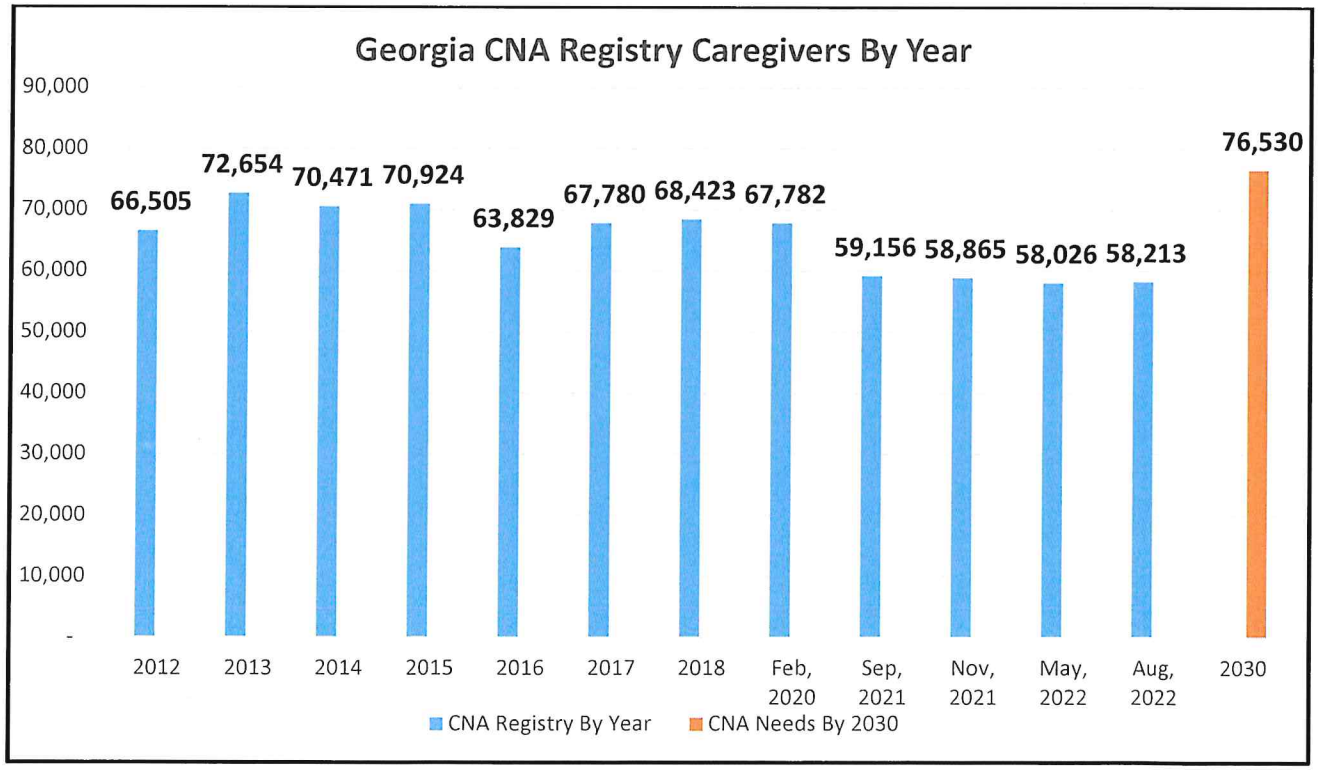
The workforce shortages that home care is currently encountering are highlighted even further in national data provided by the Bureau of Labor Statistics (BLS). With the elderly and disabled population growing, home care workers are expected to have the

greatest job growth and a high level of job openings in this decade. The job openings are driven by increasing demand, and the turnover of caregivers as they advance to more skilled positions or leave healthcare for better paying jobs in other employment sectors.





In Georgia we can partially track the caregiver workforce using the Georgia CNA Registry, a data base of certified CNA's that maintains the certifications of all Georgia CNA's. The trends of the registry are troubling and a sign of the challenges that all long-term care providers face.



The CNA counts reflect only the CNA's residing within Georgia. Using February 2020 as a benchmark, the August CNA total represents a decrease in CNA workforce of 14.1%. Other trends within this historical CNA data are summarized below:

- In 2012, the CNA Registry total represented 18.7 elderly Georgians per CNA.
- In August 2022, the CNA Registry total represents 29.5 elderly Georgians per CNA, a coverage reduction of 57.8%.
- To maintain the current registry CNA count, the Georgia CNA Registry needs to increase by 31.5% to match the demand of the growing elderly population by 2030.

It is apparent that the ever-increasing elderly population, and the decrease in the Georgia CNA Registry, are creating a serious shortage of caregivers to care for the elderly and disabled in Georgia. It should be noted that the CNA Registry comprises a large block of the caregiver workforce, but providers have the ability employ caregivers with prior experience that can qualify with a state-approved PCA test and skills check-off. While this expands the potential pool of caregivers, it is not sufficient to meet the needs of Georgians. As a result, the shortage of caregivers may result in the failure to complete key tasks on a regular basis:

- Assistance with activities of daily living (ADL's) that may include the ability to leave the bed in the morning, and go to bed at night
- Proper nutrition to assure that no meals are missed
- Assistance with feeding
- Oral hygiene
- Toileting assistance that can include changes of soiled undergarments due to incontinence
- Medication reminders
- Physician appointment reminders
- Accompaniment to physician appointments
- Help with errands including grocery store and drug store pick-ups
- Assistance with housekeeping chores
- Wound care (provided by nursing staff)
- Medication setup (provided by nursing staff)
- And many other health and welfare needs to enable a comfortable and safe environment in the home

It is this reality of unmet care needs that merits the need for serious caregiver workforce improvements to assure that Georgia's elderly and disabled get the care that they need in their homes and communities. On this basis, the HCAOA Georgia Chapter is pleased to offer the following suggestions on workforce improvements:

1. Strengthen the education and training pipeline for CNA and related programs in the Technical College System of Georgia. While these programs already exist throughout the state, some locations tend to only consider their CNA programs as stepping-stones to nursing programs, and do not treat them as career training programs and certifications. While CNA training and employment is excellent training

for nurses, it should also be considered as a career path for those that seek to be caregivers.

2. The state is nearing sixty (60) college and career locations with the majority already having CNA programs. These CNA programs need to get continuing emphasis and be a part of the curriculum in all locations. In addition, the apprenticeship program that has been initiated this year needs to be expanded to allow more home and community-based providers to serve as training and clinical sites. There are already several college and career academy programs that can serve as models for all locations, including the Griffin Regional College & Career Academy.
3. The regional workforce development boards already identify employment trends and key employment needs within their respective regions. As an example, the Three Rivers Workforce Development Board has already held forums emphasizing healthcare needs that included regional needs for caregivers in the workforce. All twelve (12) regions should be emphasizing all key healthcare job needs, identifying them as critical needs within their region and the state. Separately, the HCAOA Georgia Chapter has encouraged members to get involved in their regional workforce development boards to help with this process.
4. The approved Georgia CNA training curriculum needs to be reviewed to assure that it matches the industry. For home care, that would include the use of electronic devices to meet the needs of electronic visit verification (EVV) systems for time, attendance, care duties, and patient data. In addition, the CNA duty capabilities need to be reviewed to determine if there are other care components that could be added to a CNA without jeopardizing care. Such changes in the scope of care could free nurses to minimize the impact of nurse workforce shortages. The HCAOA Georgia Chapter recommends that a provider panel be appointed to assist in this revision, working with other long-term providers to be sure that all provider needs are met.
5. The Private Home Care Provider regulations were last updated on April 19, 2013. Since that update, key changes include the addition of fingerprinting of staff and the requirements of HB 183, the Home Care Patient Protection Act that became effective on July 1, 2015. The HCAOA Georgia Chapter recommends that a provider panel be appointed to assist in this regulatory update to be sure that the needs of the elderly and disabled are considered.
6. The expansion of Medicare Advantage Plans has provided home care as a benefit for many Medicare recipients. These plans are utilizing home care providers to provide this care. Of concern, however, is the partnership of certain carriers with providers that are not licensed in Georgia and use a business model that does not meet the licensure requirements of the Private Home Care Provider regulations. HFRD is already aware of this situation and is investigating, but it is imperative that the delivery of unskilled care of our elderly and disabled meet these regulations.
7. Reimbursement rates for Medicaid waiver programs have hindered providers from increasing pay rates to match the market dynamics. While the legislature has provided rate increases for home and community-based providers, it is still difficult for providers to match the wages found in healthcare facilities, and in competing retail and light industrial jobs. Using the Personal Support Services (PSS) reimbursement rate, the 1999 rate when adjusted for inflation (using the annual Social Security COLA rates) will be more than $10.00 per hour behind inflation in 2023. The DCH rate study that is now underway will need to be used to create a path forward for providers to be able to offer competitive pay rates. It will be imperative that all the

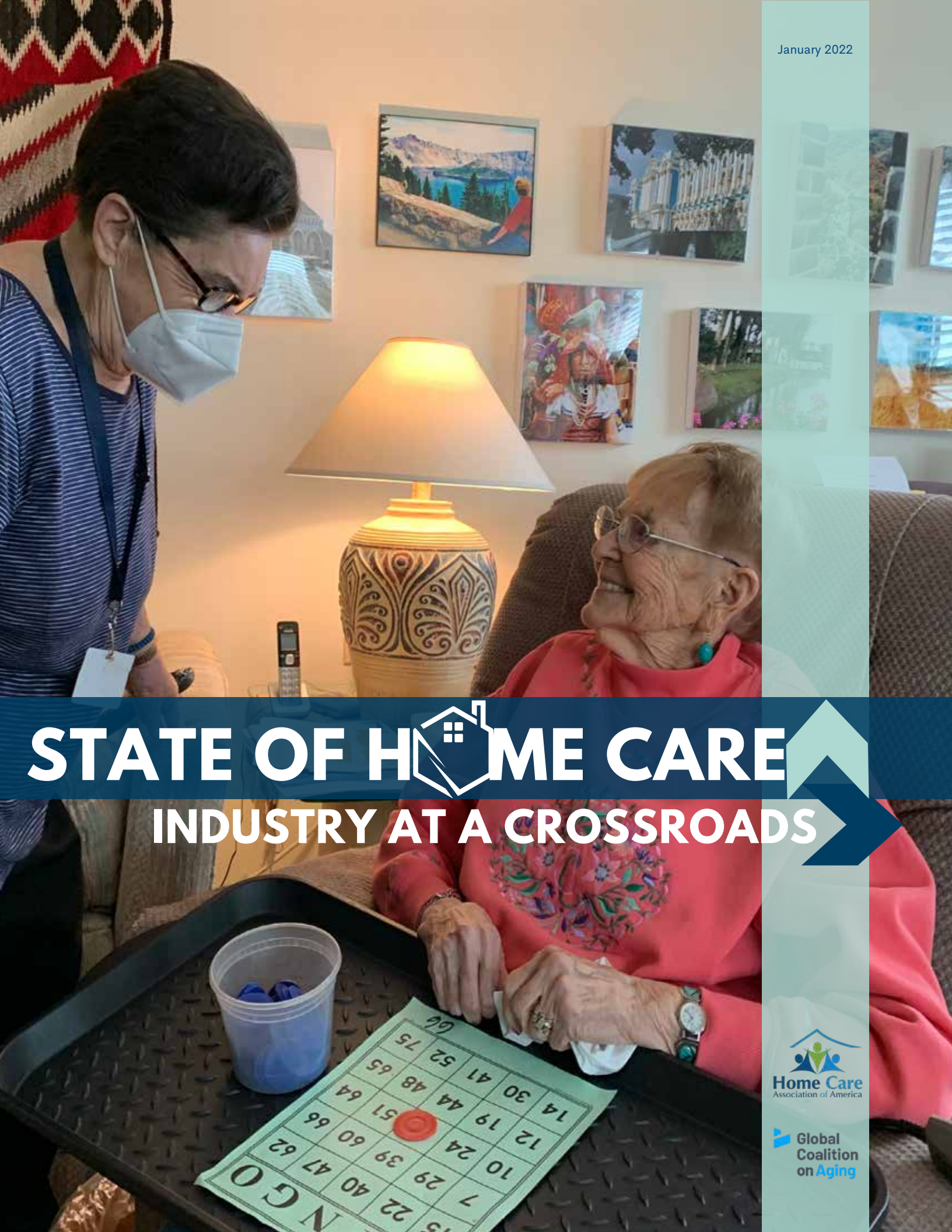
Medicaid waiver programs have reimbursement rates that allow providers to set similar pay rates.

8. Caregivers need improving benefits as an employment incentive. Many of our caregiver staff already have family members that qualify for Medicaid, but our caregiver staff does not qualify. As an incentive, a Medicaid waiver needs to be created for all caregivers employed by a home and community-based service provider. A caregiver would need to maintain an average of thirty (30) hours of employment each week working as a caregiver. It would be incumbent on the caregiver to accept assignments to maintain the 30-hour threshold, or risk losing the benefit. The provider would be responsible for maintaining a log of hours worked for each caregiver. The employment requirements would include hours working on Medicaid waiver programs and non-Medicaid programs for the elderly and disabled within the State of Georgia only.
9. Technology capability has increased the ability to monitor the elderly and disabled within their homes. The regional Area Agencies on Aging locations have supplied assistive technology to many Georgians. Remote patient monitoring (RPM) is available, and the pandemic dramatically increased the use of telemedicine for routine visits. While this technology does not replace the presence of a caregiver, it should be used to supplement care and reduce emergency room visits and hospitalizations, and as a result, lower overall healthcare costs.
10. The HCAOA Georgia Chapter has previously supported the ability to employ a relative to deliver the services for the Medicaid Elderly and Disabled Waiver Programs. This option has been available during the Public Health Emergency via the Appendix K and has helped the home care industry staff services during the continuing caregiver workforce shortage. Making this option permanent will benefit the Medicaid recipients by reducing the risk of staffing shortages.
11. Included with these recommendations is an attachment entitled the State of Home Care that details HCAOA and the home care industry. In addition, HCAOA is partnering with other associations to create the Home Care Workforce Action Alliance. It is expected that this group will be issuing workforce recommendations by the end of the year. Once they are released, we will share the details.

The HCAOA Georgia Chapter remains committed to serving the elderly and disabled community throughout the State of Georgia. We are ready to assist in any manner that is necessary to keep Georgians in their home and communities by delivering the healthcare services that they need. Should you have any questions or need further information, please contact us.

Sincerely,

Dave Lamb, Legislative Chair
Georgia Chapter
Home Care Association of America
P. O. Box 278
Griffin, Georgia 30224
E: davelamb@caremastermedical.com



January 2022

STATE OF HOME CARE

INDUSTRY AT A CROSSROADS

Home Care Association of America

Global Coalition on Aging

In 2016, the Home Care Association of America and the Global Coalition on Aging authored *The Value of Home Care Report* to showcase the positive impacts of home care (most often referred to as personal care provided in a private home) on individual care recipients, their families, health care systems and overall economic growth. In that report, we highlighted home care's increasing value to the healthcare system and the unique role it plays in keeping older Americans and those living with disabilities safe in their homes. Five years and one global pandemic later, the words in that report ring true more than ever. Since the early days of the pandemic, home care workers were deemed essential in all 50 states, going to great lengths and taking on great personal risks to do the jobs they committed to do and keeping people safe and healthy at home.

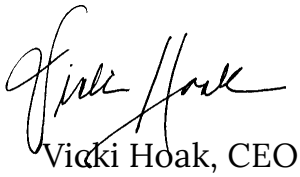
Yet the pandemic also revealed that our healthcare and long-term care systems were overwhelmed and under-prepared. Healthcare systems had only a limited supply of ventilators, pulse oximeters and intensive care units. Personal protective equipment (PPE) for healthcare and other essential workers was hard to come by.

THROUGHOUT THE PANDEMIC, THE IMPORTANCE AND VALUE OF CARE IN THE HOME, ESPECIALLY FOR OLDER AMERICANS AT RISK OF WORSENING PHYSICAL HEALTH AND SOCIAL ISOLATION, HAVE COME INTO CLEAR FOCUS.

Worst of all, the loss of life among older Americans has been harrowing.

According to AARP, 95 percent of all American COVID-19 deaths were among people 50 and older,[1] and approximately 40 percent of all deaths were in long-term care (nursing home, skilled nursing and assisted living) facilities. Throughout the pandemic, the importance and value of care in the home, especially for older Americans at risk of worsening physical health and social isolation, have come into clear focus.

I am proud that Home Care Association of America members and so many in the home care sector stepped up during these dark and frightening times – taking the actions necessary to keep their clients safe, while balancing the need to keep their families healthy and safe as well. The pandemic shined a light on how older and vulnerable populations are too often left behind. The home care industry is at a crossroads. It is our hope that this rising awareness emerging from the global crisis will create momentum for policymakers across the country to address these faults in our healthcare system. For the home care industry, it has only strengthened our focus on redoubling efforts to provide quality care and keep older Americans in their homes and safe. With greater awareness and smarter policies, home care can and will be a powerful solution to support and alleviate these issues for decades to come.



Vicki Hoak, CEO
Home Care Association of America

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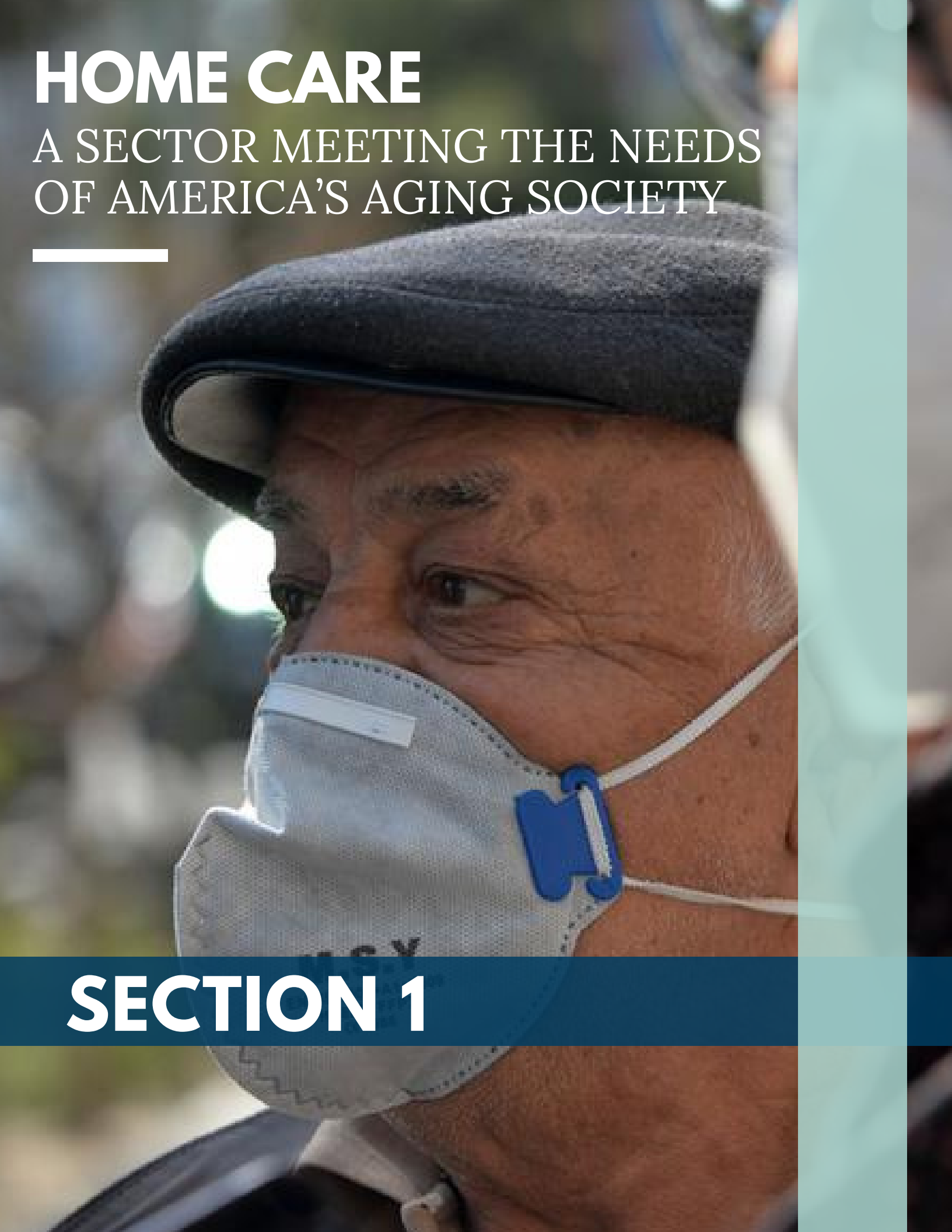


HOME CARE

A SECTOR MEETING THE NEEDS OF AMERICA'S AGING SOCIETY

SECTION 1

Differentiating Home Care

In America, there are three types of care consumers can receive in their homes: home care, home health and hospice. Even among doctors and discharge planners, home care is often confused with home health or hospice care, but it is typically provided before these services are needed or after an acute care incident, injury or a chronic disease diagnosis to monitor conditions so older adults and individuals with disabilities can remain at home as they age. Home care services do not require referrals from health care professionals; they are sometimes referred by hospitals and more often sought by families when taking care of an ill or aging loved one who requires additional assistance from a trained caregiver.

	Home-Based Care		
	Home Care	**Home Health**	**Hospice**
WHAT TYPE OF CARE?	• Long-term, continuous care • Assistance with activities of daily living (such as bathing, dressing, medication reminders, etc.); • Care for people with chronic conditions	• Brief and intermittent care, "episodic" • Medical care provided in a patient's home, such as nursing, therapy, wound care	• End-of-life care • Palliative care
WHO DECIDES?	• Individuals and families • No homebound requirement or physician order requirement	• Health care professionals • Must be homebound • Physician order and plan of care required	• Health care professionals • Prognosis of six months or less required to qualify
WHO PROVIDES?	• In states where home care is licensed, professional caregivers are vetted, trained, and insured by home care agencies	• Health care professionals including home health aides, registered nurses, physical, occupational, and speech therapists, social workers	• Hospice nurses, social workers and hospice aides
WHO PAYS?	• Individuals and families (primarily) • Private insurance • Medicaid • VA • Medicare Advantage	• Medicare • Medicaid	• Medicare • Medicaid • VA

Defining Home Care

Home care, often referred to as personal care, helps older adults maintain healthy, active lifestyles for as long as possible in the comfort of their own homes. Home care has emerged as a valuable solution to fill gaps created by traditional care models, including hospitals, nursing homes, and home health.

Home care workers – also known as professional caregivers, personal care aides or direct care workers, or in some cases, certified nursing assistants (CNAs) – who work for agencies receive professional training to enable them to assist with activities of daily living (ADLs) such as bathing, dressing, meal preparation, eating, transportation, running errands, and light housework. Most importantly, these caregivers provide vital companionship and mental stimulation by engaging their clients in conversation and other activities.

While not typically medically certified, home care workers serve as an additional set of "eyes and ears" for families, helping to ensure older adults' safety by recognizing and alerting family members and health care professionals to potential signs of declining health.

In this report, we refer to this vital and growing segment of the workforce as "home care professionals" or "professional caregivers."

Services to Keep People at Home as They Age

Home care is primarily paid for privately – by care recipients and families. However, today Medicaid, the Veteran's Administration and Medicare Advantage plans may also reimburse providers for this type of personal care. Home care services are provided by large, multi-state organizations, franchises and independently owned agencies.

While home care in the U.S. is regulated differently from state to state or not at all, the Home Care Association of America (HCAOA) supports state oversight to provide consumer protections and help ensure quality care. In the absence of national standards and the lack of regulation in some states, HCAOA has developed its Code of Conduct, a framework that serves as a basis for delivering high-quality care. The Code includes such standards as supervision, criminal background checks, appropriate insurances and adherence to a care plan. This is an important step in ensuring more care and better care is being delivered to keep people at home for as long as possible.

Examples of Home Care Services

Assistance with Activities of Daily Living

Assistance with Chronic Conditions

Companionship

Laundry and Light Housekeeping

Diet, Nutrition, and Meal Preparation

Medication Management

Transportation

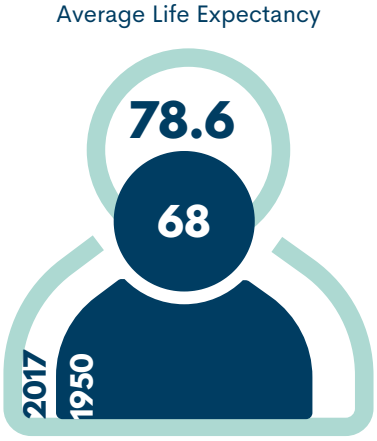
Wellness and Safety Monitoring

The Ever-Increasing Need for Care at Home

An Aging America.

By 2040, nearly 81 million people in the U.S. will be 65 years older, compared with 77 million under the age of 18.[2] This means that America will soon consist of more old than young. Through modern medicine and healthier lifestyles, average U.S. life expectancy has increased from 68 years in 1950 to 78.6 years in 2017.[3]

While life expectancy has declined by more than a year due to the COVID pandemic, the miracle of longevity remains an event to be celebrated. But it also raises new challenges that our healthcare system must be aligned, or realigned to address.



Someone turning 65 today has nearly a 70 percent chance of needing long-term care and support, according to the U.S. Department of Health and Human Services.[4] One out of five will need care for more than five years.[5] The need for care increases with age. In 2018, the percentage of older adults aged 85 and older who needed help with personal care (21%) was more than twice the percentage for adults ages 75–84 (8%) and five times the percentage for adults ages 65–74 (4%).[6] America's new age dynamics show a surging need among older adults for the highest-quality care. And if most get their preference, that care will happen primarily in their own homes.

Chronic Conditions Drive Care Needs.

With aging comes an increase in chronic conditions, but with proper treatment, prevention and care, these conditions need not be inevitable as one grows old. Right now, roughly six in 10 Americans aged 65 and up have at least one chronic condition, such as obesity, diabetes, or hypertension. About 40 percent have two or more.[7] Then there's the growing wave of people with Alzheimer's disease and other forms of dementia.

Already, more than 5 million Americans are living with Alzheimer's. Absent a medical breakthrough, that could hit 14 million by 2050.[8] And three-quarters of people living with Alzheimer's require assistance to handle the tasks of daily living.[9]

A Desire to "Stay Put."

The vast majority of older Americans want to age at home for as long as possible. However, just 59 percent believe they will actually be able to stay local either at home (46 percent) or elsewhere in their community (13 percent).[10]

Adult Children Are Less Able to Support Aging Parents.

Traditionally, older adults have relied on family members for help in dealing with the challenges of aging. This requires a safety net of a family caregiver living nearby. Most seniors don't have that safety net.

Twenty percent of adult children live more than two hours away by car from their parents.[11] Only about one-third of American families with adult children have all family members within 30 miles,[12] leaving the other two-thirds without family support.

The Family Caregiving "Balancing Act."

Many family caregivers are under severe stress – especially those in the "sandwich generation" who must balance the demands of raising children and caring for aging loved ones. The COVID-19 pandemic has only deepened that stress.

On September 22, 2021, the Recognize, Assist, Include, Support, and Engage (RAISE) Act Family Caregiving Advisory Council submitted its initial report to Congress outlining 26 recommendations to address how the federal government, state governments, and communities - in partnership with the private sector - can recognize and support family caregivers. This roadmap serves as a call to policymakers that America's caregivers must be supported through a strategy including greater adoption of person- and family-centered care in all healthcare and long-term care settings.

> *"If you're at home with someone, you've got challenges related to family dynamics. You might have kids coming home from college and trying to engage in remote learning, you might be trying to work remotely, or you might be an essential worker so that you're coming in and out of the home and there's that risk of contagion, and you may not have access to respite. So here you are trying to do all this care work, and you're not really able to get a break, you're not able to get some time to yourself. It's that much more intense if you're caring for someone with a healthcare need or disability."*
>
> *- Grace Whiting*
> *Former Chief Executive Officer*[13]
> *National Alliance for Caregiving*

Who Uses Home Care?

While home care serves people with illnesses and disabilities of all ages, the majority of home care recipients are older people with an average age of 69.[14]

Among care recipients aged 65+, more than two-thirds (69 percent) have long-term physical conditions, 39 percent have memory problems, and 21 percent have emotional or mental health issues.[15]

Selected Main Problem or Illness by Care Recipient Age[16]

Problem/Illness	Age 18-49 (N=188)	Age 50-64 (N=256)	Age 65+ (N=944)
Alzheimer's, dementia	2%	2%	15%
Back problems	8%	10%	3%
Cancer	6%	7%	6%
Developmental or intellectual disorder/disability	13%	1%	-
Diabetes	2%	8%	3%
Heart disease or attack	1%	4%	4%
Mental/emotional illness	15%	7%	2%
Mobility issues	7%	10%	13%
"Old age," frailty	-	4%	23%
Stroke	1%	6%	5%
Substance abuse	5%	3%	-
Surgery, wounds	4%	12%	5%

Value of Home Care

In *Caring for America's Seniors: The Value of Home Care*, we clarified the important benefits of home care as an emerging contributor to healthcare, the nation's economy, individuals and families.

Home Care Improves the Lives of Older Adults

Professional caregivers help seniors lead more vibrant, independent lives. They provide a range of services that serve as a lifeline for seniors while keeping them safe, healthy, engaged, and active. Important benefits of home care include:

- **Preventing falls and other common injuries** (the leading cause of non-fatal injuries, hospital admissions, and death for Americans over 65);[17]
- **Promoting medication adherence** (a problem for roughly 50 percent of seniors);[18]
- **Reducing loneliness and social isolation and promoting stimulation and companionship** (which can contribute to depression & dementia);[19]
- **Facilitating social engagement and community connections** (keeping seniors more active and engaged).

Length of Time as Family Caregiver

33%
1-3 years

44%
3-5 years

24%
5+ years

Home Care Relieves Stress and Burden on Families

Caregiving can exhaust family members and loved ones who often work full-time in addition to providing care. Today, close to 42 million Americans already serve as family caregivers for someone age 50 and up.[20] Sixty percent of family caregivers work full-time, creating challenging work/life balance issues.

On average, family caregivers spend 23.7 hours per week providing care.[21] And caring for a loved one is often a long-term proposition.

One-third of family caregivers have been providing care for one to three years, 44 percent, for more than three years, and 24 percent for five or more years.[22] This imposes a high toll on family caregivers' physical and emotional health.

By reducing the time, stress, and workload, professional caregivers can help build stronger relationships among care recipients and their families – allowing caregiving children time to be a son or daughter, and not only a caregiver.

Home Care Benefits America's Health System Through Lower Costs

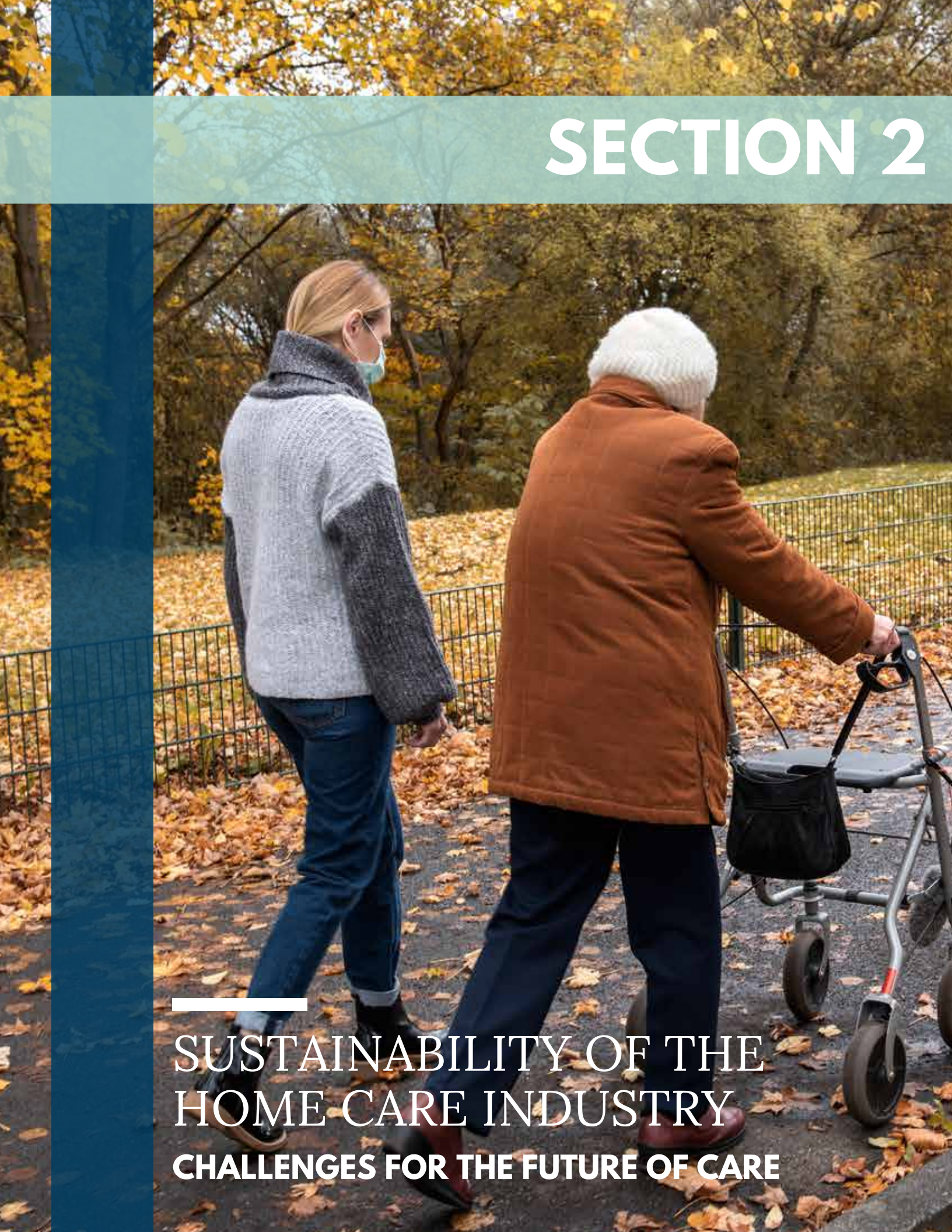
Home care has shown to be cost-effective when compared to nursing home care and when compared to not having professional care interventions at all. In 2020, the typical annual cost of in-home care for seniors was about $55,000 for an average of 44 hours of care per week – about half the annual cost of a private room in a nursing home.[23]

One study revealed that healthcare savings were realized when older adults with certain chronic conditions utilized home care services compared to those not receiving home care. Older adults (averaging 80 years old) with functional limitations who received home care resulted in $500 per member per month lower healthcare costs than those not receiving home care.[24] These savings in health plan costs were similar across patients with chronic conditions from diabetes to congestive heart failure (CHF) to chronic obstructive pulmonary disease (COPD).

A recent study published in the Annals of Internal Medicine found that more than $4 billion in Medicare costs are due to lack of non-medical support for older adults with disabilities who have trouble with self-care and household activities.[25] These are exactly the kind of services home care is ideally positioned to provide.

Further, according to one study on aging in place, providing peer support, occupational therapy, home repairs and conversations about health care goals—all of which home care can deliver—can generate annual cost savings in the hundreds of millions to billions of dollars.[26]

SECTION 2



SUSTAINABILITY OF THE HOME CARE INDUSTRY

CHALLENGES FOR THE FUTURE OF CARE

Standardization of Services & Employment Models Needed to Alleviate Strain on Industry, Workers & Care Recipients

Absence of national care standards minimizes the importance of the sector.

Strong standards – including both state oversight and national standards – are essential to elevating the home care industry and raising public perceptions of caregiving, while also helping to ensure care recipients get the highest quality of care.

Standards to emphasize caregiver training and employer expectations can also elevate work performed in this field, helping to promote compensation commensurate with the value of the services caregivers provide.

Industry fragmentation highlights need for a home care model that supports care workers.

Caregiving is typically provided through two different models: the employer-based model and the independent worker model. Caregivers that are employed through reputable agencies pay fair wages and offer training, credentialing programs, and other benefits for care workers. But those who work independently, or as contractors, may not have proper training and skills, which offers little certainty to care recipients and their families.

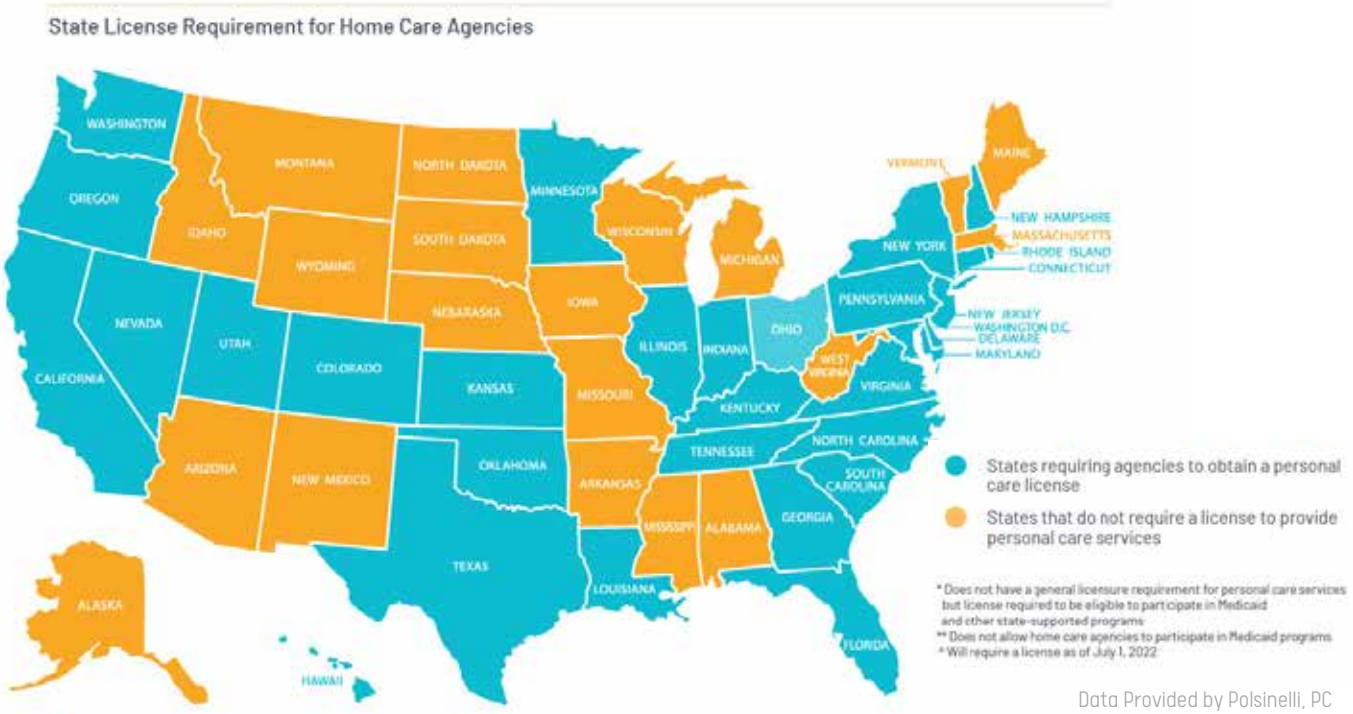
Employer-based home care ensures quality, safety, and accountability. Agencies provide background checks and comprehensive training to ensure care recipients and families have a peace of mind about their caregivers. Training opportunities offer continuous growth for employees as well as professional career pathways, access to new technology, and administrative support.

Lack of licensing across half of U.S. creates inconsistencies and inequality of care.

Licensure across states varies dramatically, with only 30 of 50 states and the District of Columbia requiring agencies to obtain a personal care license. Given rising demand and the value of the care provided, this inconsistent system is not set up to deliver the quality, consistent care that America's older citizens need and want.

Absent national standards, quality of care can be overseen, monitored, or guided through state licensure and HCAOA's own Code of Conduct, recently enacted and adopted by HCAOA members.

While the industry is increasingly recognized as an essential sector of the economy, its status among the public and policymakers has not kept pace with its growth and value. Several factors contribute to the misalignment.



Caregiver Shortage Prevents Industry Growth

Caregiver supply can't catch up to demand.

The home care industry is rising to the challenge of America's surging demand for care. What was once a cottage industry of small operations has become a powerful job creation engine, offering rewarding employment to hundreds of thousands of people who find purpose and satisfaction in caring for others.

Between 2008 and 2018, the number of home care workers increased by 151 percent – from 898,600 to 2.26 million.[27] Yet even this increase can't keep pace with demand.

While many professions are becoming automated or replaced by artificial intelligence (AI) and technology, caregiving requires a human touch. And, there are simply not enough professional caregivers to meet today's needs, let alone the future needs of our aging population.

Paul Osterman of MIT's Sloan School of Management projects a national shortage of 151,000 paid direct care workers and 3.8 million unpaid family caregivers by 2030.[28] By 2040, the shortfall will balloon to 355,000 paid and 11 million unpaid caregivers.

Caregiving recruitment waning.

Caregiver recruitment is the perennial top challenge for home care agencies. One survey found that over 70 percent of home care agencies recently turned down potential clients due to staffing shortages,[29] and more than half of HCAOA member agencies have reported turning away more than 10 clients per month.[30]

To address the shortage, many home care agencies are boosting wages, benefits and incentives, including bonuses up to $1,200. The head of one agency reported she hopes to recruit another 1,000 to 1,500 caregivers, luring them with $100 to $500 bonuses after three months.[31]

Yet, turnover remains high. In a 2018 study, 97 percent of caregivers said they were open to a new job and 65 percent reported they're always searching for new opportunities.[32] Interestingly, the pandemic has begun to reverse that trend. In 2021, Home Care Pulse reported turnover rate at 65 percent,[33] a steep decrease from previous years.

Even so, the recruitment and retention challenge requires a wholesale change in the way we look at the caregiving profession.

Profile of a professional caregiver is misunderstood.

It takes a special kind of person to be a caregiver. When asked why they joined the profession, more than 88 percent of caregivers cited a desire to help people.[35]

High-performing caregivers bring a unique mix of skills to the job, including patience, empathy, dependability, flexibility, trustworthiness, compassion, rapport, enthusiasm, and exceptional communications skills.[36]

Yet society often fails to adequately value these skills, leading to a lack of public recognition and respect for caregiving as a profession.

The demographic makeup of this workforce also lends to stereotypical misperceptions of the skills and value of the workforce. Nearly one-third of home care workers were born outside the United States.[37] By comparison, people born outside the U.S. make up less than 15 percent of the total population.[38]

Reversing misguided perceptions starts with paying caregivers commensurate with the value they provide. Across the U.S., about 40 percent of agencies are now offering sign-on bonuses, and 94 percent have increased pay, some by as much as $10 or more an hour based on experience.[39]

> *"Society's reliance on [the family caregiver] "work force" — largely taken for granted — is unsustainable. While the demand for caregivers is growing because of longer life expectancies and more complex medical care, the supply is shrinking, a result of declining marriage rates, smaller family sizes and greater geographic separation."*
>
> *- Dhruv Khullar, M.D., M.P.P.*
> *Resident Physician*
> *Massachusetts General Hospital &Harvard Medical School* [34]

> *"With the workforce the way it is, there's children at home, there's parents at home, there's people with disabilities. I see the trend that we're getting back to being concerned about one another. It's almost like a new normal now. More people need that help and support. The ones that are caregiving, the first responders, we all need that support. But sometimes we need a break. And our families need a break. There's a lot of us [caregivers] that step right in and are right there for our families and friends and people are out there for us as well."*
>
> *- Zora Bullett*
> *Professional Caregiver*

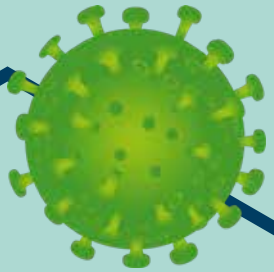
Rising to the Pandemic Caregiving Challenge

Home care workers were designated as essential employees early in the COVID-19 pandemic, who, along with other front-line workers, put themselves at great personal risk to provide care. As one home caregiver noted, "We are risking our own life, going out to work not knowing if we are going to take the virus home to our family or not."[40]

Heroic efforts to provide care during the pandemic should erase all doubts about the value of caregiving professionals to those they serve. But the pandemic has provided indisputable evidence about the value of caregiving to America's overall health care system.

Out of all patients requiring additional hospitalization following a COVID-19 diagnosis, readmissions were much lower among those receiving home care or self-care (7 percent) compared to those needing home health (12 percent) or discharged to a skilled nursing facility (15 percent).[41]

As a direct result of the COVID-19 pandemic and the high incidence of COVID deaths in nursing home residents, CMS provided $165 million in funding across 33 states to accelerate long-term care system transformation toward more care in the home and community. CMS has cited both quality care and cost savings across the care continuum as motivations for this approach.[42]



"The tragic devastation wrought by the Coronavirus on nursing home residents exposes America's over-reliance on institutional long-term care facilities. Residential care will always be an essential part of the care continuum, but our goal must always be to give residents options that help keep our loved ones in their own homes and communities for as long as possible... Home- and community-based care is not only frequently more cost effective, but is preferred by seniors and adults with disabilities seeking to maintain the dignity of independent living."

- Seema Verma
Former CMS Administrator[43]

Current Payment Systems Are Not Suited for Aging America

Building a larger professional caregiving workforce is only part of the challenge. The other major question: Who will pay for care? Long-term care – which 70 percent of adults 65 and older will require at some point – costs $55,000 annually for 44 hours per week of home care to more than $93,000 per year for nursing home or assisted living care.[44]

Current long-term care spending mix too much for families.

Current long-term care spending mix too much for families. A recent Milken Institute analysis found that individuals and families pay 52 percent of all long-term care (LTC) costs out of pocket. Medicaid pays for nearly 34 percent, primarily for low-income people or those who spend down their assets to qualify for coverage. Private LTC insurance covers less than 3 percent.[45]The financial burden of caring for our aging population—on individuals, families, and our society/economy—is simply unsustainable on today's payment model.

One step in the right direction is the bipartisan Credit for Caring Act, introduced in May 2021 in both the U.S. Senate and House of Representatives. The legislation recognizes the financial strain of caregiving, especially for working family caregivers. The tax credit would help families defray costs of keeping a loved one safe at home, such as home care services or installing smart-home technologies or ramps. While ultimately eliminated from Build Back Better plan in 2021, the legislation continues to gain support in Congress in recognition of the critical role of family caregivers to the nation's infrastructure.

Retirement savings can't fully cover caregiving need.

Retirement accounts don't provide much financial cushion. The vast majority of Americans don't have enough savings to cover the cost of care.

Seventeen percent of people 65 and up have less than $5,000 saved for retirement.[46] Among elderly Social Security beneficiaries, 21 percent of married couples and 45 percent of single people rely on Social Security for 90 percent or more of their income.[47] By 2029, 54 percent of the 14.4 million middle-income seniors will have insufficient resources to pay for care.[48]

Need to supplement Medicaid and Medicare Advantage to address care gaps.

Governments recognize the value of home care in the overall health ecosystem. Medicaid funding of nursing home care became an entitlement in the 1960s; the program now pays for care for seven out of every 10 nursing home residents.[49]

Yet this payment system effectively incentivizes older adults to choose more expensive nursing home care over the home care most of them prefer because receiving home care through government services requires going through an onerous "waiver" process. The number of people eligible is typically capped, so today there are more than 800,000 Americans waiting to receive Medicaid-funded home care.[50]

For millions of Americans who are not eligible for Medicaid because they are above the income threshold, the only option is to pay for home care themselves, unless they are veterans or have a Medicare Advantage plan that covers home care.

The U.S. is the only industrialized nation without a national public fund for long-term services and supports (LTSS), which leaves huge gaps along the care continuum. However, the state of Washington launched a fund in 2019, which initially was to begin in 2022, but has been delayed, will be supported by contributions from future care recipients, that provides recipients over 65 with a total benefit of $36,500 annually.[51]

Some states stepping in.

To supplement Medicaid and Medicare, some states offer programs to help pay for home care needs. State programs, such as Pennsylvania's lottery-funded program offering home care for those with incomes over the Medicaid limit, Nevada's COPE (Community Options Program for the Elderly), Arizona's Non-Medical, Home and Community Based Services program, and Washington's Tailored Support for Older Adults (TSOA), offer home care to keep "at risk" seniors out of nursing homes.[52]

While these efforts can help address some financial challenges, today's patchwork approach to long-term care is overly complex, inequitable, and not adequate to meet the urgent nationwide need.

When Medicaid/Medicare and state programs fail to cover costs, many turn to hiring caregivers directly. Those that hire outside professional care agencies are often left vulnerable because this option provides no requirements for criminal background checks, training, supervision, workers compensation and no backup should the caregiver become ill.

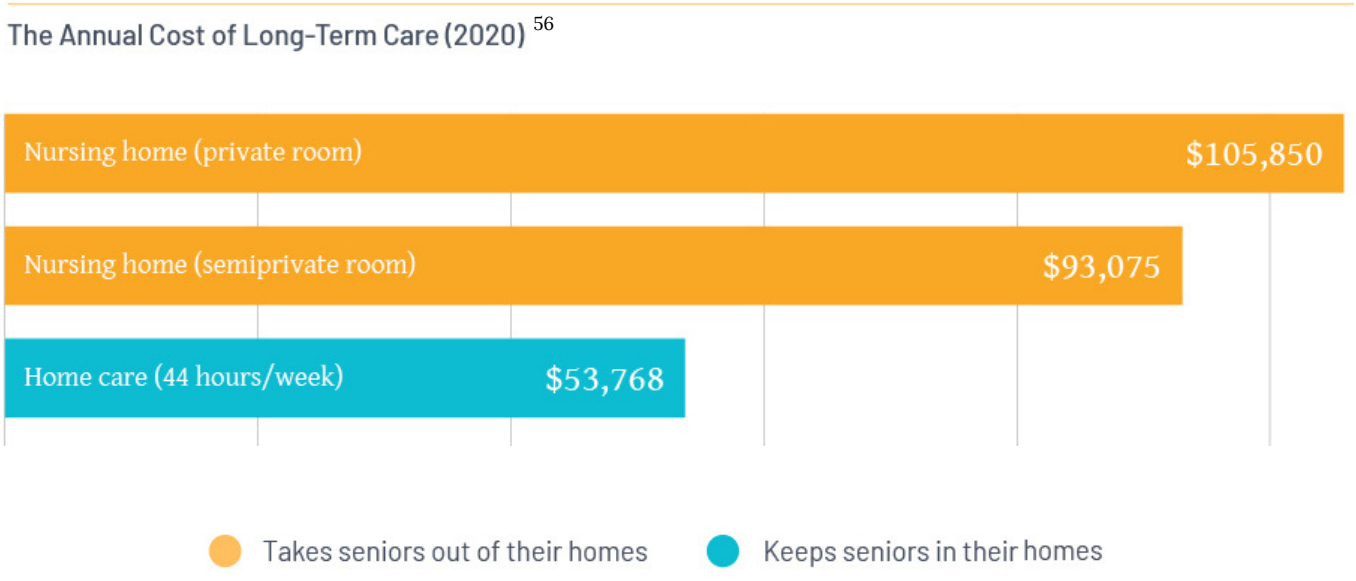
Medicare Advantage growing to meet home care demand.

In 2020, there were over 24 million Medicare Advantage members in the U.S., more than double the number in 2010 and nearly five times the amount in 2005.[53]

In 2019, the Centers for Medicare and Medicaid Services (CMS) expanded the supplemental services provided under Medicare Advantage plans to include home care if it is used to "to diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization."[54]

In 2020, CMS revised the codes again to "address social determinants of health for people with chronic disease."

This move to cover home care shows policymakers increasingly recognize the growing demand for personal care as well as the benefits – both for an individual's quality of life and on government budgets.[55]



Spotlight: Professional Caregivers

Greg Gorton

Like Caring for Family

I'm a family man, and I bring this attitude to my work as a caregiver, helping other families in times of need. I enjoy going into homes and establishing a bond with my clients and their families. As a musician, I like to play bluegrass on my ukulele for my clients, to soothe them and brighten their day. **I understand the importance of providing great care for clients, just as I wanted to for my own parents, because my clients are someone else's parents.** With 15 years of caregiving experience, I like to accept the biggest challenges – patients who have difficult lives, who may be in hospice, or whose families may be overwhelmed. I take pride in providing the best care I can and hopefully making a difference for the people and families I serve.

Zora Bullett

Working With My Heart

For me, being a caregiver is not only about providing excellent care but training others so they can provide great care as well. I've been doing this job for over a decade, and I've worked with clients facing a variety of serious health challenges, like dementia, MS and Parkinson's. **Caregiving is working with my heart as well as with my hands.** I have been trained in hospice and was honored recently when the family of a client I had served called me to stand with them at the funeral of their family member. It's a privilege to care for these precious people at the very end of their lives, giving them dignity and respect as well as the best possible care.

Renate Jefferson

Committed to Client First

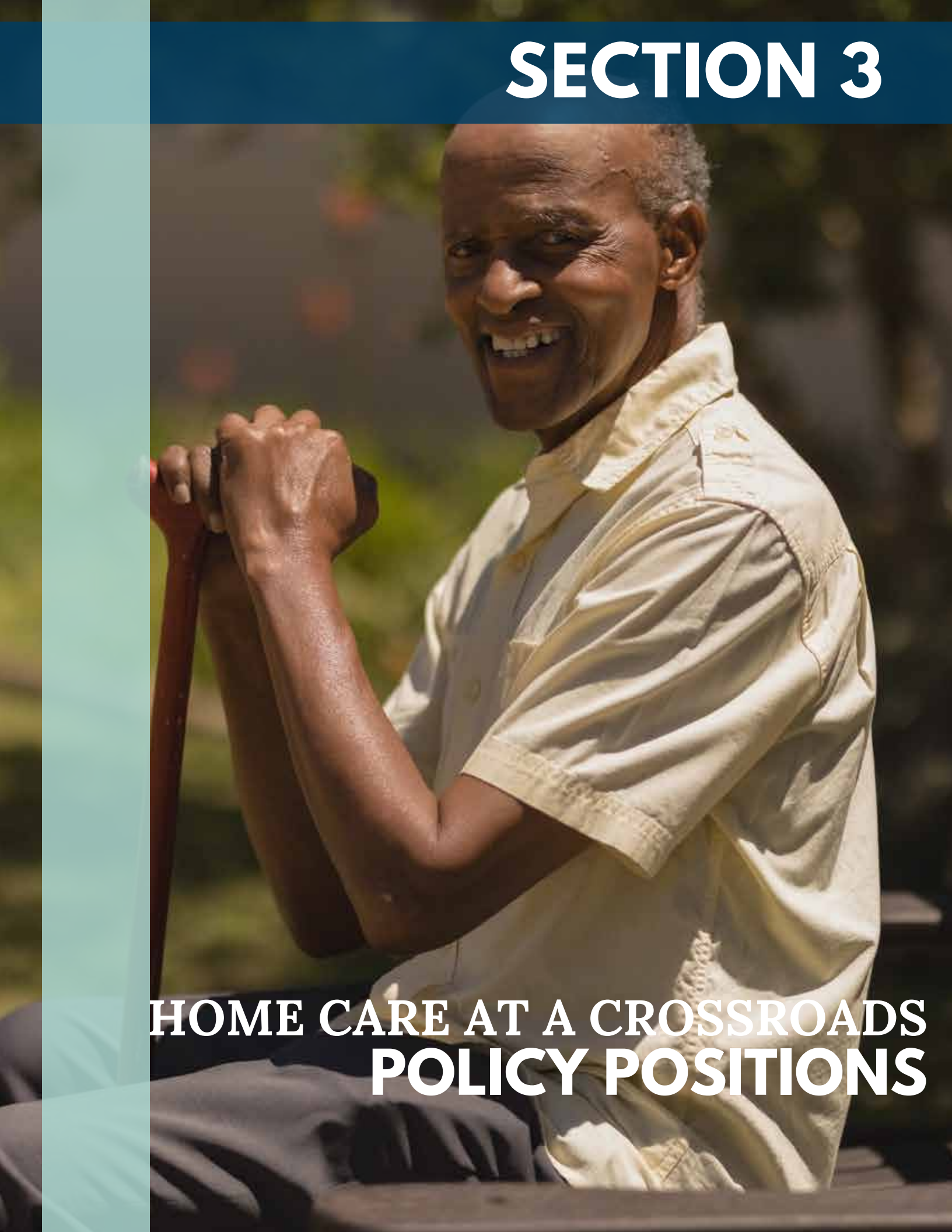
I've devoted my life to caring for the elderly as a CNA, providing them with all aspects of care and even sometimes taking care of their pets as well. This has been a satisfying career, and I appreciate all of the compliments I have received for my work. **The COVID pandemic changed so much, but it didn't change the need for caregiving.** Even when our state went into lockdown, I thought "this is my job, and my client needs me." Even as other caregivers developed COVID symptoms, I kept working, to put my client's needs first.

Paolo Moyani

From Caregiver to Citizen

My parents emigrated from the Philippines when I was 19. Just after we arrived in the U.S., I was diagnosed with a brain tumor. After surgery and follow-up chemo and radiation, I have now been cancer-free for six years. And I proudly became a U.S. citizen in 2019. **While receiving treatment, I studied to become a CNA and got my certification.** At the end of 2018, I began a long-term assignment with a deaf client. Despite all the challenges, I found effective ways to communicate with him. I taught him to dance and gave him the gift of song despite his deafness. And I showed him how to use an iPad and brought him Filipino foods so he could try a new cuisine.

SECTION 3



HOME CARE AT A CROSSROADS
POLICY POSITIONS

Over the past five years, America's healthcare policymakers, practitioners, and payors have increasingly recognized the value of home care as a vital part of the aging journey and the overall care continuum.

The COVID-19 pandemic has accelerated the integration of home care as an essential component of the healthcare system.

Yet, policy and regulation have not fully addressed this transformation.

At this crossroads, the home care industry must unite around shared policy positions. The changes require government action, but they also require industry leadership, which will elevate the caregiving profession from the inside out.

Establishing National Standards of Care

An industry-coordinated set of standards, established at the federal and state level, can assist families seeking home care services to understand the quality of care they can expect to receive. That is why HCAOA continues to promote state licensure and looks for ways to establish clearer standards at the federal level, including home care for veterans. Without standards on caregiver training, inconsistencies in types, levels and quality of service may hamper the ability of the industry to define itself as a trusted and sought-after service provider. This has implications for the safety of home care clients as well.

During the COVID pandemic, home care providers have increased starting wages and boosted incentives and bonuses to recruit and retain workers. Providers face the challenge of balancing employee compensation with the overall cost of care to clients. HCAOA members will continue to work creatively to help make caregiving financially rewarding for workers without driving costs so high that services become too expensive for families.

The industry can increase client satisfaction and trust through steps that promote uniform training, standards for caregivers, and certifications that help create strong career path at the state and federal level.

TAKING ACTION

Industry leaders should "set the bar" for national standards that balance high-quality care with the long-term financial sustainability of the industry. By doing so, home care providers will not only improve quality and accountability, but they will also be more fully integrated as a valuable component of the country's healthcare continuum.

Collecting, Evaluating and Utilizing Data to Validate the Value of Home Care

While home care is increasingly showing its value to the healthcare system and to improving the health and well-being of America's older population, it is mostly proven through anecdotes and small-scale validation studies. A number of recent studies – many referenced in this report – provide a glimpse into how hours of personal care delivered in people's homes can result in health care savings by reducing hospitalizations. And yet, sparce research on the impact of home care overall has hindered the advancement of home care in securing a place in this country's health care system.

Real data – rigorously collected and analyzed – that in turn can demonstrate cost savings will be essential if policy change is to take place. Therefore, investments must be made toward collecting, analyzing and utilizing data through large-scale studies.

TAKING ACTION

The home care industry should lead a coordinated effort to conduct studies showing how the presence of a home care aide on a continuous, routine basis can contribute to a person's health status, from ensuring medication compliance, nutritional oversight, and monitoring changes of conditions. Collecting and analyzing such data will require significant investments in time and finances, and therefore the industry will have to work together to prioritize this goal. Through partnerships with academic institutions, third-party research institutes, and government champions, the industry can ensure such research can be conducted and communicated.

Embedding Home Care in the Healthcare Ecosystem

While federal policy has gradually come to recognize the value of home care, that attention has fallen short of offering home care as an entitlement under Medicaid or fuller coverage under Medicare. Home care must be part of the policy dialogue as health systems adapt to a more value-based approach to healthcare. Policymakers should more fully integrate home care into the healthcare system as a means toward healthier lives and more financially viable budgets.

TAKING ACTION

Americans need choice in how, where and what type of care services they receive. By making home care available under Medicare and Medicaid, the federal government will give care recipients that options they want and deserve.

Supporting Caregivers: Recruitment, Training, Career Pathing

To ensure there are enough caregivers for the rising tide of aging Americans, recruitment and retention practices need to be improved – particularly given high turnover rates and the projected shortage of needed caregivers.

Home care requires people who bring a unique mix of "hard" and "soft" skills. This makes the profession a bright spot amid concerns about automation (machines replacing humans) and a future of work dominated by AI rather than human intelligence. Technology can play a role in improving home care whether by verifying the hours of care electronically or facilitating timely consultation with a health care professional.

Raising retention in the industry is not merely a matter of dollars and cents. A recent US study found many factors contribute to turnover – including job satisfaction, consistency of assignments, availability of health insurance, satisfactory work hours, training to reduce on-the-job injuries and appealing to the needs of all demographic groups.[59]

A recent report from the Global Coalition on Aging and Home Instead calls for multi-stakeholder action to build the caregiving workforce of the future. The report details four recommendations to help achieve that goal: (1) changing the perception of the caregiving profession so it is appreciated for its value to society; (2) bolstering training and education standards to ensure consistent quality and accountability; (3) supporting and rewarding caregivers commensurate with the demands of the job and the value they provide; and (4) fully integrating the home care workforce into the 21st-century health care ecosystem.

By addressing these issues, home care agencies can help ensure they not only attract more workers, but also support workers in developing long-term, satisfying careers in the home care profession. By doing so, they can also help alleviate strains on overburdened family caregivers and provide peace of mind that their loves ones are getting the quality care they need.

TAKING ACTION

Improving perceptions of the caregiving workforce can help ensure the growth of this essential group of American workers. Providers – regardless of payment source – must work together to provide the best possible working conditions, benefits, flexibility, training and career path opportunities to ensure there will enough quality workers to meet America's exploding care needs.

Financing Care in an Era of Rising Longevity

America's healthcare systems and reimbursement mechanisms were not designed for a world of rising longevity and a nation that will soon have more older people (65+) than young (18 and under). Created in large part nearly half a century ago, they are inadequate and unsustainable financially.

Government leaders are starting to recognize the added value of in-home care providers – both for individuals and our health care system as a whole.

The Senate Special Committee on Aging, for example, has proposed greater investment in home and community-based services as a means to spur economic recovery and improve the quality of life for older adults.

The Biden Administration Infrastructure Plan initially earmarked $400 billion for home and community services, later reduced to $150 billion.

The new law, if passed, would expand access to quality, affordable home care and support training for care workers. It will also expand access to Medicaid home and community-based services (HCBS) to support innovations in the industry.

To help people prepare for their future health and care needs, both the public and private sectors should continue to promote savings mechanisms that include financing for professional home care.

TAKING ACTION

Planning and saving for future long-term care needs will require multiple options, based on one's ability to save and projected care needs. Saving for care in old age should be as top-of-mind as saving for education when a child is born. Government and private-sector stakeholders must make financing for care a priority and develop a suite of options to fit the diverse financial and care needs of older Americans.

"You can't finance these 100-year lives purely by public purse or purely by private purse. You need the two to come together."

- Surya Kolluri
Managing Director, Bank of America[58]

Addressing Immigration to Ensure the Caregivers We Need

Immigrants make up a large and valued segment of the caregiving workforce. Nearly one-third of home care workers were born outside the U.S.,[60] compared to less than 15 percent of the total population.[61]

Uncertainty about America's immigration policy and the immigration status of many of these workers exacerbates the already critical shortage of home care professionals; threatens the livelihoods of immigrants who are providing care; and undermines potential opportunities for new immigrants to help supplement the caregiving workforce.

TAKING ACTION

A stable, predictable, bi-partisan immigration policy that recognizes the value of home care professionals is critical to supporting America's current immigrant caregivers and ensuring the availability of future immigrant workers who can address the growing shortfall of the caregiving workforce while building futures for their families.

> *"The reliance on immigrant workers in the home health care sector would present a continuation of current labor practices since 2.1 million immigrants are already working in the field...the U.S. immigration system lacks temporary non-immigrant and immigrant visa categories designated for low-skilled home health care workers. Consequently, passing immigration reforms that consider the needs of the home health care sector is essential."*
>
> *- National Immigration Forum*[63]

Looking Toward the Future

In recent years, home care as an industry has become more visible, more relevant and more vital to meeting the care needs of an increasingly older America. Home care is the preferred choice of most older Americans; a lifeline for millions of families with elderly loved ones; a set of eyes and ears for doctors to monitor patients; and an enormous potential source of savings to government and private health insurance programs.

Despite significant advances, many reforms will be needed to realize the full value of home care as a significant solution to America's long-term care crisis. HCAOA and GCOA look forward to working with partners across all stakeholder groups to deliver a future where every American gets the care they want, need and deserve.

The Policy Imperatives in this report above serve as a reminder that while government must step up and take a leading role, the home care industry itself must continue to evolve and innovate. By working together, policymakers and industry leaders can create a vibrant home care industry that can meet the massive demand for care services from America's aging population, create a stronger social safety net, and enable all Americans to age with satisfaction, comfort, safety and dignity.

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www.hcaoa.org

Founded in 2002, the Home Care Association of America is the industry's leading trade association for providers of home care – representing nearly 4,000 companies that employ nearly one million caregivers across the United States. HCAOA supports seniors' wellbeing and enables them to age in place by setting standards for high-quality home care; serves as a unified industry voice on key issues in Washington, D.C. and state capitals; and connects its members through education and awareness efforts. From standing up to dangerous misinterpretations of long-standing laws to ensuring that caregivers and clients are protected from abuse, HCAOA is a champion and advocate for its members, for caregivers and for seniors across America.

globalcoalitiononaging.com

The Global Coalition on Aging is the world's leading business voice on aging policy and strategy, aiming to reshape how global leaders approach and prepare for the 21st century's profound aging demographic shift. GCOA uniquely brings together a cross-section of influential global companies with common strategic interests in aging and an optimistic view of its impact. Working together with business, governments, global institutions, NGOs and academia, and recognizing the once extravagant prospect of growing old has now become the norm, GCOA shapes the dialogue and advances solutions to ensure aging is a path for economic growth, winning business strategies, and social wellbeing.

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Axxess is the leading technology innovator for healthcare at home, providing solutions that help improve care for more than 3 million patients worldwide. Trusted by more than 9,000 organizations, Axxess offers a complete suite of easy-to-use, enterprise software solutions that empower home health, home care and hospice providers to grow their business while making lives better.

INFORMATION SUBMITTED BY

THE GEORGIA JUSTICE PROJECT

October 12, 2022

Healthcare Workforce Commission
Submitted via email: HCWF.Commission@dch.ga.gov

To whom it may concern,

Georgia Justice Project applauds the work of the Healthcare Workforce Commission to address challenges in hiring and retaining healthcare workers throughout the state. We write with recommendations in furtherance of this effort, specifically as it relates to expanding the workforce through reasonable reform of occupational licensing laws as they relate to individuals living with criminal records.

For more than 35 years, Georgia Justice Project has advocated for individuals and communities affected by the criminal legal system. Every day, we seek to get Georgians back to work by removing barriers to reentry. Our experience on the ground with clients feeds directly into our policy work. Recently, we have worked closely with the business community and partner organizations to help author and advocate for significant pieces of legislation removing barriers to employment for rehabilitated individuals with criminal records. These reforms, such as SB 288 (2020, expungement reform), SB 105 (2021, early termination of probation), and SB 10 (2022, driver's license suspensions), each carried with them significant implications for the workforce, allowing employers to better utilize the talents of 3.6 million individuals with a Georgia criminal record – many of whom have not been arrested in many years and are eager to work.

Over the past two years, we have deepened our services for those hoping to pursue work in licensed fields. We have frequently advised individuals seeking to enter the healthcare profession, particularly aspiring nurses. We have developed an expertise in legislative reforms taken by our sister states that removed red tape to occupational licensing, expanding the workforce while prioritizing public safety. This experience has led to our current work with a group of legislators led by Senator Brian Strickland, the Metro Atlanta Chamber of Commerce, the Georgia Chamber of Commerce, and both government and non-profit partners to identify and promote opportunities for legislative reform.
Through our direct experience, research, and numerous conversations with stakeholders, legislators, advocates who have passed reforms in other states, and fellow non-profits, we have identified reforms that would address specific barriers facing those with criminal records who seek to work in healthcare fields. Each of these reforms has been successfully implemented by other Southeastern states. We would be grateful if the Commission considered supporting these reforms as one of many tools to enhance recruitment and retention of healthcare workers. Potential legislative reforms include:

Pre-clearance process: The most common question we receive from people with criminal records is whether they should invest time and money into the education and training necessary to obtain an occupational license, such as an RN license. This is true even for those with old, minor records. Because individuals will not receive a determination as to whether their record will prohibit them from obtaining a license until after they have completed all other licensing requirements, many otherwise qualified individuals choose not to pursue a license. This creates a significant chilling effect, shrinking the potential workforce. Several states, such as Mississippi, Arkansas, Louisiana, North Carolina, Missouri, and Indiana, have addressed this problem by creating an option for individuals to request a binding determination as to whether their criminal record will preclude them from licensure before beginning their education and training. This process typically requires disclosure of records, the option of providing mitigating evidence, and can result in a binding denial – this ensures that those seeking pre-clearance are truly invested in the process. Our partners out of state, including in Arkansas, have reported that they have not seen any significant changes to board and agency workloads as a result of this reform.

Streamlining what criminal records are considered: Georgia law provides post-conviction relief meant to facilitate reentry for rehabilitated individuals in the form of expungement and pardons. However, licensing boards and agencies are still allowed to ask about and consider expunged and pardoned offense. In addition, while many boards and agencies must generally consider the age of a conviction when evaluating its impact on eligibility for licensure, boards and agencies lack guidance as to when records are no longer relevant due to passage of time.

Many states have legislated that expunged offenses shall not be considered by licensing boards, such as Arkansas, Indiana, and Illinois. Others have also legislated that non-sexual, non-violent offenses are no longer relevant to a board's determination after a certain number of years, such as Arkansas, Missouri, and Indiana. These reforms would both give effect to post-conviction relief made available by the legislature and keep Georgia consistent with research that shows nearly all recidivism takes place within 3-5 years of an arrest. This would also enhance agency efficiency by streamlining consideration of records.

Evidence at hearings and written decisions: Licensing applicants have the right to offer evidence of mitigation and rehabilitation to licensing boards. However, the same applicants do not have the right to bring witnesses to hearings who can speak to their character. Ensuring this right would be a significant improvement to due process that would enable boards to make more holistic decisions with a minimal impact on board resources. Mississippi, North Carolina, Kentucky, Indiana, Missouri, and Iowa ensure the right to a hearing.

Further, licensing applicants are not guaranteed the right to a written decision explaining why their application was denied. Written decisions applying law to facts are fundamental to due process and would help petitioners understand whether they have a case to appeal and/or what they need to improve before applying for a license again in the future. Louisiana, Mississippi, North Carolina, Indiana, Missouri, and Iowa all require written decisions.

Access to administrative appeals: Licensing applicants are not guaranteed the right to an administrative hearing to review a licensing board's decision. Indeed, to our knowledge, only one licensing board in

Georgia allows access to the Office of State Administrative Hearings for review. This means most applicants must file a writ in Superior Court should they seek review of a board's decision. This requirement renders appeals inaccessible to almost all licensing applicants, who very often cannot afford legal representation. Access to administrative appeals would significantly improve due process and ensure substantive reforms are being put into practice. Louisiana, Mississippi, North Carolina, Kentucky, Missouri, Indiana, and Iowa ensure the right to appeal.

Tracking and publishing data: Boards and agencies do not publish data detailing how many people with criminal records apply for licensure, how many such persons are approved/denied, or other relevant data. Tracking and publicizing this data would improve transparency. Louisiana and North Carolina are examples of states that have recently enacted data reporting requirements.

Licensed facilities: Whether or not an occupation is licensed, if a job takes place in a long-term care facility, employees often need clearance to work in the facility. There are more than 210 disqualifying convictions that prevent individuals from working in a long-term care facility. Disqualification runs for 10 years after sentence completion; given Georgia has the longest probation sentences in the country, this 10-year disqualification period from the date of sentence completion can create overly long waiting periods. In addition, the 10-year period applies to all disqualifying offenses, from the most severe to the relatively minor. Modulating the disqualification period based on the severity and relatedness of an offense as well as running the disqualification period from date of conviction or release from incarceration would expand the workforce pool for long-term care facilities while still protecting public safety.

Thank you for your consideration of the above. We are very happy to discuss the above and any other issues related to occupational licensing reform. I may be reached at 404-827-0027 ext. 214 or Wade@GJP.org.

Sincerely,

Wade Askew

Wade Askew
Policy Manager
Georgia Justice Project