GEORGIA BEHAVIORAL HEALTH REFORM AND INNOVATION COMMISSION

2024 Annual Report

Prepared by:
The Center of Excellence for Children's Behavioral Health
Georgia Health Policy Center

Date:
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ACKNOWLEDGEMENTS

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Thank you to the Office of Health Strategy and Coordination, the commission's chair, and the subcommittee chairs for their work throughout the year and in preparation for this final report.

Behavioral Health Reform and Innovation Commission Leadership

- Commissioner Kevin Tanner, Chair, Behavioral Health Reform and Innovation Commission
- Dr. Brenda Fitzgerald, Subcommittee Chair, Hospital and Short-Term Care Facilities
  - Advisory Subcommittee Chair, IMD Waiver
  - Advisory Subcommittee Chair, Medicaid–Social Determinants of Health
- Dr. Eric Lewkowiez, Subcommittee Chair, Children and Adolescent Behavioral Health
- Chief Justice Michael Boggs, Subcommittee Chair, Mental Health Courts and Corrections
- Judge Sarah Harris, Subcommittee Chair, Involuntary Commitment
- Rep. Mary Margaret Oliver, Subcommittee Chair, Workforce and System Development
- Judge Kathlene Gosselin, Advisory Subcommittee Chair, Forensic Competency Advisory Committee
- Dr. Srinivas Challa, Advisory Subcommittee Chair, Dental
- Edward J. Hardin, Advisory Subcommittee Chair, Homelessness
- Debra Stokes, Advisory Subcommittee Chair, Aging Adults

Office of Health Strategy and Coordination

- Elizabeth Holcomb, Director

In Memoriam:

The Commission would like to extend its gratitude to Dr. Mark C. Johnson, whose dedication and expertise significantly contributed to advancements of behavioral health care in the state of Georgia.

2024 COMMISSION APPOINTEES, COMMISSION MEMBERS, AND SUBCOMMITTEE MEMBERS

Governor's Appointees

Commissioner Kevin Tanner, Chairman
Dr. Sarah Y. Vinson
Dr. DeJuan White
Melanie Dallas
Jason Downey
Dr. Karen Bailey
Miriam Shook
Nora Lott Haynes

Lieutenant Governor's Appointees

Sen. Brian Strickland
Sen. Kim Jackson
Sheriff Robert Markley
Anne G. Hernandez
Dr. David Bradley
Cindy Levi

Speaker of the House's Appointees

Rep. Don Hogan
Rep. Mary Margaret Oliver
Chief of Police Louis Dekmar
Gwen Skinner
Kim Jones
Judge Brenda Weaver

Commissioner Tanner's Appointees and Ex Officios

Judge Kathleen Gosselin
Commissioner Timothy Ward
Commissioner Michael Nail
Judge Bedelia Hargrove
Dr. Karen Bailey
Dr. Nicoleta Serban
Commissioner Russel Carson
Commissioner Michael Nail
Commissioner Christopher Nunn
Commissioner Shawanda Reynolds-Cobb
Dr. Srinivas Challa
Sallie Coke
Dr. Eric Lewkowiez
Dr. Garry McGiboney
Dr. Brenda Fitzgerald
Commissioner Tyrone Oliver
Dr. Lucky Jain
Commissioner Candice Broce
Donna Hyland
Commissioner Caylee Noggle
GBI Director Chris Hosey
Edward J. Hardin
Debra Stokes

Chief Justice's Appointees

Chief Justice Michael Boggs
Judge Stephen Kelley
Judge Sara S. Harris

Note: Subcommittee members for each subcommittee are identified in their respective subcommittee reports included in the appendices of this report.

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ABOUT THE BEHAVIORAL HEALTH REFORM AND INNOVATION COMMISSION

Georgia House Bill 514, in the 2019 legislative session, created the Georgia Behavioral Health Reform and Innovation Commission (BHRIC). The commission was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. In the 2022 session, the Georgia General Assembly passed House Bill 1013, the Georgia Mental Health Parity Act (MHPA), which was informed by the **commission's first report**. The act includes provisions for comprehensive behavioral health reform, specifically elements that align Georgia law with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and that help monitor compliance with MHPAEA. The Georgia law also outlines new work for the commission and extends the commission's work for two additional years. Thus far, the commission has produced 135 recommendations, of which 75% have been implemented or had action taken toward implementation. BHRIC has 24 appointed members and is chaired by former state representative and current Department of Behavioral Health and Developmental Disabilities (DBHDD) Commissioner Kevin Tanner. The commission is currently due to expire on June 30, 2025.

As outlined in the Official Code of Georgia (OCGA) Section 37-1-111, BHRIC is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues facing children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; the impact that behavioral health issues have on the court and correctional systems; legal and systemic barriers to the treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact that untreated behavioral illness can have on children into adulthood; aftercare for persons exiting the criminal justice system; aging adults' access to behavioral health care; and the impact of behavioral health on the state's homeless population.

The commission has five subcommittees tasked with reviewing these focus areas:

Subcommittee	Chaired by	Icon
Children and Adolescent Behavioral Health	Dr. Eric Lewkowiez	
Hospital and Short-Term Care Facilities	Dr. Brenda Fitzgerald	
Involuntary Commitment	Judge Sarah Harris	
Mental Health Courts and Corrections	Chief Justice Michael Boggs	
Forensic Competency Advisory Committee	Judge Kathlene Gosselin	
Workforce and System Development	Rep. Mary Margaret Oliver	

Through the work of the subcommittees, an additional five focus areas were identified, and advisory subcommittees were created for the 2024 commission year:

2024 Advisory Subcommittee	Chaired by	Icon
Aging Adults	Debra Stokes	
Dental	Dr. Srinivas Challa	
Homelessness	Edward J. Hardin	
IMD Waiver	Dr. Brenda Fitzgerald	
Medicaid-Social Determinants of Health	Dr. Brenda Fitzgerald	

The commission held two public meetings in Atlanta at the DBHDD office, on June 10, 2024, and November 25, 2024. Each subcommittee also held meetings separately and heard hours of testimony from subject matter experts, state executive agency representatives, major interest groups and advocates, and behavioral health professionals. Meeting recordings and materials are archived on the Georgia **General Assembly's website**. Each subcommittee independently drafted an appendix to this annual report to provide further details and recommendations identified by its respective committee. This summary report compiles the findings and recommendations identified as most pressing for immediate action to reform Georgia's behavioral health system.

I EXECUTIVE SUMMARY

The Behavioral Health Reform and Innovation Commission (BHRIC) created a road map for reform through its initial findings and recommendations summarized in its **Year 1 Report**. Following the release of this report in early 2021, the Georgia Office of Health Strategy and Coordination partnered with Accenture, a global consulting firm, to find ways to operationalize the commission's recommendations through legislative, budgetary, and executive actions. The resulting Accenture report concluded that Georgia's system as a whole is often fragmented and that organizations within it "act as a loose confederation rather than an intentionally designed mental health system that is coordinated and effective."[1] The authors noted, "Georgia needs a centralized mental health *system*, designed to serve its residents with appropriate care *when* and *where* they need it,"[2] emphasizing the need for a coordinated and comprehensive system.

As a result of the recommendations from both the commission's report and Accenture's report, the members of the Georgia General Assembly crafted the bipartisan Georgia Mental Health Parity Act (MHPA) under the sponsorship and leadership of the late speaker of the house, David Ralston. The act was passed during the 2022 legislative session and signed by Gov. Brian P. Kemp into law. This act paved the way for substantial behavioral health system reform in the state. The MHPA addressed several key areas needed for improved access to behavioral health services in Georgia, including enforcing and monitoring the implementation of mental health parity; growing the behavioral health

[1] Accenture. (2021, December 2). *Mental health reform action plan.* Prepared by Accenture for the Georgia Governor's Office of Health Strategy and Coordination, page 27.
[2] Accenture, page 5.

workforce; enhancing law enforcement awareness and response to mental health challenges; and building capacity to identify, prevent, and address mental health concerns. The act also created a blueprint for future reform efforts, including creating clear systems for coordination, outlining studies to better understand current system barriers, and defining future work for the commission and other collaborating entities to pursue. For the commission specifically, the act indicated new members to be appointed to the commission, outlined topics for further exploration by its subcommittees, and extended its work until 2025.

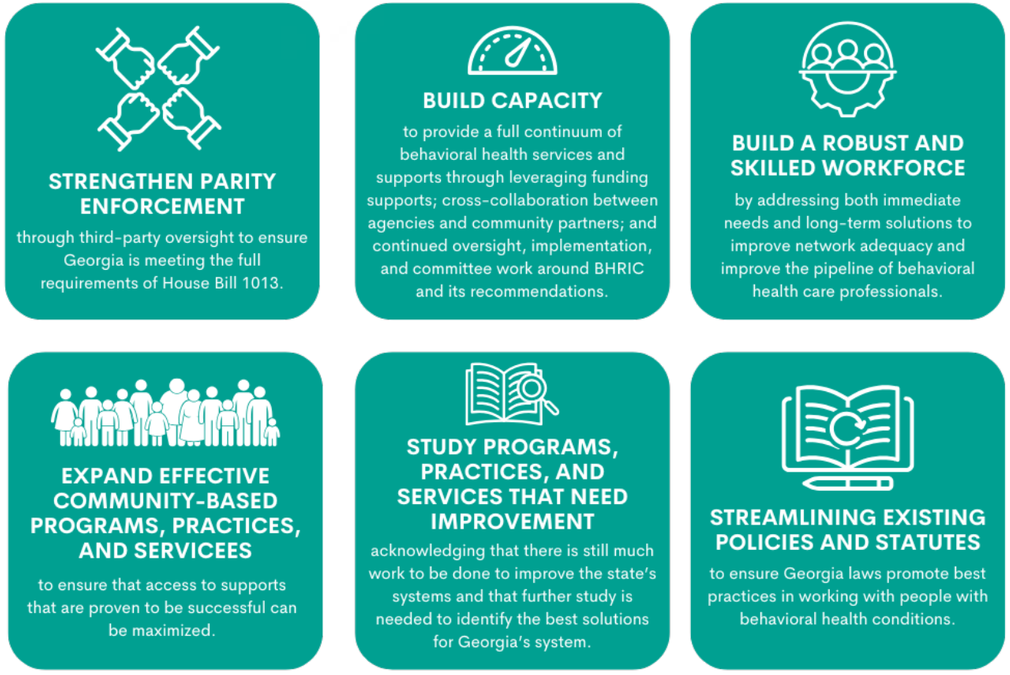
Following the legislative session and passage of the MHPA, the subcommittees have convened monthly meetings to create a refreshed set of goals published as their **Year 2** and **Year 3** annual reports. In these reports, the commission identified seven priority areas for behavioral health reform: (1) address the behavioral health workforce shortage; (2) promote data collection and information sharing; (3) build a robust crisis system with a full continuum of services; (4) build capacity within Medicaid to provide a full continuum of services; (5) expand successful community-based practices, services, and programs; (6) study practices, services, and programs that need improvement; and (7) expand existing policies and statutes. Several activities emerged in 2024 pertaining to recommendations set by the commission. These activities directly respond to, illuminate, and bring clarity to existing recommendations.

Following the precedent set in 2022 and 2023, the subcommittees met regularly in 2024 to extend and refine previous recommendations and develop new guidance based on updated information from new studies and data. The commission's five subcommittees and five advisory subcommittees heard from numerous experts in the behavioral health field on topics spanning the full continuum of practices, services, and supports. Several themes arose across the subcommittees, highlighting systemic challenges in certain aspects of the behavioral health system.

This report is the product of the meetings held by the commission's five subcommittees, five advisory subcommittees, and the expert testimony heard by its members. This report does not cover the depth and breadth of testimony heard across all subcommittees but instead aims to highlight the most pressing challenges identified. The chair and the preparers of this report met with each subcommittee chair to identify and refine their priorities to be presented to the commission and for inclusion in this report. The full commission was convened on November 25, 2024, and each subcommittee reported its findings and recommendations. This summary includes those priority recommendations and is followed by appendices for each subcommittee that provide more detail on

their individual work. These appendices give further information on the depth of testimony heard and outline additional recommendations that subcommittee members have proposed.

The compilation of priorities and actions identified by the commission's 10 subcommittees resulted in the following priority areas for behavioral health reform:



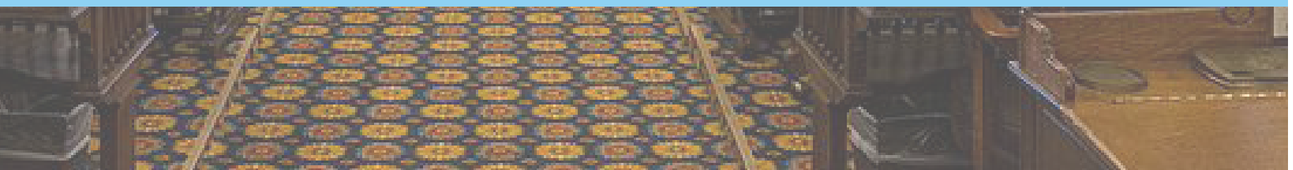
Supporting documentation for each of these recommendations can be found in the repository of meeting recordings, presentations, and agendas on the **commission's page** on the Georgia General Assembly's website. Additionally, each subcommittee has provided additional information about its activities in 2024, the recommendations they have proposed, and supporting documents for those recommendations, which are documented in the appendices to this annual report. Each subcommittee may have additional recommendations beyond the ones included here. The recommendations compiled here are considered the most pressing and most actionable to address behavioral health system reform in the next year.

SUMMARY OF SUBCOMMITTEE ACTIONS

Subcommittees also heard about the challenges faced by specific populations experiencing unique access challenges and barriers to care. The next section summarizes the work of each subcommittee as they address issues related to their topic area.

The **Children and Adolescent Behavioral Health Subcommittee** heard testimony on mental health issues for children with developmental disabilities and dual diagnoses, including barriers to accessing behavioral health care among this population. The subcommittee also heard testimony about the Certified Community Behavioral Health Clinic model, which experts testified would transform the ways in which mental health care is delivered to youth in Georgia. In addition, the subcommittee heard testimony about school-based behavioral health models of care, and experts provided information about programs and opportunities that would increase access to care for Medicaid children and families, including the expansion of tele–mental health services, which is key for ensuring that youth behavioral health needs are identified and addressed. The subcommittee heard expert testimony on the importance of screening and addressing maternal mental health issues, as caregiver mental health impacts child health and well-being. Last, the subcommittee heard testimony from coalitions working to improve youth mental health systems through different funding models, partnerships, and by addressing gaps in services.

The **Hospital and Short-Term Care Facilities Subcommittee** continued its work examining best practices in hospitals concerning treating patients with mental and behavioral health needs and barriers to providing the best care. Members heard testimony from a variety of Georgia hospitals on their innovative ways to serve patients who enter emergency departments with behavioral health needs. They also heard testimony from a variety of service providers and advocates on the barriers they are experiencing to providing medically necessary services to patients with medical health needs. Providers say that while there are few formal reports of parity violations, one reason for that may be the cumbersome process to report them because, anecdotally, they are experiencing several issues with insurance companies that they classify as parity violations. These include issues with prior authorizations, preauthorization, and reauthorization; unequal time limits for days allowed in in-patient care; and limits in network adequacy. To further their goals, the Hospital and Short-Term Care Facilities Subcommittee requested an environmental scan of best practices in other states for enforcing parity regulations.



The **Involuntary Commitment Subcommittee** continued its review of best practices in coordinating care for individuals involved in the criminal justice system who are also experiencing behavioral health challenges. For the Assisted Outpatient Treatment (AOT) pilot program, there was discussion in the subcommittee of the fact that a lack of qualified psychiatrists and psychologists available to conduct AOT evaluations was limiting the ability of communities and courts to implement AOT in their jurisdictions. The subcommittee requested an environmental scan of the AOT statutes of other states to determine the level of credentialing required for clinicians who are authorized to complete AOT assessments. The findings of the scan revealed that there is significant variability in the levels of credentialling required, ranging from no limitations other than an unrestricted clinical mental health license up to requirements similar to Georgia's, permitting only psychiatrists and psychologists to perform the evaluations. The subcommittee determined that it would be appropriate to recommend that clinical nurse specialists in psychiatry and mental health (CNS-PMHs) and certified nurse practitioners (CNPs) to be added to the list of practitioners certified to conduct AOT evaluations. In addition, the subcommittee recommended that Georgia continue to explore a DBHDD-led process for training and certification of AOT evaluators, similar to the program in place in North Carolina. Finally, Commissioner Tanner asked the committee to consider recommendations for changes to the statute regarding the issuance of orders to apprehend by the probate court, the orders by which the court effects the pickup and transportation to emergency mental health care of an individual in need of emergency mental health treatment. The subcommittee was able to hear limited testimony and recommended that the work be continued in 2025.

During the second year of the commission, the **Mental Health Courts and Corrections Subcommittee** focused on the challenge of addressing the needs of individuals who have repeated interactions with the behavioral health system, homeless services, and the criminal justice system. These individuals have been termed *familiar faces*. To further address the needs of this population the subcommittee created a Forensic Competency Advisory Committee with the support of the Council of State Governments Justice Center.

The **Forensic Competency Advisory Committee** requested environmental scans of alternatives to additional hospital-based assessment and restoration services in other states and jurisdictions. In addition, the advisory committee requested a scan of other state laws regarding the restoration of individuals charged with misdemeanors versus felonies. Recommendations were made for code adjustments to establish a process by which the court would hold a hearing before initiating the competency process and to provide shorter restoration timelines for individuals charged with nonviolent misdemeanors. Recommendations were also made for a review of competency restoration practices for individuals with cognitive and developmental impairments in 2025. In addition to recommendations regarding the adult system, through Judge Philip Jackson the advisory committee solicited feedback from the Council of Juvenile Court Judges on the juvenile competency process.

The **Workforce and System Development Subcommittee** continued its work on expanding the workforce within Georgia, concentrating its effort this year on examining licensure. The workforce subcommittee heard testimony from experts about licensure expansion, including licensure of internationally trained professionals, how to collect data from the workforce, and how to examine loan forgiveness and network adequacy. The subcommittee also heard testimony about the operationalization of digital single-session interventions. The Workforce and System Development Subcommittee also requested an environmental scan on licensure in other states. The Workforce and System Development Subcommittee continued to remain engaged with other efforts to reform licensure in the state.

The **Aging Adults Advisory Subcommittee** focused this year on hearing about successful programs for the aging adult population and the limits that are occurring with others. The advisory subcommittee heard testimony about a behavioral health coaching model in affordable housing facilities that enhances individuals' ability to stay housed and receive services. They also heard testimony about the Georgia Mental Health Access in Pediatrics (GMAP) program to examine the ways in which a similar program could be incorporated into the aging population. The advisory group also requested several research requests about the state of the aging population in Georgia, the outcomes and needs in the Behavioral Health Coaching program, and the state of geriatric providers.

The **Dental Advisory Subcommittee** focused its efforts this year on barriers to and opportunities for dental care for the population with intellectual or developmental disability (IDD). The advisory subcommittee heard from experts about the barriers to private practitioners accepting low reimbursement rates for patients who require extra care and the unique services that the IDD population has when getting regular dental care. They also heard testimony from a group in North Carolina that has a mobile dentistry operation servicing group homes and residential facilities serving the aging and IDD population.

The **Homelessness Advisory Subcommittee** spent time this year concentrating on documenting barriers to receiving mental and behavioral health services faced by individuals experiencing homelessness. The advisory subcommittee heard from experts on a housing-first approach and the scope of homelessness and behavioral health challenges in Georgia. The group then heard from a variety of service providers and experts about the barriers that they face when serving the population who have behavioral health needs, and it examined available services. The Homelessness Advisory Subcommittee had several research requests, including reporting on the state of homelessness and mental and behavioral health; examining the current state of screening for high-risk populations exiting foster care, jails, prisons, and hospitals; and information from front-line staff about their barriers and strengths.

The **IMD Waiver Advisory Subcommittee** was created this year to give representatives from the Department of Community Health (DCH) and experts in the community a chance to assess the next steps in fulfilling past recommendations around submitting an institution for mental disease (IMD) waiver. Testimony was heard from the Medicaid and CHIP Payment and Access Commission (MACPAC) experts about the various ways other states have handled the IMD exclusion. Testimony was also heard from Stuart Portman, the executive director of the Division of Medical Assistance Plans through DCH, on the requirements Georgia would

face if it were to implement an IMD waiver and the status of Georgia's progress toward expanding the continuum of care (COC).

The **Medicaid–Social Determinants of Health Advisory Subcommittee** invited expert testimony on the impacts of social factors and adverse experiences on health. Experts recommend that health care providers screen and consider other factors that may influence an individual's ability to receive health care and align Medicaid policy with screening. The advisory subcommittee also heard from a Georgia Information Network (GaHIN) representative about the services available to providers to screen and refer patients.

RECOMMENDATIONS FOR BEHAVIORAL HEALTH REFORM AND INNOVATION

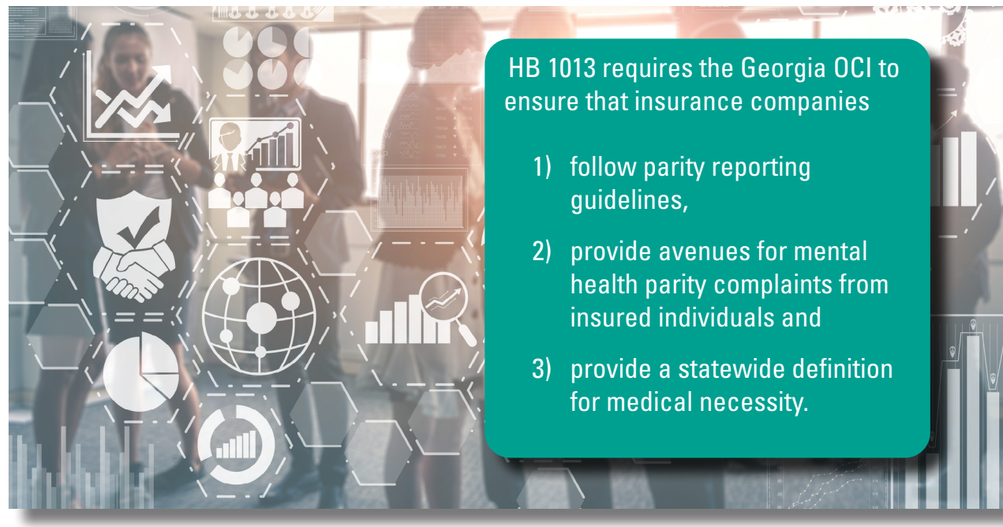
The following recommendations were crafted from the testimony heard across the 10 subcommittees of BHRIC. The full commission endorses all recommendations. The recommendations are grouped by target areas for systems improvement, and more detail about the recommendations can be found in the attached appendices containing individual subcommittee reports.

I. STRENGTHEN PARITY ENFORCEMENT

Georgia passed the MHPA **HB 1013** in 2022, and it was designed to improve access to mental health and substance abuse treatment by requiring health insurers to cover these services comparably with physical health services. This means there should be no difference in deductibles, copays, or limits on the number of visits or days of hospitalization between mental and physical health services. Among other things, HB 1013 also requires the Georgia Office of Commissioner of Insurance and Safety Fire (OCI) to ensure that insurance companies follow parity reporting guidelines, providing avenues for mental health parity complaints from insured individuals and providing a statewide definition for *medical necessity*.

The Georgia OCI and DCH have rolled out online complaint portals for insurers. To date, the complaint portals have yielded very few complaints. However, testimony heard by the Hospital and Short-Term Care Facilities Subcommittee from mental health providers in Georgia indicates that there are more parity violations than are being reported. As a result, the commission recommends refining the system that oversees parity violations to better address parity violations in Georgia. The following is a list of recommendations spearheaded by a recommendation for a third-party committee that helps oversee parity violations, including funding for research staff to assist the committee in analyzing and aggregating data received from the insurance companies, providers, employers, and insurers.

Georgia requires insurance companies to report on definitions and regularly report statistics such as the number of claims approved, denied, and appealed and information about prior authorization processes and insurance manuals. However, unlike other states, Georgia is not using the information to assess for parity violations. The third-party committee's task would be to use this data and information from parity compliance data from providers and employers to examine potential parity violations more closely. The third-party committee would be charged with asking insurance companies, providers, and insurers for additional information to ensure parity is properly enforced. This committee



would work closely with the governor's office, pending approval, to determine potential punitive measures taken against insurance companies that do not comply with parity regulations.

- Create a third-party committee that helps to oversee parity violations.

  The third-party committee should include representatives from the Georgia General Assembly, DCH, the Department of Human Services (DHS), the OCI, mental health clinicians, executives at facilities or systems providing mental health care, and advocates. The subcommittee recommends that the third-party committee consists of:

  - Two state representatives;
  - Two state senators;
  - Two DCH representatives;
  - Two DHS representatives;
  - Two OCI representatives;
  - Two mental health clinicians, including one psychiatrist;
  - Two senior executives of facilities or systems providing mental health care; and
  - Two mental health advocates.

The subcommittee also recommends establishing a team to support the work of the third-party committee, including, without limitation, research, report preparation, and educational materials creation.

The third-party committee will receive and analyze required reports from insurance companies and providers, review parity complaints, request additional information from insurance companies regarding potential parity violations, including violations of definitions of medical necessity, and create and review educational materials for parity compliance. The committee would also work with the governor's office, DCH, and the OCI to determine standard operating procedures for the third-parity commission in recommending and requiring punitive action for insurance companies that are not compliant with parity regulators.

- Provide funding for research staff to assist the third-party committee on parity.
- Enable providers to meet their legal obligations by providing parity data to the third-party commission.

In conversations with providers who testified to the subcommittee about their experience with parity violations in the system, it became clear that requiring a mandate to submit parity violation reports may be of interest. These reports would require providers to submit documentation they already have for the state to assess potential parity violations better. It would not require providers to produce data they are not collecting or that is not readily available in their systems. When fulfilling this recommendation, the subcommittee recommends that the third-party commission discuss potential avenues with representatives from large provider associations to develop a policy that allows providers to comply with their obligations easily.

The Hospital and Short-Term Care Facilities Subcommittee recommends requiring providers to submit regular parity compliance reports that will include information on:

- Types and kinds of authorization denials;
- Questionable denial practices, including without limitation coverage denials due to a patient being at their baseline measure of suicidality, such as egregious medical necessity denials including baseline measure of suicidality and other conditions and authorized stays less than 30 days;
- Time taken by providers in responding to appeals of denials — e.g., greater than three days, greater than seven days, greater than 14 days, and greater than 30 days;
- Claim denials, including retrospective denials, due to lack of medical necessity, no authorization, treatment exceeding coverage limits, noncovered services, and clean claim denial percentages of less than 10%;
- Number of unauthorized days, and the cost to the provider and patient;
- Excessive concurrent reviews;
- Number of patients discharged without an identified in-network provider for follow-up;
- Number of patients with lack of access to online verification of benefits;
- Payers failing to provide peer-to-peer reviews; and
- Payers whose contract annual increase is less than 3%.

- Regular reporting on parity compliance should be made available on an accessible portal for patients, providers, and employers.

The Georgia Data and Analytics Center (GDAC) reports regularly on parity complaints received through the Georgia OCI Consumer Complaint Portal and DCH Georgia Parity Compliance Portal. The Hospital and Short-Term Care Facilities Subcommittee recommends that this compliance information be readily accessible and include additional reporting required in Georgia law for insurance companies, including but not limited to network adequacy examinations; market conduct exams; definitions provided in medical insurance manuals for medical necessity, mental health, and substance use; metrics on prior authorization requests; claims denial rates; and reimbursement rates for Current Procedural Terminology (CPT) codes.

The purpose of regular reporting is both to hold insurance companies accountable for their actions and to allow Georgians to make educated decisions when choosing insurance providers.

- Require regularly updated patient and provider parity education.

Georgia has an opportunity to expand on its educational campaigns, explaining the concept of parity, individuals' rights, and the complaint process. Effective and accessible educational material should be culturally competent, translated into multiple languages, offered in various formats (such as on a web page, in a brochure, or in written documentation), widely distributed, and meet language access standards.

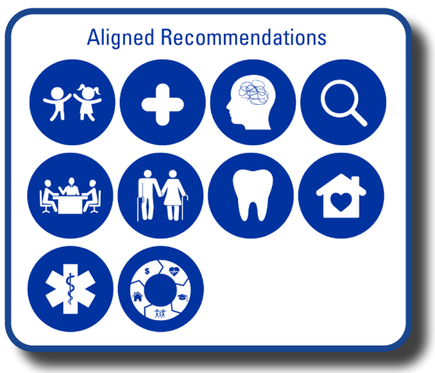
- Create a more accessible process to report parity violations, including a qualifying assessment process.

  The current process for reporting parity violations requires complainants to go through a cumbersome process of submitting several pages of required information and requiring individuals to create an account. In other states, complainants submit simplified forms to determine if their complaint is qualified. Individuals who submit complaints are then contacted for additional information.

- Create a client service position to assist individuals with reporting parity compliance issues.

  To aid individuals, providers, and employers in reporting parity compliance issues, the Hospital and Short-Term Care Facilities Subcommittee recommends that there is funding specifically for a client service position that would be responsible for assisting complainants once they have submitted a qualifying assessment and assisting any additional contacts with parity complainants.

- Create agency staffing assigned specifically for parity compliance.



Supporting testimony was heard by the Children and Adolescent Behavioral Health, Hospital and Short-Term Care Facilities, Involuntary Commitment, Forensic Competency Advisory, and Workforce and System Development subcommittees, and the Aging Adults, Dental, Homelessness, IMD Waiver, and Medicaid–Social Determinants of Health advisory subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.

II. BUILD CAPACITY TO PROVIDE A FULL CONTINUUM OF BEHAVIORAL HEALTH SERVICES AND SUPPORTS

A key part of addressing behavioral health in Georgia is ending the cyclical nature of behavioral health crises that is inherent to an inadequate COC infrastructure. One expert testified that inadequate treatment for those struggling with behavioral health can often look like cycling through crisis, emergency departments, jail, homelessness, etc. Effectively mitigating individuals from reentering the behavioral health care system, the court system, and homeless service systems in Georgia was identified as a priority by all of the subcommittees and advisory subcommittees. This includes increasing the availability of mental health services and expanding communication and coordination across the system of care.

Increase Agency, Practice, and Community Cross-Collaboration

Across all subcommittees, improving cross-collaboration between agencies, practice, and community was identified as a necessity to improve the delivery of behavioral health services. The commission recognizes the value of aligning the delivery of services financially, legislatively, and practically to improve behavioral health care in Georgia. Various recommendations in 2023 aimed to improve cross-collaboration and have had action taken. For example, the Involuntary Commitment Subcommittee recommended implementing strategies to improve communication and collaboration between the Division of Aging, the Public Guardianship Office, and DBHDD, including cross-agency training to understand the roles and limitations of each agency. This recommendation is currently in progress.

This year, upon hearing expert testimony across various subcommittees, the commission recommends:

- Creating a cross-system collaboration to manage mental health and substance use disorders. As an overlapping theme across all subcommittees, DBHDD should explore using opioid settlement funds.
- Investing in and collaborating with digital platforms that are offering

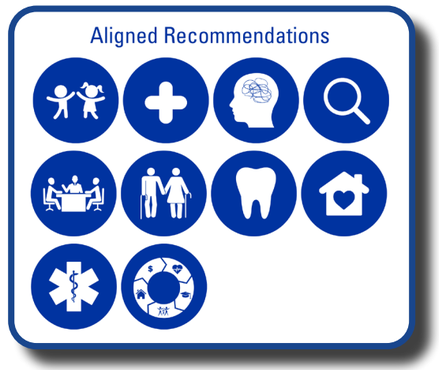
single-session interventions to integrate local Georgia resources into the platforms.

- Creating an eConsult platform for integrated care.
- Coordinating with other state agencies working on licensure, including the Joint Blue-Ribbon Commission on Licensure in the legislature and the secretary of state's office.
- Community service boards (CSBs) and COCs continuing to build formalized connections for greater collaboration between agencies.
- Promoting greater homelessness coordination, including —
    - That the coordination be implemented through an agreement among the nine COCs and DCA and DBHDD and that the coordination prioritize the alignment of state resources serving people experiencing homelessness among DBHDD, DCA, the Division of Family & Children Services (DFCS), Department of Disability Services, DHS, and the Department of Corrections (DOC), particularly related to the homeless population with behavioral health issues, mental illness, and substance use disorders, as well as individuals aging out of foster care or reentering society from jail or prison;
    - Maximizing utilization of Family Unification Program and Fostering Youth Initiative vouchers for families at risk and youth aging out of foster care including through partnerships with COCs that shall provide referrals of people currently experiencing homelessness;
    - Supporting data sharing and interoperability between state and local systems, including the HMIS (Homeless Management Information System), that reduce duplication, streamline processes, and eliminate unnecessary steps, including through GaHIN and GeorgiaUnify; and
    - Local collaboration among COCs, CSBs, and public housing authorities (ideally involving memoranda of understanding);
    - Renewing and expanding existing the Temporary Assistance for Needy Families program to divert and rapidly rehouse families experiencing homelessness and at risk of entering the child welfare system.
- Contractually aligning existing outreach teams (e.g.,PATH [Project for Assistance in Transition from Homelessness], ACT [assertive community treatment], and ICM [intensive case management] to prioritize service

to unsheltered individuals with behavioral health challenges and fund additional outreach teams where needed — specifically, funding four additional ACT teams in Atlanta that are dedicated to serving the unsheltered and coordinating with the COC for referrals and priority locations at a cost of $750,000 per team,[3] totaling $3 million annually.

- Providing state-funded supportive services in partnership with supportive housing providers, public housing authorities, and developers/providers, including housing navigation, case management, tenancy preservation, employment, and behavioral health.
- Renewing and expanding the existing program providing case managers and housing assistance to families involved with DFCS.
- Reestablishing a Georgia Coalition on Older Adults and Aging chapter for cross-sector collaboration and case management. This should include an aging liaison from each agency.
- Continuing collaboration between DBHDD and the Dental College of Georgia to ensure the exposure of dental students to people with IDD.
- Continued coordination between DCH and DBHDD in examining wraparound services and payments COM (Comprehensive Support Waiver Program) and NOW (New Option Waiver Program) waivers.

Supporting testimony was heard by the Children and Adolescent Behavioral Health, Hospital and Short-Term Care Facilities, Involuntary Commitment, Forensic Competency Advisory, and Workforce and System Development subcommittees, and the Aging Adults, Dental, Homelessness, IMD Waiver, and Medicaid–Social Determinants of Health advisory subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.



Continue Data Sharing

HB 1013 mandates the creation of a statewide system for sharing data related

[3] The cost of ACT teams is current as of the publication of this report and is in the process of being reevaluated.

to the care and protection of children across multiple departments, including DFCS, DCH, DBHDD, Juvenile Justice, and Education. The goal is to streamline data access and enhance decision-making processes.

HB 1013 also requires annual data calls to ensure compliance with mental health parity laws focusing on the use of nonquantitative treatment limitations. Agencies also must submit yearly reports to the GDAC and the General Assembly with information on complaints and violations. Furthermore, a Behavioral Health Care Workforce Database will be established to collect and analyze data on behavioral health professionals, contingent upon available funding. Accountability courts will also receive technical assistance to better interpret data and effectively serve the mental health population.

Despite these efforts, several challenges persist. Regulatory compliance with privacy laws like the Health Insurance Portability and Accountability Act limits data sharing, creating hesitancy among agencies. Cultural barriers contribute to data silos, where departments are reluctant to share information. Additionally, technical and resource limitations hinder the implementation of robust data sharing systems, particularly in resource-scarce areas.

Key entities like GDAC and the All-Payer Claims Database (APCD) facilitate data sharing. GDAC plays a critical role in establishing data sharing agreements and resolving interagency disputes, while APCD collects health care billing data to promote transparency and improve public health outcomes.

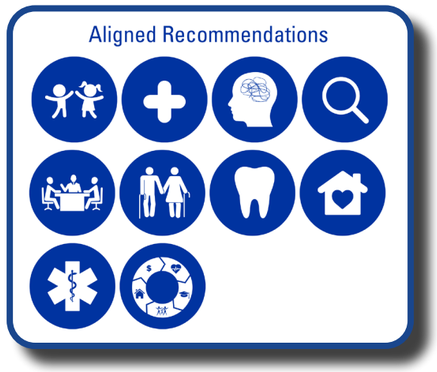
GaHIN supports secure health information exchanges, allowing providers to access patient data efficiently through services like GeorgiaConnX, GeorgiaDirect, and GeorgiaUnify.

Securing consistent funding is essential to overcoming these challenges. GaHIN has benefited from various grants, while GDAC receives state budget allocations, including $1.9 million for fiscal year 2024. Sustained financial support is crucial for fostering collaboration across public entities and improving health care and child welfare in Georgia. Additionally, state organizations have been working together to streamline data sharing agreement processes and secure appropriate agreements when necessary for the benefit of programs.

Supporting testimony was heard by the Children and Adolescent Behavioral Health, Hospital and Short-Term Care Facilities, Involuntary Commitment, Forensic Competency Advisory, and Workforce and System Development

A Behavioral Health Care Workforce Database will be established to collect and analyze data on behavioral health professionals, contingent upon available funding.

subcommittees, and the Aging Adults, Dental, Homelessness, IMD Waiver, and Medicaid–Social Determinants of Health advisory subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.



Integrate Data Sharing Platform

Social determinants of health (SDOH) include a variety of nonmedical factors that can influence individual physical and mental health and can also impact an individual's ability to fully participate in their own health care. SDOH can include but are not limited to housing, transportation, accessibility of food, and employment. Health care providers have in recent years prioritized screening and referral mechanisms to better address the health of patients. This requires extra time and effort for providers to maintain a regular list of accurate referrals.

Systems to both incentivize providers and make referrals easy are needed within Georgia.

In the 2023 report, the commission recommended that Medicaid pursue a plan to allow for funding to be used to address SDOH. As a result, the commission created the Advisory Subcommittee on Medicaid–Social Determinants of Health. After hearing testimony from a variety of experts, the subcommittee recommends the funding of an integrated data sharing platform and increased reimbursement of SDOH screening.

GaHIN is an information-sharing, integrated platform that allows the sharing of patient-level information between various sources. The goal is to support whole-person care, build trust, engage service providers, and align and coordinate care. GaHIN combines GeorgiaConnX with GeorgiaUnify. GeorgiaConnX gives providers and payers access to data from integrated hospitals, providers, state agencies, and care managers to lead care coordination. GeorgiaUnify has professional and individual access to community-based organizations, the education department, government agencies, and a resource director. With these services combined, clinical providers and service providers can access longitudinal patient care information across the entire care ecosystem on patients receiving services. In this way, providers can directly refer patients to other services such as housing, food, and transportation and also gain an understanding of previous encounters individuals may have had with other organizations. With this coordination of information, service providers can give full patient care that is specified to their unique geography and needs.

Beyond referral mechanisms, GeorgiaUnify provides a platform of built-out social screening forms. Specific coding guidelines can allow providers to receive reimbursement for those screenings, but as members of the advisory subcommittee pointed out during discussions, there is room for expansion of these approved services. Additionally, GeorgiaUnify can pull real-time reports. Information from GaHIN can be used in collaboration with parity enforcement recommendations by having the capability to create real-time reports of services rendered across sites.

Currently, GaHIN is being used by DCH and other state agencies. The capabilities of access to longitudinal patient information, SDOH screening, and closed-loop referral mechanisms would assist providers in serving patients with nonhealth barriers to care in more judicial ways.

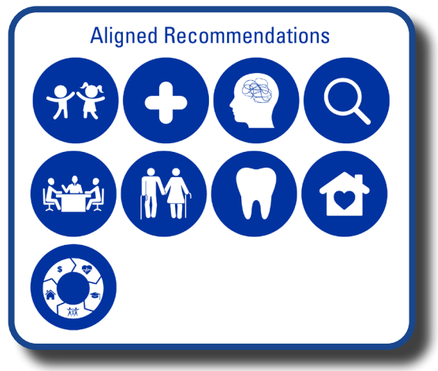
The commission recommends that permanent funding be identified to maintain current GaHIN services as well as expansion for specialty populations including:

- Evaluating the integration of aging population resources and providers into GaHIN. Aging-specific referral mechanisms and identifying gaps are recommended.
- Identifying additional expansion of GaHIN to agencies that may not be on electronic health records, such as dentists and homeless service providers.
    - To enhance dental services, special considerations should go to creating a special-needs dental directory that includes the following:
        - A list of specific IDD conditions;
        - Accommodation requests or requirements (such as bolsters, anxiety-reducing mechanisms, and sedation);
        - Dental services requested;
        - Geographic location; and
        - Language.

The commission recommends additional continual funding to purchase referral materials from CHADIS (Child Health and Development Interactive System). CHADIS is a clinically recognized platform containing multiple universal screening tools that providers can utilize to screen for SDOH needs. Currently, CHADIS is not equitably available to providers to utilize. The commission recommends that funding become available to incorporate CHADIS into GaHIN for universal availability. The Advisory Subcommittee on Medicaid–Social Determinants of Health recommends that there would be continual funding for CHADIS to be incorporated into GaHIN, which would provide up to 600 questionnaires for providers to include in their work.

To further incentivize providers to screen for SDOH, the commission recommends that DCH explore reimbursement rates or additional SDOH CPT codes and provide regular reporting of SDOH diagnosis.

Supporting testimony was heard by the Children and Adolescent Behavioral Health, Hospital and Short-Term Care Facilities, Involuntary Commitment, and Workforce and System Development subcommittees, and the Aging



Adults, Dental, Homelessness, and Medicaid–Social Determinants of Health advisory subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.

Identify a Pathway to Submit the Institutions for Mental Disease Waiver

The IMD exclusion prohibits states from claiming federal financial participation for individuals under the age of 65 who are patients in IMDs, with only a few exceptions to this rule. In turn, this exclusion has left states with limited pathways to pay for these services. As of 2019, 26 states had received approval for IMD waivers for substance use disorder services, and states are also exploring IMD waivers for mental health services. In the 2022 legislative session, the Georgia General Assembly passed Senate Bill 610, which called on DCH to submit an IMD waiver for both mental health and substance use disorder treatment. Following this in the 2023 report, the commission recommended that an IMD Waiver Advisory Subcommittee be established in collaboration with DCH leadership to identify funding and identify additional barriers that may prevent DCH from following the directive prescribed to the agency in SB 610.

When identifying barriers to the IMD waiver, the current capacity of the COC was discussed. In 2019, DCH contracted with Deloitte to study, review, and analyze waiver opportunities. From the Deloitte review, several recommendations were made for DCH to prepare them for a waiver opportunity in 2022. Alongside the study, in September 2023, DCH began a procurement process, opening a request for proposals from care management organizations.[4]

After testimony heard by the IMD Waiver Advisory Subcommittee, the commission recommends continued partnership with DCH to evaluate the best options moving forward to address the funding of additional behavioral health crisis services and to expand the crisis COC, given the upcoming changing landscape of managed care in Georgia Medicaid.

The commission recommends that DCH explore and assess alternative options to the IMD waiver to achieve similar goals, including but not limited to 1115 waivers, 1915(s), utilize in lieu of services, and state plan amendments.

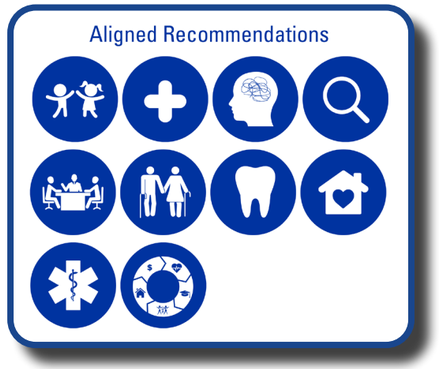
[4] For more information about procurement process, please visit **https://dch.georgia.gov/divisionsoffices/office-procurement-services**.

Supporting testimony was heard by the IMD Waiver Advisory Subcommittee and Hospital and Short-Term Care Facilities Subcommittee. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.

Continue Oversight and Implementation of BHRIC Committee Work and Recommendations

The commission recognizes the importance of continuing the work that has been established over the past four years and therefore recommends the following: DBHDD should oversee the continued rollout of BHRIC recommendations by creating and overseeing advisory committees where necessary to complete recommendations and further evaluations and research surfaced by BHRIC.

Supporting testimony was heard by the Children and Adolescent Behavioral Health, Hospital and Short-Term Care Facilities, Involuntary Commitment, Forensic Competency Advisory, and Workforce and System Development subcommittees and the Aging Adults, Dental, Homelessness, IMD Waiver, and Medicaid–Social Determinants of Health advisory subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.



III. BUILD A ROBUST AND SKILLED WORKFORCE

Testimony was heard in various subcommittees on the extreme challenge of the workforce shortages among all levels of behavioral health practitioners in

A total of $26,658,091 was added to the fiscal year 2025 budget to implement the rate study recommendations.

the state. Addressing workforce shortages in any field requires a multipronged approach, including retaining and maintaining the currently trained workforce in the field, creating an environment that encourages practitioners to come to and stay in the state, and building a robust pipeline for the future workforce across practitioner types. All levels of the workforce are important from peer support specialists and service navigators to psychiatrists and psychologists. Workforce shortages are also multifaceted and may impact various practitioner types, geographic regions, and payer statuses differently.

Recommendations from the **Year 3** report included addressing the behavioral health workforce shortage. Between the publication of that report and the work of the commission this year, various achievements have been made. DBHDD's Behavioral Health Rate Study has begun being implemented. A total of $26,658,091 was added to the fiscal year 2025 budget to implement the rate study recommendations. The fiscal year 2025 budget also proposed increasing funds to match rate implementation of the Community Behavioral Health Rehabilitation Services provider rate study for uninsured Georgians.

The following recommendations follow the recommendations and findings from expert testimony heard across the subcommittees. These recommendations build on the **Year 3** recommendations and aim both to address the immediate crisis of workforce shortages and provide a long-term pipeline with adequate capacity for Georgia's growing population.

Continuous Support and Study of Rates for Serving Specialty Populations

Paying behavioral health practitioners fair rates encourages those trained in the field to remain in the field. The commission recommends that the state continue to move forward based on the information obtained in the recent DBHDD rate study and to change rates as appropriate. The commission recommends that the state continue the support of examining rates and implement regular rate studies.

This year, the commission's new advisory groups brought additional specialty populations to the intersection of behavioral health services with aging adult services, homelessness services, and dental services. The commission recommends that the state consider these special populations as well as other specific populations with unique behavioral health needs, including children experiencing mental health and substance use disorders, children dually diagnosed with autism and behavioral health challenges, and children and adults involved with both the behavioral health and criminal justice systems. The Children and Adolescent Behavioral Health Subcommittee and the Dental Advisory Subcommittee received further testimony in support of the following recommendations:

- Provide flexible spending rates for psychiatric residential treatment facilities and child-caring institutions that will allow intensive and child-centered services and management for a wider spectrum of needs.
- Evaluate Medicaid reimbursement rates for dental services and request reimbursement rates to be evaluated yearly.

Aligned Recommendations

Supporting testimony was heard by the Children and Adolescent Behavioral Health, Hospital and Short-Term Care Facilities, and Workforce and System Development subcommittees and the Dental Advisory Subcommittee. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.

Loan Repayment and Forgiveness

Considerable discussion centered on the establishment of a new loan forgiveness and loan repayment program for mental health professionals. This new program will be in addition to the service cancelable loan program established in the Georgia MHPA. This recommendation is carried over directly from the **Year 2** and **Year 3** reports.

The Georgia MHPA called for the creation of a service cancelable loan program for students enrolled in any degree program for mental health and substance use professionals that would be administered by the Georgia Student Finance Commission. This program creates an incentive for students to enter degree programs to become mental health and substance use professionals by awarding loans to students that can be repaid through service once they are licensed and practicing in the field. Based on the subcommittee's review of other states' programs and related workforce data, it would be worthwhile for Georgia to incentivize its current workforce to practice in mental health professional shortage areas through a loan repayment assistance program for individuals who are no longer students but actively practicing in the workforce as licensed mental health or substance use professionals. Applications for the program opened at the end of 2023, and thus far there have been more than 170 applicants and $1.5 million has been awarded to 113 students.

The commission recommends continuing to build on the success of the cancelable loan program by ensuring that trainings on how to apply are available and promoted. Additionally, loan repayment assistance programs for licensed mental health or substance use professionals, conditional on five consecutive years of services in a facility with a health professional shortage area designation that serves both Medicaid and PeachCare for Kids, should continue to be established. Additionally, testimony was heard by the Dental Advisory Subcommittee leading the commission to recommend the creation of a service agreement scholarship for tuition reimbursement for dentists who would work for DBHDD.

Supporting testimony was heard by the Workforce and System Development Subcommittee and the Dental Advisory Subcommittee. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on

the subcommittees' aligned recommendations, please see their respective appendices.

Modernize Licensing Practices Across All Levels of the Behavioral Health Workforce

Another barrier to growing and sustaining the behavioral health workforce in the state that has been identified by the commission is the need to modernize and streamline the licensing system. These updates would address the workforce shortage by ensuring that the new and existing workforce can get or maintain their license to practice in the state without facing delays or overly burdensome requirements. Testimony was heard by the Children and Adolescent Behavioral Health Subcommittee and others that indicated that Georgia should amend its Medicaid State Plan to allow licensed psychologists who are Medicaid providers to bill for services provided by doctoral psychology interns and postdoctoral residents who are under their supervision without the requirement that the supervisor be present for the session. Supervision will occur at the time set aside by the intern and their supervisor, and the workforce will be developed, retained, and expanded by increasing access by supporting existing mental health staff, streamlining processes for paneling and credentialing, and expanding provider classes. Testimony was also heard by the Workforce and System Development Subcommittee and others that indicated that Georgia's licensing processes are cumbersome and deter trained professionals from engaging in the workforce. Review, modernization, and improvement of Georgia's licensing practices must also recognize the need for service providers at all levels who demonstrate cultural competence and have the ability to speak multiple languages. Other states have created special initiatives and leadership positions to address the increasing percentage of residents who do not speak English and have unique cultural histories. Revising these practices can help ensure those qualified to practice in Georgia are able to maintain the appropriate licensure level to provide services in the state and meet the diverse needs of Georgia's residents.

Georgia has recently provided funding to upgrade the licensure application process to a digital one. The Office of the Georgia Secretary of State has been rolling out GOALS, the Georgia Online Application Licensing System, for various license applications. The commission recommends continuous reporting on the use of appropriations to the secretary of state, as well as status updates and evaluations of the GOALS platform to ensure it meets the needs of the Georgia behavioral health workforce. It is also recommended that the commission

support the recommendations that come out of the Joint Blue-Ribbon Committee to Investigate Licensing.

Supporting testimony was heard by the Children and Adolescent Behavioral Health and Workforce and System Development subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.

Strengthen Georgia's Peer Support Workforce

Peer support is an evidence-based practice that utilizes people with lived experience in behavioral health interventions. Some of the proven benefits of the use of peers include lower hospital readmission rates, reduced number of days in an inpatient stay, greater use of outpatient services, improved quality of life indicators, increased rates of provider engagement, improved whole health, lower cost of services, and reduced mental health and substance abuse issues.

The commission recognizes that peers are a critical part of the behavioral health workforce and recommends that Georgia dedicate resources to ensuring sustainable funding for peer support programs and increased accountability in the training provided to peers to ensure their success in the workplace.

Specifically, the commission recommends the following:

- Provide additional and more accessible professional-development training and technical assistance for community mental health workers, peer support specialists, paraprofessionals, and health care providers and expand implementation of neonatal intensive care unit peer-to-peer support for all families with a priority focus on families experiencing substance use disorder. Some training examples include trauma-informed care, education on serving families with substance use disorder diagnosis and providing family-centered care. The Children and Adolescent Behavioral Health Subcommittee report contains an exhaustive list of training examples.
- Expand and increase payer reimbursement for certified peer support services, including youth peer support.

- Develop a process to request permission to hire people with lived experience who may have backgrounds with substance use or criminal behavior and who are living a life of recovery.

Supporting testimony was heard by the Children and Adolescent Behavioral Health and Workforce and System Development subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.

Improve Network Adequacy

There is a gap between the behavioral health workforce supply and Georgia residents' access to that supply, whether they have insurance or Medicaid coverage. The aggregate shortfall in supply is exacerbated significantly by "skinny networks" of providers. Most behavioral health professionals are not in-network. For example, the number of out-of-network behavioral health providers for children is 10 times higher than out-of-network physical health care providers. Therefore, it is important to focus on not only increasing the behavioral health workforce supply but also ensuring that the managed care organizations and health insurers provide their enrollees with sufficient access to those providers. Georgians with acute mental health needs are 16 times more likely to be forced to see out-of-network providers than Georgians with medical or surgical needs. Georgians needing to see a psychiatrist are 4.8 times more likely to be forced out of network than if they were seeking a medical or a surgical specialist. The out-of-network percentage is 2.2% for primary care physicians versus 15.3% for psychiatrists. Primary care physicians have reimbursement rates ranging from 20% to 50% higher than those for psychiatrists.

The commission recommends the following to address the issue of network adequacy:

- Include measures for availability of geriatric mental health providers when evaluating network adequacy.
- During reprocurement for the Aged, Blind, and Disabled (i.e., Supplemental Security Income eligible) and the Long-Term Supports and Services

populations, ensure that DCH build in requirements of care management organizations related to mental health parity for Medicaid recipients.

- Implement a direct payment model for Medicaid care, which will eliminate bottlenecks to accessing mental health care, enable providers to receive payments from payers even if they are not in-network, and introduce competition at the provider level. The direct payment model uses a third-party administrator to serve as a mandatory statewide clearinghouse for claims management and payment remittances, provide support to schools to ensure compliance with state and federal requirements, centralize network oversight, and function as a parity enforcer by challenging most denials. For more information on the direct payment model please see the Children and Adolescent Behavioral Health Subcommittee report.
- Pilot a mobile dental program modeled after the successful Access Dental Care program in North Carolina that is to be based at Gracewood Dental Clinic. Mobile dentistry would have the capabilities for dental visits to skilled nursing homes, group homes for those with IDD, day centers, nursing homes, and other facilities for the aging population. Full detailed recommendations can be found in the Dental subcommittee report.

Supporting testimony was heard by the Children and Adolescent Behavioral Health, Hospital and Short-Term Care Facilities, and Workforce and System Development subcommittees, and the Aging Adults, Dental, and Medicaid–Social Determinants of Health advisory subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittees' aligned recommendations, please see their respective appendices.

IV. EXPAND EFFECTIVE COMMUNITY-BASED PROGRAMS, PRACTICES, AND SERVICES

Subcommittees heard from service providers and state executive agencies responsible for the delivery of behavioral health services throughout the state. Many of the subcommittees identified specific programs that have clear evidence of supporting practices, programs, and services within the behavioral health system of care. These programs often reach only small geographic regions of the state and would benefit from additional funds to expand their reach to more areas.

Expand Effective Programs and Services for Children and Adolescents

The Children and Adolescent Behavioral Health Subcommittee identified programs that are effective in promoting optimal youth behavioral health outcomes. These programs should be expanded to increase their reach throughout the state.

The commission recommends building on several recommendations from **Year 3** to continue the expansion of the following services aimed at improving behavioral health outcomes for children and adolescents:

1. Encourage all Georgia CSBs to adopt the Certified Community Behavioral Health Center model, which is designed to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age — including developmentally appropriate care for children and youth.
2. Expand the Apex Program to more schools throughout Georgia. In addition, provide and expand access for tele–mental health access in schools and consider expanding the Apex Program reach to rural areas by use of tele–mental health as part of a plan to expand school-based behavioral health services.
3. Expand implementation of family-integrated, relationship-based care with families of infants admitted to a neonatal intensive care unit by investing in the Regional Perinatal Center Outreach Educators, coordinated by the Georgia Department of Public Health, to provide evidence-based training, technical assistance, and mentorship for staff to implement and sustain evidence-based practices for fostering developmentally attuned environments and emotional regulation.
4. Add Dialectical Behavioral Training, to the Georgia Department of Education's Mental Health Awareness Training program as part of a plan to expand school-based behavioral health services.

Additionally, the commission recommends the expansion of the following services:

- Increase or expand intensive community-based therapeutic services such as Intensive Family Interventions.
- Increased and flexible spending rates for psychiatric residential treatment facilities and child-caring institutions that allow for intensive and creative programming to better serve this population.
- Increasing resources through public-private partnerships to support parental presence in the neonatal intensive care unit.

Supporting testimony was heard by the Children and Adolescent Behavioral Health Subcommittee. These recommendations are endorsed by the full commission and were informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittee's aligned recommendations, please see its respective appendix.

Expand Effective Programs and Services for Adults

- Expand and study the AOT program.
  - The AOT program established by the MHPA is still in its infancy, with three of the programs close to capacity. To continue the work that has been begun, the commission recommends:
    - Funding to continue for five pilot projects across the state.
    - Targeted training for all CSBs and treatment providers about the use of AOT.
    - Studying AOT pilot site implementation to understand how each site utilizes funding to support staffing and operations.
    - Conducting a study to inform building an additional AOT pilot project in conjunction with misdemeanor diversion.
    - Modifying the statute to allow nurse practitioners to conduct AOT evaluations.
    - Continuing exploration of a certification process for AOT evaluators.
- Prioritize unsheltered populations for housing vouchers.

- Ensure effectiveness of highly skilled outreach teams (e.g., ACT, ICM) and fund additional outreach teams, where needed.
- Implement behavioral health screening and connection to treatment in conjunction with youth aging out of foster care (i.e., 533 individuals in 2024) (DFCS) and releasees from incarceration (DOC, local sheriffs), including the expansion of the Jail In-Reach Program.
- Invest in expanded outreach, including greater access by outreach teams to higher levels of behavioral health expertise, including ACT teams with experience with the unsheltered.
- Provide state-funded supportive services in partnership with supportive housing providers.
- Expand the existing aging resource database, EmpowerlinePRO, to include more behavioral health resources.

Supporting testimony was heard by the Involuntary Commitment Subcommittee, and the Aging Adults and Homelessness Advisory Subcommittees. This recommendation is endorsed by the full commission and was informed by corresponding recommendations from the noted subcommittees. For more details on the subcommittee's aligned recommendations, please see its respective appendix.

V. STUDY PROGRAMS, PRACTICES, AND SERVICES THAT NEED IMPROVEMENT

Subcommittees noted areas where additional study will help the commission identify appropriate solutions to address ongoing challenges within the behavioral health system. The following studies are recommended to be undertaken by the commission in the coming year:

- Study and conduct an environmental scan to identify best practices for defendants with IDD or who have dementia and are currently not included in the code for involuntary commitment. Develop appropriate recommendations for legislative language.
- Continue investigation into the order to apprehend processes next year to allow sufficient time for consideration of data and stakeholder input. (IC)

- Monitor and evaluate CSBs and hold them accountable for working with COCs and other partners to serve the homeless population with behavioral health issues. (DBHDD)
- Pilot a temporary, intensive harm-reduction safe haven model to serve a population too ill for congregate housing or immediate entry into traditional supportive housing.
- Implement behavioral health screening and connection to treatment in conjunction with youth aging out of the foster care system (i.e., 533 individuals in 2024) (DFCS) and releasees from incarceration. (DOC, local sheriffs)
- Address barriers to the Georgia Housing Choice Voucher Program utilization across the state and expand voucher availability. (DBHDD)
- Conduct an evaluation of the Atlanta Regional Commission Behavioral Health Coaching Pilot Program for expansion. Once evaluated, explore options for sustainable funding, including potential billing mechanisms.
- Study and conduct an environmental scan of the processes that are in place to ensure that the needs of incompetent and unrestorable youth are met. Develop appropriate recommendations for revisions to the current process.
- Study and conduct an environmental scan of service options for youth who are involved in the competency process, both restorable and unrestorable. Develop appropriate recommendations for a continuum of services that could be offered by community providers and DBHDD.
- Continue to refine processes for tracking data related to juvenile competency, ensuring that data are collected throughout the full process.
- Georgia allows advanced practice registered nurses and physician assistants to prescribe Schedule II medications, currently limited to a five-day supply of hydrocodone and oxycodone in emergency situations to individuals over age 18. Conduct an evaluation of this expanded prescription authority and analysis of practices in other states and what additions might be appropriate at this time for Georgia.
- Study and evaluate potential tax credits and incentives for dental offices that provide care for IDD patients as an incentive for existing private practices and experienced practitioners.

VI. STREAMLINE EXISTING STATUTES AND POLICIES

Subcommittees also identified specific statutes and policies that need refining to support system reform. The commission recommends the following changes be made to the noted statutes and policies.

Refine Policies and Practices Impacting Adults

- Provide a continuing source of flexible grant funding to meet specific local needs (all COCs, not just Georgia's Balance of State COC) that align with each COC's respective strategy, such as:
  - Supportive services to complement permanent supportive housing;
  - Funding for homeless solutions, e.g., the Melody, in other parts of the state;
  - Support service provider capacity, especially in unserved and underserved parts of the state;
  - Housing vouchers and services for those who do not meet clinical criteria of serious and/or persistent mental illness required by Georgia's Housing Choice Voucher Program;
  - Dedicated staff to provide in-reach to jails and prisons to promote comprehensive reentry plans;
  - New strategies that address specific, targeted needs;
  - Shelter operations;
  - Diversion funding facilitating quick exits from homelessness; and
  - Specifically, provide annual funding for supportive services for 500 units in development in the city of Atlanta that will service people experiencing homelessness with severe behavioral health challenges at approximately $6.5 million annually.
- Request the Georgia Board of Dentistry to allow dental professionals continuing education credit for providing care to people with IDD.

Refine Policies Impacting Access to Services for Children and Adolescents

- Streamline the current 59-step provider enrollment process:
  - Adopt continuous enrollment rather than having windows of opportunity; and
  - Create an expedited approval process for providers already contracted for services by state agencies.
- Allow approved DFCS foster families serving developmentally disabled youth to transition to DBHDD host homes as the youth age out of foster care and still require their residential setting.
- Require the child-serving state agencies to revise the process for criminal background checks to allow for reciprocity when not legally prohibited. This would eliminate the time and expense required to get identical checks for different agencies.
- Modify the waiver request process for difficult-to-fill positions, allowing additional flexibility, such as a broader range of acceptable experience and educational background.

Refine Policies and Practices Impacting Services for Persons Involved in the Criminal Justice and Behavioral Health Systems

- Recommend that OCGA Section 17-7-130 (b) be modified to include language that a judge will hold an initial hearing regarding defense requests for the competency process. Identify and implement procedures and unified rules to provide guidance to the court and alternative suggestions for the defense regarding the language change.
- Recommend adjustments to restoration processes:
  - For nonviolent misdemeanors, DBHDD would have 45 days to report on the progress to restore the defendant's competency to stand trial (instead of the 90 days allowed for felonies).
    - The advisory committee was not able to fully agree on a definition of a nonviolent misdemeanor but did agree that driving under the influence and domestic violence misdemeanors would be excluded from this process.
  - If the defendant is not restored, DBHDD would have 90-120 more days (instead of the nine months allowed now in all cases) to continue to work with the defendant for restoration.
  - If the defendant is not restored at that point, the case would be dismissed unless the prosecutor chooses to file for an extension and shows a compelling state interest in pursuing the charge. Defendants would also be referred to the local CSBs for ongoing treatment.

APPENDIX A: SUBCOMMITTEE ON CHILDREN AND ADOLESCENT BEHAVIORAL HEALTH

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on Children and Adolescent Behavioral Health

2024 Annual Report

Chair

Eric Lewkowiez, MD

Members

David Bradley, DMD

Garry McGiboney, PhD

Gwen Skinner Ed.S, LMFT

Sarah Vinson, M.D.

Miriam Shook

Commissioner Shawanda Reynolds-Cobb

November 22, 2024

Report prepared with assistance from the Georgia Health Policy Center (GHPC) and the Center of Excellence for Children's Behavioral Health (COE) at Georgia State University

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas including the Subcommittee on Children and Adolescent Behavioral Health chaired by Dr. Eric Lewkowiez (2022-2024).

During 2024, the Subcommittee on Children and Adolescent Behavioral Health held six public meetings on topics including updates on DBHDD's programs related to children and adolescents, network adequacy and parity, addressing children with developmental disabilities and multiple needs, increasing access to mental health services at the community level, improving mental health systems, infant and maternal mental health; psychological services for Medicaid children and families, youth mental health systems change and school-based mental health.

This report includes information and recommendations to address child and adolescent behavioral health in Georgia from testimony from mental health experts including pediatricians, social workers, school-based practitioners, community-based providers, and others with expertise in children and adolescent behavioral health.

List of Presenters to the BHRIC Subcommittee on Children and Adolescent Behavioral Health 2024

BHRIC Subcommittee on Children and Adolescent Behavioral Health Eric Lewkowiez, Chair, Garry McGiboney, David Bradley, Gwen Skinner, Miriam Shook, Sarah Vinson, Commissioner Shawanda Reynolds-Cobb		
Support to the BHRIC Subcommittee on Children and Adolescent Behavioral Health Dr. Ann DiGirolamo (GHPC/COE), Ashlie Oliver (GHPC/COE), Courtnee King (GHPC/COE)		
Presenters to the BHRIC Subcommittee on Children and Adolescent Behavioral Health 2024		
Date	**Topic**	**Presenter**
Date	Topic	**Presenter** Presenter's Title
06/20/24	Georgia Department of Behavioral Health and Developmental Disabilities Update	**Brenda Cibulas** Executive Director of the Division of Behavioral Health **Dante' McKay** Former Director of the Office of Children, Young Adults, and Families
07/18/24	Network Adequacy and Parity	**Dr. John Constantino** Chief, Behavioral and Mental Health, Children's Healthcare of Atlanta
08/15/24	Addressing Children with Developmental Disabilities and Multiple Needs	**Heather Stanley** Program Director, MATCH, DBHDD **Danielle Fish** Clinical Specialist, MATCH **Catherine Smith** Chief Strategies Officer, Youth Villages **Tanya Anderson** Executive Director, Youth Villages GA **Gwen Skinner** Vice President of Operations, Devereux Advanced Behavioral Health GA
9/19/24	Increasing Access to Mental Health Services at the Community Level	**Telisha Campbell** Director of Clinical and Leadership Development, Georgia Hope

		Jennifer Rivera School-based Program Director, Georgia Hope **Jennifer Hibbard** Chief Executive Officer, View Point Health
10/24/24	Mental Health Systems; Infant and Maternal Mental Health; Psychological Services for Medicaid Children and Families	**Roland Behm** Managing Director, Co-Founder, Georgia Mental Health Policy Partnership **Arianne Weldon** Strategic and Innovation Manager, Georgia Family Connection Partnership **Kathi Frankel** Community of Practice Facilitator, 2Gen Family Integrated Care **Dr. Whitney Kleinert** Therapist **Dr. Susan McCarthy-Furman** Adjunct Associate Professor, Department of Psychiatry and Behavioral Sciences, Emory University
11/7/24	Youth Mental Health Systems Change; School-based Mental Health; Addressing Gaps in Therapeutic Services	**Alex Briscoe** Executive Director, Public Works Alliance **Bonnie Hardage** Executive Director, Jesse Parker Williams Foundation and Co-Chair, Mental Health Funders Collaborative **Ebony Johnson** Senior Director, Brighter Future, United Way of Greater Atlanta and Mental Health Funders Collaborative **Eve Byrd** Executive Director of Mental Health, The Carter Center **Dimple Desai** Senior Manager, Voices for Georgia's Children

		Mary Kathryn Velazquez Staff Attorney, Georgia Appleseed Center for Law and Justice **Emily Anne Vail** Executive Director, Resilient Georgia **Dr. Jordan Murphy** CEO, Center for Interrelational Science and Pediatrics

Summary of Presentations to Subcommittee

June 20, 2024

Georgia Department of Behavioral Health and Developmental Disabilities Update

DBHDD is a key agency involved in implementing the recommendations that come from the Children and Adolescents subcommittee. They presented updates relevant to the committee regarding current programs related to children and families.

Presentations from Brenda Cibulas, Executive Director of the Division of Behavioral Health and Dante' McKay, former Director of the Office of Children, Young Adults, and Families

Brenda Cibulas shared that the department is very attuned to the mental health needs of children, adolescents, and their families in the state, especially since the needs that arose during the pandemic are not over. She introduced Mr. Dante' McKay and highlighted his work creating and leveraging partnerships.

Dante' shared DBHDD's legislative updates starting with the APEX program. He provided background information for APEX sharing that APEX was developed and operated by DBHDD since 2015; APEX is a program that embeds therapists and parent certified peers into school settings. The program has three primary goals: Early Detection, Access, Coordination and a fourth informal goal related to workforce development. The core APEX model is a three-tiered model. Tier 1 is universal prevention and is appropriate for 90% of students, Tier 2 is at-risk and is appropriate for 7-10% of students, Tier 3 is identified and is appropriate for 3-5% of students. The top 3 referral reasons for APEX are depression, classroom conduct, and behavior outside of the classroom and the top 3 diagnoses are ADHD, depressive disorder, and anxiety disorder. The top intensive intervention used is individual counseling by embedded therapists. There are three evidence-based practices implemented including cognitive behavioral therapy (CBT), solution focused therapy, and trauma focused CBT. APEX is operated in 48% of rural Georgia counties.

During the 2024 legislative session $1M was added to the FY 2025 APEX budget to expand telemedicine services. The goal is to pilot one to three different models: 1) continue working with DBHDD enrolled providers with telemedicine capacity 2) provide direct grants to 1 to 2 school districts, 3) contract with a Regional Education Service Agency (RESA).

During the 2024 legislative session $15.5M was added to DBHDD budget for the construction of a new C&A Crisis Stabilization Unit. There are four current operating CSUs in Dekalb County, Coweta County, Bibb County, and Chatham County. The new CSU will replace an existing building from the 1900s and will be located 45 minutes outside of Savannah, Georgia. It will include temporary observation, a new service for children in the

state of Georgia and will provide residency opportunities for new doctors in partnership with Gateway. 2010 was the last time funds were dedicated to building a new CSU in Georgia.

Dante' then shared information about the Multi-Agency Treatment for Children (MATCH) program which was created by HB 1013. The MATCH planning committee recommendations include access to a pool of available funds, designated authority to make temporary exceptions, document state policies and regulations that create barriers, staff and technology, pilot projects, incorporate voices, and avoid creating additional bureaucracy. Phase I of the project focuses on state-level MATCH infrastructure while Phase II focuses on pathways to care which are still in development. Phase II focuses on the local-level infrastructure such as the local interagency planning teams (LIPTs) which is one entry point of many. The goal is to connect LIPT work to the rest of Georgia's ecosystem.

The Match Clinical Team (MCT) meets every two weeks and is staffed by DBHDD's Office of Children, Young Adults and Families. The MATCH no "wrong door" referral pathway is working to streamline processes from start to finish. The MATCH continuum of care is piloting interventions in four categories 1) in-home with guardian supervision 2) out of home where reunification is not an option 3) step down level of care and 4) specialized residential services. DBHDD received $9M from the Department of Health and Human Services to support MATCH.

Dr. McGiboney reflected that MATCH is working exactly as intended and applauded Dante' for the way that the program has unfolded. He mentioned that he has heard from parents participating in MATCH who have foster children and who have previously tried everything with no success that the MATCH process was "a miracle."

It was asked if MATCH also looks at the braiding of funding similar to how Tennessee does it. Dante' responded that they are not there yet. So far, the funds have come from Interagency funds transferred from DHS to DBHDD.

Dante' then presented on the child and adolescent strategic plan (Georgia Code 49-5-220), Georgia's formal system of care (SOC) infrastructure. Pillars of system of care have been codified since the 1980s including the requirement that the state publish a state plan, the formation of the Behavioral Health Coordinating Council (BHCC), the requirement that MATCH operate under the BHCC, and local interagency planning teams (LIPTs). A goal is to improve better coordination between the various components of the children's behavioral health system of care in Georgia. The BHCC delegates the SOC state plan development to Mindworks Georgia (formally the Interagency Directors Team/IDT). Collaborators include

Georgia state child serving agencies, non-profits, private foundations, community agencies, managed care participants, and Georgia State University. Mindworks developed its current three-year plan organized around five goal areas including equitable access, sustainable workforce, whole person health, purposeful funding with the goal of increasing blending and braiding opportunities, and system evaluation. There is further specificity within each workgroup.

Lastly, Dante' presented on Certified Community Behavioral Health Clinics (CCBHCs), a specially designed clinic that provides behavioral health services (similar to an FQHC). In order to become certified the centers must meet certification criteria and develop prospective payment rate approval. A certification team within DBHDD assesses CCBHC candidates in areas including staffing, access to services, care coordination, quality, scope of services, and national accreditations. Certification through DBHDD is required. For Georgia, CCBHC required accreditations need one of either Commission on Accreditation of Rehabilitation Services, Council on Accreditation of Services for Children and Families, Council on Quality and Leadership, or the Joint Commission and the National Association for Dually Diagnosed. There are nine services that CCBHCs are required to provide including crisis services, outpatient primary care screening and monitoring, screening, assessment, diagnosis and risk assessment, outpatient mental health and substance use services, psychiatric rehabilitation services, case management, person-centered treatment planning, community-based mental healthcare for veterans, and peer, family support and counselor services. The Prospective Payment System (PPS) is waiting on approval of the first PPS which will happen in October of this year, then a Cost Report will need to be submitted which is how the rate will be developed. The long-term goal to sustain CCBHCs is through Medicaid with some state funds. A state plan amendment has been submitted in partnership with DCH and they are waiting to hear back for approval. The focus to launch this initiative will be on community service boards (CSBs).

During the Q&A, Dante' shared that CCBHCs are designed to level the playing field allowing CSBs to incorporate a number of costs that they are not able to now. There are several services that CCBHCs can capture the costs for; this sets a minimum floor in terms of what they have to offer to gain this certification and access to the enhanced rate.

Dr. Cibulas shared that some of the services that haven't been able to be offered through CSBs have been services for 0 to 4 years old which is a big change. There is a greater focus on physical health. They must have documented clearance so that they share individuals with other medical organizations. They are working so they can accept all payers. This is a challenge because it will include many different processes regarding billing, reimbursement, and reconciliation that have not been done with all payers. This will be helpful especially in rural Georgia. She goes on to explain that the PPS rate is a rate that

encompasses a lot of the operations and services that did not previously qualify as a fee for service delivery model. There will potentially be more case management and community health workers in the future. Now, the wrap around and full approach can be constricted. They are hoping that by going through all costs and organizationally defining those costs can help identify a "triggering event" which is what gets billed.

Dante' also clarified during the Q&A that any facility that wants to be certified as a CCBHC must go through DBHDD.

Dr. Cibulas shared that the future plan is for all CSBs to convert to CCBHCs and that is the model that DBHDD would like to endorse. It is important to understand over the next year what is happening with the current four because there are a lot of lessons to learn. They have been able to do that effectively with a smaller number. Once they see what the strengths and potential weaknesses of the model are it will help as they bring other CSBs on. They are lucky right now with the base rate. The base rates are sitting with CMS right now as well as the PPS, but one of the drivers has been being able to have adequate reimbursement so at least for those who are not going forward at this moment but are in development, the ability to bill with the increase in base rates that we expect will happen in August or September will give some financial oxygen to the current CSBs who are not yet aligned. It takes a lot of work as there is an infrastructure that is required to accomplish the triggering event perspective and there are new outcomes that are more HRSA intended. Aligning those things is part of the work to make this more of a whole health model.

Regarding telehealth access, Dr. Cibulas shared that there are new rules being discussed aside from broadband access. It should still be possible to offer that more routinely if that is helpful. It is recognized that not only in the rural areas but mostly in the rural areas there are issues with transportation, work, time. Telehealth is an efficient model to some people and to some people it is not. We want to be able to offer a variety of ways to connect with different individuals. It is not always easy with children and adolescents. They need to see how this model can be used but it is definitely part of what needs to be done.

Regarding parent involvement in this model, Dante' shared that the way the system is funded now, the child is the client, so services are based upon the child. The way that they have attempted to incorporate parents has been through programs like APEX with the survey data collected looking at whether parents are feeling supported. The High-Fidelity Wraparound model includes parents and/or guardians. Some DBHDD staff have completed the DECAL Two Gen Academy which includes capstone projects for various agencies on ways that the state can be better on developing programs and supporting multiple generations. That is the way it has been approached so far but the CCBHC model will allow them to approach it differently.

July 18, 2024

Children's Healthcare of Atlanta Comprehensive Behavioral Health Plan

Presentation from Dr. John Constantino, Chief, Behavioral Health and Liz and Frank Blake Chair for Children's Behavioral Health, Children's Healthcare of Atlanta Professor, Department of Psychiatry and Pediatrics at Emory University and Adjunct Clinical Professor of Psychiatry and Behavioral Sciences at Morehouse University School of Medicine

Dr. Constantino reported on a recent endowment provided to CHOA for the Zalik Center, a children's mental healthcare center whose data will be used to simulate mental health parity for children in Georgia. Dr. Constantino presented on the factors at CHOA that influenced the opening of the Zalik Center, the state of children's mental health services in Georgia, and preliminary outcome data from the Zalik Center.

Dr. Constantino opened the presentation with a synopsis of where the program started. Children's Hospital of Atlanta (CHOA) recruited Dr. Constantino to become their first system Chief of Behavioral and Mental Health in August of 2022. At that time there was a significant portfolio of services that were particularly concentrated within the confines of their three children's hospitals, the Hughes Spalding hospital, the Scottish Rite hospital, and the Egleston hospital. Within that program and within the Marcus Autism Center, there was a robust portfolio of activity in behavioral and mental health which has not changed. The Behavioral and Mental Health program has 25 PhD medical psychologists embedded in medical specialty programs within their clinics. Dr. Constantino shared that historically CHOA hadn't had much activity in outpatient mental health but in August of 2022 they opened a small prototypic outpatient service and were providing 1,000 consults per year according to the Georgia Access Line.

CHOA has continually offered consultation for behavioral crisis to patients admitted for medical reasons. Since 2022, CHOA continually sees about 6,000 behavioral and mental health patients per year and conducts about 1,000 patient consultations per year across the three hospitals.

CHOA has continued to promote and emphasize triage services for individuals entering their emergency room and has been working on new innovations in the space of mental and behavioral health. One example Dr. Constantino gives is the emphasis on outpatient specialty services for children at CHOA. Dr. Constantino shared that while mental health for children is a collective responsibility of the primary care system, community, school and social services, CHOA programs aspire to answer the question, what can healthcare systems optimally do to support the entire ecosystem for children's mental health. CHOA does this by continually asking themselves how their resources can be optimally used to boost the system.

While this enterprise on outpatient care was getting ready to start, there were a few key things happening simultaneously federally and in the state of Georgia. In 2020 the federal Strengthening Behavioral Health Act was passed. The Act emphasized that it was the responsibility of insurers and providers when considering mental health parity to consider and ensure adequate capacity to deliver medically necessary mental health services. In 2022, the Georgia Legislature passed HB 1013 to help enforce the fulfillment of mental health parity and help enforce the Strengthening of Behavioral Health Act. Alongside these changes, The Board of Trustees of CHOA approved an endowment for long-term subsidy of new Behavioral and Mental Health services to simulate mental health parity with a representative population for a fraction of its 60% Medicaid population. The endowment was designed to simulate what mental health parity would look like and cost, because currently it is not a reality, as there isn't network adequacy or enough funding. In planning for this endowment, CHOA is seeking to document and demonstrate what the outcomes would be if mental health parity was a reality.

One year into developing the Outpatient Mental Health program (Zalik Center), an article was published by CHOA that summarized for pediatricians the strategy for establishing a model of transformation care in which all the endowment would not be focused into one area but rather across the continuum of care. Dr. Constantino shared that CHOA wants to fill the gaps across the continuum and to support providers of outpatient services in the community. They wanted to develop a program that added to services that the community was already providing and not replace it. This is where the program can demonstrate the simulation of mental health parity, by giving evidence-based treatment to children and tracking their condition. An improvement in their condition would be a strong case to fulfill mental health parity law.

Dr. Constantino shared that one of the great things about this opportunity is that the endowment does not go away. The endowment renews itself every year based off the interest of the endowment. As these are not funds that disappear, the program can continue on and should be able to reach an estimated 5,000 to 10,000 children per year. Dr. Constantino clarified that there are many factors that go into treatment cost and simulating mental health parity, which is why there is such a large range of how many children could be reached per year. Dr Constantino went on to share that if the number of patients is reached every year, there would be anywhere from 100,000 to 200,000 children enrolled into the program over a generation. Those enrolled would be receiving care that supplements what the community can already do and elaborated by the health system. In addition, the children will be monitored in a rigorous way to show to the government and scientific community what the costs and outcomes are that come from mental health parity.

Dr. Constantino shared that when thinking about how to optimally allocate these resources CHOA had several factors that they considered such as impact, equity, community linkage,

and sustainability. The aspiration of the program is for CHOA to have the resources and capabilities to fill the gap in service provision that community and existing workforce cannot. In this way, the idea that money would not all be allocated on the crisis side, but rather throughout the system, came from an article called *Addressing the Pediatric Mental Health Crisis: Moving from a Reactive to a Proactive System of Care*. Dr. Constantino explained that the article emphasizes that we must allocate resources to a proactive system. The goal is to change the entire framework of the system, which allows for sustainability.

Dr. Constantino emphasized that in addition to aspiring to create a proactive rather than reactive system the program aspires to adhere to the evidence-based interventions of the field. The program is implementing currently known evidence-based practices in clinical care to a subset of the entire population of children in Georgia and demonstrating the outcomes. The program is not concentrating on discovering or researching practices that are not already evidence based. There are several research studies that document the short-term benefits of specific evidence-based interventions, but there are no studies that follow a long-term, large-scale delivery of evidence-based practices.

The overall goal of the program is for children enrolled to be able to utilize services they already have access to and ensure that recommended therapies are equitably available to all children enrolled. Dr. Constantino shared that to do this, the program is starting with building a strong workforce which CHOA has had success with. The focus of recruitment for the program has been physicians and psychiatric mental health nurse practitioners to help the already strong complement of psychologists within the system to assemble a transdisciplinary treatment plan for each child that is enrolled.

Dr. Constantino shared three goals as part of the behavioral and mental health expansion at CHOA. These goals are to deliver a comprehensive array of high quality, medically necessary elements of care for a representative population of children with serious mental health conditions or risks, put an emphasis on each child receiving COMPLETE evidence base of the field; care is organized around individual needs of a child and his/her family (not by discipline, service line, or bureaucracy): systematic resolution of fragmentation of care; and quasi-randomization for a 60% Medicaid population within a large health system capable of epidemiologic capture of risk populations.

As the goal of the program is to organize service not around a service line but around a child and their family, the approach of the program has been organized around the population of families. Following this, the program's efforts and resources have been divided into three principal populations. Population I includes Infants & Children at risk in a primary care practice, population II includes unmet mental health needs identified by CHOA providers, and population III includes crisis recovery care for youth identified in

hospitals. CHOA has a grasp of the crisis population; about 6,000 encounters per year across 3 hospitals.

In wrapping up the presentation Dr. Constantino shared the findings from the Outpatient Mental Health program (Zalik Center) including: among the first 982 children seen through 5/1/24, there were 335 instances of medically necessary elements of the treatment plan that were unavailable; over the past year, more than 5,000 unique children presented to Children's Emergency Departments for one or more behavioral crises. At each visit, it is determined whether any of the listed evidence-based mental health treatments have ever been obtained; of 600 unique patients that had multiple visits, comprising 1200 ED behavioral crisis visits, for 20% of patients with >1 visits, none of those evidence-based services were established either time they visited. Through the Zalik Center, they have implemented Dialectical Behavioral Therapy (DBT), and they have been able to gather preliminary data on its impact. They track patients referred to DBT therapy and track what happens if they do receive services. So far in the last 6 months, there was a 15-fold reduction in the number of ER crisis encounters for the patients who received DBT services at the Zalik Center when compared to the patients who are discharged from the ED after a behavioral crisis for suicidality.

Dr. Constantino concluded by saying that they have already begun establishing an accountable care model of children's mental health within a large medical system. The program has already begun to show where the gaps in service are, and this gives a chance for the collective of the community to decide how they are going to solve these gaps.

During the Q&A portion of the presentation, Dr. Constantino shared that more people are paying for psychiatric care out of pocket out of desperation. The problem is people pay out of pocket and self-pay out of desperation when insurance doesn't have an answer for them. In mental health, some of the most competent clinicians don't take insurance because there is such a large market for self-pay. Self-pay is not the only index of mental health parity but is a very robust indication. Medicaid kids cannot self-pay ever, which makes it a breeding ground for inequity. He also shared that the goal is to switch to a systematic mandatory parity violation reporting system.

August 15, 2024

Addressing Children with Developmental Disabilities and Multiple Needs

Presentations from Heather Stanley, Program Director, Multi-Agency Treatment for Children (MATCH), Georgia Department of Behavioral Health and Developmental Disabilities, Danielle Fish, Clinical Specialist, Multi-Agency Treatment for Children (MATCH), Tanya Anderson, Executive Director, Youth Villages, Georgia, Catherine Smith, Chief Strategy Officer, Youth Villages, and Gwen Skinner, Vice President of Operations, Devereux Advanced Behavioral Health Georgia

Heather Stanley presented on behalf of the MATCH clinical team (MCT), a subcommittee of the state MATCH committee. She began the presentation by providing background information on the MATCH program. MATCH was created out of HB 1013. The MATCH clinical team is focused on providing access to care, collaboration across state agencies, identifying gaps in services, and looking for opportunities to improve those gaps.

There has been a shift in the new, reimagined MATCH because the old MATCH operated at the local level, and it was about placement rather than creative options and bringing people together to seek alternative solutions. While there are placement concerns, the focus is on creative solutions. The question is, what in Georgia would make the life of this individual better and how can the MCT creatively work around those barriers that they are experiencing?

The MATCH Clinical Team has been able to accomplish several things over the past year. They received access to funding that allowed them to create several pilots, with some still being in development. They have identified some policies and regulations that have created barriers to access. They have also identified the need for treatment options not in the current continuum. They have tried to be strategic in the gap awareness and how to create some options to fill those gaps.

The MATCH Clinical Team has been able to identify the continuum of care whether that is in-home, out of home, step down treatment options, or long-term community options. Through the use of the urgent care funds, they have been able to create several pilots as well as an emergency room pilot that is up and running. Then, there is a continuum of high-fidelity wraparound and respite options. A transition program has been created that is specific to IDD males where they can enter a short-term program, learn independent living skills and have opportunities to be independent while living in community. It is a 7-bed unit. There are 5 currently enrolled, 1 accepted, and 7 have been served in total since it began.

The emergency room department (ED) pilot, in partnership with Viewpoint health and CHOA, aims to reduce the time in an ED to provide a resource where youth can get connected and move out of those EDs.

The urgent care pilot encompasses intensive in-home, housing plus care, and a new child and adolescent temp ops (temporary observation placement) which has not been available for children and adolescents up to this point. The temp ops are for individuals who are having a crisis event, but the service does not look like a traditional hospital setting. It is an opportunity for a more welcoming and less traumatic experience when it comes to determining the level of care needed.

Some highlighted pilots include an intensive in-home therapy pilot with Wellroot that is being implemented currently which is located in the Tucker area. There is a contract pending with Youth Villages for their Intercept program. There is also a new option for adolescents that are not IDD, Positive Growth, which is an independent living plus treatment option for adolescents that are 16-21. The contract has been approved and is waiting for implementation. Several of these programs aim to serve populations outside of Metro Atlanta including the Youth Villages, Murphy-Harpst, and Positive Growth pilots. The MATCH Clinical Team has tried to not only identify the gaps in services but also identify providers that can expand their reach that are willing to serve outside of their normal catchment areas.

Heather Stanley then provided some MATCH clinical team updates. Official referrals to the MATCH clinical team began in August and 38 individuals have been seen so far. There have been over 70 Non-MATCH Clinical Team staffings attended. Some examples of non-MATCH clinical team staffings include individuals with commercial insurance, and individuals with dual diagnosis who are not demonstrating behaviors consistent with a diagnosis. There has been an increase in the average staffings with an increase from an average of two a month to an average of six a month due to an adjustment in criteria. Additionally, two new members from DOE have been identified to attend the next round of clinical team meetings. From feedback from the MATCH state committee, opportunities are being explored to provide coordination and support and working with systems that are already in place including potentially expanding the certified peer work that currently exists.

After receiving feedback, the following adjustments have been made to the MATCH criteria: The original dual diagnosis criteria have been modified to include behaviors consistent with a diagnosis in lieu of diagnosis; the age criteria were modified from 0-17 to 0-24 if DFCS or DJJ is involved; the Hospital/ED/CSU involvement criteria were modified to include individuals who can demonstrate that their current treatment options are not providing adequate support; and the Multi-system involved state agencies criteria were expanded to include safety net providers, local education agencies, LIPTs, corrections, and others.

Some preliminary trends have been observed over the past year including increased referrals that only contain Behavioral Health Diagnoses and behaviors in lieu of diagnosis

since criteria changes, increased referrals from individuals experiencing Reactive Attachment Disorder and Borderline Personality Disorder, increased need for intensive trauma-focused care, and an emerging need for in-home childcare from skilled therapeutic professionals without parent or adult supervision present. This is a form of respite, but respite is usually considered short-term, a couple of days out of the home. However, parents are looking for professionals to come and provide care while they are not there. This is still being thought through in terms of how to fill that gap. Some strategic planning opportunities include looking at long-term sustainability options and also looking at the MATCH capacity as interest and usefulness continues to grow.

During the Q&A portion of their presentation, Heather Stanley shared that all pilot projects are going through evaluation and the plan is to demonstrate that it is successful and be able to replicate it for other areas of the state so either the current provider can expand even more or replicate the programs to other areas of the state.

Tanya Anderson and Catherine Smith then presented on Youth Villages' Intercept program sharing that Youth Villages is a national non-profit organization that serves youth and families in 27 states. In Georgia, there are the residential programs and two community-based programs. Around 11,000 children are served per day with 500 of those being in the residential programs. The presentation will cover intensive in-home services and focus on prevention work.

Catherine Smith shared her personal experience with Youth Villages' Intercept program. When she first started, she had a caseload of five families which she had to see 2-3 times a week at places that were most convenient for them. She shared that one of her first families was a single mom of an adopted boy who had been diagnosed with bipolar disorder and had been hospitalized for a suicide attempt. From this family she learned that the young boy had unresolved trauma from his previous foster home that he never received services for, his mother suffered from depression and did not feel equipped to handle his physical and verbal aggression toward her nor his suicidality. She shared that from this family she learned the importance of 24-hour on call for families. After a period of about 5 months, Catherine was able to equip the mother with the skills she needed to keep herself and her son safe. With this family, she worked on repairing relationships so that the mother's community could assist her with respite, she got the mother reconnected with her church after she stopped attending, she also worked with the school to implement safety plans, she got the son involved in extracurricular activities, and lastly she got them set up with their local mental health center to obtain the ongoing medication they needed. Catherine shared that this is an example of many families dealing with hardships so difficult that traditional services cannot give them what is needed to be successful. Catherine then shared that after working with families, she started to ask questions around evaluation as she was curious if these services were working. She learned that the services do work and in addition to the internal data science department that tracks the young people a year post-discharge, three rigorous evaluations have been done. The results were as follows:

- Placement Study #1: Intercept reduced the odds of out-of-home placement by 53% following the first maltreatment investigation
- Placement Study #2: Examining a more recent sample of youth in a shorter evaluation window, intercept reduced the odds of out-of-home placement by 37% following a maltreatment investigation
- Permanency Study: Compared to a matched comparison group the odds of achieving permanency were 24% higher with Intercept.

Catherine shares the state of Youth Villages today. Youth Villages has over 36 years of experience serving more than 10,000 children and families daily and 43,000 annually. Youth Villages has 4,500 staff nationwide and 100 locations in 26 states and D.C. In expanding the Intercept program to more states, some states have used innovative policies to fund these nontraditional mental health services. Medicaid is funding Intercept programs in North Carolina, New Hampshire, Ohio, Oregon, and Tennessee. Some states are also using child welfare federal funding to cover services for families that do not have Medicaid benefits.

Dr. Lewkowiez asked if this model is similar to multi-systemic family therapy (MST). Catherine responded that it is similar. Youth Villages was the first organization to provide MST outside of clinical trials. They developed Intercept because the MST model had some specific criteria, and Intercept is able to have a little bit of a bigger impact.

Tanya Anderson shares that Intercept services have been provided on a very small scale in Georgia in partnership with DFCS since 2008. The goal is to partner with CMOs and child wellbeing agencies to do more prevention work and grow the impact in the state. They are interested in furthering the conversation about onboarding the right resources to fund other similar interventions emphasizing that it is a collective effort to get sustainable outcomes for children and families. Tanya turns it back over to Catherine to provide some policy recommendations for the committee.

Catherine shared some key considerations including creating a system that includes intensive in-home services for families that need it the most; investing in outcomes, not units of service; and keeping reimbursement simple.

She then shared some options for Georgia to explore to fund intensive in-home service models including continuing to expand services under the state's Title IV-E Prevention Plan, leveraging existing mechanisms within the Medicaid system (i.e. flexibility under EPSDT or creation of In Lieu of Service definitions), and pursuing a waiver (1115 or 1915b(3)) or a state plan amendment as a more long-term solution.

Before concluding, Catherine shared that Youth Villages offers ride alongs to meet families and hear what they need and what works for them and that Tanya Anderson would be happy to coordinate those.

Dr. Gwen Skinner presented on Devereux Advanced Behavioral Health in Georgia. She introduced her presentation by providing an overview of Devereux. The Devereux Family Standard is that the programs are the same type of programs that they would have their own families in. 40% of trustees are people who have had a relative or have themselves been in their services. Devereux was founded in 1912 by Helena Devereux. It is a nonprofit who serves 25,000 children and adults in 13 states every year. They serve behavioral health needs and lifespan services for people with Autism or another IDD. In Georgia, Devereux is known for its children's behavioral health services. Devereux has invested funding into creating a culture of safety and trust. They are accredited by Praesidium which specializes in preventing abuse in organizations that serve youth and vulnerable adults.

Devereux Georgia has over 350 employees, a diverse payer and regulatory mix, and more than 600 youth served annually in all programs. The Devereux Georgia Continuum of Care includes specialty foster care, child caring institution, and PRTFs.

The Specialty Foster Care serves youth ages 0-21 with a range of special needs. In partnership with DFCS, they are developing homes in a 50-mile radius of the campus. They recruit homes to meet the needs of children, adolescents, sibling groups who have experienced significant trauma, developmental delays, and intellectual and/or physical differences. There are select foster parents who provide respite care and monthly trauma-informed training for them.

Grace's Place is a 24-bed Child Caring Institution which serves youth ages 12-17 in the custody of DFCS. It is intended to be a 3–6-month program that accepts male/female youth that are confirmed or conditionally confirmed Commercial Sexual Exploitation of Children (CSEC). It is a secure facility and intended for youth with PTSD, trauma, anxiety, depression, and behavioral issues. The services offered include medical/psychiatric assessments and care, nursing, forensic exams and interviews on site, case management, trauma-focused therapeutic services, academic support in a fully accredited school in partnership with Gwinnett County Public Schools, life skills training, and therapeutic recreation. The building is provided by DJJ, and the contract is through DFCS. Grace's Place operates under Positive Behavioral Interventions and Supports (PBIS) and is a stage system. All staff are trained in Safe and Positive Approaches. Therapists are trained in DBT and Viewpoint provides therapy.

Within the PRTF there are 5 programs including the Discovery program which serves pre-adolescent males and females ages 10-13. The Butterfly program serves adolescent and emerging young adult females ages 14-21. The Phoenix program serves adolescent and young adult males ages 14-21. The Journey program is for young adult males aged 14-21 with intellectual differences. They are working now to develop a female counterpart

program. The program is focused on developing vocational and life skills. The newest program is Odyssey which is for 18–21-year-old males with IDD that are MATCH referred. This program focuses on community integration and emphasizes vocational and life skills. The PRTFs utilize evidence-based practices including PBIS, CBT, TF-CBT, DBT, CSEC, social skills training, substance use education, and functional behavior analysis. The education program is accredited and part of the Cobb County School system. All personnel are certified by Georgia Professional Standards Commission and all special education teachers hold dual certifications that include a content area. There are specialized courses for college and career preparation, ServSafe certification, and specialized remedial programs and support.

Family Engagement and Customer Service Excellence is an important component of Devereux as well. Devereux has family therapy, family visitation centers, financial support for food and travel to remove barriers, use of video conferencing to support family therapy and treatment planning, parent peer support research, and a full time Client and Family Advocate.

After sharing her recommendations to the committee, Ms. Skinner shared that she thinks the committee would need to sit down as a committee and discuss these recommendations and that Commissioner Tanner would be open to hearing from the committee that these are some easy fixes. They take time and they take work, but it is not like passing a law and it does not require funding. She also shared which recommendations would fall under which agency. Planned Respite and Developing Provider Reimbursement Methodology would be through DCH, Lived Experience would be convening the child serving agencies, the Enrollment Process and Foster Families Transitioning to Host Families is DBHDD. She would be happy to draft a letter and request some work on these items once the committee decides which ones we want to go after.

Increasing Access to Mental Health Services at the Community Level

Presentations from Telisha Campbell, Director of Clinical and Leadership Development Georgia Hope, Jennifer Rivera, School-Based Program Director Georgia Hope and Jennifer Hibbard, Chief Executive Officer, View Point Health

Jennifer Rivera and Telisha Campbell presented on behalf of Georgia HOPE and Health Connect America. Georgia HOPE is a private organization providing community-based services, family preservation, mental health and substance use support in Georgia for over 20 years. They provide services at clients' homes, in schools, and through telehealth. These services include mental health assessments and substance use assessments, medication services, and individual and family counseling.

They were awarded the APEX grant in 2016 allowing them to provide services in schools. They utilized the grant by serving the uninsured and underinsured students in the state with the aim of creating a partnership with the schools. Georgia HOPE aims to embed clinicians in with the school staff to remove stigma and allowing the students to feel comfortable receiving services in schools. Services include, but are not limited to individual/family counseling, skill building, groups and camps.

School-based mental health (SBMH) is important because 4 out of 5 children ages 6-17 who have mental health problems do not receive any help. Suicide is the leading cause of death among adolescents ages 5-24. 1 in 10 children have a mental health condition which impairs their function. 1 in 4 high schoolers report feelings of depression which have likely increased over the years. Major mental health conditions may occur in children as young as 7. Elementary age children with mental health needs may miss up to 22 days of instruction. Elementary age children with mental health needs are 3x more likely to be suspended or expelled. These statistics highlight why it was so important to embed services in the schools, to ensure that children are not missing as many days of school.

GA HOPE started offering school-based services in 2016 in Murray County Schools, a rural part of Georgia. They were recognized by the state as the model for early intervention services. Currently Georgia Hope has partnerships with 18 school districts/counties in GA and serves 140 schools.

To support the school-based services, GA HOPE uses a team approach – assessor, therapist, client support, and they would like to have a peer support specialist. SBMH staff are expected to serve their clients in the community during summer and winter breaks. Outcomes include 74% improvement in attendance, 75% improvement in testing, 82%

improvement in academic performance, 85% reduction in disciplinary referrals and 100% of parents surveyed agreed that their child is better at handling daily life.

In January 2020, Georgia HOPE started providing tele-mental health services right before the pandemic and pivoted when the pandemic started in March so that clients were not disrupted. A study conducted from 2006 to 2010 using outcomes of 98,609 U.S. Department of Veterans Affairs patients enrolled in tele-mental health services found that, psychiatric admissions of tele- mental health patients decreased by an average of 24.2%. Additionally, patients' days of hospitalization decreased by an average of 26.6%. The number of admissions and the days of hospitalization decreased for both men and women and in 83.3% of the age groups studied.

A study of 242 patients in rural Missouri who received both telepsychiatry plus in-person visits following an inpatient admission or an emergency department visit found that hybrid care may be more effective than in-person visits alone. In terms of access, patients were seen 7x faster and were 34% more likely to be seen 1x/month. A 2013 literature review indicated that tele-mental health is effective for diagnosis and assessment across many populations. It is effective for disorders in many settings, it is comparable to in person care and increases access to care.

A 2017 literature review also highlighted the benefits of tele-mental health including how it has multiple capabilities and technologies even for those who are not comfortable with technology.

Georgia HOPE advocates for tele-mental health in schools due to there being a lack of qualified clinicians in certain areas especially the rural areas; there are multiple types of schools with varying needs; there is a need for specialized therapists, including bilingual therapists; there is a need for family engagement which is more feasible with tele-mental health options; and lastly for transient populations.

Comparison Data was collected by Georgia HOPE pre-implementation of teletherapy (July 2019-August 2019) and post-implementation of teletherapy (July 2020-August 2020). The data showed that clients received an intake appointment 70% quicker than pre-tele therapy and there was a 10.5% increase in clients receiving services. After intake, clients received a therapist or Community Support Services (CSS) 73% more quickly.

In one SBMH county, an on-site therapist was lost due to re-location but was able to remain available through teletherapy and was able to continue services with the same children. Prior to this, the school was resistant to the use of teletherapy, however they were able to see the benefits of the continuation of care.

Pre-implementation of teletherapy, Georgia HOPE served 8 students in one school system and post-implementation Georgia HOPE was able to serve 125 students. Due to that county's openness to teletherapy, several other county's followed suit when COVID forced the closure of many school systems. In another county following the COVID school shut down, 171, or 60%, of their students continued to be seen by their therapist or CSS. They were also able to implement virtual groups.

Some benefits of tele-mental health include that it brings care to patients and allows for children to be served when absent, reduces travel time which is relevant for those who do not have access to transportation, improves satisfaction with healthcare costs, reduces delays in care, enables continuity in care by giving children the opportunity to be seen by the same therapist, reduces stigma, improves coordination of care, and increases access to bilingual services, specialists, and licensed clinicians. There is also potential for decreasing the costs of services. The goal is to provide service without being a financial burden. Additionally, it increases family engagement as it is often a barrier if the parent cannot leave work to attend their child's appointments; tele-mental health makes this convenient for them. However, telehealth is not appropriate for every child (high risk, ADHD, etc.). There is concern over managing crisis situations via telehealth in which they need to be moved to a secure location. In-person connection also proved to be a hurdle because if they do not see you, they do not become invested in you and trust may not be built. There was resistance from some school districts who feel like children rely on technology too much. However, it can be proved that telehealth is beneficial.

During the Q&A, Dr. Lewkowiez noted that there is a concentration of providers in the metro area. Rural parts of the state suffer the most. This is a way to see patients without having to make a long drive or fly. A lot of families do not have the transportation to transport their children to appointments. Transportation is one of the first things that will hit you when you are in poverty. There is not a lot of public transit in rural parts of Georgia. He is not sure what we can do to help with resistance from schools, but it seems like a reasonable way to bridge the distance from where the providers are and where the students who need to be seen are. He thinks kids with developmental disabilities are sometimes difficult to evaluate on telehealth and some of the younger kids have a harder time, but adolescents do just fine. He then asked if the presenters had any thoughts about how to decrease the reluctance of schools to which they responded that educating them on how technology is used in tele-mental health services, so they understand that kids are not just staring at a tv. The other resistance they have is the staffing component. There is a concern that kids cannot be in the room by themselves, and we have to abide by HIPPA, but they cannot staff someone to be with the children. Also, showcasing success stories at different schools. When the newer generation enters the workforce, they might be more open to it.

The presenters also shared that all 140 schools have the option of tele-mental health. Some are staffed with individuals, but every MOU has the option, and it is discussed per school. The APEX providers are the ones providing the telemental health. They also shared that there is an issue with staff turnover. Pay is often an issue. People get into the field with a misunderstanding of how much you are supposed to make as a therapist right out of school which comes into play.

Jennifer Hibbard, CEO of View Point Health then presented on the CCBHC model. CCBHCs serve all ages including children and adolescents. A CCBHC is not only a new Medicaid provider type, but a new way of delivering behavioral health care. For the first time, there is a federal definition of community-based behavioral health care. There has been a long history of institutionalizing individuals with behavioral health needs, however, in the 60s there was a big movement to change that and move individuals into the community. It was not until 2014-15 that a federal definition was created for how to provide community care. Having a federal definition creates a standard that must be met, as the important word in CCBHC is "certified." Standards ensure access to care and stringent criteria that is consistent and common among all CCBHCs nationwide. CCBHCs use a funding mechanism called a prospective payment system, and it requires collaborative partnerships. Meaning the CCBHC has core services that it has to offer but is required to collaborate with primary care, law enforcement, education, social services, etc.

In 2014 CCBHCs were established through the Excellence in Mental Health Care Act. In 2017, there was a demonstration program where 8 states joined to implement CCBHCs in their states. In 2018, SAMHSA released planning grants for states to apply to work on becoming a state that would offer a CCBHC. In 2020, two more states were added to the demonstration. Georgia entered around 2020 when DBHDD and several community organizations received planning grants. Currently, there are 500 CCBHCs and grantees in 46 states. Georgia does not yet have operating CCBHCs, however there are several SAMHSA planning grantees.

There are nine required CCBHC services including 24/7 access to crisis care, outpatient mental health and substance use services, person and family centered treatment planning, community-based mental health care for veterans, peer family support and counselor services, targeted case management, outpatient primary care screening and monitoring, psychiatric rehabilitation services, and screening diagnosis and risk assessment.

To indicate the difference between Community Service Boards (CSBs) and CCBHCs, an example scenario was provided. "Mary" is an adult and hears voices and does not know where to get help. She starts taking a prescription opioid to try to help which turns into an addiction, then overdoses one day. Emergency responders are called, and she is revived and transported to the local emergency department. She is discharged from the hospital and given an appointment to a local provider and recommended medication assisted

treatment. She goes to the referral, but they do not offer this service, and she is referred again to somewhere 2 hours away. One day she is in a mental health crisis in public and the police are called, and she is put in jail. She is referred for substance use treatment but there is a 6-week delay. She continues in this cycle of crisis, ED, jail, etc. In a CCBHC model, instead she could be contacted by a care coordinator that is employed by the CCBHC that works for the hospital, and she could be followed up with because she had been prescribed opioids. They could offer a same day appointment at the CCBHC in which transportation would be provided. Most CCBHCs will provide medication assisted treatment and she will also be screened for mental health issues. She is connected to a psychiatric treatment facility then upon discharge she is connected to ensure she has what she needs to be stabilized and maintains her treatment. This transforms the way behavioral health care is delivered in Georgia.

There are several key differences between traditional mental healthcare delivery models and CCBHC Services. Nationally, the traditional mental healthcare delivery model suffers from adequate access to care with low reimbursement rates, workforce shortages, an inability to recruit and retain staff, and limited capacity to meet the demand for treatment resulting in clinics turning away patients or placing them on long waiting lists. Conversely, CCBHCs are required to see everyone regardless of payer source or location and nationally, 100% of CCBHCs have hired new staff to meet the demand for treatment. Traditional service delivery models also suffer from long wait times. CCBHCs are required to provide same-day access to services where the national average is 48 days from referral to intake. Another key difference is the use of Evidence-based practice (EBP). EBP is not required in traditional delivery models and there is no guarantee of high quality, comprehensive care. CCBHCs, however, are required to utilize EBP and provide a comprehensive array of services including 24/7 access to crisis care, integrated health care, care coordination, medication assisted treatment, and peer/family support. 36% of substance use facilities offer medication assisted treatment (MAT) but 92% of CCBHCs offer MAT. Lastly, traditional delivery models are usually grant funded or fee-for-service where CCBHC is a prospective payment system which is a sustainable model that is not reliant on grants. In Georgia, due to limited resources, a large portion of funding goes toward crisis services. The CCBHC model is trying to move the needle towards prevention services in hopes of lowering crisis services needed.

Georgia is the second worst in the nation for access to care due to a volume-based payment system, driven by funding and overly focused on acute needs. With a CCBHC model Georgia will have integrated, whole-person care, value-based payment, driven by local needs, and a prevention focus.

October 24, 2024

Mental Health Systems; Infant and Maternal Mental Health; Psychological Services for Medicaid Children and Families

Presentations from Roland Behm, Managing Director, Co-Founder, Mental Health Policy Partnership; Arianne Weldon, Strategic and Innovation Manager, Georgia Family Connection Partnership; Kathi Frankel, Community of Practice Facilitator, 2Gen Family Integrated Care; Dr. Whitney Kleinert, Therapist; Dr. Susan McCarthy-Furman, Adjunct Associate Professor, Department of Psychiatry and Behavioral Sciences, Emory University

Roland Behm started by providing background information sharing that mental illness is a chronic condition of youth. Half of all lifetime mental illnesses begin by age 14, three-fourths begin by age 24. In Georgia, there is a clear and present danger in which almost half the students who took the GA Student Health Survey for the 2023-2024 school year felt depressed, sad, or withdrawn at least once in the preceding thirty days, and 37,326 had those feelings for all thirty days. 240,445 of the students experienced intense anxiety, worries or fears in the past thirty days, 176,653 of the students experienced severe mood swings in the past thirty days, 123,477 of the students avoided food, threw up or used laxatives in the past thirty days, and 38,000 of the students attempted suicide one or more times in the past 12 months. There are actions that need to be taken that differ from what has been done so far.

Mr. Behm then summarized four aspects of his presentation including the Directed Payment Model, Digital Platforms, Single Session Interventions, and Costs and Funding. Single Session Interventions are scalable solutions to the youth mental health crisis and are able to be accessed via digital platforms or by human interactions, it is embedded into spaces where youth seek help and is integrated with paths to further support. Broadening the workforce by using non licensed providers. Some of this will conceivably be funded by Managed Care Organization (MCO) tax and Medicaid in lieu of services, and Health Related Social Initiatives, HRSIs, that work with CHIP.

Transforming mental healthcare for GA's children means structural reforms that address the challenges of finding, accessing, and receiving high-quality, appropriate, and timely care.

The areas that the presentation will look at are funding, workforce, ecosystem, and public information. Putting this forward for consideration to see how they all interact and interrelate. Improving the mental health of Georgia's children is a consorted effort that will involve many people, organizations, and groups.

Georgia's future is a direct payment model for Medicaid care and what it does is looks to schools to become mandatory providers for payers, it looks to eliminate bottlenecks to accessing mental healthcare, it enables providers to receive payments from payers even if they are not in network, it introduces competition at the provider level, and it uses a third-party administrator (TPA) to serve as a mandatory statewide clearinghouse for claims management and payment remittances, provide support to schools to ensure compliance with state and federal requirements, centralize network oversight, and function as a parity enforcer by challenging most denials. Schematically, the third-party administrator plays a key role. There is an intersection between schools, providers and payers.

The statewide multi payer fee schedule constitutes a fundamental shift in ensuring access by Georgia's children to mental and behavioral health care, a shift that is needed due to existing access structures failure to provide medically necessary mental health care. The fee schedule will establish a set of necessary school-based behavioral health services of which insurers and MCOs must provide reimbursement. The fee schedule will list minimum reimbursement rates, appropriate billing codes, and provider types for each service. Services provided as part of the fee schedule shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.

The fee schedule purpose is to define the scope of covered services, identify applicable billing codes and rates, and specify provider types that are eligible to bill.
Mapping the fee schedule to services could look like a graph with the vertical axis being five levels including service intensity going from low to high and the horizontal axis representing cost per unit and level of autonomy going from low to high.

The idea behind the fee schedule benefits is that it increases access to a variety of school-linked behavioral health services, eases administrative complexities for schools by streamlining processes and requirements and applies to multiple payers.

The TPA will serve as a mandatory statewide clearinghouse for claims management and payment remittances and provide support to schools to ensure compliance with state and federal requirements, centralize network oversight including certain functions necessary to ensure the integrity of the program, and establish common credentialing processes and policies for use statewide. The TPA will also enforce parity compliance by appealing coverage denials, providing data to relevant regulators and publicly posting data. The goal is to appeal each and every time because the goal is to get as much care as possible. If there is a system to make it cost free the payers will be less likely to deny claims because they know they will be faced with an appeal. Each appeal will cost them time and money. The data will be available to the public so that when Georgians are making decisions about which provider to choose, they can understand which ones are complying with parity.

Mr. Behm responds to a question asking why not include all healthcare providers? He shares that in a sense all healthcare providers can be included because they can come under the schools, but they cannot make all providers mandatory providers. It can be done for schools under Medicaid and under the ACA, but it cannot be done for providers themselves. The goal is to sweep all providers under the umbrella of the schools as mandatory or essential providers.

This is not something that can be done overnight, it is a 3-4 year process to get it up and running. A series of one-time investments enabling educational entities to build the necessary capacity, infrastructure and partnerships needed to achieve a long-term and sustainable funding model. The funding aims to improve fee-schedule readiness and expand access by increasing the availability, equity and range of behavioral health services, and growing capacity through training and development of infrastructure. Setting up schools to have the capacity to implement things like youth peer-to-peer programs, and student services including a network of members across all counties to provide training and resources to educators.

Single session interventions will be part of this overall focus on enabling treatment for more students. SSIs are trying to address the problem of the up to 80% of youth with mental health needs who are not receiving services for any reason. A lot of students who cannot get services through normal avenues can get access through SSIs that have shown a path toward improving accessibility, cost effectiveness, and completion rates for evidence-based youth mental health services. The clinical benefits include high acceptability, and cost effectiveness of SSIs which make them a common-sense mental health safety net. It can also be used for youth that are on waiting lists to receive care in the meantime to reward those who do reach out for help. The SSIs will be available on digital platforms and should be available through human interaction such as through someone at school, community centers, etc. Individuals do not need to be licensed and can be community health workers, peers, etc. Some people will want human intervention and others will not. The idea is to make it available where and when it is convenient for youth.

Research strongly supports the effectiveness of SSIs. There are benefits to youth, creating a universally-accessible 24/7, evidence based mental health support platform, embedded into spaces where youth already seek help, which will greatly benefit youth across demographics and geography. There are also benefits to schools in that schools are uniquely poised to connect youth with the very kinds of resources to which they lack equitable access through other avenues.

The existing examples of SSI interventions include the ABC Project, Project Body Neutrality, Project Personality, Project RISE, Project SAVE, and single session consultations. This is a library of interventions that would continue to grow over time as continued effectiveness can be demonstrated.

To fund this program, Georgia could implement CMO tax funding. A tax aimed at Care Management Organizations that would require CMOs to pay a hypothetical $2 billion to the state each year for a period of 3-4 years. The CMOs would be financially neural since the tax is reimbursed by state and federal Medicaid funds. This is not Medicaid expansion; other states are accessing funding that can be available to Georgia as well.

Health services initiatives (HSIs) funding works off of the Children's Health Insurance Program (CHIP), in which a percentage of CHIP funding can be used to address certain things. The benefits of the HSIs are that while it is focused on CHIP recipients, it can also be used for broader groups of people including all students.

"In lieu of services" (ILOS) funding is a flexible wrap-around Medicaid-funded service that Georgia can integrate into its population health strategy. These services are provided as a substitute for, or for the avoidance of, other covered higher cost/higher intensity services such as ER utilization, a hospital stay, skilled nursing facility admission, or a discharge delay. It is limited to 5% of overall Medicaid spending which is equal to $700M in Georgia.

The digital platforms are Closegap and Koko which interact with SSIs. Closegap is a nonprofit that provides a digital platform designed to support children's emotional well-being through daily emotional check-ins and mental health resources. It aims to empower children by giving them a tool to express their feelings and helps educators and caregivers identify kids who might need additional support. The platform is used in schools, afterschool programs, and community organizations. The benefits include early intervention, emotional literacy, empowerment, and support for educators to monitor the emotional climate of their classrooms. We need to ensure that there is as much available care as possible and we need to have as many options available to us.

Koko is a digital platform that provides AI-driven, peer-to-peer emotional support. It leverages AI and crowd sourcing to help individuals navigate mental health challenges by offering real-time, solution focused guidance in a brief, anonymous, and accessible format. It works by the user submitting a concern, receiving peer support, AI enhancement to help filter and improve responses, suggesting supportive language and refining advice to make it more helpful and empathetic, and a feedback mechanism in which users fate the responses they have received, helping to create a positive feedback loop and improve the quality of the support offered on the platform.

We do not need Georgia to say yes, we can do digital SSIs, it is available to anyone. What we want is for Georgia to get on board so we can integrate local resources into the digital platforms. It would probably take $6-8M to get this up and running in Georgia. These are one and done costs so we could conceivably have these services available within 12-18 months.

In terms of additional ecosystem elements, one of these builds on Children's Healthcare of Atlanta's (CHOA's) work on outpatient suicide intervention. CHOA is finding that the program is working out very well. This builds on that model but sets it within a school district. School-based outpatient suicide intervention provides more effective, less traumatic, and less costly treatment for suicidal persons by substituting outpatient care for ED admission and subsequent hospitalization. After the startup costs, it is self-funded. This intervention is significantly less expensive than a visit to the ER. School districts in large cities could consider this and make it available through telehealth for the more rural areas. Through telehealth it is equally as effective.

Another additional ecosystem element is dyadic services, which should be considered in terms of supporting children 0-5 and their caregivers. It uses an integrated approach that enables early screening and treatment of behavioral health conditions, and addresses trauma before it escalates. By involving the entire family, it also screens for broader health and social issues.

Another one is an eConsult platform for integrated care which connects pediatricians, primary care physicians and other providers to behavioral health professionals to receive consultation and guidance when providing behavioral health care. Ideally, this would be a public-private partnership in which a state agency partners with someone like CHOA for example, to provide synchronous behavioral health consults and warmline support.

There is widespread and material noncompliance with parity obligations by health insurers and Medicaid care management organizations. It is reflected in out-of-network frequency, in which Georgia's children are 10x more likely to have to go out of network for mental health care, and low reimbursement rates which are a large reason for Georgia's inadequate provider pool.

The low reimbursement rates data comes from a study published in April of this year and is specific to Georgia. For example, Georgia is the worst in accessibility of sub-acute residential mental health care treatment. In Georgia, accessing physical care is 103x more likely than on the mental health care side.

Lastly, it should not be as hard as it is to get an appointment with a provider, so there should be an online appointment scheduling and compliance tool that will provide regulators with near real-time measures of insurers' compliance with their network adequacy obligations. This also creates a public facing score card of insurers' compliance with network adequacy requirements which will enable Georgians to make educated decisions when selecting health insurance plans. Then on the backend, there should be an automated online claims denials appeal process that will make it easy to make claims denials by health insurers and Medicaid care management organizations. Significantly less

than 1% of coverage denials are appealed, notwithstanding more than 40% of appeals being successful. The data generated by the automated appeal tool should be a material element of the state's parity compliance process, including the online public posting if the numbers of denials, appeals, and appeal results per health insurer or CMO.

November 7, 2024

Youth Mental Health Systems Change; School Based Behavioral Health; Addressing Gaps in Therapeutic Services for Children and Adolescents

Presentations from Alex Briscoe, Executive Director, Public Works Alliance, Bonnie Hardage, Executive Director, Jesse Parker Williams Foundation and Co-Chair, Mental Health Funders Collaborative, Ebony Johnson, Senior Director, Brighter Future, United Way of Greater Atlanta and Mental Health Funders Collaborative, Eve Byrd, Executive Director of Mental Health, The Carter Center, Dimple Desai, Senior Manager, Voices for Georgia's Children, Mary Kathryn Velazquez, Staff Attorney, Georgia Appleseed Center for Law and Justice, Emily Anne Vall, Executive Director, Resilient Georgia, Dr. Jordan Murphy, CEO, the Center for Interrelational Science and Pediatrics

Alex Briscoe shared that their initial charge was to help a group of 40 funders in Georgia understand the youth mental health crisis and the actions that can be taken to address it. Mental health and substance use disorders are the leading causes of disease burden in the U.S. This is a uniquely American phenomenon, and this crisis has been growing for youth. Before the pandemic, there was a 104% increase in inpatient visits for suicide from 2006-2011. There was a 50% increase in mental health hospital days between 2006-2014. After the pandemic, there was a doubling in emergency department utilization. One in four young adults between 18 and 24 say they have considered suicide because of the pandemic.

The numbers are higher for rural children. 75% of Georgia's counties are rural. One in three rural children grow up in poverty. 40% of Georgia's counties have no pediatrician.

Pathology is not driving the youth mental health crisis, adversity must be addressed. It is possible to reimagine mental health as a support for healthy development. There is a growing understanding of social determinants of health (SDOH) and adverse childhood experiences (ACEs). Understanding those two factors is important to understanding the recommendations.

Georgia leads the nation in many things related to addressing mental health including creating HB 1013, peer support specialists, non-law enforcement response to mental health, and the APEX program.

Other accomplishments include that school nurses are learning how to bill Medicaid, more providers are being trained in child parent psychotherapy (CPP), CSBs are converting to CCBHCs, and DBHDD conducted a rate study.

There is a real opportunity to address a crisis in the lives and experience of children and families. Public opinion, policymaker and philanthropic agendas are aligned making a tremendous opportunity to do things at scale. Public systems hold the key to change, specifically Medicaid.

When talking about Medicaid we are talking about children. In Georgia, 53% of children are covered by Medicaid and CHIP. 69% of participants in Medicaid are under 18. Children in rural Georgia are enrolled at almost double the rates. Children have unique access to federal matching dollars in that they do not have to be sick to access care. Medicaid guarantees access to care for children through EPSDT. Georgia's EPSDT screening and referrals have improved dramatically in recent years on physical health but not mental health.

Three CMOs provide Medicaid coverage for children. These contracts are up for re-procurement.

The recommendations are developed from informant interviews, focus groups, feedback and interaction, recommendations for philanthropy and partners. Advocates, providers, public systems, and philanthropy were engaged.

Georgia has a "last mile" problem. Georgia's efforts are not reflected in reimbursement policies and practice from the CMOs. Three CMOs provide Medicaid coverage for children (these contracts are currently in re-procurement). Too many things are left up to the CMOs and there is no consistency in terms of required investment.

Ebony Johnson introduced the Mental Health Funders Collaborative (MHFC). MHFC was founded in 2016 and is a group of 40 funders from family, community, and corporate foundations committed to improving Georgia's mental health system.

During the Q&A Mr. Briscoe shares that the crisis is a uniquely American phenomenon because in 2009 the internet was made available on mobile platforms which brought things to young people before they were ready for them (political discourse, school shootings, violence) and this created a feeling of a lack of safety. Young people were taught toxic messages before they could understand them. Guns are made increasingly available as well as access to substances.

He also addresses a question asking if CCBHCs could be a way to thread through all of their recommendations. He shares that the conversion to CCBHCs is going to be tough. Not every CSB is going to be ready for the conversion. Providers will double or triple revenue if they are converted to CCBHCs. FQHCs are the sleeping giant of childhood mental health system. Yes, it should lead to a significant expansion in care because providers can live off of the reimbursement they are getting.

He then spoke more about the importance of later mental health treatment by reducing requirements for diagnosis stating that in high acuity settings, youth were not seriously mentally ill but lived through traumatic circumstances. If we were able to help them through the challenges of their lives earlier, their mental health challenges would not have gotten as serious.

Next, the committee heard from the School-Based Behavioral Health Collaborative. The collaborative involves the Carter Center, Georgia Appleseed, Resilient GA, and Voices for Georgia's Children. They were founded in 2018 with the vision of making School-Based Behavioral Health (SBBH) as common as the school lunch.

The SBBH Collaborative achievements include hosting regional forums across the state to gather experts and stakeholders to understand the needs and next steps in school mental health programs across the state, providing technical assistance to communities to begin new school-based programs through partnership with FQHCs and CSBs, creating data-driven resources to promote program models, funding opportunities and best practices, supporting policy priorities that advance SBBH across the state, and launching a website, schoolbasedbehavioralhealth.org, as a resource to schools, providers, and community advocates.

The SBBH Collaborative is data driven and has a data mapping tool. Data are presented in a geo map and are organized by state, region, county, and school district. It includes data related to SBBH programming, student achievement and wellness, risk and protective factors. The data sources include county-level census data, school data from the Office of Student Achievement and the Georgia Student Health Survey, and American Community Survey data. The behavioral health geo map identifies the number of counties implementing select state and federally funded SBBH programs and informs identification of areas needing support and services. The data can be utilized to inform programmatic planning and funding allocations. This tool supports data-based decision making but it is important to understand communities in their context. The education map identifies the percent of 6-12th grade students who reported having seriously considered attempting suicide in the past 12 months and informs identification of areas needing targeted support and services. This data is utilized to inform programmatic planning, and targeted curricula for suicide prevention, funding allocations and identification of community partnerships. There are nuances to the information that the committee is working on visualizing. The goal is to also understand what these trends look like at a regional level.

There is an increased interest in expanding SBBH. The Speaker of the House and the State Superintendent have expressed interest in this.

The different models of SBBH include school community partnership, which can range from single services to full service, GA APEX programs, screening and referral services, and an in-house full-service model.

During the Q&A Dimple Desai addressed a question asking how much of the APEX cost is covered by CMOs. She shared that it is her understanding that it is 60-70%. With other models, workforce has been a challenge and continues to be with the APEX model. The data has trended a little bit differently in recent years.

Regarding telehealth, she shares that APEX is getting ready to do a telehealth pilot. During the pandemic providers had to scramble to move to providing virtual services which positioned them well to get comfortable with the technology and some of the things that you don't think about such as connecting students to physical services if they need it. Also, there is indication that the program has evolved to the world post-COVID.

Finally, the committee heard from Dr. Jordan Murphy, the CEO for the Center for Interrelational Science and Pediatrics.

The Center for Interrelational Science and Pediatrics does training, professional development, and research to help address gaps in care. Dr. Murphy grounds the presentation in the families that she serves which are individuals who are high risk and have experienced high adversity, trauma, homelessness, incarceration, and other ACEs. We need to work to address any gaps in the system and also adapt as the needs of children are changing.

Suicide and homicide rates have increased among young children. Firearms are now the number one cause of fatality for young adults. There was a 62% increase in suicide from 2007 through 2021 with the largest annual increase from 2016 to 2017 at 10%. There was a 60% increase in homicide in 2014 through 2021 with the largest annual increase from 2019-2020. So, these trends were being seen before the pandemic and were exacerbated after. These trends represent missed opportunities to be supportive.

In 2023, 13% of female and 6% of male high school students attempted suicide. Females more often attempt suicide and males more often complete suicide. There needs to be effort to reimagine the system to reach those who have attempted suicide, so they are not added to the mortality statistics.

The 2023 Youth Risk Behavior Survey recognized areas of improvement including a decrease in persistent feelings of sadness or hopelessness between 2021-2023 from 42% to 40%. There are still areas of concern including being threatened or injured at school, being bullied, and missing school due to safety concerns. A total of 20% considered suicide and 9% attempted suicide one or more times.

Georgia ranked 49th in access to mental health care, 47th for workforce availability and 44th for youth with depression who did not receive treatment. In Georgia, 150 to 159 counties have inadequate access to care.

Dr. Murphy emphasizes that in Georgia, there is an imbalanced focus on treatment rather than prevention.

In addition to provider shortages and gaps in availability of care, there are groups of youth who are not positive that they can safely interact with the system including youth who have concerns related to family stress, safety, perception of need, or communication.

To address therapeutic gaps in care for Georgia's children and adolescents, the center wanted to figure out ways to put more support into prevention and utilize and introduce wellness skills across the spectrum as early as possible so focusing on the 0 to 5 age group. The steps that have been taken to make that happen include:

Step 1) Ask youth how they would like to receive therapeutic support.
Youth were asked and responded with relatability, trust, skills, and location.
Step 2) Utilize wellness focused therapeutic interventions that can be used in a peer-to-peer approach that are accessible, low cost, and tiered.
Some of the modalities include the Community Resiliency Model in which clients learn about the biology of the nervous system, how our body normally responds to stress and six wellness skills that can help to reset the natural balance of the nervous system. Another is Cognitive Behavioral Therapy which is widely utilized and evidence based.
Step 3) Implement and measure outcomes.
Some questions that youth had were how do I know when to get help and does therapy actually work?

A measurements-based care outcomes approach can be used to address gaps in care and measure and see improvement. This consists of three key factors including routine check-ins, shared learning of data, and collaborative readjustments.

During the Q&A, Dr. Murphy shared that the use of peers makes the training more interactive and also benefits the group to see their peers teaching them about stress responses and using appropriate language.

Dr. Murphy answers a question asking if the Community Resiliency Model is something that is taught. She shares that it has been taught in GA for about 8 years, but it is actually a global model and because it is so adaptable it is appropriate for different cultural groups. There are a lot of trainers at Grady hospital and community organizations.

Dimple adds that the Community Resiliency Model has been implemented in some of the school-based initiatives as well and it is really diverse in settings.

Recommendation Priorities

The Subcommittee on Children and Adolescent Behavioral Health identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

1. Encourage all Georgia Community Service Boards to adopt the Certified Community Behavioral Health Clinic (CCBHC) model that is designed to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age – including developmentally appropriate care for children and youth.
2. Expand the Apex program to more schools throughout Georgia. In addition, provide and expand access for telemental health access in schools and consider expanding the Apex program reach to rural areas by use of telemental health as part of a plan to expand School-Based Behavioral Health services.
3. Expand implementation of family integrated relationship-based care with families of infants admitted to a neonatal intensive care unit (NICU) by investing in the Regional Perinatal Center Outreach Educators, coordinated by the Georgia Department of Public Health, to provide evidence-based training, technical assistance, and mentorship for staff to implement and sustain evidence-based practices for fostering developmentally attuned environments and emotional regulation.
4. Add Dialectical Behavioral Training (DBT) to the Georgia Department of Education's Mental Health Awareness Training program as part of a plan to expand School-Based Behavioral Health services.
5. Provide additional and more accessible professional development training and technical assistance for community mental health workers, peer support specialists, paraprofessionals, and health care providers and expand implementation of NICU peer-to-peer support for all families with a priority focus on families experiencing substance use disorder.[1]

[1] *Community Mental Health Workers*: Trauma-Informed Care: training on how to support individuals with a history of trauma, particularly those facing mental health and substance use challenges; substance use disorders (SUD); education on understanding, identifying, and managing SUD within families; cultural competency: ensuring services are culturally relevant and sensitive to diverse populations; case management skills; tools for coordinating care and connecting families to additional resources. *Peer Support Specialists*: facilitation of Peer-to-Peer support: techniques for guiding discussions and support groups, especially for families in NICUs or dealing with SUD; crisis Intervention: skills to assist individuals or families in immediate crisis; motivational interviewing: helping families find internal motivation to overcome challenges, particularly related to substance use; boundary setting: training on maintaining professional boundaries while providing empathetic support. *Paraprofessionals*: foundational knowledge in mental health; basic understanding of mental health disorders and the impact on families, especially in NICU or SUD contexts; communication skills: how to effectively communicate with individuals under stress or trauma; knowledge of how to direct families to appropriate professional services or support networks. *Health Care Providers*: screening for SUD; training on using tools to detect substance use in families, including mothers and caregivers; family-centered care in NICU; providing emotional and psychological support for families with NICU infants, with a specific focus on those affected by SUD; integrated behavioral health care; how to incorporate mental health and substance use services into routine medical care.

6. Address the provider licensing issues that cause delays and negatively impact the mental health workforce. Specifically, amend Georgia's Medicaid State Plan to allow licensed psychologists who are Medicaid providers to bill for services provided by doctoral psychology interns and postdoctoral residents who are under their supervision; and develop, retain, and expand the workforce by increasing access by supporting existing MH staff, streamlining processes for paneling and credentialing, and expanding provider classes.
7. Provide flexible spending rates for Psychiatric Residential Treatment Facilities (PRTF) and Child Caring Institutions (CCI) that will allow intensive and child-centered services and management for a wider spectrum of needs.
8. Establish higher pay rates for Behavioral Health providers who work with children and adolescents. Specifically, address practice and reimbursement barriers for mental health services delivered by primary care providers and social determinants of health and replicate what DBHDD is doing to professionalize Intellectual and Developmental Disabilities (IDD) direct care staff by adopting a provider reimbursement methodology that is used on a routine basis to ensure provider rates are sufficient to support professionalizing BH direct care staff.
9. Require CMOs to reimburse obstetric and pediatric providers for maternal mental health screenings and referrals from the prenatal to postpartum period.
10. Streamline the current multi-step provider enrollment process.

    a. Adopt continuous enrollment rather than having windows of opportunity.
    b. Create an expedited approval process for providers already contracted for services by state agencies.

The Children and Adolescent Behavioral Health Subcommittee identified the following recommendations as priorities needing additional study for future consideration.

1. Allow approved DFCS foster families serving IDD youth to transition to DBHDD host homes as the youth age out of foster care and still require their residential setting.
2. Require the child serving state agencies to revise the process for criminal background checks to allow for reciprocity when not legally prohibited. This would eliminate the time and expense required to get the identical checks for different agencies.
3. Modify the waiver request process for difficult to fill positions allowing additional flexibility such as a broader range of acceptable experience and/or educational background.
4. Develop a process to request permission to hire persons with lived experience who may have backgrounds with substance use/criminal behavior and are living a life of recovery.
5. Add planned respite as an option for outpatient services.
6. Invest in and collaborate with digital platforms that are offering Single Session Interventions to integrate local Georgia resources into the platforms.

A full list of recommendations is included in the appendix of this report.

More detailed notes from each of the 2024 Presentations can be made available upon request. Please contact Dr. Ann DiGirolamo (adigirolamo@gsu.edu).

BHRIC Child and Adolescents Subcommittee Full Recommendations List (2024)

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations	Notes	Alignment with Past Recommendations	Alignment Across other Committees/Workgroups
Addressing Children with Developmental Disabilities and Multiple Needs	Streamline the current 59-step provider enrollment process a. Adopt continuous enrollment rather than having windows of opportunity b. Create an expedited approval process for providers already contracted for services by state agencies			X		Facilitating agency-DBHDD		
Addressing Children with Developmental Disabilities and Multiple Needs	Allow approved DFCS foster families serving IDD youth to transition to DBHDD host homes as the youth age out of foster care and still require their residential setting			X		Facilitating agency-DBHDD, DHS		
Addressing Children with Developmental Disabilities and Multiple Needs	Require the child serving state agencies to revise the process for criminal background checks to allow for reciprocity when not legally prohibited. This would eliminate the time and expense required to get the identical checks for different agencies			X		Facilitating agency-DBHDD, DHS, DJJ, GBI		Workforce and Systems Development
Addressing Children with Developmental Disabilities and Multiple Needs	Modify the waiver request process for difficult to fill positions allowing additional flexibility such as a broader range of acceptable experience and/or educational background			X		Facilitating agency-DHS/ORCC		
Addressing Children with Developmental Disabilities and Multiple Needs	Develop a process to request permission to hire persons with lived experience who may have backgrounds with substance use/criminal behavior and are living a life of recovery			X		Facilitating agency-DBHDD, DHS, DJJ		
Addressing Children with Developmental Disabilities and Multiple Needs	Replicate what DBHDD is doing to professionalize IDD direct care staff by adopting a provider reimbursement methodology that is used on a routine basis to insure provider rates are sufficient to support professionalizing BH direct care staff			X		Facilitating agency-DBHDD, DHC, DCH, DJJ		
Addressing Children with Developmental Disabilities and Multiple Needs	Add planned respite as an option for outpatient services		X	X	X	Facilitating agency - DBHDD, DHS		
Addressing Children with Developmental Disabilities and Multiple Needs	Increase access to intense trauma focused care (residential and community-based) for 18-21 year old adults and children in state		X	X	X			
Addressing Children with Developmental Disabilities and Multiple Needs	Add Dialectical Behavior Therapy (DBT) training to the Georgia Department of Education's Mental Health Awareness Training program as part of a plan to expand School Based Behavioral Health services.		X	X	X			
Addressing Children with Developmental Disabilities and Multiple Needs	Increase planned and crisis respite options for non DJJ/DFCS involved youth		X	X	X			
Addressing Children with Developmental Disabilities and Multiple Needs	Create/expand in state residential services for IDD/ASD diagnosed youth and/or those with co-occurring complex medical issues		X	X	X			
Addressing Children with Developmental Disabilities and Multiple Needs	Increase or expand intensive community-based therapeutic services; lack of availability of Intensive Family Interventions (IFI) across the footprint of the state		X	X	X			
Addressing Children with Developmental Disabilities and Multiple Needs	Expand minimum and maximum age ranges for PRTFs.			X				
Addressing Children with Developmental Disabilities and Multiple Needs	Expand age ranges/services for ASD crisis services (CSU and crisis homes).			X		Context from presenter: 6 years old is the youngest minimum age requirement with other's having older age requirements, therefore it is hard for younger aged children to find beds as parents. It is also difficult for the 18-21 year olds, particularly if they are their own legal guardian.		
Addressing Children with Developmental Disabilities and Multiple Needs	Increase access to services for infant and early childhood especially as it pertains to Reactive Attachment Disorder (RAD) and attachment disorders		X	X	X			
Addressing Children with Developmental Disabilities and Multiple Needs	Increase access to specialized care for individuals exhibiting inappropriate sexual behaviors		X	X	X	Context from presenter: There are 10 beds at the CSU for ages 10-14 and six beds for ages 10-17 at the crisis homes. In addition to expanding the age range, there is a need to increase the number of beds available.		
Addressing Children with Developmental Disabilities and Multiple Needs	Increase options to prove medical necessity for PRTF authorization when psychological evaluation is not available			X				
Addressing Children with Developmental Disabilities and Multiple Needs	Identify ways to increase housing/temporary shelter options for teens and families			X				Touched on in the homelessness workgroup
Addressing Children with Developmental Disabilities and Multiple Needs	Identify ways to provide specialized childcare for families with children/teens with complex behavioral health concerns (BH/ASD/IDD)		X	X	X			
Addressing Children with Developmental Disabilities and Multiple Needs	Develop a process for educating families on legal guardianship process for ASD/IDD individuals who are approaching 18		X	X	X			

Addressing Children with Developmental Disabilities and Multiple Needs	Identify and implement a follow-up process once recommendations are made at Match Clinical Team (MCT)			X	X			
Addressing Children with Developmental Disabilities and Multiple Needs	Allow Match Clinical Team (MCT) the ability to access urgent care funds to create unique treatment options for complex individuals		X	X				
Addressing Children with Developmental Disabilities and Multiple Needs	Develop a process for an expedited contracting process for MATCH providers/pilots			X				
Addressing Children with Developmental Disabilities and Multiple Needs	Identify long-term capacity and sustainability for Match Clinical Team (MCT)		X	X				
Addressing Children with Developmental Disabilities and Multiple Needs	Increase access to transportation to remove barries to access healthcare.	X	X	X				
Addressing Children with Developmental Disabilities and Multiple Needs	Provide family treatment while youth are in the PRTFs or CSUs.		X	X	X			
Addressing Children with Developmental Disabilities and Multiple Needs	Create a system that includes intensive in-home services for families that need it the most		X	X	X			
Addressing Children with Developmental Disabilities and Multiple Needs	Continue to expand services under the state's Title IV-E Prevention Plan	X	X	X	X			
Addressing Children with Developmental Disabilities and Multiple Needs	Leverage existing mechanisms within the Medicaid system (i.e. flexibility under EPSDT or creation of In Lieu of Service definitions)	X	X	X	X		Reccomended in 2022, 2023	SDOH Workgroup, IMD Waiver Workgroup
Addressing Children with Developmental Disabilities and Multiple Needs	Pursue a waiver (1115 or 1915b(3)) or a state plan amendment as a more long-term solution	X	X	X	X		Reccomended in 2023	SDOH Workgroup, IMD Waiver Workgroup
Network Adequacy & Parity	Shift reporting of parity violations from self-reporting to a mandatory reporting system that allows reporting of both individual and mass violations	X	X	X	X			Hospital Access & Short Term Care Subcommittee
Network Adequacy & Parity	Address reimbursement rate disparities for telehealth providers by a) subsidizing the implementation of telemental health services or b) working with partners to increase reimbursement rates	X	X	X	X			
Network Adequacy & Parity	Increased and flexible spending rates for Psychiatric Residential Treatment Facilities (PRTF) and Child Caring Institutes (CCI) that allow for intensive and creative programming to better serve this population. This would also assist in reducing the state custody 'hoteling' challenge since more PRTFs and CCIs would be likely to accept these youth.	X	X	X	X		Recommended in 2023	
Increasing Access to Mental Health Services at the Community Level	Increase outreach and education around the benefits of tele-mental health for school-based services; specifically to school boards.		X	X	X			
Increasing Access to Mental Health Services at the Community Level	Encourage all CSBs to adopt CCBHC as the Behavioral Healthcare System for GA by supporting DBHDD in establishing the certification process; there are 12 CSBs in GA that are in the process of being certified		X	X	X		Recommended in 2023	
Increasing Access to Mental Health Services at the Community Level	Support the funding necessary for the Prospective Payment System		X	X	X		Recommended in 2022	
Mental Health Systems	Invest in and collaborate with digital platforms that are offering Single Session Interventions to integrate local Georgia resources into the platforms		X		X			
Mental Health Systems	Implement a direct payment model for Medicaid care which will eliminate bottlenecks to accessing mental healthcare, enable providers to receive payments from payers even if they are not in network, and introduce competition at the provider level. This will use a third-party administrator (TPA) to serve as a mandatory statewide clearinghouse for claims management and payment remittances, provide support to schools to ensure compliance with state and federal requirements, centralize network oversight, and function as a parity enforcer by challenging most denials	X	X	X	X			
Mental Health Systems	Evaluate implementing Care Management Organization (CMO) tax funding		X	X				
Mental Health Systems	Implement "in lieu of service" (ILOS) Medicaid funding to support families receiving services		X		X			Hospital Access & Short Term Care Subcommittee, SDOH Advisory Committee, IMD Waiver Advisory Committee
Mental Health Systems	Integrate outpatient suicide intervention into schools (similar to model at CHOA)		X		X			
Mental Health Systems	Consider dyadic services to support children 0-5 and their caregivers				X			

Mental Health Systems	Create and invest in an eConsult platform for integrated care which would connect pediatricians, primary care physicians and other providers to behavioral health professionals to receive consultation and guidance when providing behavioral health care		X	X	X	GMAP currently has something like this for pediatricians and is looking to expand to other providers		
Mental Health Systems	Invest in and create an online appointment scheduling and compliance tool that embeds an automated online claims denials appeal process		X	X	X			
Infant and Maternal Mental Health	Create an awareness campaign for practitioners, communities, families, policymakers and others to the needs of families' requiring hospitalization in the NICU			X	X			
Infant and Maternal Mental Health	Include education during the prenatal period for families expecting a baby to the implications of premature birth and family leave				X			
Infant and Maternal Mental Health	Develop listening tools for hospital staff to assess needs that may present barriers to spending time with their baby. Common barriers to parental presence in the NICU include transportation/long commutes to the hospital, cost of parking/lodging/meals, financial imperatives to return to work, and lack of resources for sibling care.		X	X	X			
Infant and Maternal Mental Health	Include coverage through health insurance to provide support for families including lodging, food, transportation and job security to address these types of social drivers of health and increase families' ability to engage with their infants while in the NICU – positively impacting maternal and infant mental health	X	X	X		This would be in-lieu of services	Recommended in 2022	
Infant and Maternal Mental Health	Increase resources through private-public partnerships to support parental presence in the NICU			X	X		Recommended in 2022	
Infant and Maternal Mental Health	Expand implementation of NICU peer-to-peer support for all families with a priority focus on families experiencing substance use disorder a)Expand access to training and implementation of NICU Peer Recovery Coaching b)Develop and implement an approach during the NICU stay to create a plan of safe care with families impacted by substance use disorder.		X	X	X		Recommended in 2022	
Infant and Maternal Mental Health	Expand implementation of family integrated relationship-based care with families of infants admitted to the NICU by investing in Regional Perinatal Center Outreach Educators to provide evidence-based training, technical assistance, and mentorship for staff to implement and sustain evidence-based practices for fostering developmentally attuned environments and emotional regulation.		X	X	X			
Infant and Maternal Mental Health	Require CMOs to reimburse obstetric and pediatric providers for maternal health screenings and referrals from the prenatal to postpartum period.		X	X			Recommended in 2023	
Psychological Services for Medicaid Children and Families	Address the provider licensing issues that cause delays and negatively impact the MH workforce. Specifically, amend Georgia's Medicaid State Plan to allow licensed psychologists who are Medicaid providers to bill for services provided by doctoral psychology interns and postdoctoral residents who are under their supervision without the requirement that the supervisor be present for the session. Supervision will occur at the time set aside by the intern and their supervisor	X	X	X	X			
Psychological Services for Medicaid Children and Families	Include CPT Code 90791 Diagnostic Evaluation as a covered service in the Georgia Medical Policy Provider Manual for psychology services.		X	X	X	Completed	Recommended in 2022	
Youth Mental Health Systems	Make it easier to qualify for care by reimagining access criteria and linking eligibility to the true drivers of the youth mental health crisis (remove strict diagnostic criteria for access to care)			X	X			
Youth Mental Health Systems	Meet children and families where they are by providing mental health services at pediatric appointments, churches, and schools and treat parents with their children.		X		X			
Youth Mental Health Systems	Develop, retain, and expand the workforce by increasing access by supporting existing MH staff, streamlining processes for paneling and credentialing, and expanding provider classes.	X	X	X	X			
Youth Mental Health Systems	Hold health plans accountable to children by acknowledging the centricity of the managed care plans and holding them accountable to the needs of children through the benefit design and data dashboards			X				

		Recommended in 2023								
	x				x	x	x	x	x	
Youth Mental Health Systems	Go get the federal matching dollars; maximize matching funds and formally require CMO accountability and contribution							x	x	
School-Based Behavioral Health	Expand the school healthcare workforce to meet the needs of GA's children - increase the number of school nurses							x	x	
School-Based Behavioral Health	Increase funding for and expand APEX and other school-based mental health programs across the state. In addition, provide and expand access for telemental health in schools and consider expanding the APEX program to reach rural areas by use of telemental health.							x	x	
School-Based Behavioral Health	Ensure GA Medicaid and CHIP is cover services provided in schools (both in person and through telehealth)								x	
School-Based Behavioral Health	Ensure schools and districts have the needed provider types can be reimbursed by the appropriate payer								x	
School-Based Behavioral Health	Support schools through requiring or strongly recommending faculty and staff training and providing access to necessary tools							x	x	
School-Based Behavioral Health	Increase awareness and funding of proven tools, such as PBIS, Positive School Climate and Student Health Survey							x	x	
Addressing Gaps in Therapeutic Care for Children and Adolescents	Expand prevention and early intervention approaches							x	x	
Addressing Gaps in Therapeutic Care for Children and Adolescents	Additional training and technical assistance and support for community health workers, peer support specialists, paraprofessionals, and health care providers							x	x	
Addressing Gaps in Therapeutic Care for Children and Adolescents	Address practice and reimbursement barriers for mental health services delivered by primary care providers and social determinants of health when developing delivery systems.								x	

APPENDIX B: SUBCOMMITTEE ON HOSPITAL AND SHORT-TERM CARE FACILITIES

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on Hospital and Short-Term Care Facilities

2024 Annual Report

Chair

Dr. Brenda Fitzgerald

Members

Jason E. Downey
Senator Brian Strickland
Dr. Michael Robert Yochelson
Kim Jones
Senator Kim Jackson
Donna Hyland
Commissioner Candice Broce
Commissioner Christopher Nunn

November 2024

Report prepared with assistance from Georgia Health Policy Center

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas including the Subcommittee on Hospital and Short-Term Care Facilities chaired by Dr. Brenda Fitzgerald (2020-2024).

During 2024, the Subcommittee on Hospital and Short-Term Care Facilites held three public meetings on topics related to mental health innovations in emergency room department and reports of parity compliance issues and a strategy for mental health care for youth.

List of Presenters to the BHRIC Subcommittee on Hospital and Short-Term Care Facilities 2024

BHRIC Subcommittee on Hospital and Short-Term Care Facilites
Dr. Brenda Fitzgerald, Chair
Commissioner, Christopher Nunn, Commissioner Candice Broce, Senator Brian Strickland, Senator Kim Jackson Dr. Michael Robert Yochelson, Kim Jones, Donna Hyland, Jason E. Downey

Support to the BHRIC Subcommittee on Hospital and Short -Term Care Facilites
Ana LaBoy, Georgia Health Policy Center & Ashlie Oliver, Georgia Health Policy Center

Presenters to the BHRIC Subcommittee on Hospital and Short-Term Care 2024

Date	Topic	Presenter
Date	Topic	**Presenter** Presenter's Title
June 26, 2024	Mental and Behavioral Health Innovation in the Emergency Room	Willowbrooke at Tanner, Tanner Health Systems Kenneth J Genova, MD, Executive Medical Director/Vice President Paula Gresham, Vice President/Hospital Administrator Wayne Senfeld, Executive Vice President
		Grady Health System, Anne Hernandez, LCSW, Vice President for Behavioral Health
		Piedmont Healthcare, Fiona Hall, LPC Vice President Behavioral Health
August 28, 2024	HB 1013: Mental Health Parity Implementation Barriers, Facilitators and Opportunities	Mr. Roland Behm Co-founder of the Georgia Mental Health Policy Partnership
	Access to MBH Care Updates: Skyland Trail	Ms. Beth Finnerty, Skyland Trail President and CEO Dr. Ben Hunter, Skyland Trail Chief Medical Officer Ms. Lori Langston, Payer Relations Manager
	Access to MBH Care Updates: Hillside	Ms. Emily Acker Hillside President and CEO
October 23, 2024	Strengthen Youth Mental Health: Essential Strategies for Georgia's Future	Alex Briscoe, Principal, Public Works Alliance; and Executive Director, California Children's Trust

		Bonnie Hardage, Executive Director, Jesse Parker Williams Foundation; and Co-Chair, Mental Health Funders Collaborative Ebony Johnson, MPA, CNP, Senior Director, Brighter Future, United Way of Greater Atlanta; and Co-Catalyst, Grantmaking, Mental Health Funders Collaborative

Summary of Presentations to Subcommittee

Mental and Behavioral Health Innovation in the Emergency Room

Representatives from Willowbrooke at Tanner, Grady Health Systems, and Piedmont were asked to present about the innovative programs in their emergency departments to serve patients with mental and behavioral health issues.

Fiona Hall, Piedmont Health Systems

Ms. Hall gave information on how Piedmont Health systems addressed patients who enter their emergency room with Behavioral Health issues. In 2022, Piedmont brought mental health services internal, previously it was contracted outwardly. The hospital system has a variety of hospitals with different sizes, patient contexts and other factors which makes it difficult to have a one size fits all approach in all hospital systems. Across their system, they see about 25,000 patients for behavioral health services within the system, primarily through the emergency room. For patients who enter the emergency room with behavioral health issues, they have spaces that are ligature free, and have their own space or pod. Staff trained on assessment services are available 24/7 for assessments, and clinicians prioritize medication management for patients during their time in the emergency room.

Kenneth Genova, Willowbrooke, at Tanner Hospital

Mr. Genova gave information about Willowbrooke at Tanner, a facility where individuals needing mental health services can go instead of the emergency room to gain access to services. Tanner, similar to other hospitals, will often find a group of individuals who come to the emergency room in a mental health crisis. While the emergency room may be able to triage the individual, the emergency room is not the appropriate level of care for individuals in this scenario. Patients can go to Willowbrooke as an access point of care. Individuals can review decisional screening free of charge to determine what level of care would be appropriate for their context. Of those who are screened, 30% need to be hospitalized, with the majority needing to be stabilized without a need for an inpatient stay.

Ann Hernandez, Grady Health Systems

Ms. Hernandez gave information on the center created at Grady to serve individuals who need specific mental or behavioral health services and who come to the ER. Grady has a smaller unit within the Emergency Department that was added in 2015, which includes 12 dedicated rooms that are ligature-free. In this area, individuals can be evaluated and stabilized. More than half (60%) of the patients who visit this area are discharged from the psychiatric area to their homes without additional stays in the hospital.

Grady also has a crisis intervention unit, an open milieu with 28 chairs, an open nursing station, and appropriate comfortable furniture. In this area, patients can get mental health and substance use assessments, peer support, and counseling from experienced staff,

including psychiatrists and substance use counselors. The average stay to stabilize an individual in this unit is about 26 hours.

HB 1013: Mental Health Parity Implementation Barriers, Facilitators and Opportunities

Mr. Roland Behm Co-founder of the Georgia Mental Health Policy Partnership

Mr. Behm gave an overview of what is included in HB1013, the Mental Health Parity Act in Georgia. He first started by describing the procedure changes from the law including the definition of medical necessity. Until HB1013 there was not a statutory definition of medical necessity. Insurers and managed care organizations are required to use the definition. Mr. Behm explained that although this was a mandate, many different organizations use their own definitions, and CareSource was the only organization that used the proper documentation. Other insurers Milliman Care guidelines (MCGs) are 3rd party clinical guidelines to determine coverage and medical necessity.

Provider organizations APA, AACAP, AACP, ASAM wrote a letter stating that these guides were not considered with other medical guidelines for 4 reasons: 1) Major associations have not reviewed the guidelines because they are proprietary, 2) The MCG algorithm is customizable by the company who uses them, 3) There is no publicly available data connected to these guidelines and 4) the lack of transparency. As a result of these guidelines, maternal mental health, neonatal abstinence syndrome care, and coordinately specialty care for first episodes of psychosis are some but not all diagnoses that have not been deemed medically necessary care.

Mr. Behm explained that failing to adhere to parity guidelines harms patients, their estates, parents, Georgia Medical providers, and Georgia Taxpayers. In discussion, Mr. Behm argued that there are avenues to prosecute insurance companies for failing to adhere to the medically necessary guidelines, which could include disqualification or disbarment. However, the lack of substantial data precludes enforcement at the highest level.

Access to MBH Care Updates: Skyland Trail

Ms. Beth Finnerty, Skyland Trail President and CEO

Dr. Ben Hunter, Skyland Trail Chief Medical Officer

Ms. Lori Langston, Payer Relations Manager

Ms. Finnerty presented on the history of Skyland Trail, which is a private nonprofit behavioral health treatment facility that has 5 campuses with a total of 108 beds. A little half of the individuals they serve (60%) are 18-25. They mainly treat patients for depression and anxiety. They have a variety of services available, including vocational services, educational services, adjuster therapists and primary care.

Next Dr. Hunter presented on some of the problems that providers face when delivering care due to limitations from insurers. The first issue is the coverage limits and network adequacy that patients oftentimes encounter. Patients often have limits on psychiatry visits per year

or treatment days in their insurance plan not commiserate with their physical health coverage. There are also fewer providers who are paneled because of the low reimbursement rates for mental health services. The reimbursement rates discourage future providers from choosing psychiatry.

Dr Hunter explained that when providers do choose to accept insurance, they run into a slew of other issues, including difficulty with authorizations and revenue processes. Payors can take more than two weeks to return a decision on preauthorization or reauthorization of treatments. This often results in uncompensated services or premature discharge for patients. For claims that are denied, payors frequently require phone calls and faxes that can take a lengthy amount of time and effort. The appeal process is both complicated and not transparent.

The last issue that Dr. Hunter expanded on was on the definition of Medical Necessity. Insurers will often deny services for individuals under the guise of "baseline" mental health stability. This baseline may be one that clinically would indicate treatment, but is denied by insurance companies because this is a status quo of a given patient.

Access to MBH Care Updates: Hillside

Ms. Emily Acker

Hillside President and CEO

Ms. Acker began her presentation by agreeing with the previous presentation from Skyland Trails. Acker testified that Hillside has had to double the size of the finance and utilization department to keep up with the difficulty from the insurance companies.

Acker began describing Hillside, a treatment facility with 91 beds that has been in Atlanta for 135 years. They treat children through metro Atlanta. About 60% of patients receive treatment under Medicaid or other state funds. They serve about 900 children and families a year.

Acker reports that since the passing of HB1013 in 2022, there has been an increase in Medicaid rates for PRTFs, and she has seen an increase in discussion and advocacy for parity issues in Georgia. However, she reports that many things have remained unchanged, including variations in the definition of medical necessity between insurers, the preauthorization and reauthorization process, and issues with the coordination of benefits.

Acker pointed out that while based on statewide reports, there are only a few formal reports of parity violations, that is not due to a lack of violations but rather complexity of the process. Acker reports that, in her experience, families and providers do not always understand what is included in parity violations. When they do understand, the process is difficult and very cumbersome.

These issues in parity can cause harm to Georgians. There is an impact on treatment outcomes for patients. Parents of children are limited in their network options. Georgia

providers experience an increase in the cost of hiring finance staff members. Georgia facilities oftentimes will treat patients for medically necessary treatments free of charge, requiring them to raise funds for scholarships through donors or fundraisers.

Strengthen Youth Mental Health: Essential Strategies for Georgia's Future

Alex Briscoe, Principal, Public Works Alliance; and Executive Director, California Children's Trust

Bonnie Hardage, Executive Director, Jesse Parker Williams Foundation; and Co-Chair, Mental Health Funders Collaborative

Ebony Johnson, MPA, CNP, Senior Director, Brighter Future, United Way of Greater Atlanta; and Co-Catalyst, Grantmaking, Mental Health Funders Collaborative

Alex Briscoe presented on a plan to help treat Georgia children for mental health. Mr. Briscoe outlined a 5-step plan to build capacity for mental health. First is to make it easier to qualify for care, which would include a change in how individuals can access care. The next strategy is to provide mental health services where Georgia families are, including pediatric appointments, in community areas. This includes treating parents with their children in a dyadic care model. The third is to address the workforce crisis by developing, retaining, and expanding the existing workforce. The next is to hold health plans accountable. Moreover, the last is to maximize the federal match on funds.

Additional Content to Highlight

Georgia passed the Mental Health Parity Act HB 1013 in 2022, designed to improve access to mental health and substance abuse treatment by requiring health insurers cover these services comparably with physical health services. This means there should be no difference in deductibles, copays, or limits on the number of visits or days of hospitalization between mental and physical health services. Among other things, HB1013 also requires the Georgia Department of Insurance to ensure that insurance companies follow parity reporting guidelines, providing avenues for mental health parity complaints from insured individuals and provides a definition for medical necessity. Testimony from this year's experts indicate that there are far greater parity violations than are currently being reported to the Insurance Commissioner's Office or Department of Community Health.

Recommendation Priorities

The Hospital and Short-Term Care Facilites Subcommittee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

1. **Create a third-party committee that helps to oversee parity violations.**

   The third-party committee should include representatives from the Georgia General Assembly, the Department of Community Health (DCH), the Department of Human Services, the Office of the Commissioner of Insurance, mental health clinicians, executives at facilities or systems providing mental healthcare, and advocates. The subcommittee recommends that the third-party committee consist of:

   - 2 State Representatives
   - 2 State Senators
   - 2 Department of Community Health representatives
   - 2 Department of Human Services representatives
   - 2 Insurance Commissioner Office representatives
   - 2 mental health clinicians, including one psychiatrist
   - 2 senior executives of facilities or systems providing mental healthcare
   - 2 mental health advocates

   The subcommittee also recommends establishing a team to support the work of the third-party committee, including, without limitation, research, report preparation, and educational materials creation.

   The third-party committee will receive and analyze required reports from insurance companies and providers, review parity complaints, request additional information from insurance companies regarding potential parity violations, including violations of definitions of medical necessity, and create and review educational materials for parity compliance. The committee would also work with the Governor's office, the Department of Community Health, and the Office of the Insurance and Safety Fire Commissioners to determine standard operating procedures for the third-parity commission in recommending and requiring punitive action for insurance companies that are not compliant with parity regulators.

   The third-party committee would be responsible for assisting with recommendations 3 and 4 and would work closely with other groups in Georgia to address parity.

2. **Provide funding for research staff to assist the third-party committee on parity.**

3. **Enable providers to meet their legal obligations by providing parity data to the third-party commission.**

   In conversations with providers who testified to the subcommittee about parity violations of their systems experience, it became clear that requiring a mandate to submit parity violation reports may be of interest. These reports would require providers to submit documentation they already have for the state to assess potential parity violations better. It would not require providers to produce data they are not collecting, or that is not readily available in their systems. When fulfilling this recommendation, the subcommittee recommends that the third-party commission discuss potential avenues with representatives from large provider associations to develop a policy that allows providers to comply with their obligations easily.

   The Hospital and Short-Term Care Facilites Subcommittee recommends requiring Providers to submit regular parity compliance reports that will include information on:

   - Types and kinds of authorization denials
   - Questionable denial practices, including without limitation coverage denials due to a patient being at their "baseline measure of suicidality, such as egregious medical necessity denials including baseline measure of suicidality and other conditions and authorized stays less than 30 days
   - Time taken by Providers in responding to appeals of denials – e.g., greater than 3 days, greater than 7 days, greater than 14 days, and greater than 30 days
   - Claim denials, including retrospective denials, due to lack of medical necessity, no authorization, treatment exceeding coverage limits, non-covered services, and clean claim denial percentages of less than 10%
   - Number of unauthorized days, and the cost to the provider and patient
   - Excessive concurrent reviews
   - Number of patients discharged without an identified in-network provider for follow-up
   - Number of patients with lack of access to online verification of benefits (VOB)
   - Payers failing to provide peer-to-peer reviews
   - Payers whose contract annual increase is less than 3%

4. **Regular reporting on parity compliance should be made available on an accessible portal for patients, providers, and employers.**

The Georgia Data and Analytics Center (GDAC) reports regularly on parity complaints received through the Georgia Insurance Commissioner Complaint Portal and the Department of Community Health Georgia Parity Compliance Portal. The Hospital and Short-Term Care Facilites subcommittee recommends that this compliance information be readily accessible and include additional reporting required in Georgia law for insurance companies, including but not limited to Network Adequacy examinations, Market Conduct Exams, definitions provided in medical insurance manuals for medical necessity, mental health and substance use, metrics on prior authorization requests, claims denial rates, and reimbursement rates for CPT codes.

The purpose of regular reporting is both to hold insurance companies accountable for their actions and to allow Georgians to make educated decisions when choosing insurance providers.

5. **Require regularly updated patient and provider parity education.**

Georgia has an opportunity to expand on its educational campaigns, explaining the concept of parity, individuals' rights, and the complaint process. Effective and accessible educational material should be culturally competent, translated into multiple languages, offered in various formats (such as on a webpage, in a brochure, or in written documentation), widely distributed, and meet language access standards.

6. **Create a more accessible process to report parity violations, including a qualifying assessment process.**

The current process for reporting parity violations requires complainants to go through a cumbersome process of submitting several pages of required information and requiring individuals to create an account. In other states, complainants submit simplified forms to determine if their complaint is qualified. Individuals who submit complaints are then contacted for additional information.

7. **Create a client service position to assist individuals with reporting parity compliance issues.**

To aid individuals, providers and employers in reporting parity compliance issues, the Hospital and Short-Term Care Facilites Subcommittee Recommends that there is funding specifically for a client service position who would be responsible for assisting complaints once they have submitted a qualifying assessment and assist any additional contacts with parity complaints.

8. **Create agency staffing assigned specifically for parity compliance.**

DRAFT Data Request Form for Providers

	Category	Subcategory	Number
1	Aggregate number of denials		
2	Number of denials by explanation		
		Not medically necessary	
		Lack of prior authorization	
		Treatment exceeds coverage limits	
		Failure to follow utilization management rules	
		Service not covered by policy	
		Out-of-network provider	
		Inadequate documentation	
		Incorrect billing code	
		Other	
3	Time to communicate coverage decision		
		Mean time	
		Average time for longest 10%	
		Average time for shortest 10%	
4	Numbr of days in care awaiting coverage decision		
5	Number of days in care following denial		
6	Mean time for payment receipt		
7	Number of claims reviewed after payment		
8	Amount of payment clawbacks		$

Please note any matters of concern (i.e., “suicide baseline”)
Please attach any additional documents that would assist in understanding your concern

Georgia Health Policy Center

Georgia State University | Andrew Young School of Policy Studies

Parity Environmental Scan

Presented to Behavioral Health Reform and Innovation Commission

October 2024

Prepared by Ana LaBoy

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BACKGROUND

Georgia passed the Mental Health Parity Act HB 1013 in 2022, designed to improve access to mental health and substance abuse treatment by requiring health insurers cover these services comparably with physical health services. This means there should be no difference in deductibles, copays, or limits on the number of visits or days of hospitalization between mental and physical health services. Among other things, HB1013 also requires the Georgia Department of Insurance to ensure that insurance companies follow parity reporting guidelines, providing avenues for mental health parity complaints from insured individuals and provides a definition for medical necessity.

The following report summarizes our research methods, followed by our findings about how other states have written mental health parity (also referred to herein as "parity") into their laws and regulations based on publicly available information from states' legislative records.

METHODS

Researchers at the Georgia Health Policy Center conducted an environmental scan to summarize the options states use in their parity enforcement. Researchers examined state legal and legislative records of states.[1] Researchers also examined publicly available reports on states insurance department website. In response to the request for information, two states, Illinois and West Virginia were chosen for examples, as they were similar to Georgia, and used multiple methods for enforcement of mental health parity.

TOOLS TO ENFORCE PARITY

Our research indicates that states use various mechanisms to enforce parity, including avenues for insured individuals, providers, and employers to report complaints for review, regular reviews of coverage and outcomes, and regulations in the state code. States with high levels of parity enforcement have a variety of modes to ensure insurers have equal coverage of both mental and physical health.

Feedback from Insured Individuals, Service Providers and Employers

Though it may look different from state to state, states have adopted several mechanisms for insured individuals and other parties to elevate individual parity violations to the state's regulatory agency. In some states, insured persons are responsible for submitting parity complaints through an online portal or via telephone. Other states also have avenues for service providers to submit individual and group complaints and for employers to submit complaints on behalf of plans available to their employees. Complaint portals range in

[1] Additional references and links are available in the Appendix.

simplicity. Most complaint portals require the submission of substantiating documentation, including written denials, appeals, or communication with the insurance provider.

Many states have multiple educational campaigns explaining the concept of parity, individuals' rights, and the complaint process. Effective and accessible educational material should be culturally competent, translated into multiple languages, offered in various formats (such as on webpage, in a brochure or in a written documentation) widely distributed, and meet language access standards.

States also use various avenues to review data from the complaint portal and preemptively address anecdotal complaints. Some states have either a state-run or a third-party workgroup meeting to discuss potential violations and address pertinent or ongoing issues. Other states have robust insurance commissioners' offices that will conduct evaluations and reviews.

Reviews of Coverage and Outcomes

Beyond individual complaints, states may require insurance companies to submit regular parity regulation compliance reports. Some states require insurance companies to include written definitions in their manuals for phrases such as medical necessity, mental health, and substance use. States also require insurance companies to submit metrics on prior authorization requests regularly, claims denial percentages, and reimbursement rates for various CPT codes. In some states, insurance companies must also submit information on Network Adequacy.

States with strong enforcement mechanisms conduct regular reviews. Market Conduct Exams are used in states to verify that payors are acting in compliance with state regulatory requirements. Other states complete regular Network Adequacy examinations, including the number and types of providers in the network, provider access for patients, and average wait times for scheduled appointments. States regularly report violations and actions taken toward insurance companies that have not followed state regulations and publicly report resolutions, including fines and required changes in administrative guidelines.

Enforcement Mechanisms[2]

States address parity violations and complaints in several ways. One option for states is to require insurance companies to change their policies to match state guidelines. This is limited to changing prior authorization requirements, definitions, covered services, and policies around denials and acceptance. If states do not have violations recorded in insurance records, they can investigate further into insurance companies' protocols by requesting additional information from insurance companies. States oftentimes will use complaints and insurance provider documentation to understand where to investigate further. Insurance commissioners' offices have punitive options when states have parity violations. In some states' codes, insurance companies can be fined, or their state certification can be revoked or suspended.

[2] Beyond scans of state policies, researchers also referenced Presskreischer, R., Barry, C. L., Lawrence, A. K., McCourt, A., Mojtabai, R., & McGinty, E. E. (2023). Enforcement of the Mental Health Parity and Addiction Equity Act: State Insurance Commissioners' Statutory Capacity. Psychiatric services (Washington, D.C.), 74(6), 652–655. https://doi.org/10.1176/appi.ps.20220210

STATE EXAMPLES

The following section provides examples of parity regulations in Illinois and West Virginia. Both states have similar approaches to parity enforcement, with multiple avenues of enforcement, in different political climates, and are considered to have best practices.

Illinois

Illinois provides avenues for consumers and providers to file complaints online in a portal developed by the Illinois Department of Insurance. Illinois provides several avenues of education for consumers, including videos, links to federal and state-developed resource guides, consumer guides, and how-to guides to navigate that complaint portal. Beyond complaints, Illinois has a third-party workgroup with 11 members who meet regularly to address pertinent parity issues and produce an annual report[3]. The Illinois Department of Insurance and the Illinois Department of Health and Family Services are required by law to prepare an annual report[4] that must be available on the Department of Insurance website. In 2024, the Illinois Department of Insurance completed two market examinations, which resulted in 15 fineable violations and $500,000 in fines, $195,000 of which were due to mental health parity violations. The State of Illinois also regularly conducts Mental Health Parity Audits to flag potential violations based on health plan utilization and prior authorization data.

West Virginia

West Virginia's Office of the Insurance Commissioner (OIC) also allows consumers to file a complaint online or via mail, email or fax. The insurance office offers detailed information on all complaint forms of what is required to submit a complaint. The OIC has simplified the process by not requiring consumers to create an account with the commissioner's office, and a one-page complaint form to collect the information. Annually, the OIC must submit a publicly available report[5][6] that must contain carrier compliance, including financial requirements and treatment limits (quantitative and non-quantitative) and comparative reports between insurance carriers in the state. These reports also include Market Conduct exams, and flag

[3] Working Group Regarding Treatment and Coverage of Substance Abuse Disorders and Mental Illness: Annual Report, Produced by State of Illinois Department of Insurance, 2023

[4] Compliance Actions Under State and Federal Mental Health Substance Use Disorder Coverage and Parity Laws: Joint Annual Report to the General Assembly, produced by the Illinois Department of Insurance and Illinois Department of Health and Family Services 2024

[5] Mental Health Parity 2023. 2022 Plan Year, Produced by the State of West Virginia Office of the Insurance Commissioner

[6] Mental Health Parity 2024, 2023 Plan Year, Produced by the State of West Virginia Office of the Insurance Commissioner

potential parity violations, requiring the OIC to follow up and document their actions to enforce their parity regulations. For example, the OIC's 2023 report includes insurance carriers' required reporting of flagged potential violations, which was then followed up in the 2024 report.

CONCLUSION

Georgia has the opportunity to expand upon HB1013's foundation of requiring mental health parity. One such recommendation is to enhance HB1013's requirement to develop and implement an online complaint process and reporting processes, by adding into the current Act enforcement requirements and mechanisms to ensure insurers implement their own guidelines to avoid potential penalties.

Additional requirements could include comparative assessments, including publicly available presentations of metrics insurance companies are required to submit. Georgia has an opportunity to expand its punitive options, including the option to fine insurance companies who have parity violations. Other states also include a third party responsible for reporting and managing parity issues. These potential options would further operationalize existing mandates and requirements.

APPENDIX:

Additional State Information and Links

State	Insurance Commissioner's Office	State Parity Bill	Additional Information
Georgia	- Georgia Insurance Commissioner Complaint Portal - Department of Community Health Georgia Parity Information	HB1013	Georgia Data Analytics Center Mental Health Parity Reporting
Indiana	- Paper Insurance Complaint Form - Indiana Insurance Company Complaint System	HEA 1092	- Department of Insurance Report on Parity Bill- Includes an insurance checklist - Company Complaint Index
Maryland	-Maryland Insurance Administration Health Insurance	Md. Code, Ins. § 15-144	- Mental Health Parity Reports -Maryland Parity Enforcement Timeline Legal Action Center -2023 Interim Report on Nonquantitative Treatment Limitations and Data
Mississippi	-Mississippi Insurance Department	SB 2678	- Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Report -Health Insurance 101 and Mental Health Parity

State	Insurance Commissioner's Office	State Parity Bill	Additional Information
New York	- New York Consumer Complaint- Paper Consumer Complaint Reports are also available in multiple languages that can be filled out and printed (Examples: English, Spanish, Yiddish)	Timothy's Law	-New York Educational Materials from Office of Mental Health -Compliance with the Mental Health Parity and Addiction Equity Act Comprehensive Report: New York Medicaid Managed Care, Alternative Benefit Plan, and Children's Health Insurance Program - Parity Reports -Informational Brochure from Attorney General Office -New York State Office of Mental Health Parity Compliance Toolkit
New Mexico	-Insurance Health Care Provider Complaint Form -New Mexico Office of Superintendent of Insurance	SB 273 N.M. Stat. § 13-7-26	- Compliance Review by Office of the Superintendent of Insurance
Tennessee	Tennessee Commerce and Insurance: Complaint Form	SB 2165	Fairness in Mental Health and Substance Use Insurance Coverage - Mental Health Parity in the TennCare and CoverKids Programs 2017
Texas	- Texas Administrative Code -Ombudsman Behavioral Health Help	-HB 2595	-Texas Parity Overview -Texas Mental Health and Substance Use Disorder Parity Rules -Study of Mental Health Parity to Better understand Consumer Experiences with Accessing Care: August 2018

Additional Resources

- The Mental Health Parity and Addiction Equity Act: Center for Medicare and Medicaid Services
- Parity Track- Website run by The Kennedy Forum that track parity related legislation, provides resources and consumer supports
- Medicaid Parity Resources: Includes resources created by the Center for Medicare and Medicaid Services
- Commonwealth Fund
  - JoAnn Volk and Christina L. Goe, "Building on Behavioral Health Parity: State Options to Strengthen Access to Care," To the Point (blog), Commonwealth Fund, May 25, 2023. https://doi.org/10.26099/7pht-w940
  - JoAnn Volk, Emma Walsh-Alker, and Christina L. Goe, Enforcing Mental Health Parity: State Options to Improve Access to Care (Commonwealth Fund, Aug. 2024). https://doi.org/10.26099/b2p1-m204

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APPENDIX C: SUBCOMMITTEE ON INVOLUNTARY COMMITMENT

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on Involuntary commitment

2024 Annual Report

<u>Chair</u>

Judge Sarah Harris

<u>Members</u>

Justice Michael Boggs
Judge Bedelia Hargrove
Judge Stephen Kelley
Karen Bailey
Nora Lott Haynes
Dr. DeJuan White

November 6, 2024

Report prepared with assistance from Christy Doyle, Georgia Health Policy Center

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas including the Subcommittee on Involuntary Commitment chaired by Judge Sarah Harris (2023-2024).

During 2024, the Subcommittee on Involuntary Commitment held one public meeting on topics including the shortage of psychiatrists and psychologists to perform AOT evaluations, and the possibility of nurse practitioners being added to the list of approved clinicians. They also discussed the possibility of developing a credentialing program for certified AOT examiners, and continuing evaluation of AOT as a diversion option for individuals with high mental health needs. Regarding the transportation of individuals experiencing mental health crisis, the subcommittee continued to discuss options for enhancing non-law enforcement transport services. Finally, per the request of Commissioner Tanner, the subcommittee began to discuss the processes guiding the development and issuance of orders to apprehend in probate courts.

Subcommittee Findings

The subcommittee had considerable conversation about the fact that shortages in the mental health workforce, specifically psychiatrists and psychologists, were limiting the ability of jurisdictions to implement AOT. The shortages mean that some jurisdictions are unable to meet the requirement to have two doctors conduct evaluations before a petition for involuntary outpatient treatment can be brought in front of the court. Judge Harris requested that Georgia Health Policy Center (GHPC) conduct an environmental scan of AOT laws in other states to identify the levels of clinician credentialling required for AOT evaluations. The environmental scan identified that there is a wide range of approaches to AOT evaluators and their credentials, and the subcommittee identified two models for further discussion: the addition of nurse practitioners to the list of approved evaluators, and the establishment of a certification training program with associated testing requirements for clinicians who conduct evaluations. The subcommittee has made a specific recommendation regarding adding nurse practitioners to the code, and has recommended further exploration

of the certification process after scheduled testimony from the model program in North Carolina was cancelled due to the presenter's need to respond to Hurricane Helene.

The subcommittee has received regular updates regarding the alternative transportation pilot being operated by Georgia Pines CSB in southwest Georgia, and has recommended that the project continue to be funded and outcomes tracked.

Commissioner Tanner requested that the subcommittee review the legal parameters for the issuance of an order to apprehend (OTA), the order by which the probate courts instructs law enforcement to transport an individual experiencing a mental health crisis for assessment. Judge Harris requested and received data regarding OTAs in DBHDD regions, which she briefly reviewed with the subcommittee. After some discussion and given the remaining time in the committee year the subcommittee agreed that the question warranted more robust conversation, review of the provided data, and input from stakeholders, and recommended that it be continued in 2025.

Recommendation Priorities

The Involuntary Commitment Subcommittee identified the following recommendations from the discussions over the past 12 months as priorities for immediate action.

- Consider modification to the AOT statute to add Certified Nurse Practitioners (CNP) and Clinical Nurse Specialist/Psychiatric-Mental Health (CNS -PMH) to the list of clinicians authorized to conduct AOT evaluations.
    a. This could be modified to a recommendation to create an exception process for rural areas to allow CNP/CNS-PMH nurses to conduct evaluations in those areas.
- Recommend continued exploration of a certified evaluator process similar to the Certified Examiner provision in place in North Carolina.
- Recommend continued monitoring of the Transportation Alternative Pilot program in place in SW Georgia
- Recommend continuing investigation into OTA processes next year to allow sufficient time for consideration of data and stakeholder input.

Appendix A

Competency restoration alternative costs

July BHRIC Meeting

Forensic Competency

July 24, 2024

Georgia Health Policy Center

Themes

- Few studies discuss concrete costs
- Fewer discuss cost shifting
- Many that do include actual costs are outdated
- Most studies refer to savings, seen or expected

Commonly assumed areas of savings

The most frequent assumptions of areas of saving include:

- Jail-based restoration
  - Reduced hospital days
  - Faster initiation of restoration services
  - Possible faster restoration, based on faster initiation of services
- Outpatient restoration
  - Reduced jail days
  - Reduced hospital days
  - Reduced sheriff's department transportation costs

Comparison of daily rates

- A 2019 literature review identified the cost ranges for:
  - Hospital-based restoration: $300-$1000/day
  - Jail-based restoration: $42-$222/day
  - Outpatient restoration: $100-$500/day
- Age of articles found was an identified limitation

Competency Restoration for Adult Defendants in Different Treatment Environments. Graham S. Danzer, Elizabeth M.A. Wheeler, Apryl A. Alexander, Tobias D. Wasser. Journal of the American Academy of Psychiatry and the Law Online Feb 2019, JAAPL.003819-19; DOI: 10.29158/JAAPL.003819-19

Risks of cost shifting

- Possible cost shifting from state to local
  - In FY21, New York State began billing counties for 100% of the costs of hospital-based restoration, up from the previous rate of 50% established in 1977 [1]
  - A 2018 cost-benefit analysis of Travis County TX's jail-based restoration program indicated:
    - Overall cost increase to county of $698,788
    - Overall cost savings for the state of $1,107,928
    - This analysis had some limitations
      - Was completed as a master's thesis
      - Was forced to make some assumptions that may be inaccurate, such as an assumption of 14-day wait times for transportation to state hospital[2]

1. New York State Association of Counties. A Blueprint for Change: Reforming Mental Health Competency Restoration in New York State. Sept 2021. https://www.nysac.org/media/elxn4dsl/blueprint_for_change_competency_restoration_730report.pdf
2. Muller, K. (2018) *A Benefit-Cost Analysis of Jail-Based Competency Restoration Services in Travis County, Texas*. [Masters thesis, Texas State University]. Texas State University digital https://digital.library.txst.edu/server/api/core/bitstreams/e00edc5c-38f5-4945-97c7-5fdb01f68d20/content

Appendix B

BHRIC Mental Health Courts/Forensic Advisory Subcommittee Environmental Scan of Misdemeanor Competency Restoration Laws, Policies and Practices

Delivered to Judge Kathlene Gosselin, Subcommittee Chair

Purpose of Study

In 2019, the Georgia legislature established the Behavioral Health Reform and Innovation Commission (BHRIC). Under the leadership of Kevin Tanner, now the Commissioner of DBHDD, the BHRIC was charged with conducting a systematic review of the behavioral health system in Georgia, including a examination of the impact behavioral health issues have on the court and correctional systems.

Judge Kathlene Gosselin, chair of the Mental Health Courts/Forensic Advisory Subcommittee, has been asked to provide recommendations from the subcommittee regarding possible legislative and practice changes that would align Georgia's competency restoration processes with national best practices, as well as reducing the backlog of competency evaluation and restoration cases currently in the system. She requested that the Georgia Health Policy Center (GHPC) assist the subcommittee by gathering data regarding the national landscape of competency evaluation and restoration, particularly for individuals charged with misdemeanor offenses.

Key questions posed by the committee included:

How do other jurisdictions differentiate competency assessment and restoration for misdemeanors versus felonies?
What specific modifications and/or processes do other jurisdictions use to address the competency process for misdemeanants?
What are the best practices in relation to the competency processes for misdemeanants?

Methods

To respond to these questions, GHPC used the following strategies:

- Conducted a literature review of academic and grey literature.
- Conducted an environmental scan which included reviewing the codes and processes of other states and agencies specific to these processes.

Summary Findings

Historical context

Although the concept of legal competence has been dated to as early as the 14th century,[1] modern application of the concept begins with the US Supreme Court case *Dusky vs United States* in 1960. In this ruling the court indicated that "the test must be whether the defendant has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding and a rational as well as factual understanding of proceedings against him." [2] Although *Dusky* applied to federal court proceedings, the standard was also adopted by the states over time.[3] [4]

In 1972, the Court further clarified in *Jackson vs. Indiana* that individuals could not be indefinitely detained solely based on their involvement in the competency process [5] and that the duration of an individual's detainment for competency be not "more than the reasonable period of time necessary that he will attain that capacity in the foreseeable future."[6] However, *Jackson* did not establish guidance or time limits on the length of confinement.

Current landscape

As a result of the ambiguities left by the Supreme Court in the *Dusky* and *Jackson* decisions, there is little standardization across states and jurisdictions. In addition, use of the competency process has increased almost threefold in the past several decades, part of the unintended consequence of the criminalization of the symptoms of mental and behavioral health disorders following widespread closures of psychiatric hospitals in the mid-1900s.[7] [8]

Backlogs have become common at several points in the process. The most frequent challenges are timeframes required to complete competency evaluation; timeframes for delivery of completed evaluations to the courts; the duration of competency restoration; and, determination of situations in which alternatives to courts and the competency process are appropriate.

Traditionally, evaluation and restoration has occurred in hospital settings, most often those operated by a state mental health authority. However, as use of the competency process has increased alongside shortages in the nation's behavioral health workforce, [9] [10] states are examining other ways of addressing the challenges of the process. In addition, numerous government agencies, research institutions, and non-profit organizations have partnered to evaluate system bottlenecks and to pilot and implement of solutions. Approaches include:

- Alternatives to the traditional inpatient evaluation and restoration model;
- Different processes for misdemeanor vs. felony offenses;
- Statutory timelines for the steps in the process;
- Use of risk assessments to help drive decisions;
- Diversion processes to transition individuals with high mental health needs from legal to treatment systems and/or court and treatment partnership, including robust referral, treatment, and case management services for individuals who are released and/or diverted.

<u>Alternatives to the traditional inpatient evaluation and restoration model</u>

As of 2018, 35 states had laws that permitted outpatient restoration, while 16 states (including Georgia) had developed formal processes to deliver such services.[11] State practices vary widely in terms of the nature of the offenses that may be restored in jails or in the community. Numerous initiatives have been implemented in various states to help decrease the number of individuals in jails awaiting competency assessments and/or restoration beds. Examples include:

Florida, which has developed a unique continuum of services. Individuals charged with non-violent felonies who are found incompetent can be sent to the Miami-Dade Forensic Alternative Center, where they receive stabilization services. Once the individuals are determined to be sufficiently stable, they transition to a secure residential placement to complete restoration. Once restored, a treatment plan aimed at successfully transitioning the individual back to the community and which includes ongoing case management is developed and implemented.[12] Initial outcome data from the program demonstrated reductions of 68% in jail bookings and 94% of jail days for those who participated in the program and remained linked to services. [13]

Louisiana, which has developed a specific residential treatment program for individuals who are found to be unrestorably incompetent. This 40-bed program focuses on providing skill-building and treatment services that include daily living skills, education about managing their mental health symptoms, and managing their medications.[14]

Hawaii, which provides restoration services in a non-secure group home setting that includes treatment, peer supports, psychiatric services, and case management.[15]

<u>Different process for felony vs. misdemeanor offenses</u>

Some states have identified different competency processes for violent vs. non-violent offenses, while others have chosen to develop different processes for individuals charged with felony vs. misdemeanor offenses. Most often such processes focus on non-violent

misdemeanors, although an increasing number of jurisdictions consider non-violent felonies or low-level drug charges for alternative processes as well.

There's significant variability in how these practices are operationalized. New York and Florida, for example, do not prosecute misdemeanor cases where competency is an issue[16]. New York reserves the outpatient restoration process for individuals with felonies and does not specify eligible offenses, focusing instead on criteria such as lack of dangerousness, housing stability, willingness to participate, lack of substance use issues, and a lack of unique/severe medical needs. District attorneys must agree to a defendant's participation in the process and participants are returned to the court system if they fail to comply with conditions of enrollment.[17] Wisconsin and Louisiana rely on similar criteria for its outpatient restoration, although in practice Louisiana's program receives referrals predominantly for individuals with non-violent, misdemeanor offenses.[18] [19]

The statute in Hawaii specifies that individuals found incompetent of petty, non-violent misdemeanors will be automatically diverted.[20] Alaska, which has historically dismissed misdemeanor charges but provided minimal supports following dismissal, recently opened 10 jail-based restoration beds for individuals charged with felonies and 10 outpatient, clinic-based restoration slots for individuals charged with misdemeanors. The outpatient misdemeanor beds are designed to help connect individuals with community resources and mental health courts, providing the necessary supports to help reduce the individual's further contact with the criminal justice system.[21]

There have also been suggestions that some misdemeanors should be from the competency process altogether. In the 2021 brief, "Leading Reform: Competence to Stand Trial Systems," the National Center for State Courts recommended that consideration be given to automatic diversion of some misdemeanor offenses if the question of competency is raised, although they acknowledged that there could not be a "one size fits all" approach or a laundry list of applicable charges.[22]

Statutory timelines for the steps in the process

Most states have established timeframes for the provision of the competency assessment and the provision of the completed evaluation to the court, but the variability in those timeframes is significant. Colorado, for instance, allows 21 days for an inpatient evaluation, while in Arkansas the limit is 60 days. In Connecticut, the evaluation must be completed within15 days from court and returned to the court within 21 days of the order.[23]

States have also implemented limitations on the amount of time an individual may be held for competency restoration. Again, the range of those limitations is broad. Some chose to go with specified time limits. Florida allows a six-month initial restoration period, while Idaho allows an

initial 90-day restoration period with a possible 180-day extension. Illinois and Iowa allow an initial order of 30 days, with the possibility of extensions.[24]

Other efforts to speed the process include waiving competency hearings. Several states, including Colorado, Hawaii, Idaho, and Minnesota, allow the competency hearing for individuals accused of misdemeanors to be waived if all parties agree to the findings.[25] Other states establish the timeframes in which competency hearings must be held, again with significant variability.

In alignment with Supreme Court rulings on the issue, states cap the length of time that an individual can be held for restoration, but all do so differently. A frequently used standard for misdemeanors is that an individual may not be held longer than the maximum sentence for their most serious charge, while some states, such as Colorado identify a percentage of the maximum sentence for the most serious charge.[26] In some states, the court may order various alternatives to confinement for individuals who are found incompetent on misdemeanor charges. In California, for instance, the court may order up to a year of diversion for misdemeanor charges, with dismissal following successful completion of diversion. For individuals who do not qualify for diversion, alternatives such as conservatorship or outpatient treatment can be considered.[27]

Use of risk assessments to help drive decisions

Use of risk assessments has been common in juvenile justice settings for decades. However, the use of validated risk tools pre-trial and at the point of diversion is becoming more common in adult competency processes, and use has been suggested by the National Center for State Courts.[28] Many Texas programs use risk assessments as part of the process of determining whether an individual is a good candidate for outpatient restoration[29], and many North Carolina jurisdictions have used risk assessments for over a decade.[30] Colorado has issued statewide guidance recommending the use of risk assessments, directing that an evidence-based risk assessment be used whenever possible.[31]

Diversion processes to transition individuals with high mental health needs from legal to treatment systems and/or court/treatment partnerships, including robust referral, treatment, and case management services for individuals who are released and/or diverted

The increase in diversion has generated the need for a variety of alternatives for individuals who would historically be involved in the competency process. Diversion can occur at any point in the process. Pre-arrest options can include police-led interventions such as co-response units and police partnerships with community providers, such as Atlanta's LEAD program, which allows law enforcement officers from partner law enforcement organizations to offer diversion

to individuals who may otherwise have been arrested for issues relating to mental health or substance use.[32] [33]

Post-arrest diversion opportunities are also widespread. Examples of these include problem-solving courts such as drug courts and veterans courts.[34] [35] Other options include assisted outpatient treatment (AOT) programs and guardianships.[36] [37] As previously discussed, numerous states also have post-competency diversion options primarily related to connecting individuals to appropriate resources and levels of care.

Most competency diversion programs and alternatives rely on the availability of appropriate treatment services and case management of needs such as housing, employment, and supports for participation in continued treatment. Programs such as Florida's Miami-Dade Forensic Alternative Center and Alaska's Alaska Psychiatric Institute's outpatient program include a continuum of care that helps assure that individuals have the necessary resources and treatment to remain stable in the community and avoid future legal difficulties.

Community-based alternatives such as Atlanta's LEAP program offers front-end connections to community and treatment resources aimed at preventing an individual from entering the criminal justice system at all. AOT programs rely on a robust care team that includes the judge, treatment providers, and other key partners. Court-based case management is also becoming more common. Called by a variety of titles such as court liaisons or forensic navigators, these staff can assist at all points of the process, helping to assure timely assessments, coordination of calendars, restoration in the appropriate least restrictive environment, and facilitating connections to ongoing treatment providers and other resources.[38] [39]

Conclusion

Although increases in the use of the competency process and backlogs in the legal and restoration systems are widespread, a range of options is now available to jurisdictions to address the situation. Alternatives include expansion beyond the traditional parameters of the criminal justice and state hospital systems to create enhanced opportunities for improved care for at-risk individuals.

Appendix C

BHRIC Involuntary Commitment Review of: Involuntary Transportation Practices; AOT Evaluation Clinician Credentialling Requirements

Delivered to Judge Sarah Harris, Subcommittee Chair
August 8, 2024

Purpose of Study

In 2019, the Georgia legislature established the Behavioral Health Reform and Innovation Commission (BHRIC). Under the leadership of Kevin Tanner, now the Commissioner of DBHDD, the BHRIC was charged with conducting a systematic review of the behavioral health system in Georgia, including an examination of the impact behavioral health issues have on the court and correctional systems.

An area of particular focus for Commissioner Tanner and the BHRIC is the investigation of alternatives to mandatory law enforcement transportation to emergency receiving facilities for individuals in mental health crisis. The Involuntary Commitment Subcommittee is examining the issue, and Judge Harris asked the Georgia Health Policy Center (GHPC)to conduct an environmental scan of other state practices.

In addition, the Involuntary Commitment Subcommittee oversees the state's Assisted Outpatient Treatment (AOT) pilot. Judge Harris noted that the current legal requirement that an AOT assessment be conducted only by a licensed physician or psychologist has proved to be a barrier to implementation, particularly in rural areas where such professionals may be unavailable. She asked GHPC to conduct a review of the legal requirements for credentialling of individuals conducting AOT assessments in other states that utilize AOT for subcommittee review.

Key questions posed by the committee included:

How do other states/jurisdictions address the need for involuntary transportation for individuals experiencing a mental health crisis?
What alternatives/combinations of alternatives are being used and piloted?

What level of credentialling is required in other states to perform an assessment for AOT petition?

Methods

To respond to these questions, GHPC used the following strategies:

- Conducted a literature review.
- Conducted an environmental scan, reviewing the codes and processes of other states and agencies specific to these processes.

Summary Findings

Context

Involuntary Transportation

The practice of mandating that law enforcement officers provide involuntary transportation of individuals experiencing a mental health crisis has presented numerous challenges. These include:

High costs for law enforcement agencies. A 2019 report indicated that nationwide, about 10% of law enforcement budgets were spent responding to and transporting individuals with mental health needs.[1]

Long distances travelled, especially for rural communities/agencies.[2]

Utilization of significant amounts of officers' time. In 2017, 165,295 hours, or more than 18 years, were used for transportation of people with mental health needs.[3]

Officers also spent considerable time waiting for individuals to be assessed/admitted to care.[4]

Because of this, many jurisdictions are developing other transportation options, or a range of transportation options.

AOT Assessment

Per Georgia code, a physician or psychologist must provide the certification that an individual is in need of involuntary outpatient treatment.[5] However, there is a critical lack of mental health providers in Georgia. The Health Resources and Services Administration's (HRSA) July 2024 Health Professional Shortage report for Mental Health indicated that 152 of 159 counties were designated as a whole-county shortage area for mental health professionals.[6] In a 2022 report, the Georgia Board of Health Care Workforce indicated that in 2020, 90 Georgia counties had no psychiatrists,[7] while a 2022 NAMI publication indicated that 76 counties had no psychologist.[8]

Because of these shortages, some communities and courts that would like to establish AOT programs have been unable to do so due to the unavailability of psychiatrists and psychologists required to complete the assessments and certifications.[9]

Current landscape

Involuntary Transportation Landscape Review

Oklahoma

Oklahoma's alternative transportation initiative, RideCARE, serves as the model for the transportation pilot currently underway in southwest Georgia. The RideCARE program works in collaboration with the state's 988 program to provide transportation to treatment facilities for individuals experiencing a mental health crisis. The program contracts with local transportation vendors to provide a safe alternative to law enforcement transportation. Trained drivers in specially equipped vehicles are used, rather than traditional ambulance or law enforcement vehicles.[10]

Through the RideCARE process, the usual co-response/virtual assessment processes occur, and law enforcement can still provide transport for those individuals who are determined to be unsafe for RideCARE services. However, if the nearest treatment facility is more than 30 miles from the law enforcement officer's operational headquarters, RideCARE may be contacted for transportation. RideCARE's official response time targets are: arrival within 90 minutes of contact, with a target of 60 minutes. Arrival times of greater than 120 minutes must be approved by a representative of the Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS) or by a representative of the contracted agency, per the ODMHSAS description of the program .[11]

Virginia

In 2021, Virginia completed the state-wide roll out of a program that they began in 2019. At that time, the program operated 23 vehicles out of five regional hubs, and included vehicles equipped for the needs of transporting children such as booster seats. Unmarked vehicles with plain-clothes, trained drivers respond to individuals of all ages, 24 hours a day, 7 days a week.[12]

Virginia's rollout has encountered several challenges, including COVID-19 and staffing difficulties, which have slowed impact of the program.[13] In addition, advocates have expressed concerns with the response timelines, which considers units which can respond within six hours to be "available to respond".[14] The state has expanded funding for the program and is piloting adaptations to the model that include modifying exclusion criteria and utilizing Special Conservators of the Peace (trained but unarmed individuals hired by the court) to assist with transportation when needed.[15]

Minnesota

Minnesota's Protected Transportation program utilizes unmarked vehicles with specially trained drivers as an alternative to ambulance or law enforcement transport. The vehicles have

safety locks and a clear barrier between the driver and the individual being transported. A specific assessment is used by responding crisis team members to determine the individual's eligibility for alternative transport, and resultant approvals are single-event specific. An attendant is required in addition to the driver, unless the individual being transported has been stabilized in an emergency department and the total distance of the transport is less than 100 miles.[16] In 2015, the state Medicaid authority identified this as a Medicaid-billable service, reducing some barriers to use.[17]

Nebraska
Nebraska's Targeted Adult Service Coordination (TASC) program utilizes crisis response teams comprised of a licensed clinician and mental health technician, who are available 24/7 and respond at the request of law enforcement. Although TASC providers have up to two hours to respond, they have begun using telehealth strategies to allow for remote assessment and support of on-site law enforcement officers. The program is available in 16 Nebraska counties, including the state's two largest cities of Lincoln and Omaha, and is provided by three private vendors via state contract.[18] [19]

Iowa
Iowa's state law allows local jurisdictions the option of utilizing law enforcement, ambulance, or alternative transportation. The Iowa code specifics that, "A transportation service that contracts with a mental health and disability services region for purposes of this paragraph shall provide a secure transportation vehicle and shall employ staff that has received or is receiving mental health training."[20] Utilization of such alternatives is at the discretion of the local communities.

<u>AOT Assessment Evaluation Provider Credentialling</u>
In response to a request by Judge Harris, a scan of the AOT laws of Southeastern states and the credentialling requirements for providers who are authorized to provide assessment and certification was conducted.

Alabama
In Alabama a licensed medical doctor or qualified mental health professional

Alabama's AOT statute[21] specifically states that a court may order an individual to either inpatient or outpatient treatment. However, there is no specific information in this section regarding the clinical assessments necessary for presentation to the court. Instead, all references in the code indicate that the determination must be made on "clear and convincing evidence." Specific providers are referenced only in terms of the need for "temporary treatment," and references are made to providers who have agreed to provide such treatment,

e.g. "such treatment shall be supervised by a licensed medical doctor or qualified mental health professional who has willingly consented to treat the respondent." That section does specify that a licensed physician must be the ordering physician for hospitalization.
The terms "physician" and "qualified mental health professional" are not defined in the definitions code section.[22]

Florida
In Florida, two opinions are required from a psychiatrist or psychologist, with provisions available for small communities who do not have adequate doctors available

Of the states bordering Georgia, Florida appears to have one of the most restrictive laws regarding the credentialling of the mental health professional who must conduct the evaluations. Two clinical opinions are required, both of which must be provided by either a psychologist or a psychiatrist. Both examinations must take place within 72 hours of the petition (10 days is a more common timeframe). However, there are allowances for smaller communities, and general MD or nurse practitioner can perform the second opinion.[23] Given the difficulties faced by many small/rural Georgia communities, a two-tiered approach may be worth consideration.

Kentucky
Kentucky's law includes all licensed behavioral health professionals

Kentucky's AOT statute states that an evaluator must only be "a qualified mental health practitioner."[24] The definition of qualified mental health practitioner given in the definitions section is inclusive, listing MDs, psychiatrists, psychologists, NPs, PAs, and licensed master's level providers.[25]

North Carolina
In North Carolina psychiatrist or psychologist, or other licensed provider who has gone through the state certification process.

North Carolina statute mandates that an individual receive an examination from a commitment examiner who is different from the proposed treatment provider.[26]

An earlier section requires that evaluations be performed by certified examiners, stating that psychiatrists and psychologists are qualified to provide such evaluations, and that other professionals, to include "licensed clinical social worker, a master's or higher level degree nurse

practitioner, a licensed clinical mental health counselor, a licensed marriage and family therapist, or a physician assistant" may be certified by the state Secretary of Health and Human Services for periods of up to three years. Successful completion of a standardized involuntary commitment training and associate exam are required for certification.[27]

South Carolina
South Carolina requires two examinations, one of which must be a licensed physician. The state Department of Mental Health may register other professionals based on standards established by the Department.

Like Florida, South Carolina requires two concurring evaluations prior to commitment, stating that "...the court shall appoint two designated examiners, one of whom must be a licensed physician, to examine the person and report to the court their findings as to the person's mental condition and need for treatment."[28]

The definitions for this section indicate that, "'Designated examiner' means a physician licensed by the Board of Medical Examiners of this State or a person registered by the department as specially qualified, under standards established by the department, in the diagnosis of mental or related illnesses."[29]

Tennessee
Tennessee ncludes all licensed behavioral health professionals
Tennessee's AOT statute states: "The court shall not order assisted outpatient treatment unless an examining physician or a professional designated under § 33-6-427(a) or (b) who has personally examined the proposed patient no more than ten (10) days before the filing of the petition..."[30]
The referenced definition section of the code states the following:

a. If a person is a licensed psychologist designated as a health service provider by the board of healing arts and is actively practicing as such, the person may take any action authorized and perform any duty imposed on a physician by §§ 33-6-401 — 33-6-406.
b. The commissioner may designate a person to take any action authorized and perform any duty imposed on a physician by §§ 33-6-401 — 33-6-406 to the extent the duties are within the scope of practice of the profession in which the person is licensed or certified, if the person:
    1. Is a qualified mental health professional under § 33-1-101 or is a licensed physician assistant with a master's degree and expertise in psychiatry as determined by the department based upon training, education or experience;
    2. Is licensed or certified to practice in the state if required for the discipline; and

3. Satisfactorily completes a training program approved and provided by the department on emergency commitment criteria and procedures."[31]

The definition of "qualified mental health professional" is in yet another section, which defines qualified mental health professional as "a person who is licensed in the state, if required for the profession, and who is a psychiatrist; physician with expertise in psychiatry as determined by training, education, or experience; psychologist with health service provider designation; psychological examiner or senior psychological examiner; licensed master's social worker with two (2) years of mental health experience or licensed clinical social worker; marital and family therapist; nurse with a master's degree in nursing who functions as a psychiatric nurse; professional counselor..."[32]

Virginia:
Virginia has a psychiatrist or psychologist, or other licensed provider who has gone through the state certification process

Virginia's AOT code mandates that "(i) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available" and "(iv) any examiner's certification" will be included in the things the court will consider at each involuntary commitment hearing.[33]

This section also points to the overall involuntary admission statute, which references a required examination and an appointed examiner. The definition of appointed examiner is "psychiatrist or a psychologist who is licensed in Virginia by the Board of Medicine or the Board of Psychology and is qualified in the diagnosis of mental illness or, if such a psychiatrist or psychologist is not available, a mental health professional who "(i) is licensed in Virginia through the Department of Health Professions as a clinical social worker, professional counselor, marriage and family therapist, or psychiatric advanced practice registered nurse; (ii) is qualified in the assessment of mental illness; and (iii) has completed a certification program approved by the Department"[34] and indicating that, "The examiner chosen shall be able to provide an independent clinical evaluation of the person and recommendations for his placement, care, and treatment."[35] Evaluations can not be provided by an individual who is employed by the facility that will provide treatment for the individual unless the clinician is employed by, "state hospitals, the U.S. Department of Veterans Affairs, and community service boards."[36]

Conclusion

Alternatives to traditional law enforcement transportation of individuals experiencing a mental health crisis are becoming more common around the nation, with several states implementing or piloting alternative processes. Most of these are regionalized or local efforts, although Virginia has implemented at the state level.

Although Assisted Outpatient Treatment (AOT) is a treatment model that is in widespread use, implementation of program specifics varies widely across jurisdictions. The question of the credentials of clinicians who are approved to conduct AOT evaluations is one illustration of this variability.

APPENDIX D: SUBCOMMITTEE ON MENTAL HEALTH COURTS AND CORRECTIONS

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on

Mental Health Courts and Corrections

2024 Annual Report

Chair

Chief Justice Michael Boggs

Members

Sheriff Andy Hester

Judge Brenda Weaver

Judge Kathleen Gosselin

Stan Cooper

Commissioner Michael Nail

November 2024

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas including the Subcommittee on Mental Health Courts and Corrections chaired by Justice Michael Boggs (2020-2024).

To further the work of the subcommittee Chief Justice Boggs formed the Advisory Committee on Forensic Competency. This report includes the work and recommendations of the advisory committee supported by the Mental Health Courts and Corrections subcommittee.

APPENDIX E: ADVISORY SUBCOMMITTEE ON FORENSIC COMPETENCY

Georgia Behavioral Health Reform and Innovation Commission

Advisory Subcommittee on Forensic Competency

2024 Annual Report

Chair

Judge Kathlene Gosselin

Members

Judge Penny Freesemann
Judge Victoria Darrisaw
DA Herb Cranford
ADA Nikia Smith Sellers
Judge Patsy Porter
Judge Eric Brewton
Brandon Bullard
Chris van Rossem
Judge Phillip Jackson
Judge Michael Key
Judge Saah Harris
Judge Kenya Johnson
Dr. Emile Risby
Dr. Julie Oliver
Dr. Kiana Wright

November 6, 2024

Report prepared with assistance from Christy Doyle, Georgia Health Policy Center

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas including the Advisory Subcommittee on Forensic Competency chaired by Judge Kathlene Gosselin (2023-2024).

During 2024, the Subcommittee on Advisory Subcommittee on Forensic Competency held 4 public meetings relating to the process for evaluation and restoration for competency to stand trial for individuals with serious mental health needs. Much of the conversation centered around the need to develop alternatives to the traditional hospital-based models of evaluation and restoration, as well as diversion alternatives to legal system involvement for individuals with high mental health needs who are charged with non-violent misdemeanor offenses.

Additional conversation centered on the challenges faced by individuals charged with non-violent misdemeanor offenses who have a diagnosed cognitive disorder or intellectual disability and who are not restorable on the basis of their diagnoses.

Subcommittee Findings

Misdemeanor Restoration

In the advisory committee's first meeting, Judge Gosselin indicated that the group had been charged with the recommendation of parameters for misdemeanor competency as its primary goal for this session. She indicated she would like the subcommittee to identify a continuum of responses that could be proposed as possible legislative changes. Possible options listed included: diversion to AOT or similar program; mental health courts, guardianship. She also mentioned that she made some contacts with judges in Texas and Colorado, two states who are leading the nation in this work, at a recent judicial conference.

Towards that end, the advisory committee requested two scans from the Georgia Health Policy Center (GHPC) in the course of its work. The first was a brief scan of the national

landscape that suggested that most states/jurisdictions allow outpatient misdemeanor restoration, and that some prohibit misdemeanor restoration but require some sort of diversion. The review also suggests that the decision points tend to be around violent vs. nonviolent misdemeanors rather than misdemeanors and felonies. The second was an environmental scan of costs and savings associated with competency restoration alternatives in other jurisdictions. Savings included lower per day rates for jail- and community-based services versus hospital-based services. Identified challenges included cost shifting from state to local budgets.

Over its four public meetings, the advisory committee reviewed timelines and parameters in place in other states and jurisdictions for competency evaluation and restoration, and used that information to develop recommendations for possible legislative changes to Georgia's competency evaluation and restoration code section. These changes focused on shorter timelines for restoration of individuals with high mental health needs who are charged with non-violent misdemeanors. The advisory committee engaged in robust conversation about the nature of charges that should be included and omitted, and although they were unable to develop a full definition of "non-violent", the advisory committee agreed that domestic violence and impaired driving misdemeanor charges should be excluded.

The advisory committee also developed additional review parameters for use of the competency processes for individuals with high mental health needs who are charged with non-violent misdemeanor offenses. They developed two new processes, the first of which creates an initial hearing to inquire what reasons the defense has to request the evaluation. The advisory committee determined that there should be procedures in place to allow the defense to request an ex parte hearing or to file something under seal if the reason has to do with the facts surrounding the charge. Otherwise, the procedure should be briefly outlined to give the judge both preliminary questions, consistent with the standards for competency, and alternative suggestions for the defense, such as connections with mental health services available in that particular circuit. Examples are jail staff trying mental health medications, or any peer support available through the local CSB. This should be on the record with an order entered in the case. The second added a recommendation to dismiss charges if an individual is not restored after the extended restoration period unless the prosecution chooses to file for an extension and show a compelling state interest in pursuing the charge.

Diversion alternatives in lieu of court proceedings were also discussed, with Judge Harris providing information regarding the use of Assisted Outpatient Treatment as a strategy, and discussion of involuntary outpatient treatment orders issued via probate and superior court. Judge Freesemann emphasized the need to assure that sufficient community services are available for individuals who are diverted.

Finally, the advisory committee acknowledged the needs of individuals with cognitive and intellectual disorders and discussed how poorly suited the traditional competency processes are to the needs of this population. The group determined that this should be a topic of study in 2025.

Recommendation Priorities

The Forensic Competency Advisory Committee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

1. Recommend that O.C.G.A code section 17-7-130 (b) be modified to include language *that a judge will hold an initial hearing regarding defense requests for the competency process* Identify and implement procedures and unified rules to provide guidance to the court and alternative suggestions for the defense regarding language change.
2. Recommend adjustments to restoration processes:
    a. For non-violent misdemeanor, DBHDD would have 45 days to report on the progress to restore the defendant's competency to stand trial. (Instead of the 90 days for felonies).
    b. If the defendant is not restored, DBHDD would have 90-120 more days (instead of the 9 months allowed now in all cases) to continue to work with the defendant for restoration.
    c. If not restored at that point, the case would be dismissed unless the prosecutor chooses to file for an extension and show a compelling state interest in pursuing the charge. Defendants would also be referred to the local CSBs for on-going treatment.
    d. Note: the advisory committee was not able to fully agree on a definition of nonviolent misdemeanor, but did agree that DUI and domestic violence misdemeanors would be excluded from this process.
3. Recommend that next year's work focus on the needs of individuals with cognitive and developmental disorders in relation to the competency process

Misdemeanor Restoration

In addition to recommendations regarding the adult system, through Judge Philip Jackson the advisory committee solicited feedback from the Council of Juvenile Court Judges on the juvenile competency process. The recommendations included:

1. Study and conduct an environmental scan of the processes that are in place to assure that the needs of incompetent and unrestorable youth are met. Develop appropriate recommendations for revisions to the current process.
2. Study and conduct an environmental scan of service options for youth who are involved in the competency process, both restorable and unrestorable. Develop appropriate recommendations for a continuum of services that could be offered by community providers as well as DBHDD.
3. Continue to refine processes for tracking data related to juvenile competency, assuring that data are collected throughout the full process.
4. Recommend DBHDD allocate additional resources to the oversight of the juvenile competency process.

APPENDIX F: SUBCOMMITTEE ON WORKFORCE AND SYSTEM DEVELOPMENT

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on Workforce and System Development

2024 Annual Report

Chair

Representative Mary Margaret Oliver

Members

Cindy Levi

Dr. Nicoleta Serban

Sallie Coke

November 15, 2024

Report prepared with assistance from Georgia Health Policy Center

Contents

Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; the impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees to review these focus areas, including the Subcommittee on Workforce and System Development, chaired by Representative Mary Margaret Oliver (2020-2024).

In 2024, the Subcommittee on Workforce and System Development held two public meetings. The following topics were covered: licensure of internationally trained professionals, workforce data collection, loan forgiveness, network adequacy, parity, and digital Single Session Interventions

This report includes a summary of the subcommittee's public meetings and their 2024 recommendations.

List of Presenters to the BHRIC Subcommittee on Workforce and System Development 2024

BHRIC Subcommittee on Workforce and System Development Rep. Mary Margaret Oliver, Chair Cindy Levi, Dr. Nicoleta Serban, Sallie Coke		
Support to the BHRIC Subcommittee on Workforce and System Development Ashlie Oliver, Georgia Health Policy Center, Courtnee King, Georgia Health Policy Center		
Presenters to the BHRIC Subcommittee on Workforce and System Development 2024		
Date	**Topic**	**Presenter**
Date	Topic	**Presenter** Presenter's Title
7/30/24	Licensure of Internationally Trained Professionals; Workforce Data Collection; Loan Forgiveness; Network Adequacy	**Darlene Lynch** Legal & Policy Director, Georgia Appleseed, BIG (Business & Immigration for Georgia) Partnership **Kanti Chalasani** Director, GDAC **Hayley Corbitt** Director of External Affairs, Georgia Student Finance Commission **Chet Bhasin** Executive Director, Georgia Board of Healthcare Workforce **Roland Behm** Co-Founder, Georgia Mental Health Policy Partnership
10/21/24	Parity, Digital Single-Session Interventions	**Dr. Jessica L. Schleider** Clinical Psychologist for Children and Adolescents, Associate Professor of Medical Sciences, Pediatrics, and Psychology at the Northwestern University School of Medicine. Director of the Lab for Scalable Mental Health

Summary of Presentations to Subcommittee

Licensure of Internationally Trained Professionals; Workforce Data Collection; Loan Forgiveness; Network Adequacy

The committee heard from Darlene Lynch, the Legal and Policy Director at Georgia Appleseed, regarding the barriers to licensing for internationally trained behavioral healthcare professionals in Georgia. Ms. Lynch shared that Georgia has a healthcare workforce crisis in which the state is trying to fill 240,000 healthcare positions in less than a decade; however, there are not enough physicians able to be trained to meet the demand. One solution would be to allow people from across the globe to join the local workforce. Georgia already has a deep pool of global talent, as one in ten Georgians are immigrants. Additionally, a large percentage of the healthcare workforce are legal immigrants from around the world. So, while Georgia relies heavily on global talent, it is not being maximized. Many of the 3,000 refugees that come to Georgia each year are healthcare professionals who are now underemployed in the U.S., 26% of Georgia immigrants with healthcare degrees are unemployed or under-employed. Around 263,000 internationally trained behavioral healthcare professionals live in the US and are willing to move states to return to practice. To be a mental health practitioner in Georgia, however, foreign providers are required to repeat requirements previously met when living abroad to become licensed. Reducing barriers for internationally trained behavioral healthcare professionals to practice in Georgia is important to support the workforce shortage. It could also expand multilingual care to the over one million Georgia residents who are immigrants, many of whom have limited English proficiency.

Many states have taken steps toward licensing reform, making them more attractive to international medical professionals. One such state is Tennessee, which passed legislation to provide provisional licensure to foreign-trained healthcare providers for two years.

The following progress has been made to reform licensing requirements in Georgia:

- Since 2021, study committees and commissions have been formed to maximize global talent, which the Secretary of State has endorsed.
- SB 529 was introduced during this past legislative session with high-level support. This bipartisan licensing reform bill would ease barriers to practice for experienced international physicians.
- The first statewide gap analysis in Georgia is being conducted by the Department of Behavioral Health and Developmental Disabilities (DBHDD) to look at mental health needs in immigrant and refugee communities.
- Children's Healthcare of Atlanta developed initiatives around culturally and linguistically responsive care.
- A Dekalb County Community Service Board hired its first case manager to serve refugee and immigrant families.

Next, the committee heard about workforce data sharing from Kanti Chalasani, the Director of Georgia Data Analytics Center (GDAC). Ms. Chalasani shared that data sharing among Georgia agencies has been challenging. GDAC was established in 2019 to improve "public health and the safety, security, and wellbeing of GA residents" through data sharing and analysis. In September 2023, the Governor signed an Executive Order ordering GDAC to facilitate data sharing between executive state agencies. In accordance with this order, GDAC worked with executive state agencies to develop and publish data sharing agreement templates and data sharing request templates. In May of 2024, the templates were published. A survey is being conducted to gather all data sharing agreements (DSAs) by all executive agencies established in FY 24. The intent is to build a library of DSAs to make future DSAs faster. GDAC is currently waiting for this survey to be completed.

Ms. Chalasani shared that she believes Georgia is ahead of the nation in data sharing. GDAC has been recognized nationally and at the state level for the work done in navigating the data sharing laws. With respect to HB 1013, GDAC worked closely with the Department of Human Services (DHS), the Office of the Commissioner of Insurance (OCI), and the Department of Community Health (DCH) to collect all mental health parity complaints, which are published on GDAC's website.

Regarding statewide childcare and protection data sharing, GDAC worked closely with DHS to build the DSA language. The review of data sharing agreements has been completed and they are now working on gathering signatures to finalize the data agreement. GDAC has built a technology solution with a modern platform for data ingestion, where they build data pipelines to share information between agencies. This solution has been showcased to DHS.

As part of HB 1013, GDAC has collected over 5,000 data elements, including about 5.6 million records. They are in the beginning stages of conducting data analysis, and preliminary data analysis has been submitted to DCH.

GDAC has published an annual report on its website that summarizes all the work that GDAC has done in FY24. The Dashboard released in FY24 includes: Consolidated Health Care Workforce, Pain Management Clinics, EMS Workforce, EMS Education Programs, State Charter School Commissions Accountability, and All Payer Claims Database dashboards published. GDAC keeps this data current and updates weekly, monthly, and quarterly.

Hayley Corbitt, the Director of External Affairs at the Georgia Student Finance Commission, updated the subcommittee on loan forgiveness programs, as outlined in HB 1013. Ms. Corbitt shared information about the HOPE scholarship and 20 other grant and service cancellable loan programs, including the behavioral health profession service cancellable loan. The service cancellable loan was created by HB 1013. This program aimed to generate more behavioral health professionals who practice in Georgia. It offers eligible graduate students up to $20,000 a year in exchange for one year of working in the state. Grantees are eligible to receive the grant up to 6 times, totaling up to $120,000. The application opened at the end of 2023. Thus far, there have already been over 170 applications, and $1.5 million has been awarded to 113 students and there have already been over 170

applications. The application is available on georgiafutures.org. Students need a GA futures account and a submitted FAFSA application to apply. Ms. Corbitt shared that the committee could help spread awareness about the program.

Lastly, Roland Behm, one Co-Founder of the Georgia Mental Health Policy Partnership, shared information about network adequacy. He relayed that there is a gap between the behavioral health workforce supply and Georgia residents' access to that supply, depending on whether they have insurance or Medicaid coverage. The aggregate shortfall in supply is exacerbated significantly by "skinny networks" of providers. The majority of behavioral health professionals are not in-network. For example, the number of out-of-network behavioral health providers for children is 10 times higher than out-of-network physical healthcare providers. Therefore, it is important to focus on not only increasing the behavioral health workforce supply but ensuring that the managed care organizations and health insurers provide their enrollees with sufficient access to providers. Provider lists also need to be updated to represent providers actively providing care as lists often include providers who are no longer practicing, are not taking insurance, have moved their offices, etc. A 2017 report found that 21% of health plans included less than one-fourth of available providers, and another 20% included fewer than 40% of available providers.

There are significant differences between reimbursement rates for mental and behavioral healthcare and general healthcare providers. The general healthcare workforce has reimbursement rates 50% higher or more for the same codes. When there is an overall workforce shortage, there is no incentive for a provider to go in-network when they will get substantially less money.

Georgians with acute mental health needs are 16 times more likely to be forced to see out-of-network providers than Georgians with medical/surgical needs. Georgians needing to see a psychiatrist are 4.8 times more likely to be forced out of network than if they were seeking a medical or a surgical specialist. This phenomenon increases the cost to access behavioral health.

There are 25% more shortage areas for primary care physicians (PCPs) than mental health providers. The out-of-network percentage is 2.2% for PCPs versus 15.3% for psychiatrists. PCPs have reimbursement rates ranging from 20-50% higher than those for psychiatrists.

The goal is to ensure a more robust representation of behavioral health workers in the network. One possibility is to create a framework in which clients do not have to call everyone listed in the directory to try and find a provider. Instead, there could be an online provider appointment scheduling system in which clients indicate the type of provider they would like and book the appointment. This tool would give regulators real-time measures of insurers' compliance with network adequacy obligations.

Digital Single Session Intervention for Youth Mental Health

The committee heard from Dr. Jessica Schleider, Director of the Lab for Scalable Mental Health. She suggested that meaningful transformation of youth mental health care requires reckoning with three sobering realities, including 1) 80% of youth with mental health needs do not access any form of support, 2) Supports that do exist are structurally incompatible with how many youth (want to) engage with care, and 3) The most common number of interactions youth have with mental health support is one.

The systems created do not match how youth access services. Treatment delivery systems need to change so people can access care. One recommendation to facilitate this change is to increase the number of providers that are available to help. Provider shortages are too severe to fix access-to-care problems through workforce expansion alone. Creative, innovative approaches are needed to fill these gaps. The mission of Lab for Scalable Mental Health is to design, test, and disseminate brief, barrier-free interventions to reduce mental health problems at scale. This is done primarily by developing and studying single-session interventions (SSIs). SSIs are specific, structured programs that intentionally involve just one visit or encounter with a clinic, provider, or program. SSIs may be accessed on one *or* many occasions. It is a one-at-a-time approach, not a one-and-done approach, that recognizes that one session can still have an impact. SSIs can be self-guided or human-facilitated and may be accessed within or outside formal healthcare settings. In all cases, SSIs drop the (often false) assumptions that clients will return and instill the belief that meaningful change is possible at any moment for any person, starting from a context of competence in the patient.

Decades of research tell us that SSIs can help in some cases as much as longer-term treatments. Dr. Schleider shared her meta-analysis of data concerning the average effect of a single intervention compared to the average effect of a full-length youth intervention. The data shows that the effects of single sessions are relatively comparable to full-length interventions. Further research is needed to determine what about the single sessions makes them impactful. Recently, an umbrella review found that there had been 415 clinical trials of SSIs that indicated that treatment had an overwhelmingly positive benefit on both mental health and service use outcomes. SSIs will not replace existing forms of treatment, but they can bridge otherwise unfillable gaps in mental health systems.

The Lab for Scalable Mental Health's evidence-based SSIs have now served over 70,000 youth, young adults, and parents. They are accessed through grant-funded clinical trials, but most via nonprofit, organizations, local government, and community partnerships. The SSIs were co-designed with youth and translated into eight languages. All SSIs are accessible as needed for youth with or without formal diagnoses. Each SSI targets a modifiable, short-term belief or behavior where short-term improvements in perceived control, autonomy, and hope to spur meaningful, long-term change up to 9 months later. Two SSIs are certified by an independent nonprofit, Blueprints for Healthy Youth Development as "dissemination ready." The materials are publicly available for use. Forty

percent (40%) of youth accessing these interventions are racial/ethnic minorities, and 75% are LGBTQ+. These two groups are the most likely to go without services.

Digital single-session interventions all include psychoeducation about brain science to boost buy-in, peer stories to strengthen relatedness, action plans to streamline skill use, and sharing advice to solidify learning.

Single-session consultations (SSC) are delivered by a mental health professional or trained lay provider. The provider training is 2 hours. The SSC itself lasts 30-60 minutes total and is deliverable by professional and lay providers who have no mental healthcare backgrounds. This solution-focused SSI can reduce hopelessness, increase agency, and prevent symptoms from worsening in people on therapy waiting lists.

Recently, the Lab for Scalable Mental Health's work has shifted from focusing on evidence generation to evidence deployment. They are leveraging community partnerships to determine sustainable models for scaling up SSIs to fill service gaps. They are developing a user-friendly, digital self-guided SSI platform with their tech partner, Koko, a digital mental health nonprofit. The Lab of Scalable Mental Health is working with stakeholders and partners in multiple states to develop a dissemination toolkit, embed the platform into systems of care, and make culturally appropriate platform adaptions.

The platform will eliminate wait times for evidence-based support and increase connection with existing community services. It will include 1) an easy onboarding process and optimized user interface, 2) mental health self-screening, 3) an AI-powered risk detection system, 4) an evidence-based digital SSI tailored to the primary problem, 5) a suite of additional SSIs available 24/7, and 6) instant connection to local services. Having access to treatment through the platform will alleviate distress from common mental health problems in the short- and long-term, boost receptivity and hope that mental health treatment can help, and bridge the gap between need and support for youth who might otherwise fall through the cracks.

The platform is helpful for youth with unmet mental health needs who would otherwise go without timely support. The platform will also help professionals and lay health workers or clinics to support youth between sessions. Barriers to youth receiving mental health care include stigma, hidden symptoms, long waiting lists, and provider shortages.

Georgia may want to consider adopting an implementation toolkit for the state and initiate a 1-to-2-year pilot project. While the basic platform features will be free for youth everywhere, there are low up-front fees for customizing referrals to reflect local mental health services. The Lab for Scalable Mental Health charges a one-time fee to adapt implementation toolkits to target settings. They will also offer two services for an additional cost, supporting large-scale evaluations of the platform's impact and training healthcare workers to deliver SSIs. Possible next steps include a 1-to-2-year pilot project and adapted implementation toolkit for GA.

Recommendation Priorities

The Workforce and System Development Subcommittee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

I. Licensure

The issue of licensure was presented to the subcommittee during 2022 committee testimony. It has continued to be an identified barrier to addressing the behavioral health workforce shortage. This issue was also identified in the 2023 Deloitte Workforce Innovations Report for the Department of Behavioral Health and Developmental Disabilities (DBHDD). Specifically, the report recommended that Georgia offer out-of-state reciprocity within the year to immediately expand the workforce. Similarly, the 2023 Senate Study Committee on Expanding Georgia's Workforce identified enhancing and expanding licensing reciprocity in high-demand fields as a top legislative recommendation. The National Alliance on Mental Illness (NAMI) reported that states with restrictive scope of practice limitations, on average, have a 30% rate of unmet mental healthcare needs among adults. Currently, 39 states have enacted some form of licensure reciprocity for mental health clinicians . License reciprocity removes unnecessary barriers, encourages healthcare providers from other states to practice in Georgia, and enables Georgia providers to expand their practices.

The Georgia Secretary of State (SOS) should continue recognizing the national movement to ease the transfer of mental health licenses across state lines and from other countries by taking legislative steps to make licensures more consistent nationally. Licensure issues receive bipartisan support. The entire General Assembly recognizes the need to address workforce shortages in high-demand fields. For example, SB 373 was introduced and passed which provided for mandatory licensure portability for marriage and family therapists licensed and in good standing in other states to become licensed in Georgia. In addition, the General Assembly also passed SB 195 which adopted the Social Work Licensure Compact that authorized the state to facilitate recognition of licensed clinical social workers seeking licensure in Georgia. Each year, the General Assembly continues to recognize the importance of easing licensure and removing unnecessary obstacles.

1. Coordinate recommendations from other study committees on licensure

Several state entities are working to improve licensure in Georgia, including the Georgia Senate and House Joint Blue-Ribbon Committee to Investigate Licensing Issues. The committee is co-chaired by Representative Matt Hatchet and Senator Blake Tillery. The committee is tasked with researching licensing issues within the Secretary of State's Professional Licensing Board Division and developing solutions and recommendations.

The Workforce and Systems Development Subcommittee would like to support the recommendations that come out of the Joint Blue-Ribbon Committee to Investigate Licensing.

2. Continue efforts to improve out-of-state license reciprocity and use of existing interstate compacts

An environmental scan was conducted to assess Georgia's alignment with other states that have acted regarding license reciprocity. Other states have passed legislation to join national compacts that allow providers' licenses to be valid in all states that are part of the compact. Georgia is currently part of four out of five national licensing compacts including compacts for counseling, nursing, psychology, and social work. There is opportunity for Georgia to join the school psychology compact and be attuned to other national compacts that are established.

Additionally, several states have universal licensure recognition, which allows providers to work in their state if they have 1) a license in another state or 2) experience working in a state that does not offer licensure.

3. Enhance opportunities for internationally trained behavioral health professionals

Georgia is continuing to increase in ethnic and racial diversity, which also increases the need for culturally competent and equitable health services and providers. Furthermore, Georgia's population has shown an exponential increase in foreign-born people who now reside in the state, contributing to 10% of Georgia's population. In addition to facing a behavioral health workforce shortage, fewer minority and foreign-born behavioral health providers are accessible and readily available to serve these communities. There is a need for internationally trained behavioral health professionals; however, barriers may impede their licensure. Other states have reduced these barriers through temporary licensure and pathways for internationally trained behavioral health professionals, making licensure easier to navigate, obtain, and use. Other activities supporting this work include establishing culturally competent divisions within state agencies such as DBHDD, creating incentive programs, implementing National Standards for Culturally and Linguistically Appropriate Services (CLAS), improving coordination between agencies and programs, and culturally responsive crisis services.

Tennessee became the first state to address this issue by passing legislation during the 2023-2024 legislative session to provide provisional licensure to foreign-trained healthcare providers for two years. The provider must be able to show that they are a graduate of an international medical school and provide proof of an offer of employment within Tennessee to be eligible for this temporary license. With this temporary license, providers can work in accredited health-serving institutions with a postgraduate training program. The bill states that after two years, the provider may receive full licensure contingent upon remaining in good standing.

The subcommittee recommends that Georgia adopt similar legislation to address the issue of internationally trained behavioral health professionals.

4. Modernize the licensing process

Georgia has recently provided funding to upgrade the licensure application process to a digital one. The Georgia Secretary of State Office has been rolling out GOALS, the Georgia Online Application Licensing System, for various licensure applications.

This upgrade is an important investment in system modernization. The 2023 Deloitte report notes that states can take various tactics and approaches to enhance digital-only platforms. The upgrading process is lengthy and takes considerable and continued investment. The review suggests that a long-term plan to digitize and update the platform should include application intake, license and permit management, enforcement and compliance, inspections, examinations, cash management, and reporting. Georgia's investment in the digital application process could also be expanded to include other licensure mechanisms. Illinois has recently undergone a similar process (HB2394) to Georgia and is investing in transitioning several licensure processes to digital. The review also suggests that requirements barriers can be eliminated from different licensure boards, enhancing the feasibility of using digital platforms. These suggestions include removing the requirement of notarization, physical signature, and written documentation and simplifying regulations for licensure where appropriate. The Michigan Social Modernization House Bills 5184 and 5185, which have not yet been passed, attempt to modernize social worker requirements. Specifically, the bills propose removing the ASWB (Association of Social Work Boards) exam requirement for social workers, which has been criticized as lengthy and inequitable. Instead, the bill requires a shorter jurisprudence exam for individuals. This change would follow the more modern practices of other states, including Maine, Minnesota, New York, Illinois, Utah, and North Dakota.

The subcommittee recommends continuous reporting on the use of appropriations to the Secretary of State, as well as status updates and evaluations of the GOALS platform to ensure it meets the needs of the Georgia behavioral health workforce.

II. Grow a Skilled and Robust Behavioral Healthcare Workforce

Georgia faces severe behavioral healthcare workforce shortage issues, with 989 geographic areas considered mental health professional shortage areas as of October 2024. Additionally, most existing providers are not in-network for any insurance company. For children, for example, the number of out-of-network behavioral health providers is 10 times as high as out-of-network physical health providers. Fostering a strong behavioral health workforce is critical to continued efforts to implement parity in Georgia by increasing network adequacy and overall access to care.

The subcommittee recognizes the importance of investing in and developing current and incoming talent. It seeks to establish the Georgia behavioral health workforce as a career destination.

The subcommittee further recommends that the state create investment pathways for professional development through continuing education that will allow individuals to grow within the State. To create a pipeline for the future workforce, the subcommittee

recommends cross-agency collaboration to fund, promote, and provide incentives for behavioral workforce educational programs, such as dual-enrollment programs.

1. Flexible scheduling and benefits for staffing

The subcommittee recommends expanding the opportunity to offer benefits to part-time behavioral health staff to make entry to the workforce more enticing. Georgia should also continue experimenting with the possibility of offering other flexible scheduling option and follow its outcomes closely.

2. Amend Medicaid State Plan to maximize eligible services and utilize providers in training

The low number of psychologists in Georgia largely contributes to issues in accessing mental healthcare. The subcommittee recommends that the Medicaid State Plan is updated to include CPT Code 90791 Diagnostic Evaluation as a covered service in the Georgia Medical Policy Provider Manual for psychology services. It also recommends amending Georgia's Medicaid State Plan to allow licensed psychologists who are Medicaid providers to bill for services for provided by doctoral psychology interns and postdoctoral residents who are under their supervision.

3. Invest in peer support workforce

Peer support is an evidence-based practice that utilizes people with lived experience in behavioral health interventions. Some of the proven benefits of the use of peers include lower hospital readmission rates, reduced number of days in an inpatient stay, greater use of outpatient services, improved quality of life indicators, increased rates of provider engagement, improved whole health, lower cost of services, and reduced mental health and/or substance abuse issues.

The subcommittee recognizes that peers are a critical part of the behavioral health workforce and recommends that Georgia dedicate resources to ensuring sustainable funding for peer support programs and increased accountability in the training provided to peers to ensure their success in the workplace.

4. Loan repayment assistance program for mental health and substance use disorder professionals

HB 1013 called for the creation of a service cancelable loan program for students enrolled in any degree program for mental health and substance use professionals, which is administered by the Georgia Student Finance Commission. This program creates an incentive for students to enter degree programs to become mental health and substance use professionals by awarding loans to students, which can later be repaid through service once they are licensed and practicing in the field. Based on the subcommittee's review of other states' programs and related workforce data, it would be worthwhile for Georgia to incentivize its current workforce to practice in mental health professional shortage areas

through a loan repayment assistance program for individuals who are no longer students but actively practicing in the workforce as a licensed mental health or substance use professional. Applications for the program opened at the end of 2023, and thus far there have been over 170 applicants and $1.5 million has been awarded to 113 students.

The subcommittee recommends continuing to build on the success of the cancelable loan program by ensuring that trainings on how to apply are available and promoted. Additionally, the subcommittee recommends that loan repayment assistance programs for licensed mental health or substance use professionals, conditional on five consecutive years of services in a facility with a HPSA designation that serves both Medicaid and PeachCare for Kids, continue to be established.

5. Invest in innovative workforce solutions

Richmond County School System in Georgia is partnering with DBHDD to expand telehealth options and Single Session Intervention (SSI) platforms designed for school-age children seeking help. This platform gave an additional opportunity and avenue for Georgia's children to connect with when they have mental health concerns or challenges.

The subcommittee recommends that the state follow the Richmond School District program and research from other states to reach children accessing digital platforms independently, without costs, application obstacles, or password requirements, to express mental health concerns. Georgia could refer to other pilot projects giving school systems additional tools to reach children who are actively looking online for help, and proposals with specific costs for services. It is predicted that school-age children in distress will use online platforms to talk about their worries and to seek help. The state can use and support information from the SSI digital platform to connect them with the available services they may need.

III. Evaluate Programs, Practices, and Policies

Every year the General Assembly considers legislation relating to scope of practice for a variety of mental health providers, and these discussions overlap sometimes with portability of licenses discussed in this report. Addressing the restrictive practice environment for Advanced Practice Nurses (APRNs) and Physician Assistants (PAs) in Georgia can be a step toward alleviating this shortage, as these highly trained professionals are well-prepared to deliver primary and specialized care. Removing barriers, including granting advanced practice more authority and adjusting prescribing regulations, can enhance healthcare access across the state, particularly in underserved areas. Currently, Georgia requires APRNs and PAs to practice under physician oversight, limiting their ability to operate independently. This dependency restricts advanced providers' capacity to deliver care in rural and medically underserved communities, as the availability of supervising physicians can be scarce. This is especially problematic where APRNs with national board certifications as Psychiatric Mental Health Nurse Practitioners are unable to establish practices in their hometowns. Thirty states have already adopted full practice authority, and Georgia is in the minority of states that restrict practice authority.

1. Modifications of Barriers to Practice for Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) in Georgia

Georgia allows APRNs and PAs to prescribe Schedule II medications, currently limited to a 5-day supply of hydrocodone and oxycodone in emergency situations to individuals over age 18. The subcommittee would like to know the impact and benefit of the expansion.

The subcommittee recommends an evaluation of this expanded prescription authority and analysis of practices in other states and what additions might be appropriate at this time for Georgia.

2. Evaluate Legislative Actions Taken

In recent history, multiple legislative actions have been taken to allow additional mental health professionals to perform guardianship and conservatorship evaluations for court proceedings. These recent efforts, including HB 375 and its legislative path, should be reviewed and new recommendations offered.

The subcommittee recommends that an evaluation of legislation pertaining to guardianship and conservatorship evaluations for court proceedings be completed and new recommendations be put fourth based on the findings.

Alternative disciplinary procedures have been offered based on the successful history of legislation enacted for physicians and veterinarians. New bills offering alternative

disciplinary procedures to include mental health workers and nurses have been offered and have passed the House but not made it to final action and implementation through the Senate.

The subcommittee recommends these past legislative efforts to expand alternative disciplinary proceedings for mental health professionals be offered for passage in the 2025 Session.

Brief: Removal of Barriers to Practice for Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) in Georgia

The State of Georgia faces a critical shortage of healthcare providers, especially in rural areas, where residents often lack access to timely and comprehensive care. Addressing the restrictive practice environment for APRNs and PAs can be a significant step toward alleviating this shortage, as these highly trained professionals are well-prepared to deliver primary and specialized care. Removing barriers, including granting full practice authority and adjusting prescribing regulations, can enhance healthcare access across the state, particularly in underserved areas.

1. Granting Full Practice Authority

Problem: Currently, Georgia requires APRNs and PAs to practice under physician oversight, limiting their ability to operate independently. This dependency restricts advanced providers' capacity to deliver care in rural and medically underserved communities, as the availability of supervising physicians can be scarce. This is especially upsetting as well experienced APRNs with national board certifications as Psychiatric Mental Health Nurse Practitioners are unable to establish practices in their home towns.

Solution: Granting full practice authority to APRNs and PAs would allow them to practice independently, enabling them to respond effectively to community health needs without the limitation of a supervisory agreement. At present, 30 states (including DC and US territories) have already adopted full practice authority, which has led to improved healthcare access, especially in underserved areas, without compromising the quality of care. Georgia is one of 11 states that restricts practice authority.

2. Authorization to Prescribe Schedule II Medications

Problem: APRNs and PAs in Georgia are restricted in their ability to prescribe Schedule II medications (currently only a 5-day supply of hydrocodone and oxycodone, in emergency situations to individuals over the age of 18), limiting their capacity to manage a full scope of mental health conditions. Georgians in rural areas experience mental health issues like ADD/ADHD, anxiety, and depression as frequently as urban settings, yet providers often cannot prescribe the necessary treatments independently.

Solution: Further expanding prescription authority to include Schedule II medications that can treat mental health disorders would empower APRNs and PAs to provide comprehensive care to rural and medically underserved communities where mental health care is limited. This change would enable advanced providers to manage these conditions without requiring patients to travel long distances for specialized or physician-provided care, which is often impractical for rural residents.

3. Establishment of Alternative Discipline Programs for Impaired APRNs and PAs

Problem: Currently, Georgia lacks a robust, alternative discipline program tailored to APRNs and PAs dealing with substance abuse or other impairments. Without such a program, APRNs and PAs risk losing their licenses and livelihoods if they seek help, which can discourage those struggling from pursuing the rehabilitation they need.

Solution: Establishing an alternative discipline program that allows impaired APRNs and PAs to undergo rehabilitation while protecting their licenses would support a safer, more resilient healthcare workforce. Programs like this exist in other states, providing a structured approach to recovery that ensures patient safety and fosters a culture of support and accountability. SEE SB 12 below.

Conclusion

Removing barriers to practice for APRNs and PAs is essential to addressing Georgia's healthcare needs, particularly in rural and underserved areas. Granting full practice authority, extending prescribing rights, and creating supportive programs for impaired providers will enable these professionals to deliver high-quality, accessible care where it's needed most. Embracing these reforms not only aligns Georgia with a growing national movement toward independent practice but also invests in the health and well-being of its communities.

Quick Reference of Previous Bills and Current Initiatives

2023-24 HB 215: A BILL to be entitled an Act to amend Chapter 26 of Title 43 of the O.C.G.A., relating to nurses, so as to provide for licensure of advanced practice registered nurses; to revise definitions; to provide for licensure requirements; to provide for renewal of licenses; to provide for a misdemeanor to practice advanced nursing practice without a license; to amend Article 3 of Chapter 2 of Title 40 and Article 2 of Chapter 34 of Title 43 of the O.C.G.A., relating to prestige license plates and special plates for certain persons and vehicles and medical practice, respectively, so as to authorize advanced practice registered nurses and physician assistants to execute affidavits certifying an individual is disabled for purposes of obtaining special vehicle decals for persons with disabilities; to provide for related matters; to repeal conflicting laws; and for other purposes

- Died in chamber. Disability added to final version of 557. APRN licensure section of the bill was included in SB 449 in the 2024 session.

2023-24 HB 557: A BILL to be entitled an Act to amend Chapter 34 of Title 43 of the Official Code of Georgia Annotated, relating to physicians, assistants, and others, so as to authorize physicians to delegate the authority to advanced practice registered nurses and physician assistants to prescribe Schedule II controlled substances; provide for requirements; to provide for automatic approval of nurse protocol agreements and job descriptions under certain conditions; to provide for legislative findings; to provide for related matters; to repeal conflicting laws; and for other purposes.

- Final signed version on 4/22/24: This bill authorizes physicians to delegate the authority to advanced practice registered nurses (APRNs) and physician assistants (PAs) to prescribe certain Schedule II controlled substances, such as hydrocodone and oxycodone, in emergency situations **AND ONLY TO** individuals over the age of 18. It also provides for automatic approval of nurse protocol agreements and job descriptions under certain conditions to streamline the process at the Georgia Composite Medical Board. Additionally, the bill authorizes APRNs and PAs to execute affidavits certifying an individual is disabled for purposes of obtaining special vehicle decals for persons with disabilities.

HB 1046: A BILL to be entitled an Act to amend Code Section 16-13-72, Code Section 31-6-2, and Article 7 of Chapter 7 of Title 31 of the O.C.G.A., relating to the sale, distribution, or possession of dangerous drugs, definitions relative to state health planning and development, and home health agencies, respectively, so as to authorize advanced practice registered nurses and physician assistants to order home healthcare services; to amend Title 43 of the O.C.G.A., relating to professions and businesses; to authorize the Georgia Board of Nursing to establish a professional health program to provide for monitoring and rehabilitation of impaired healthcare professionals; to repeal the prohibition on delegating to advanced practice registered nurses the authority to sign death certificates; to provide for related matters; to repeal conflicting laws; and for other purposes.

- Final signed version 4/23/24: This bill authorizes advanced practice registered nurses (APRNs) and physician assistants (PAs) to order home healthcare services, sign death certificates, and perform certain other healthcare-related tasks that were previously limited to physicians. The bill also creates the Georgia Commission on Maternal and Infant Health to make policy recommendations and measure the quality and effectiveness of perinatal care in the state. Changes to APRN protocol supervision ratios from 4:1 to 8:1.
    - Unfortunately, the bill mandated training of APRN's prior to allowing them to sign death certificates. The training was made the responsibility of the Medical Board not the Board of Nursing. To date, they have not made the training available.

SB 164: A BILL to be entitled an Act to amend Chapter 26 of Title 43 of the Official Code of Georgia Annotated, relating to nurses, so as to provide for licensure of advanced practice registered nurses; to revise definitions; to provide for licensure requirements; to provide for

renewal of licenses; to provide for a misdemeanor to practice advanced nursing practice without a license; to provide for related matters; to repeal conflicting laws; and for other purposes.

- Vetoed as stated but later passed as SB449 with substituted language approved by the Governor's office to create APRN licenses effective September 2025

Major Current Bill in need of support:

SB 12: To amend Title 29 of the Official Code of Georgia Annotated, relating to guardian and ward
so as to revise the list of providers who are authorized to participate in the processes for appointment of a guardian for an adult, the modification and termination of such guardianship, and the appointment of emergency guardian; to revise the list of providers who are authorized to participate in the processes for appointment of a conservator for an adult, the modification and termination of such conservatorship, and the appointment of emergency conservator; to provide for limitations on the powers and duties of certain emergency conservators; to amend Title 43 of the Official Code of Georgia Annotated, relating to professions and businesses, so as to provide certain licensure requirements and programs for certain healthcare professionals; to authorize the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists to establish a professional health program to provide for monitoring and rehabilitation of impaired healthcare professionals; to authorize the Georgia Board of Nursing to establish a professional health program to provide for monitoring and rehabilitation of impaired healthcare professionals.

- This bill is important as it directly affects our focus by expanding access to providers who can assist in the needed examinations before appointments of guardianships for adults who are impaired and unable to make decisions for themselves.
- It also protects the licenses of impaired mental health providers while they are undergoing treatment and rehabilitation of their own mental health issue.

Georgia Health Policy Center

Georgia State University | Andrew Young School of Policy Studies

BHRIC Workforce Subcommittee: Licensure Environmental Scan

Prepared by the Georgia Health Policy Center
August 30, 2024

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EXECUTIVE SUMMARY

The Georgia General Assembly has made efforts in the past few years to modernize licensure requirements, making it easier for trained professionals to work in Georgia. Including forming several working groups, passing and drafting vital pieces of legislation to modernize requirements for licensure, and increasing funding for enhanced digital systems for licensure application. Despite the ongoing efforts, Georgia has been facing workforce shortages compounded by licensure delays for all professions, including behavioral health professions.

The following brief describes strategies that states have used, such as increasing licensure acceptance for individually licensed in other states or countries, allowing providers to practice across state lines without licenses from each state, and streamlining processes to get those who relocate to Georgia working when they have already been licensed in other states. Additionally, there are opportunities for continued funding for digitizing and modernizing the licensure application process and all monitoring, payment, and compliance practices. Lastly, some states have modernized individual licensure policies to prevent bias and streamline licensure for mental health professions. And there are continued opportunities for modernization of licensure requirements for various licenses.

BACKGROUND

In Georgia the interest in modernization of the licensure process has increased in the past several years, as workforce shortages and a surge in licensure requests make timely licensure for trained workforce paramount. The Georgia Secretary of State's Office manages the administration of licensure for trained professionals, with oversight over 40 licensing boards, all of whom have different procedures, requirements and fees to obtain licensure. Legislative action is required to modify or change licensure requirements.

There are several solutions other states have adopted to increase the ease of licensure portability and reciprocity, including adopting policies around international license providers, licensure portability, compact licensure, and universal licensure. Georgia's expansion of any or all these policies could help to remove barriers for trained professionals to begin working in Georgia. The following report, details existing modernization efforts in Georgia, along with opportunities for an increase of modernization of licensure for legislative, administration and agencies.

GEORGIA

Georgia has been experiencing a behavioral health workforce shortage, which has been exacerbated by licensure issues that have affected all licensed occupations. In Georgia, 982 geographic areas are considered mental health professional shortage areas. The Behavioral Health Reform and Innovation Commission Workforce Group has recommended in their report from 2021, 2022, and 2023 to modernize licensing practices across all levels of the Behavioral Health workforce

The Georgia Secretary of State's office established a commission in 2023, GA WORKS (Growing All Workforce Opportunities by Remaking the Scope) Licensing Commission to investigate barriers for employment for trained professionals. The Georgia General Assembly has introduced and passed several pieces of legislation in recent years modernizing and updating licensure application processes and requirements for various jobs.

The Georgia General Assembly created the Joint Blue-Ribbon Committee on Licensure in 2024 and the GA Works Licensing Commission in 2023 to investigate the ongoing problems with licensure.

MODERNIZATION OF LICENSURE

Licensure, considered an intrastate activity, is managed differently in various states. States have different professions licenses, licensure requirements, and processes for licensure application. The standardization of medical practices across state lines and the increase in telehealth availability, acceptance, and innovation are key components to ensuring those who seek behavioral health can find a provider. States have addressed licensure in various ways, including broadening licensure acceptance across state lines and for foreign trained professionals and modernizing the application process.

Internationally Licensed Practitioners

Internationally recognized providers often go unlicensed because of the difficulty of transferring licenses within the system. According to a 2017 study, approximately 32% of immigrants and refugees in Georgia with professional backgrounds in healthcare were underutilized in their field.[1] This underutilization is largely due to barriers to practice, including strict and inconsistent regulations regarding licensing for foreign-trained professionals.

Like other states, Georgia has individual boards that oversee the various licenses required to practice in the state. Internationally trained professionals face different requirements for licensure depending on the specific behavioral health professions. The Board of Professional Counselors, Social Workers, and Marriage and Family Therapists does not have a pathway for internationally trained professional licensure and does not recognize internationally trained licenses. However, the Board of Psychology and the Board of Psychiatry offer licensure at the board's discretion. The Boards of Psychology and Psychiatry also have vastly varied requirements for licensure based on the country of professional training. The Board of Nursing is the only behavioral health licensing board in Georgia that recognizes foreign-trained professionals and has a pathway to licensure.[2]

In an attempt to reconcile requirements for licensure for internationally trained professionals, other southern states such as Tennessee, Florida, and Virginia have recently passed legislation that provides various solutions to encourage internally trained talents to become licensed and practice their profession.

Tennessee

In Tennessee, 28% of immigrants with health-related degrees were underutilized in the healthcare industry as of 2017.[2] Tennessee became the first state to address this issue by passing legislation during the 2023-2024 legislative session to provide provisional licensure to foreign-trained healthcare providers for two years. The provider must be able to show that they are a graduate of an international medical school and provide proof of an offer of employment within Tennessee to be eligible for this temporary license. With this temporary license, providers can work in accredited health-serving institutions with a postgraduate training program. The bill states that after two years, the provider may receive full licensure contingent upon remaining in good standing.

Florida

Florida, with one of the largest immigrant populations in the United States[3], had a 27.8% underutilization rate as of 2017.[2] In the 2023-2024 legislative session, Florida passed SB 7016, which will grant provisional licensure to immigrants who have graduated from a foreign medical school and completed a residency program that is "substantially similar" to training provided in the U.S. The applicant must have also practiced for at least four years in a foreign country and have an offer of employment from a Florida healthcare provider. To maintain eligibility for this provisional license, the applicant must maintain employment for two years, after which they will be eligible for an unrestricted license.

Virginia

Virginia had a 22.9% underutilization rate as of 2017.[2] In the 2023-2024 legislative session, the Virginia General Assembly passed HB 995, a bill that allows for up to two years of provisional licensing for foreign-trained healthcare professionals who are practicing at an institution with a postgraduate training program. Applicants are eligible if they have graduated from a medical institution with similar training to the United States, been licensed in another country, and practiced professionally for at least five years. They may receive an unrestricted license after two years.

Licensure Portability

One of the biggest issues with the current system of behavioral health licensure is license portability, or the ability of providers to practice across several states without having to apply for a separate license. This has become especially relevant with the growing availability of telehealth services, which has made behavioral health services more accessible for individuals across the country.[4] Practitioners testify that tele behavioral health services provide comfort and convenience for patients to receive services.[5]

States' provision of temporary emergency licensure during the COVID-19 pandemic illuminated what service delivery could look like without the rigidity of license portability restrictions. Georgia's Composite Medical Board offered temporary licenses to out-of-state providers from the beginning of the public health emergency until April 2022.[6] New Jersey, another state that offered temporary licensure during the pandemic, released a study in 2023 addressing the impacts of the temporary licensure on mental healthcare, finding that mental healthcare service provision was enhanced and diversified.

Compact Licensure

According to HRSA, there are 982 mental health professional shortage areas in Georgia. For areas like these, telehealth services are critical to increasing accessibility to care. However, licensing portability restrictions have caused barriers to accessing care for those populations that especially rely on telehealth. Some states have proposed legislation to join national compacts that allow for license portability and reciprocity to address this issue.

Compact licensing addresses barriers to license portability by allowing behavioral healthcare professionals to practice in member states without having to obtain a separate license. Different national compacts exist for distinct behavioral health professions, including counseling, nursing, psychology, school psychology, and social work. Georgia was the first state to sign the Counseling Compact. It also joined compacts for nursing, psychology, and social work, and there is opportunity to join the School Psychology Compact and others.

Universal Licensure[7]

Universal licensure recognition allows relocated workers to start work once they enter a new state if they have 1) a license in another state or 2) experience working in a state that does not offer licensure. Georgia has passed universal licensure for a few licenses but does not include any healthcare occupations.

Additionally, Georgia's requirements for universal licensure are stricter than those of other states. Georgia requires that the state from which the worker's licensure comes have the same level of requirements for licensure, or substantial equivalency, for licenses to be dictated. Additionally, licenses can only be given to practitioners from states that have similar scopes of practice or similar professional activities. Georgia is one of only two states requiring both rather than just similar scopes of practice. Georgia also will require open book exams that concentrate on practice, called jurisprudence exams for individuals to be licensed.

Georgia has an opportunity to expand universal licensure to healthcare professions. When considering requirements, Georgia has an opportunity to consider requiring either substantial equivalency or scope of practice requirements, rather than both. In the passage of universal licensure, other states have emphasized the importance of a quick turnaround for licensing requests, and have required a 60-day maximum for the establishment of a universal licensure. This addition removes additional time burdens individuals may face before joining the workforce. The passage of universal licensure could be one option to remove barriers for trained healthcare professionals.

Digital Upgrades to Licensure Procedures

Georgia has recently provided funding to upgrade the licensure application process to a digital one. The Georgia Secretary of State Office has been rolling out GOALS, the Georgia Online Application Licensing System, for various license applications. This upgrade is an important investment in modernization.

In a review developed by Deloitte,[8] states can take various tactics and approaches to enhance digital-only platforms. The process is lengthy and takes considerable and continued investment. The review suggests that a long-term plan to digitize and update the platform should include application intake, license and permit management, enforcement and compliance, inspections,

examinations, cash management, and reporting. Georgia's investment in the digital application process could also be expanded to include other licensure mechanisms. Illinois has recently undergone a similar process (HB2394) to Georgia and is investing in transitioning several licensure processes to digital.

The review also suggests that requirements barriers can be eliminated from different licensure boards to enhance the ability to use digital platforms. These include removing the requirement of notarization, physical signature, and written documentation, and simplifying regulations for licensure where appropriate. The Michigan Social Modernization House Bills 5184 and 5185, which have not yet been passed, is an attempt to modernize requirements for social workers. Specifically, the bill proposes to remove the ASWB (Association of Social Work Boards) exam requirement for social workers, which has been criticized as lengthy and inequitable, and instead require a shorter jurisprudence exam for individuals. This change would follow the more modern practices of other states, including Maine, Minnesota, New York, Illinois, Utah, and North Dakota.

CONCLUSION

Georgia's General Assembly and licensure boards have many options to continue to reduce the burden of obtaining licensure in Georgia and incentivize trained mental health professionals to work in the state. Many of these opportunities center around the acceptance of licensures from other states and countries, revamping Georgia licensure requirements for various behavioral health professions. Georgia's investment in the digital upgrades to the licensure application system is an important step in the system's modernization, and a continued investment in digitizing other aspects of the system may be of interest to legislators.

[1] Brain Waste among U.S. Immigrants with Health Degrees: A Multi-State Profile, Migration Policy Institute, 2020
[2] Removing Barriers for Foreign Trained Mental Health Professionals, Voices for Georgia's Children
[3] U.S. Immigrant Population by State and County | migrationpolicy.org
[4] Expanding Access to Behavioral Health Services Through Telehealth | Telehealth.HHS.gov
[5] Why Telehealth for Mental Health Care Is Working > News > Yale Medicine
[6] State Emergency Declarations Licensures Requirements COVID-19
[7] Policy Brief: 2024 Update to the Survey of Universal Licensing Reforms in the United States, Kihwan Bae and Dargyyn Deyo, The Knee Center for the Study of Occupational Registration
[8] How State Government Can Leverage Digital to Transform Licensing Services

APPENDIX G: ADVISORY SUBCOMMITTEE ON AGING ADULTS

Georgia Behavioral Health Reform and Innovation Commission

Advisory Subcommittee on Aging Adults

2024 Annual Report

Chair

Debra Stokes

Members

Breanna Sims

Becky Kurtz

Eve Byrd

Jocelyn Wise

November 7, 2024

Report prepared with assistance from Georgia Health Policy Center

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of Georgia's behavioral health system of care. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees to review these focus areas, and an additional five advisory subcommittees, including the Aging Adults Advisory Subcommittee chaired by Debra Stokes.

During 2024, the Advisory Subcommittee on Aging Adults held three public meetings on the background of issues facing aging adults, innovative programs addressing behavioral health challenges and potential tools for education.

This report includes a summary of public meetings and the Advisory Subcommittee on Aging Adults recommendations for addressing behavioral health.

List of Presenters to the BHRIC Subcommittee on Aging Adults 2024

BHRIC Advisory Subcommittee on Aging Adults *Debra Stokes, Chair* Breanna Sims, Becky Kurtz, Eve Byrd, Jocelyn Wise		
Support to the BHRIC Advisory Subcommittee on Aging Adults Ashlie Oliver, Georgia Health Policy Center and Ana LaBoy, Georgia Health Policy Center		
Presenters to the BHRIC Subcommittee on Aging Adults 2024		
Date	**Topic**	**Presenter**
Date	Topic	**Presenter** Presenter's Title
August, 16, 2024	Summary of Aging Adults in Georgia- The Growing Numbers	Ashlie Oliver, Georgia Health Policy Center
	Housing Options for Aging Adults with Behavioral Health Challenges	Becky Kurtz, ARC, Behavioral Health Coaching Pilot
August 30, 2024	Behavioral Health Coaching Pilot Project: A Deep Dive	Ana LaBoy, Georgia Health Policy Center Ashlie Oliver, Georgia Health Policy Center
	Georgia Mental Health Access in Pediatrics (GMAP): How Can it Adapt to Aging Population	Josephine Mhende Program Manager GMAP
September 13, 2024	Behavioral Health Coaching Pilot Project Data	Ana LaBoy, Georgia Health Policy Center Ashlie Oliver, Georgia Health Policy Center

Summary of Presentations to Subcommittee

Summary of Aging Adults in Georgia- The Growing Numbers

Representatives from the Georgia Health Policy Center, who work as research support for the BHRIC advisory groups and subcommittees, presented on the scope of behavioral health as it intersects with aging. Dr.LaBoy first reviewed the statistics in Georgia, highlighting the issue of access that many in Georgia face. Next, she presented data on the relationship between loneliness and social isolation, physical health issues and economic situations, and levels of depression. Presenting data from Health Affairs, she discussed how older adults have higher rates of suicidality. She presented data from the census indicating that there will be an increase in population of individuals in the next 15 years. Georgia

Housing Options for Aging Adults with Behavioral Health Challenges

Ms. Kurtz presented on the Behavioral Health Coaching Pilot. ARC collaborates with affordable senior housing providers provide behavioral health coaches for older persons who have unmanaged behavioral health symptoms.. The coach is responsible for connecting individuals to services and following up on any needs. These coaches regularly interact with residents and act as a vital resource for residents to stay in their housing successfully. The Department of Community Affairs funds a similar service replicating the ARC model and is provided by the Southern Georgia Area Agency on Aging.

Behavioral Health Coaching Pilot Project: A Deep Dive

The Georgia Health Policy Center representatives presented research requests regarding the Behavioral Health Coaching Pilot Projects that emerged from the previous discussion. The ARC program is ongoing, providing services to about 300 clients. They have two full-time and one part-time coach who work directly with clients through three organizations at 17 different affordable housing locations. The program has one full-time supervisor and has an ongoing contract with the Fuqua Center for Late-Life Depression to provide clinical support. In FY2023, coaches spent 2,189 total contact hours, with each visit ranging 3.9 hours. Hours of contact may include research and service coordination. Each housing organization pays for the program and includes clinical supervision, mileage reimbursement for coaches, and budgetary lines for services and support for clients. This program has been extremely successful in providing individualized care and preventing evictions for aging individuals.

Georgia Mental Health Access in Pediatrics (GMAP)

Dr. Mhende was invited to present to the aging adult's subcommittee on the work of the the Georgia Mental Health Access in Pediatrics group (GMAP) because in previous advisory subcommittee meetings, it was revealed that there were very few providers who specialize in geriatric care and there is a need for educational resources for behavioral health

providers. GMAP is a resource pediatric providers can use to gain additional information on how to treat patients who have mild to moderate behavioral health concerns.

GMAP has three components: provider education, behavioral health telecommunication, and a referral network. The provider education component, Project ECHO, provides training to pediatric providers to expand their ability to treat individuals with behavioral health care, targeting specifically rural and underserved areas. There have been 22 cohorts of Project ECHO, which includes focuses on topics such as adverse childhood experiences, anxiety, depression, eating disorders, early childhood mental health, and substance and addictive disorders, among many others. Secondly, GMAP has an access line that allows providers to consult experts on patient care questions, including medication follow-up, procedures for next steps, and follow-up advice. There are two regional lines available for 30 hours a week. The majority of calls to the hotline involve medication management. The top concerns that are discussed are ADHD, anxiety, autism, depression, disruptive impulse control, and conduct disorder/behavioral disturbance. Lastly, GMAP hosts a referral network that provides care coordination and referrals to be available for pediatric providers as needed.

Behavioral Health Coaching Pilot Project: Data

The Georgia Health Policy Center reviewed additional research requests. They spent time facilitating a discussion about implementing the behavioral health coaching expansion. Based on existing information, there is a need for a formal process evaluation, which would help to understand the learnings from the program and give to funders about the program.

Advisory Committee Findings

Aging Population in Georgia

The aging population has unique challenges as it relates to behavioral health. According to the World Health Organization, loneliness and social isolation are key risk factors for both mental and physical health later in life, and policies that prevent ageism and discrimination lead to positive mental health outcomes.[1] There are an estimated 14% of adults who are 60+ years of age that are living with a mental disorder, and 10.6% of years lived with disability are caused by mental disorders.[1] Older adults have higher rates of suicidality compared to other age groups. Alzheimer's and dementia also are linked to poor mental health outcomes.[2]

The aging population is growing, with the latest US Census data reporting 15.1% of individuals in Georgia are over 65 years of age.[3] There is an estimated increase of 46% of individuals experiencing Alzheimer's disease or related dementia (ADRD).[4] The National Core Indicators for Aging and Disabilities estimate that 35% of aging adults have chronic

[1] World Health Organizations- https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults#:~:text=By%202030%2C%20one%20in%20six,live%20with%20a%20mental%20disorder
[2] https://www.cdc.gov/nchs/data/databriefs/db483.pdf
[3] https://data.census.gov/profile/Georgia?g=040XX00US13
[4] https://dph.georgia.gov/AlzheimersDisease

psychiatric or mental health diagnoses, and only 15% have mental health services that they can receive.[5]

Aging Workforce Statistics in Georgia

In initial meetings of the Advisory Subcommittee on Aging Adults, members were interested in learning about the number of the behavioral health workforce specifically trained for aging adults.

The advisory subcommittee asked the Georgia Health Policy Center to research the following questions on the state of the existing Georgia workforce that specifically treats the geriatric population.

How many geriatric psychiatrists are in GA and where are they and how are they structured?

There are 15 psychiatrists that specialize in geriatric psychiatry in GA according to the American Association of Geriatric Psychiatry.[6]

5 in Atlanta, GA
3 in Augusta, GA
1 in Berkeley Lake, GA
1 in Columbus, GA
1 in Gainesville, GA
1 in Kennesaw, GA
1 in Macon, GA
1 in Smyrna, GA
1 in Stockbridge, GA

How many other certified programs are there in GA that specialize in geriatric care?

- Fuqua Center for Late-life Depression: Atlanta, GA[7]
- Lakeview Behavioral Health Hospital's geriatric inpatient program: Norcross, GA[8]
- Piedmont Eastside inpatient geriatric behavioral health: Snellville, GA[9]

[5] https://nci-ad.org/
[6] American Association for Geriatric Psychiatry - Improving Care in Aging Adults (aagponline.org)
[7] Fuqua Center For Late-Life Depression at Wesley Woods - Emory University - Atlanta, Georgia | Fuqua Center for Late-Life Depression
[8] Geriatric Program | Atlanta, GA | Lakeview Behavioral Health Hospital
[9] Inpatient Geriatric Behavioral Health at Eastside | Piedmont Healthcare

- Riverwoods Behavioral Health System's Supportive Care Unite for adults 65+: Atlanta, GA[10]

How many and where are the geriatric nurse practitioners in Georgia?

There are 163 geriatric nurse practitioners in Georgia[11] and 105 are in the Metro Atlanta area.

Fulton County: 35	Clarke County: 4	Cook County: 1
Dekalb County: 22	Hall County: 3	Crisp County: 1
Gwinnett County: 20	Richmond County: 3	Early County: 1
Cobb County: 12	Thomas County: 3	Effingham County: 1
Henry County: 5	Carroll County: 2	Floyd County: 1
Forsyth County: 4	Muscogee County: 2	Gordon County: 1
Fayette County: 3	Troup County: 2	Grady County: 1
Cherokee County: 2	Union County: 2	Habersham County: 1
Clayton County: 1	Walton County: 2	Jackson County: 1
Douglas County: 1	Baldwin County: 1	Laurens County: 1
Bibb County: 7	Brooks County: 1	Pierce County: 1
Houston County: 6	Bulloch County: 1	Tift County: 1
Chatham County: 4	Candler County: 1	Towns County: 1

[10] Leading Older Adult & Senior Psychiatric Health Programs | Atlanta, GA | Riverwoods Behavioral Health System
[11] Find Geriatric Nurse Practitioners in Georgia | US News Doctors

Recommendation Priorities

The Advisory Subcommittee on Aging Adults identified the following recommendations from the testimony heard over the past 5 months as priorities for immediate action.

1.Conduct an evaluation of Atlanta Regional Commission's Behavioral Health Coaching Model for expansion. Once evaluated, explore options for sustainable funding, including potential billing mechanisms.

The Atlanta Regional Commission (ARC) has spearheaded a service model called the Behavioral Health Coaching Model at 17 affordable housing communities in metro Atlanta. Each affordable housing community has the regular presence of a coach available to assist with whole-centered person care and maintains regular contact with residents. The program not only helps to connect clients with needed care but is a pivotal component that helps to enable those who may have extra behavioral health needs to maintain stable housing. Without this care, those with uncontrolled behavioral health needs can face eviction or removal from their communities. Its goal is to improve housing stability, quality of life, access to community-based services, and a stronger linkage for those in affordable housing to behavioral health supports.

The program has been evaluated externally during a ramp-up stage in 2022 to evaluate the outcomes of residents after one year in the program. However, there have been several attempts in recent years to conduct a large-scale process and programmatic evaluations.

The Aging Advisory Subcommittee recommends funding to conduct a formal evaluation to determine the next best area to expand the program. Once the program is evaluated, The Aging Advisory Subcommittee recommends exploring potential funding options, including existing funding mechanisms from housing providers and potential expansion of funding from other groups, including the Department of Community Affairs

2.Expand the existing aging resource database, EmpowerlinePRO, , to include more behavioral health resources.

ARC funds and maintains EmpowerlinePRO, an aging resource database. The consumer-focused Empowerline website includes both an availability to search for available resources (from a simplified version of EmpowerlinePRO resources) and the availability to talk with a professional either via email or telephone to assist with

locating resources. Professionals have access to a more robust and detailed resource database. The consumer-focused website also includes information about pertinent events, up to date maps for available senior centers, and the option to request speakers.

3.Reestablish a Georgia chapter of the Coalition on Older Adults and Aging for cross-sector collaboration and case management. This should include an aging liaison from each agency.

Georgia previously had the Georgia Coalition of Older Adults and Behavioral Health (GCOABH) that had representatives from the Georgia Division of Aging Services (DAS), the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) present. There were members from other community organizations, family advocates, and health serving organizations, The Georgia Department of Public Health (DPH) and the Center for Disease Control and Prevention. The reestablishment of this group, including an aging liaison from DAS, DHBDD, DPH, The Georgia Department of Community Health (DCH), and the Georgia Department of Community Affairs (DCA). The group should also include other community organizations such as Georgia Council on Aging and the Alzheimer's Association Georgia Chapter. This group would be tasked with collaboration between and across agencies to best address aging adults' mental health needs and identify gaps and barriers for the population.

Once established the Georgia Coalition of Older Adults and Behavioral Health can be responsible for recommendations 4,5 and 9.

4.Create collateral and implement mandatory trainings for providers, agencies, caregivers and community on available Medicaid waiver resources.

Older adults have various options of coverage through Medicaid waivers in Georgia. Providers, caregivers, and patients do not have accessible toolkits and trainings to understand all available mechanisms to receive services. When trainings are available, they are not always implemented and infiltrated into every action in agencies. Materials and trainings should be regularly updated and presented.

The Georgia Coalition of Older Adults and Behavioral Health (GCOABH) should be responsible for managing these trainings.

5.Create collateral and implement mandatory training for providers, agencies and community on Medicare and Medicare Advantage billing.

Billing for Medicare and Medicare advantage plans can be a cumbersome task for those serving the aging adult population. There are not readily available and updated trainings on billing. Without proper training guides, aging adults may be unable to receive proper mental health services when available.

The Georgia Coalition of Older Adults and Behavioral Health (GCOABH) should be responsible for managing these trainings.

6.Funding for reimplementing Division of Family and Children Services (DFCS) to send eligibility specialists to senior centers to assist older adults in applying for benefits.

Previously the Department of Families and Children services sent specialists to senior centers to assist older adults in applying for services, including but not limited to health insurance, Supplemental Security Income (SSI), and Supplemental Nutrition Assistance Program (SNAP). The eligibility specialists were vital to ensuring that aging adults receive all resources available to them.

7.Create a quarterly report that includes current contact information for data specialists at each agency and provide recent data pertaining to the aging population from state and local agencies.

Data specifically about the aging population is not readily available. Specific aging information is necessary to make policy decisions regarding the aging population. The Advisory Subcommittee on Aging Adults recommends that there is a quarterly report The Georgia Coalition of Older Adults and Behavioral Health (GCOABH) should create with updated contact information for each agency and the following information and

- Department of Community Health
  - Quarterly report of the number of Medicaid recipients with a dementia diagnosis
  - Report on the number of annual hospitalizations of clients with a dementia diagnosis
  - Long-Term Services & Support provider list by county with listing of services (For example: personal support specialist, homemaker, skilled care, adult day health, etc.)
- DBHDD
  - Quarterly Report of the number of 60+ clients they're serving and reported by county.
  - Number of Community Service Board (CSBs) which bill Medicare; training to be provided
  - Number of dual eligibles on DBHDD roles
  - Number of Crisis Line/ 988 calls received from/ on behalf of 55+
  - Monthly report of the number of referrals to ADRC

- Monthly report on NOW/COMP waiver waitlist by county
- Department of Public Health
  - Number of Local Health Departments (LHD) that are approved to bill Medicare for services and how many 65+ clients is each LHD serving?
  - County data on HIV+ population and top three chronic conditions
- Department of Community Affairs
  - Quarterly report of the number of housing benefit recipients are 60+ Statewide
- Council of Probate Judges
  - Monthly report of the number of people under guardianship (non-DHS guardianships) and in which counties;
  - Monthly report on number seeking guardianship; number that guardianship is being revoked;.
- Division of Family and Children Services
  - SNAP client demographics data; DFCS & Child Support data on clients who are cared for by an older adult caregiver (60+)

8.Evaluate integration of aging population resources and providers into the Georgia Health Information Network (GaHIN). Recommend aging specific referral mechanisms and identify gaps.

GaHIN serves adults throughout Georgia, allowing healthcare providers to have whole patient data from other providers throughout Georgia, and have an up to date referral mechanism. The Advisory Subcommittee on Aging recommends that GaHIN representatives evaluate the current inclusion of aging specific resources to GaHIN, and determine and take action on next steps to incorporate aging resources into future iterations of the GaHIN platforms.

9.Create avenues for establishing an education portal for geriatric providers (i.e. nurse practitioners, office staff, nurses, home visitors).

Mental health providers serving the aging adult population may lack the necessary resources to address specific aging related issues as it relates to mental health. The Advisory Subcommittee on Aging Adults heard information about GMAP, which would be a model for a potential education portal for geriatric providers.

This action can be housed under the Georgia Coalition of Older Adults and Behavioral Health (GCOABH).

10.When evaluating Network Adequacy, include measures for the availability of geriatric mental health providers.

In the state of Georgia, there is a limited number of providers who specialize in geriatric health. According to the American Association of Geriatric Psychiatry, only 15 psychiatrists in the state specialize in geriatric psychiatry. The majority of those providers are only available in the metro Atlanta area. There are only four geriatric-certified programs in Georgia, all of which are located in the metro Atlanta area.

When accounting for Network Adequacy, measures for the availability of geriatric mental health providers should be evaluated to ensure that all ages of the population have access to available mental health services.

11.During re-procurement for the Aged, Blind, and Disabled (i.e. SSI eligible) and the Long-Term Supports and Services populations ensure DCH build in requirements of CMOs related to mental health parity for Medicaid recipients.

The Georgia Department of Community Health is in the middle of re-procuring the Care Management Organizations. When developing the contracts for the CMOs for the Aged, Blind and Disabled population and the Long-Term services and supports, DCH should include specific language ensuring mental health parity.

12.Parity enforcement committee should include a representative with expertise on parity issues facing the aging population.

Parity for Medicare Advantage plans, which are licensed under Georgia state law, has been an ongoing issue for the aging adult population. Coverage under these plans vary and should be evaluated based on parity laws for other insurance providers. A representative with expertise on this parity issue, as well as other parity issues facing the aging adult population, needs to be present on any parity compliance groups.

Scope of Aging and Behavioral Health in Georgia

Georgia Health Policy Center

August 16, 2024




Georgia Health Policy Center

1

Mental Health in Georgia

- Diagnosis
  - 8.47% had a major depressive episode
  - 4.7% had thoughts of suicide
  - 1.45% have made suicide plans
- 29.4% of individuals reported symptoms of anxiety or depression
- 28.3% unable to access counseling or therapy
  - Those in rural areas were more likely to reach out to 988 for care

2

GA Mental Health Information

- Access to care overall is an ongoing issue for all Georgians
  - America Health Rankings list at 47 out of 50 in access to care based on number of mental health providers
    - 185.9 per 100,000 Georgia
    - 324.9 per 100,000 US average
  - Ranks 48 out of 50 for access to care based on the percentage of uninsured folks in GA
    - 11.7% uninsured in GA
    - 8.00% US average
- According to Kaiser Family Foundation 58% of those who have mental illness have private insurance coverage

3

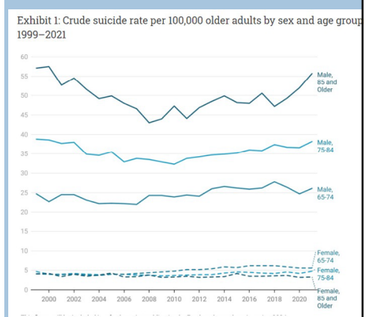
Mental Health of Older Adults

- Loneliness and social isolation key risk factors for mental health and health issues later in life[1]
  - Social connection mediates the negative health and mental health issues aging adults face
  - Policies that prevent ageism and discrimination lead to positive mental health
  - Dementia is a pressing issue, can cause symptoms of psychosis and depression
- 14% of adults 60+ live with a mental disorder[1]
- 10.6% of years lived with disability are caused by mental disorders for older adults[1]

4

Mental Health of Older Adults

- Older adults have higher rates of suicides than other age groups[2]
  - Between 2001-2021 suicide rates increased for men ages 55-74 and women 55-84
- "Social isolation, physical impairment and economic circumstances lead to higher rates of depression, compromised wellbeing and suicide"[3]



https://www.healthaffairs.org/content/forefront/suicide-rates-high-and-rising-among-older-adults-us

5

Mental Health of Older Adults

- RAND Health and Retirement Survey- Older adults with depressive symptoms are 1.4 times more likely to live alone and more than 3x as likely to feel lonely than those without depressive symptoms[4]
- Using data from the National Survey on Drug Use and Health, 64% of older adults who receive mental health care did not have a clinical diagnosis[2]
- Barriers to access services
  - Costs
  - Limited clinicians who deal with aging population
  - Isolation
- The same issues that cause mental health issues, also can cause aging adults to be susceptible to housing issues as well[5]
  - Aging adults who experience homelessness for the first time after age 55, oftentimes is caused by stressful life events, such as death of spouse, loss of work, eviction or health problems

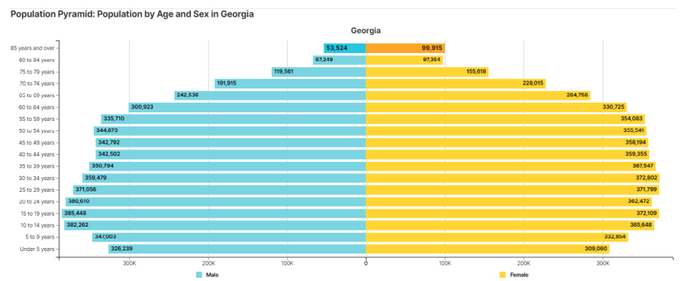
6

Georgia Population of Aging Adults

- US Census reports 15.1% of individuals in Georgia are over 65 years of age[6]
  - US Census Bureau estimates that 20% of individuals in Georgia will be 60+ by 2030
- Over 130,000 Georgians of all ages are estimated to have Alzheimer's disease or related dementia (ADRD). With the increasing Georgia aging population, this number is expected to increase to about 190,000 in the next decade - an increase of about 46%[7]

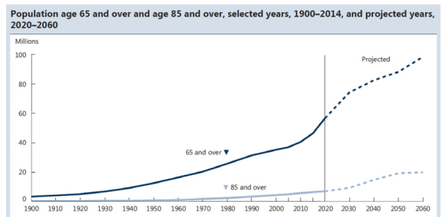
7

US Census Data by Age and Sex



8

Rapidly-Changing Demographics



Source: U.S. Census Bureau

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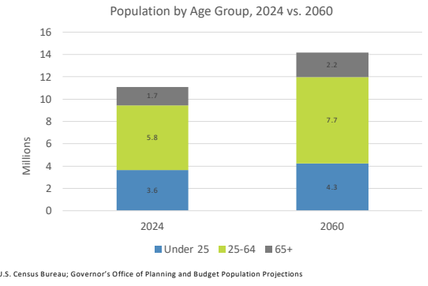
Growth of Older Adult Population in Georgia



Sources: U.S. Census Bureau; Governor's Office of Planning and Budget Population Projections

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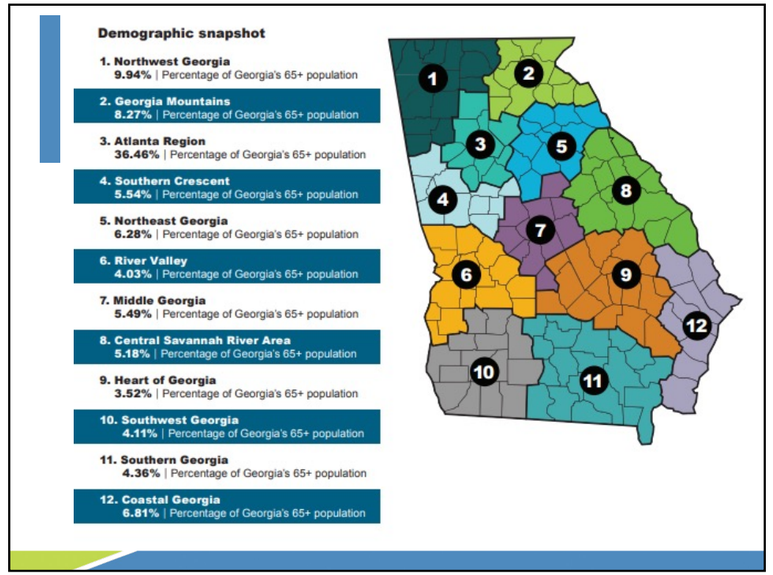

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Aging Adults in Georgia: National Core Indicators for Aging and Disabilities

National Core Indicators for Aging and Disabilities (NCI-AD)- standard of measure for quality of life and outcomes for older adults and adults with physical disabilities that is used by state agencies that deal with aging and physical disability

*Many are not connected to long term services and supports so they are not represented in this sample or estimations

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Aging Adults in Georgia: National Core Indicators for Aging and Disabilities

- An estimated 35% of individuals had chronic psychiatric or mental health diagnosis
- Estimated 11% do not have family or friend who live with them
- An estimated 15% are unable to see family and friends as they would want
- Average of 15% have mental health services they can receive
  - 91% said they have access to mental health services**

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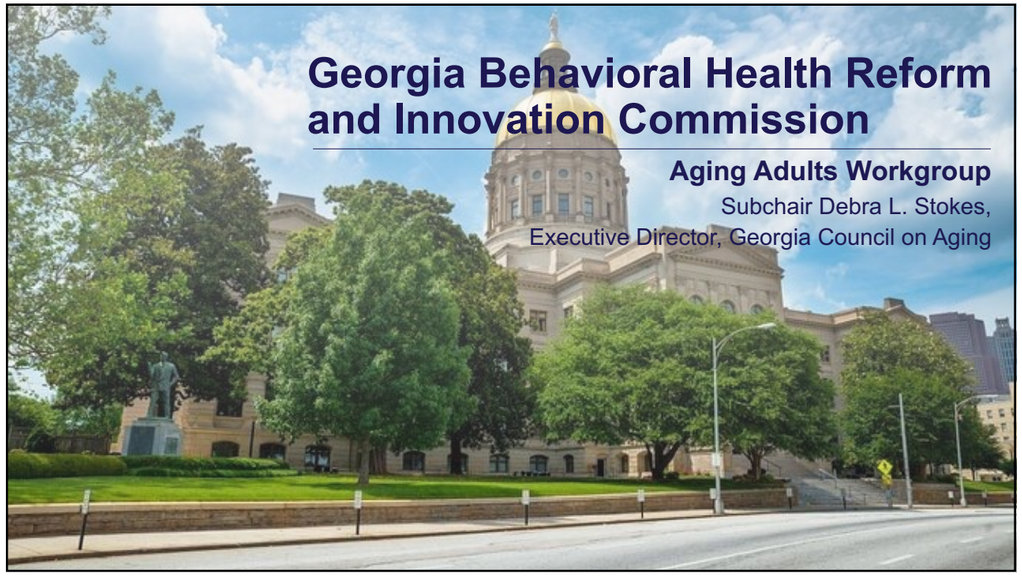

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Thank You

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Georgia Aging Population

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- Over 130,000 Georgians of all ages are estimated to have Alzheimer's disease or related dementia (ADRD). With the increasing Georgia aging population, this number is expected to increase to about 190,000 in the next decade - an increase of about 46%[7]

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2

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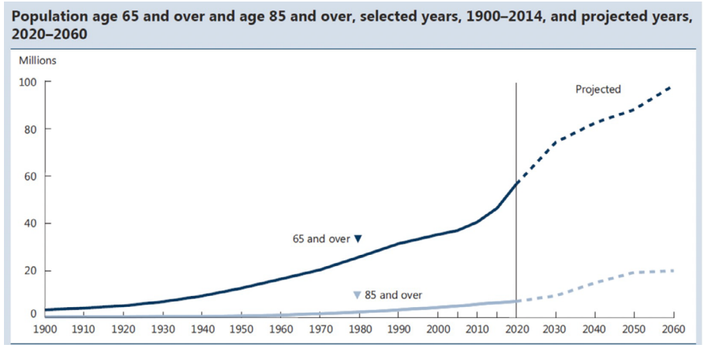
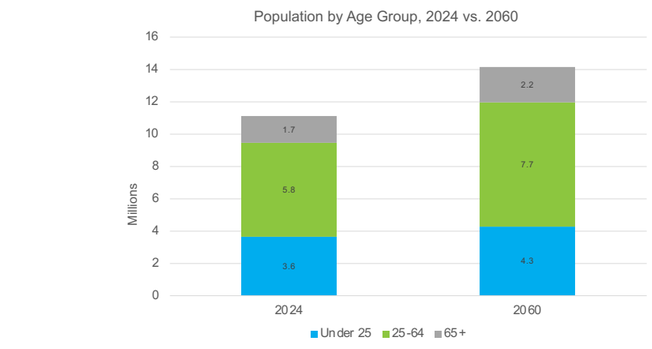


Source: U.S. Census Bureau

3

3

Growth of Older Population in Georgia



Sources: U.S. Census Bureau; Governor's Office of Planning and Budget Population Projections

4

4

Mental Health of Older Adults

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- An estimated 15% are unable to see family and friends as they would want
- An average of 15% have mental health services they can receive

7

7

Committee work

- Through the five meetings held by the subcommittee between August and September, the following themes were discussed:
  - Lack of providers who specialize in geriatric care; gap in expertise
  - Increasing health issues among older adults
  - Need for educational resources for behavioral health providers
  - Need for treatment in rural and underserved areas
  - Need for affordable housing

8

8

Recommendations

- Conduct an evaluation of ARC Behavioral Health Coaching Pilot Program for expansion.
  - *Committee has received a letter of support and interest to expand program from LeadingAge
- Expand existing aging resource database, Empowerline, to include more behavioral health resources.
- Create collateral and training for providers and caregivers on available Medicaid resources for the aging population.
- Create a quarterly report that includes current contact information for data specialists at each agency and provides recent data on the aging population from state and local agencies.
- Evaluate integration of aging population resources and providers into GaHIN network. Recommend aging specific referral mechanisms and identify gaps.

9

9

Recommendations

- Create avenues for establishing an education portal for geriatric providers (i.e. nurse practitioners, office staff, nurses, home visitors).
- Create a taskforce of aging population experts for cross-sector collaboration and case management. This taskforce should include an aging liaison from each agency.
- When evaluating Network Adequacy, include measures for the availability of geriatric mental health providers.
- During re procurement for the Aged, Blind and Disabled (i.e. SSI eligible) and the Long-Term Supports and Services populations ensure DCH build in requirements of CMOs related to mental health parity for Medicaid recipients.

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GEORGIA MENTAL HEALTH ACCESS IN PEDIATRICS (GMAP)

BEHAVIORAL HEALTH REFORM and INNOVATION COMMISSION WORKGROUP on AGING ADULTS

August 30, 2024

Georgia Mental Health Access in Pediatrics

CENTER OF EXCELLENCE FOR CHILDREN'S BEHAVIORAL HEALTH
integrating research, policy, and practice

Georgia Health Policy Center

1

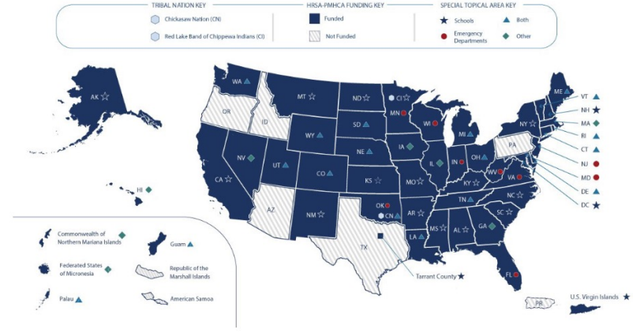
Agenda

- Overview of GMAP and program partners
- GMAP core services and goals
- Program outcomes
- Measuring impact

Georgia Mental Health Access in Pediatrics

2

National Facts – HRSA Grant



- Funding began in 2018 with **$10 million dollars** to fund 21 PMHCA programs.
- In 2021, the American Rescue Plan provided additional funding of **$12.9 million dollars**.
- **Programs now reach 46 states**, the District of Columbia, the U.S. Virgin Islands, the Republic of Palau, the Chickasaw Nation, the Red Lake Band of Chippewa Indians, the Federated States of Micronesia, and the Commonwealth of Northern Mariana Islands and Guam. **54 Pediatric Mental Health Care Access Programs.**

https://mchb.hrsa.gov/programs-impact/programs/pediatric-mental-health-care-access

3

Program Rationale

HRSA Maternal & Child Health

Pediatric Mental Health Care Access (PMHCA) Program Fact Sheet

PMHCA Overarching Program Goal

Promote behavioral health integration into pediatric primary care by using telehealth modalities to provide high quality and timely detection, assessment, treatment and referral for children and adolescents, with behavioral health conditions, using evidence-based practices and methods.

PMHCA Program Purpose

Promote behavioral health integration in pediatric primary care in new or existing telehealth access programs.

Provide training and education to support the treatment of children and adolescents with behavioral disorders.

Support telehealth consultation and referral to a local pediatric behavioral health provider, to the extent possible.

Serve as a resource for pediatric primary care providers, psychiatrists, mental health professionals, and care coordinators.

4

Program Rationale

72% of Georgia's counties are deemed as Mental Health Professional Shortage Areas, ranking Georgia 48th among all states in access to mental health care (NAMI Georgia).

Georgia Mental Health Access in Pediatrics

GMAP's goal is to build the knowledge base of primary care providers and provide helpful resources to increase their confidence in behavioral health care delivery.

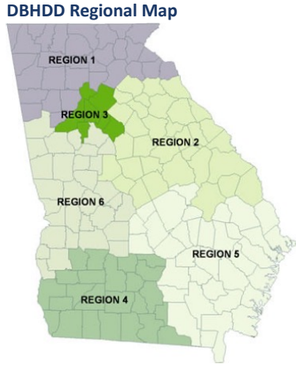
-Nearly 1 in 6 U.S. youth aged 6–17 experience a mental health disorder each year.[1]
-In Georgia, 10.4% of children ages 3 – 17 reported anxiety or depression in 2020.[2]

5

GMAP Overview

- Purpose: GMAP increases pediatric providers' comfort to treat and manage mild-to-moderate behavioral health concerns in day-to-day practice
- Focus Population: Primary care providers in Georgia, serving children and youth ages 0 to 21
- Catchment Areas: DBHDD Regions 3, 4, and 5

DBHDD Regional Map



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GMAP Program Partners

Georgia Mental Health Access in Pediatrics

The Office of Children, Young Adults and Families at the Department of Behavioral Health and Developmental Disabilities has partnered with these agencies to pilot the GMAP program in Georgia.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN
Georgia Chapter

AUGUSTA UNIVERSITY
MEDICAL COLLEGE OF GEORGIA

Children's℠
Healthcare of Atlanta

CENTER OF EXCELLENCE FOR CHILDREN'S BEHAVIORAL HEALTH
integrating research, policy, and practice

D·B·H·D·D

mindworks GEORGIA
THRIVING OUTCOMES START HERE

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $2.09 million with 20% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. Government.

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Georgia Mental Health Access in Pediatrics

GMAP increases pediatric providers' comfort to treat and manage mild-to-moderate behavioral health concerns in day-to-day practice through:

Provider Education

Project ECHO®

Project ECHO® is a collaborative model for behavioral health knowledge sharing and care management that helps clinicians and community providers better serve their patients through advanced curriculum and training, along with discussions on current case studies.

Behavioral Health Teleconsultation

Children's Healthcare of Atlanta & Georgia Chapter, American Academy of Pediatrics Advice Lines

Behavioral health specialists provide HIPAA compliant guidance on treatment and management of pediatric behavioral health conditions through telephonic consultation to providers.

Referral Network

Georgia-Specific Resource Directory

Care coordination services are available for the families that providers serve through a directory of behavioral health specialists, organized by county.

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Program Goals

Georgia Mental Health Access in Pediatrics

GMAP increases pediatric providers' comfort to treat and manage mild-to-moderate behavioral health concerns in day-to-day practice through:

- **Provider Education**
- **Behavioral Health Teleconsultation**
- **Referral Network**

Goal 1:	Goal 2:	Goal 3:
Implement training *to increase the number* ***of pediatric primary care providers in Georgia*** *who are trained to screen, treat and/or refer children affected by behavioral disorders,* ***especially those who live in rural and underserved areas.***	*Provide* ***support*** *to the* ***pediatric primary care workforce*** *in Georgia through access to regional pediatric mental health teams providing* ***behavioral health consultations, referral information, and care coordination.***	Consolidate and expand disparate resource and referral databases to **build and sustain** a comprehensive on-line **resource of behavioral health providers in Georgia.**

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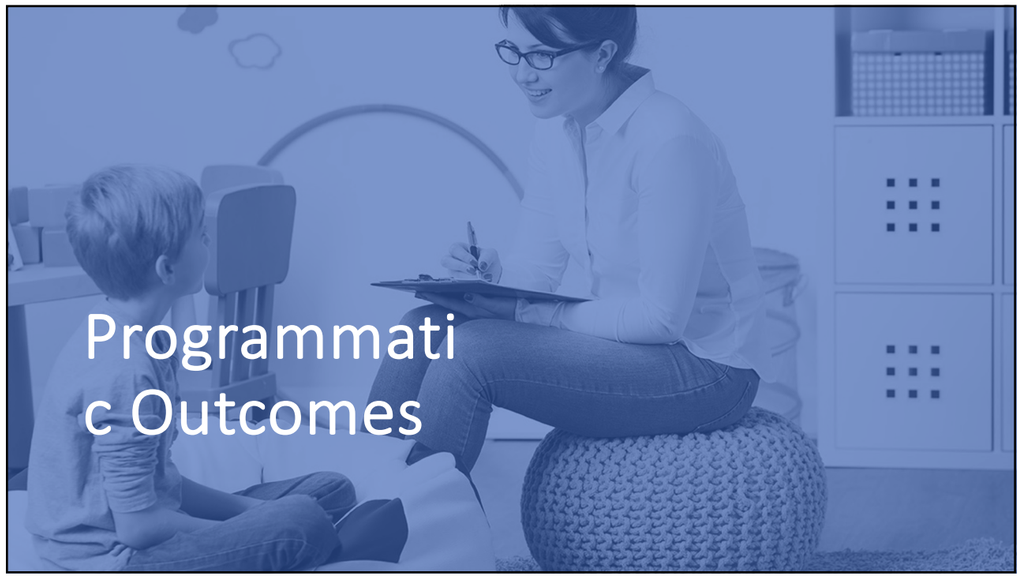

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GMAP Program Reach: Enrollment

- 171 pediatric clinicians enrolled to date
- The following pediatric specialties are represented as GMAP enrollees:
  - Pediatricians
  - Nurse Practitioners
  - Registered Nurses
  - Physician Assistants
  - Doctor of Osteopathic Medicine
  - Certified Pediatric Nurse Practitioners
  - Licensed Mental Health Counselors
  - Case Investigators
  - Child w/ Special Health Care Needs District Director

GMAP Program Enrollment by DBHDD Regions

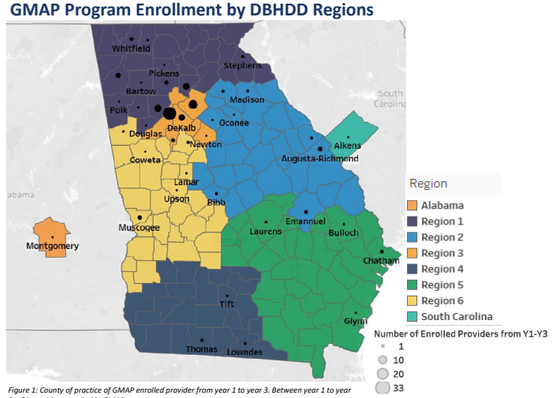

Figure 1: County of practice of GMAP enrolled provider from year 1 to year 3. Between year 1 to year 3, 171 providers enrolled in GMAP.

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Provider Education: Project ECHO

- 22 ECHO cohorts to date, clinicians often participate in multiple cohorts
- Pediatric clinicians continue to guide topic selection through needs assessment to gauge priority areas
- Behavioral Health focus areas for GMAP ECHOS have included:
  - Adverse Childhood Experiences
  - ADHD and Oppositional and Disruptive Behaviors
  - Anxiety
  - Anxiety & Depression: 2 cohorts (Year 1) 2 cohorts (Year 3)
  - Building Resilience
  - Communication Disorders
  - Coordination Between Medical and Education Systems
  - Eating Disorders
  - Early Childhood Mental Health (2 cohorts)
  - Essential Topics in Early Childhood Mental Health (2 cohorts)
  - Learning Disabilities
  - Managing Anxiety & Depression (3 cohorts)
  - Managing ADHD in Pediatric Setting
  - Pediatric OCD
  - Substance and Addictive Disorders

12

GMAP Teleconsultation Line

- 2 regional lines operating for a total of 30 hours per week
  - CHOA: Regions 1 – 3 (20 hours) staffed by Advance Practice Nurse Practitioners
  - GA-AAP: Regions 4 & 5 (~10 hours) staffed by Child and Adolescent Psychiatrists
- Top behavioral health concerns discussed during teleconsultation calls
  - ADHD, Anxiety, Autism, Depression, Disruptive Impulse-Control, Conduct Disorder/Behavioral Disturbance
- Top reason for teleconsultation calls:
  - Medication management
  - 78% of teleconsultation calls in year 3 were for medication management of diagnosed behavioral health concerns

*Year 3 ends 09/29/2024

	# of consultations and/or referrals per year	Cumulative Consultations and/or referrals
Year 1 September 2021- 2022	286	286
Year 2 September 2022- 2023	296	582
Year 3* *Ends September 2024	163	745

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GMAP Program Reach: ECHO and Teleconsultation Line

- 397 unique clinicians have either participated in Behavioral Health ECHO and/or called the teleconsultation line for support with patient cases
- All DBHDD regions are represented

GMAP Program Engagement by DBHDD Regions

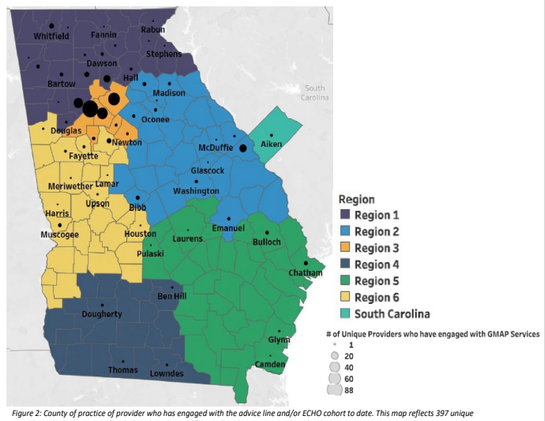

Figure 2: County of practice of provider who has engaged with the advice line and/or ECHO cohort to date. This map reflects 397 unique providers who have engaged with the advice line and/or ECHOs. The map is organized by the six DBHDD regions in Georgia.

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Assessing Program Reach and Provider Engagement in Georgia

Georgia Mental Health Access in Pediatrics

- ✓ Tracking our reach across Ga with providers who have engaged with the program
- ✓ Identify existing provider deserts and opportunities for further outreach
- ✓ Sustainability & Strategic mapping sessions
- Best approach to *quantify* impact
  - Estimates on the # of potential patients who could be (directly or indirectly) served by the program **(e.g., # of kids under 21 served per capita; # of clinicians per capita)**

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Future Directions

Program Expansion

- Include more health provider specialties that focus on pediatric health.
- Enhance the resource directory to ensure all regions have access to behavioral health resources.
- Increase outreach to rural counties in Ga

Measuring Program Impact & Successes:

- Accurately quantify the program's cost-effectiveness, showing that participation in GMAP not only supports prevention and early intervention but also yields tangible benefits.

Sustainability & Additional Funding Opportunities:

- Establish collaborative partnerships with community organizations, new partners, and state and national-based associations.

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For More Information

Scan the code or visit gacoeonline.gsu.edu/gmap.

Georgia Mental Health Access in Pediatrics

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Thank You

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Mariam Mahgoub, MPH
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integrating research, policy, and practice

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gacoeonline.gsu.edu

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Helpful data from State Agencies

Department of Community Health

- Quarterly report of the number of Medicaid recipients with a dementia diagnosis
- Report on the number of annual hospitalizations of clients with a dementia diagnosis
- Long-Term Services & Support provider list by county with listing of services (For example: PSS, homemaker, skilled care, ADH, etc.)

DBHDD

- Quarterly Report of the number of 60+ clients their serving and reported by county.
- Monthly report of the number of referrals to ADRC
- Monthly report on NOW/COMP waiver waitlist by county

Department of Public Health

- Number of Local Health Departments (LHD) that are approved to bill Medicare for services and how many 65+ clients is each LHD serving?
- County data on HIV+ population and top three chronic conditions

Department of Community Affairs

- Quarterly report of the number of housing benefit recipients are 60+ Statewide

Council of Probate Judges

- Monthly report of the number of people under guardianship (non-DHS guardianships) and in which counties.

Division of Family and Children Services

- SNAP client demographics data; DFCS & Child Support data on clients who are cared for by an older adult caregiver (60+)

LeadingAge Georgia

October 10, 2024

Ms. Debra Stokes
Executive Director
Georgia Council on Aging
47 Trinity Ave. SW, 1st Floor
Atlanta, GA 30334

Dear Ms. Stokes,

LeadingAge Georgia is an association that supports non-profit and other mission-driven organizations that provide housing and services for older adults. We are delighted that you are representing older adults in discussions about the behavioral health needs of Georgians with the Behavioral Health and Reform Commission.

LeadingAge members are providers across the continuum of care, from independent living, adult day centers, personal care homes and assisted living homes as well as nursing homes, life plan communities and hospice providers. Our association routinely asks our members what their biggest challenges are, and we seek to find solutions for them.

We serve over fifty affordable housing communities for older Georgians. The management of these communities tell us that their biggest challenge is residents with unmet behavioral health needs. This challenge impacts the quality of life for the resident as well as for the entire community. Our members are reluctant to evict these residents because they know that these residents have virtually no other housing options. Several of our member communities have benefitted from the behavioral health coach program of the Atlanta Regional Commission. The initiative identifies residents in need of a behavioral health coach and the coach builds a rapport with the resident, and then helps him or her access services. The initiative has been incredibly successful and has improved the lives of older adults in the communities. We strongly encourage the Commission to support the expansion of this program through funding from the State.

Best regards,

Ginny Helms

Ginny Helms
President and CEO LeadingAge Georgia

LeadingAge Georgia/Georgia Institute on Aging ▪1266 W. Paces Ferry Rd NW, Ste 501, Atlanta GA 30327 ▪ 404.872.9191

APPENDIX H: ADVISORY SUBCOMMITTEE ON DENTAL CARE FOR INDIVIDUALS WITH INTELLECTUAL DEVELOPMENT DISABILITIES

Georgia Behavioral Health Reform and Innovation Commission

Advisory Subcommittee on Dental Care for Individuals with Intellectual Development Disabilities

2024 Annual Report

Chair

Dr. Srinivas Challa

Members

Dr. Kim Cole

Dr. Nancy Young

Dr. David Bradley

Dr. David Reznik

November 20, 2024

Report prepared with assistance from the Georgia Health Policy Center

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas. From work in previous years, the Commission created an additional five Advisory Subcommittees to delve into specific topics and populations, including the Dental Subcommittee chaired by Dr. Srinivas Challa.

During 2024, the Advisory Subcommittee on Dental Care for I/DD Populations held two public meetings on topics including taking special needs patients to the OR and the North Carolina Access Dental Group.

This report includes a summary of public meetings and the Advisory Subcommittee on Dental recommendations.

List of Presenters to the BHRIC Advisory Subcommittee on Dental Care for the I/DD Population 2024

BHRIC Advisory Subcommittee on Dental Care for the I/DD Population Dr. Challa, Chair, Dr. Kim Cole, Dr. Nancy Young, Dr. David Bradley, Dr. David Reznik
Support to the BHRIC Advisory Subcommittee on Dental Care for the I/DD Population Ana LaBoy, Georgia Health Policy Center, Ashlie Oliver, Georgia Health Policy Center, Courtnee King, Georgia Health Policy Center
Presenters to the BHRIC Dental Advisory Subcommittee on Dental Care for the I/DD Population 2024

Date	Topic	Presenter
October 25	Taking Special Needs Patients to the OR	Dr. Brad Hall Director, GPR Residency Program at Piedmont in Athens
November 1	Access Dental Group (North Carolina)	Dr. Bill Milner, Dentist Betsy White, Dental Hygienist

Summary of Presentations to Subcommittee

Taking Special Needs Patients to the OR

Dr. Brad Hall Director, GPR Residency Program at Piedmont in Athens

Summary of topic:

The committee heard from Dr. Hall who graduated from MCG and then opened a practice in Athens. The GPR is a hospital-based program where they were seeing a lot of compromised patients and many patients with intellectual disabilities including ASD, Downs Syndrome, and other disabilities making it difficult to receive care. The wait list was very long. The OR carves out a regular spot which is critical for these patients. Adult special needs patients require specialized care which can be more laborious for caregivers. The hospital requirements for care can create scheduling challenges. They lost block time at MCG for a short period of time which was problematic and only made the wait time longer. When patients and families are treated, the importance of their needs are clear, and more needs to be done to care for them. Most practitioners do not do specialized care since there is no return on investment as reimbursement is inadequate. Dr. Hall had a wait list even though he did not publicize that he was working with special needs patients. He aimed to establish GPR in Athens and felt that it was achievable. He approached Piedmont because they recently started a graduate education program in Athens and it seemed like dental would be a low risk add for them. It took a year and a half for everyone to commit to the idea. They just interviewed and accepted their second class. They see adult special needs patients every Friday. When the program was started, they made it known that they were taking these patients and had a long line relatively quickly. When they started screening patients, many parents were wondering how they were able to get in so quickly because there is always a backlog for services for this population. The reason providers don't do this is you have to have training, you have to receive privileges, and the Medicaid waiver process is convoluted since patients cannot comply with treatment. Most patients have significant co-morbidities and are on OR recall. Despite this, it is a colossal need. Dr. Hall's practice is scheduled out until next year, and DCG is also scheduled out for the next year. The hope is for the current GPR trainees to want to go into this type of practice.

During the Q&A Dr. Hall shared that the second group of residents in the program will start next year. There are three residents accepted as that is all they can currently handle, and the providers get one day a week with the residents. The residents do an ER rotation and an anesthesia rotation through Piedmont. All of the residents are DCG students as they felt it was important to focus on Georgia. Dr. Hall also shared that they do IV sedation for some patients, but it is few and far between since it can be high risk. Most patients are general anesthesia patients. There are some exceptions with high-functioning special needs patients such as patients with Downs Syndrome who may be eligible for IV sedation.
Dr. Hall shared that he would send out information regarding how new Medicaid reimbursement rates might affect these services and let the committee know if they had additional questions to reach out to him.

Access Dental, North Carolina

Dr. Bill Milner, Dentist and Betsy White, Dental Hygienist

Summary of topic:

Betsy White shared a PowerPoint presentation explaining the makeup and success of the Access Dental Group.

Betsy shared that North Carolina wanted to have a statewide solution for comprehensive high-quality dental services and they felt mobile dentistry was the solution. The Access Dental mobile units serve 15- 18 patients per day, with the staff of one dentist, two dental hygienists and two dental assistants. It takes 15-20 mins to set up the dental chairs and equipment and at the end of the day all of the equipment is loaded back into the truck. The truck is 17ft long, fits in traditional parking spaces and can hold two dental setups.

Access Dental contributes its initial and continued success to the buy-in of the community.

The mobile dental units treat the following populations:

- Skilled Nursing Homes
- Continual Care Retirement communities
- Group homes for those with I/dd
- PACE
- HIV/AIDs
- Community based special care patients
- Community based Older adult program

For patients in this community, being in a supportive environment can help with the success of outcomes with treatment.

The mobile dentists do use sedation and a dental wrap when necessary.

- 15% of group home patients need both sedation and wrap
- 14% only sedation
- 19% only the wrap

In the last 12 months, Access Dental performed almost nine thousand dental procedures and roughly seven thousand preventative and diagnostic services. Seventy percent of their services are preventative, and they can keep people on a 3–6-month recall.

Dr. Cole noted that transportation is a huge barrier for this population, this program goes to the captive audience which makes a huge difference in what you are able to accomplish. She went on to say you become the guest, and they are the host creating a completely different atmosphere for the population.

Betsy went on to share challenges the program has faced including:

- Figuring out the logistics and funding is not easy
- Understanding how they wanted to grow it and finding the right people to do it over time
- The landscape of nursing homes changed for NC creating a bigger ask for them which is why they doubled from 2018 to 2015, and they have since doubled in size again up to date.
- Started with NC dental society for buy in
- Workforce can pose as an issue

The program is financed in collaboration with North Carolina facilities. With this collaboration they are now able to get 28 cents on the dollar for services and charge partners a dental director's fee. They found that the partners are happy to do this because in the end it is cost-saving for them.

Lastly, they shared that Access Dental has patient centered results. They provide patient centered care by skilled providers with the tools and experience to interact and work with the population. As a result, less of the population is going under general anesthesia because they are able to keep up with general maintenance.

During the Q&A Access Dental shared that they connect with the behavioral health specialist through going to the group homes where the whole team is located and meeting with them. They create a relationship between the dentist and the behavioral specialist, where they are able to give the team the patient's medical history. Because they are at the group home, the BH specialist is there the whole time helping them along the way. They are only able to give 2mg of sedation and they are successful.

Additional Content to Highlight

The State of Georgia and the United States Department of Justice entered a settlement agreement to cease all admissions of individuals with developmental disabilities to state-operated, federally licensed institutions ("State Hospitals") and by July 1, 2015 "transition all individuals with developmental disabilities in the State hospitals from Hospitals to Community settings". De-institutionalization resulted in individuals who previously received dental care in DBHDD institutions seeking similar services in the community. Leading to the I/DD population, about 220,000 individuals in Georgia, potentially requiring specialized dental care that is not readily available in the community.

I/DD individuals tend to have greater oral health problems compared with those without disabilities. The population often suffers greater oral health problems due to some of the unique barriers to care.

I/DD individuals visit the dentist less frequently had not visited a dentist in 2 or more years compared to in households not experiencing disability.

I/DD individuals are twice as likely to experience high dental anxiety compared to patients not experiencing disability.

I/DD individuals visit Emergency Departments for dental care or pain 3 times more often compared to households not experiencing disability.

Common barriers and challenges to care include finding a dentist who will accept Medicaid, finding a dental practice with experience or willingness to treat people with I/DD and transportation to the dental office.

Common reasons why dentists choose not to treat I/DD patients included but are not limited to;

- Lack of recognition of need for this underserved patient population
- Lack of expertise to treat and manage patients with special needs
- Non-compliance of patients during in-office treatment
- Fear of liability/malpractice due to complex medical history
- Lack of support equipment in most dental offices
- Patient transportation issues with high no show and cancellation rates
- Unwillingness of office to allot more time on the schedule to address the treatment modifications needed
- Operatory limitations and room logistics
- Lack of adequate sedation training and support options
- Insufficiently trained support staff
- For the lengthy procedures dentists don't feel they are compensated enough
- Insufficient Medicaid reimbursement
- Limited number of credentialed dentists and limited amount of Ambulatory Surgical Centers and Operating Room time
- Difficulty in coordination of follow-up care with caregiver and/or home facility

The cost for a dentist to take care of the I/DD population is approximately 4x over and above what Medicaid pays. The higher cost comes from the increased staffing needs, care coordination, greater complexity, higher specialization, and more time associated with providing care to the population. On average, the CDC calculated that Medicaid spends 3.6x more per person with IDD than without IDD.

For the more medically complex and the more behaviorally challenged individuals, the cost of providing transdisciplinary care is roughly eight - ten times the cost of providing care to the neurotypical patient. This subsect I/DD group represents the top 30% of the I/DD cost curve.

As of Oct 1st, 2024 Medicaid in GA covers adult dental services similar to pediatric dental services and reimburses at 35% of fair market value. Sedation services are also covered for adult I/DD patients with Medicaid. The average dental office overhead is 50%-60%. Accounting for the financial barrier that causes many dentists to choose not to treat the I/DD population.

Through the research of the advisory subcommittee they have found that other states have had success with the following when treating I/DD dental patients:

- Mobile Dentistry
- Tele-dentistry
- Increasing the number of GPR and AEGD programs
- Contracting with private dentists to treat I/DD population
- Specialty Clinics within the dental colleges
- Higher Medicaid reimbursement rates
- Tiered reimbursement rates
- Alternative sources of funding such as federal grants

Recommendation Priorities

The Dental Advisory Subcommittee identified the following recommendations from the testimony heard over the past 6 months as priorities for immediate action.

1. Create a Special Needs Dental directory
    - The directory should include the following;
        - A list of specific I/DD conditions
        - Accommodation requests or requirements (such as bolsters, anxiety reducing mechanisms, and sedation)
        - Dental services requested
        - Geographic location
        - Language
2. Pilot a mobile dental program modeled after the successful Access Dental Care program (North Carolina) that is to be based at Gracewood Dental Clinic
3. Increase collaboration between DBHDD and DCG to ensure the exposure of dental students to people with I/DD.
4. Create a service agreement scholarship for tuition reimbursement for dentists who would work for DBHDD
5. Request GA Board of Dentistry to allow dental professionals continuing education credit for providing care to people with I/DD
6. Explore and evaluate avenues to offer a tax credit to dental offices that provide care for I/DD patients. Incentivizing established practitioners.
7. Continued coordination between DCH and DBHDD in examining wraparound services and payments (COMP & NOW waivers)
8. Evaluate Medicaid reimbursement rates for dental services and request reimbursement rates to be evaluated yearly
9. Continue the work of the Dental Advisory Subcommittee beyond this Commission year to allow for further exploration of recommendations and solutions.

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GEORGIA STATISTICS

Georgia I/DD population, 2022

- 170,640 Georgians (based off study from 1990s)
- 226,000 care giving families

Percentage of Adults with I/DD Who Received Basic Dental Care, by State, 2018
Georgia - 17%

Medicaid Fee-for Service Reimbursement of Dentist Charges

- Child dental care services – 43.8%
- Adult dental care services - xx

Estimated Total Cost and States' Share of Total Cost to Provide Extensive Dental Coverage to Adults with I/DD, in States with Emergency or No Coverage (2018)
Georgia

- Total cost: $2,549,957
- Cost to state: $840,721

Estimated Total Cost Reductions and States' Share of Total Savings Resulting from Providing Basic Dental Coverage to Adults with I/DD, in States with Emergency-Only or No Coverage (2018)
Georgia

- Total cost savings: $3,735,944
- Cost savings to state: $1,231,741

States with 1915 Waiver or 1115 Demonstration Coverage of Dental Benefits for Adults with I/DD, in 2018, Among States with No or Emergency Only Medicaid Dental Benefits for the General Adult Population
Georgia

- Level of dental coverage for general adult population: Emergency only

- Waiver coverage of dental benefits for adults with I/DD: Yes

Distribution of dentists according to Volume of Medicaid patients see in the past year

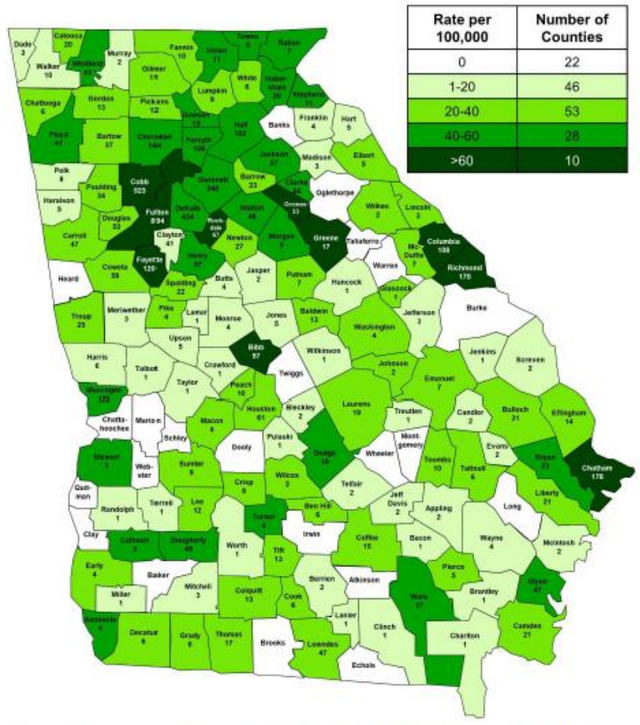
- 75% of dentists in GA are not enrolled in Medicaid and don't have any Medicaid patients
- 6% of dentists in GA are enrolled in Medicaid and don't have any Medicaid patients
- 1% of dentists in GA are enrolled in Medicaid and have 1-9 Medicaid patients
- 4% of dentists in GA are enrolled in Medicaid and have 10-100 Medicaid patients
- 15% of dentists in GA are enrolled in Medicaid and have 100+ Medicaid patients

Distribution of Dentists by County
https://healthcareworkforce.georgia.gov/document/document/2021-dentist-workforce-reportpdf/download

Counties with no Dentists, 2021

In the 2019 Dentist Workforce Report, 21 counties had no dentists practicing there. This year, 22 counties have no dentists practicing there. Since 2019, the two counties of Talbot and Crawford have gained a dentist. The three counties of Burke, Dooly, and Montgomery have lost a dentist since 2019.

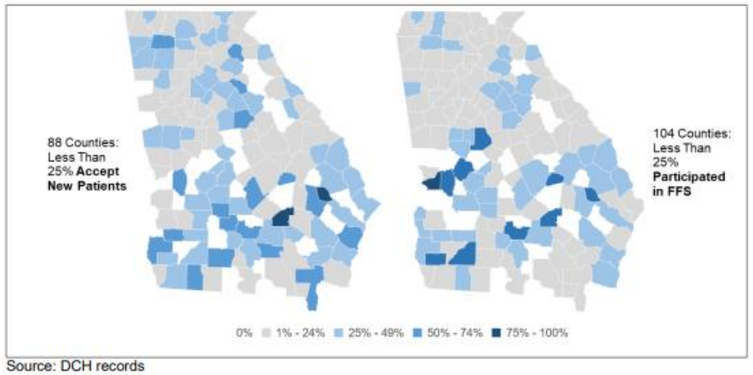
Rate of Dentists per 100,000 Population, 2021



The map above shows the rate of dentists per 100,000 county residents, with darker colors indicating higher rates. In general, the metro areas of Atlanta, Athens, Augusta, Macon, and Savannah have higher rates of dentists than more rural areas.

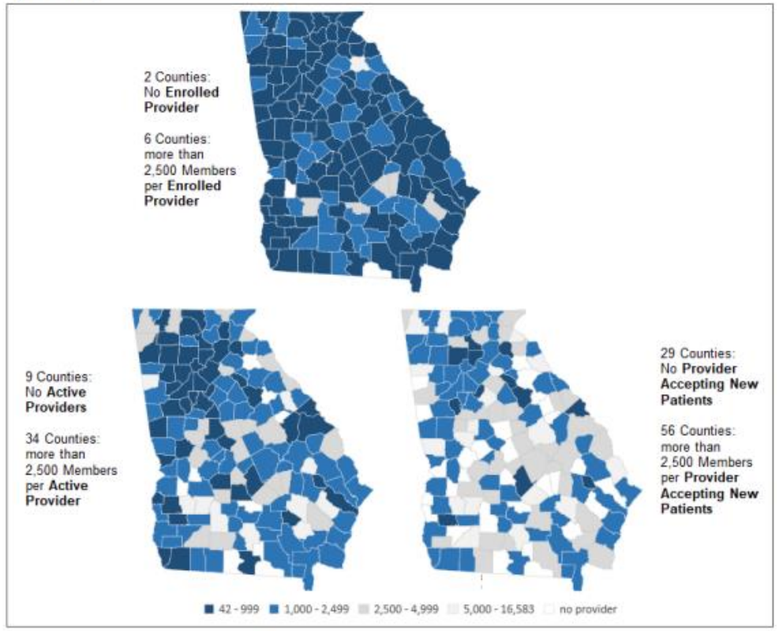
[Medicaid Dental Providers Audit]

Exhibit 8
In Most of Georgia's 159 Counties, only a Portion of Providers Accept New Patients or Actively Participate in the Medicaid Fee-For-Service Program (CY2019)



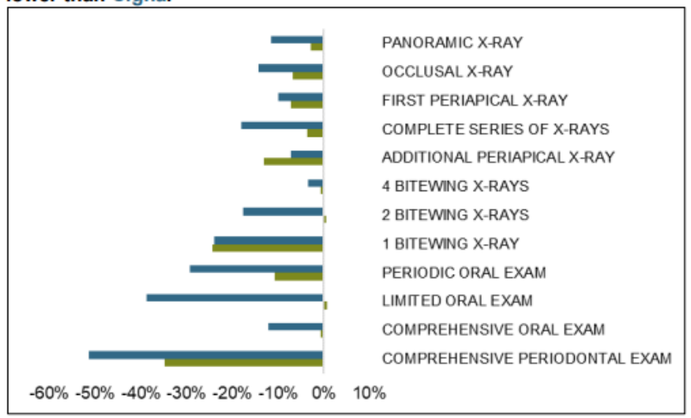
Source: DCH records

Exhibit 9
The Ratio of Medicaid Members to Providers Varies by County and Increases When Considering Only Providers Accepting New Patients (CY2019)



Source: DCH records

Exhibit 10
Fee-For-Service rates are 9% lower overall than Delta Dental and 20% lower than Cigna.



Source: Georgia Department of Administrative Services

Appendix A: Table of Recommendations

There is no coordinated management of the Medicaid dental program. (p. 6)
1. DCH should assign staff to implement a coordinated, data driven approach to managing the Medicaid dental program.
The rate at which Fee-For-Service children utilize dental services is decreasing and is lower than rates for managed care and other states. (p. 7)
2. DCH should establish goals for dental utilization among its Fee-For-Service member children, such as a minimum percent of members receiving dental care annually.
3. DCH should monitor dental service utilization among its Fee-For-Service member children and identify potential causes for declining or insufficient rates.
DCH's compliance with federal standards does not ensure that Fee-For-Service members have sufficient access to dental services. (p. 10)
4. In assessing its Fee-For-Service provider network, DCH should analyze the number of providers who accept new patients and actively participate in Medicaid.
5. DCH should track the ratio of Fee-For-Service beneficiaries to active providers accepting new patients on a county level to identify areas of the state that lack meaningful access.
6. DCH should conduct "secret shopper" calls similar to those used for CMO provider network studies to determine whether Fee-For-Service beneficiaries can obtain dental appointments in a reasonable timeframe.
DCH should increase its efforts to encourage provider participation in the Medicaid Dental Program. (p. 13)
7. DCH should systematically and routinely assess Fee-For-Service reimbursement rates for dental services. In these studies, DCH could compare Fee-For-Service to managed care, DOAS, and other state Medicaid rates. Based on the results, DCH should adjust rates to ensure they are competitive with other Medicaid programs and private insurers.
8. DCH's Medicaid program should consider collaborating with the State Office of Rural Health to recruit providers to practice in HPSAs by providing assistance to these providers in obtaining eligibility for the National Health Service Corps loan repayment and scholarship program.
9. DCH should consider collaborating with DPH to encourage local public health clinics to provide dental services in counties or areas with a shortage of Medicaid dental providers.
10. DCH should research and emulate other states' efforts to increase the number of dental providers in the Medicaid Fee-For-Service network, including providers that serve children with disabilities.
Georgia Medicaid does not cover adults' preventive dental care, which can lead to untreated dental issues, higher medical costs, and avoidable hospital visits. (p. 17)
11. The General Assembly should consider providing adult members access to preventive and diagnostic dental care. To control costs, the General Assembly should consider measures such as establishing annual caps or co-payments.

RANKINGS AND FEE REIMBURSEMENT

2023 MSDA National Profile of State Medicaid Dental Programs: Benefits and Reimbursement Report

I/DD care looks to be more extensive in: Connecticut, DC, Iowa, Massachusetts, Michigan, Nebraska, and Oregon.

Other data to consider:
Top states offering extensive adult Medicaid dental benefits (dashboard ranks all 50 states and DC)

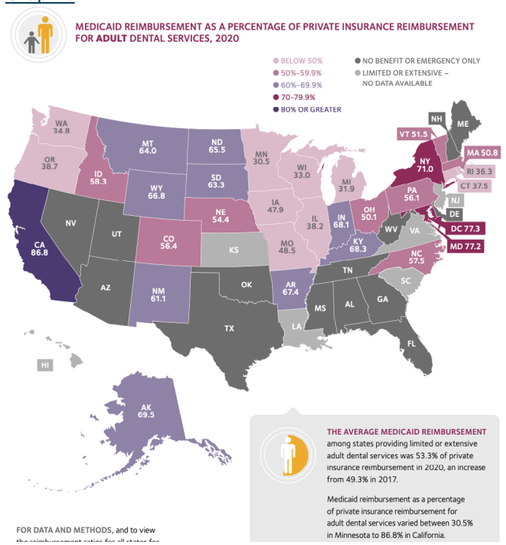
1. D.C.
2. New Jersey
3. Hawaii
4. Maine
5. Tennessee
6. Montana

Additional Info

- D.C.
  - DC Fee Schedule download
  - Medicaid reimbursement - 54% child fees and 13% adult fees
- New Jersey
  - NJ Dept of Banking and Insurance Dental Fee Schedule
  - Medicaid reimbursement - 54% child fees and 13% adult fees
- Hawaii
  - HI Fee Schedule download
  - Medicaid reimbursement - 38.9% child fees and emergency benefits for adults
- Maine
  - ME Fee Schedule download
  - Medicaid reimbursement - 47.9% child fees and 50.8% adult fees
- Tennessee
  - Effective January 1, 2023, all adult TennCare members have dental benefits. Adult members are now able to see a dentist at no cost to them for all medically necessary, covered dental services, which consist of regular exams, x-rays, cleanings, fillings, crowns, and more.
- Montana
  - MT Fee Schedule download
  - Medicaid reimbursement – 52.5% child fees and 53.2% adult fees
  - Additional Services and Populations Waiver - 11- W-00181/8
    - Waiver authority: 1115
    - Populations: Individuals who are ages 65 and over, blind, or disabled.

- Dental benefit summary: Coverage of dental services beyond the State Plan's current $1,125 annual limit to beneficiaries determined categorically eligible as aged, blind, and disabled (ABD).
- https://justiceinaging.org/medicaid-waivers-improve-access-to-oral-health/

Graphic



5 states providing dental care to the IDD population beyond normal coverage, 2023
12 states reported covering one or more services for adults with intellectual or developmental disabilities that are generally not provided to other adult beneficiaries ages 21–64.

1. **Arizona**[1]
    a. Limited oral evaluation
    b. Cleanings
    c. Fluoride application
    d. Periodontal services
    e. Complete dentures
    f. Partial dentures
    g. Reline and rebase
2. **Louisiana**[2]
    a. Limited oral evaluation
    b. Periodic oral evaluation and comprehensive oral evaluation
    c. Cleanings
    d. Fluoride application
    e. Fillings
    f. Crowns
    g. Anterior root canal therapy
    h. Posterior root canal therapy
    i. Periodontal services
    j. Partial dentures
    k. Extractions
3. **Nevada**[1]
    a. Limited oral evaluation
    b. Cleanings
    c. Fluoride application
    d. Fillings
    e. Crowns
    f. Anterior root canal therapy
    g. Posterior root canal therapy
    h. Periodontal services
    i. Anterior root canal therapy
    j. Posterior root canal therapy
    k. Complete dentures
4. **Texas**[1, 3]
    a. Annual benefit maximum
    b. Limited oral evaluation
    c. Periodic oral evaluation and comprehensive oral evaluation
    d. Cleanings
    e. Fluoride application
    f. Fillings
    g. Crowns
    h. Anterior root canal therapy
    i. Posterior root canal therapy
    j. Periodontal services
    k. Complete dentures
    l. Partial dentures
    m. Reline and rebase
    n. Extractions
5. **Utah**[1]
    a. Limited oral evaluation
    b. Cleanings
    c. Fluoride application
    d. Fillings
    e. Crowns
    f. Anterior root canal therapy
    g. Posterior root canal therapy
    h. Complete dentures
    i. Partial dentures
    j. Extractions

[1] Emergency only coverage for general adult population
[2] enrolled New opportunities waiver, Residential option waiver, or the Supports waiver
[3] Adults in LTSS waiver programs

PROMISING PRACTICES

Orange Grove Center (TN)
Our collective goal - that of our families, our staff, our professionals, our supporters - has always been for those we serve to live a life they want to live: a life full of opportunities - to work, to play, to earn, to worship, to have fun, to live and laugh with friends and family.

Since 1953, Orange Grove has been a place of hope and possibilities for families who have loved ones with an intellectual and/or developmental disability (IDD). And now, these hopes and possibilities involve more and more of our programs and services taking place all over the community rather than in one place.

Dental clinic
Data shows that poor oral health and lack of access to dental care are experienced at a higher rate by those with disabilities. With that in mind, the dental clinic on our main campus at 615 Derby Street is a unique practice in our area, where anyone with an intellectual and/or developmental disability, regardless of their participation in Orange Grove programs, can be treated.

When creating treatment plans, the individual nuances of patients are always respected. Their needs and preferences may differ from that of a neurotypical patient; for instance, an individual may visit the clinic several times before they are comfortable enough to be examined. To mitigate potential adverse outcomes, the desensitization process is allowed to play out in real time, and all services in the clinic are done without the need for sedation. If needed, more involved dental procedures requiring sedation can still be performed by our team, who is credentialed at a local ambulatory surgery center.

As part of Orange Grove's effort to expand the curricula for clinical education programs to include units of study regarding patients with IDD, the clinic partners with the University of Tennessee, Memphis and Chattanooga State Community College. Every fourth-year dental student from UT spends one full day at our clinic, and Chattanooga State dental hygiene students do rotations at Orange Grove during their second year of study.

Maryland
Maryland In 2018, Senate Bill 284—Maryland Medicaid Assistance Program—Dental Coverage for Adults—Pilot Program (Chapter 621 of the Acts of 2018) was signed into law.26 The bill called for the development of an adult dental benefit for people ages 21 to 64 years who are dually eligible for both Medicare and Medicaid. Neither Medicaid nor Medicare cover general dental services for adults in Maryland. The bill required the Maryland Department of Public Health to amend its 1115 Medicaid waiver so that dental services could be covered for the estimated 38,510 dual eligibles. Maryland's 1115 waiver program is a statewide mandatory managed care program for Medicaid enrollees. In 2019, the Adult Dental Pilot was implemented. This "carve-out" program covers diagnostic, preventive, and restorative services, as well as dental extractions. The annual benefit is capped at $800 per person.

In June 2022, the state of Maryland officially notified the Centers for Medicare and Medicaid Services (CMS) that the Adult Dental Pilot program will be phased out after January 1, 2023. Legislation passed in the State General Assembly requires the expansion of the benefits to all enrolled Medicaid adults. Dental coverage will also be expanded to include enhanced restorative services such as crowns, oral surgery, endodontics, and periodontal services. The benefit will not require cost sharing, and the $800 cap will be eliminated.

Louisiana
Louisiana Medicaid is expanding its comprehensive dental care to adults ages 21 years and older with I/DD who are enrolled in the New Opportunities Waiver, Residential Options Waiver, or Supports Waiver. More than 12,000 people have access to the new dental coverage that began July 1, 2022. The coverage includes diagnostic services, preventive services, restorative services, endodontics, periodontics, prosthodontics, oral and maxillofacial surgery, orthodontics, and emergency care. The expansion was part of the Louisiana Department of Health's Fiscal Year 2022 Business Plan, Together: Building a Stronger LDH and a Healthier Louisiana.27

New Hampshire
New Hampshire Medicaid will launch an adult dental benefit for people ages 21 years and over beginning April 1, 2023 after Governor Christopher Sununu signed into law HB103 and SB 422 on July 1, 2022. This signing culminates years of work by stakeholders across the state to close the gap in oral health care services for many disadvantaged adults living in New Hampshire. The benefit will cover medically necessary services including care coordination and transportation to dental appointments. A $1,500 annual per member cap will be implemented excluding the costs of preventive services. Cost sharing will be applied for non-preventive services for those members whose incomes fall above 100 percent of the federal poverty level. This amount is limited to 5 percent of household income. A settlement with a vendor created the funding source for this benefit.

RECCOMENDATIONS

Recommendations to State Medicaid Agencies and Programs

1. State Medicaid agencies should create unique dental programs through new or existing 1115 Demonstration, 1915 (c), and 1915 (k) authorities, specifically designed to meet the needs of adults with I/DD. Such programs should include coverage for oral health education services for I/DD members, parents, and caregivers; tele-dental oral health education; and preventive services. In addition, support care coordination between medical and dental providers as well as enable services to address the special needs of people with I/DD, and the social determinants of health.

2. Medicaid dental programs should implement value-based payment models that link reimbursement to provider incentives, provider performance, and patient outcomes for people with I/DD, and incentivize providers to reduce use of the operating room and shift to more cost-effective treatment settings.

3. Medicaid dental programs and Medicaid MCPs should collect and use risk factor data including and not limited to physical, oral, social, race/ethnicity, and gender identity to assess and improve oral health and oral health care equity for all Medicaid beneficiaries.

4. State Medicaid agencies should enhance Medicaid reimbursement to providers who participate in certified continuing education unit clinical dental training programs for people with I/DD.

Key Recommendations

- As we acknowledge that federal legislation can require a lengthy process for passage, NCD also recommends that states should add dental benefits for adults with I/DD to existing or new 1915(c) and 1915(i) waivers or 1115 demonstrations. States can refer to waivers in other states that extend dental coverage to adults with I/DD as a starting point or template to design their own programs. States should consider available data about and evaluations of these waiver programs to prioritize the types of dental services and target populations to include in their own waivers. States can use available data as guidance to maximize access to key, cost-effective dental services while balancing available funding.
- States should create greater transparency concerning managed care reimbursement rates. The lack of dental providers who participate in Medicaid remains a barrier to receipt of dental care. There is a lack of publicly available data about Medicaid Managed Care Organization reimbursement rates for dental care providers and creating policies that incentivize dental providers to participate requires an analysis of current rates.
- States should fund additional programs that would improve oral healthcare for people with I/DD. Other barriers to oral health care must be addressed and could be funded through the Medicaid program, including expanding the dental workforce whose members have expertise in treating adults with I/DD through continuing education programs, implementing programs that improve daily oral care provided by caregivers, and improving education and support for good oral hygiene for adults with I/DD. Additionally, states must address transportation barriers. States should coordinate services between DD agencies and Medicaid providers.

MEDICAID DENTAL POLICY

Child
Medicaid covers dental services for all child enrollees as part of a comprehensive set of benefits, referred to as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Though oral screening may be part of a physical exam, it does not substitute for a dental examination performed by a dentist. A referral to a dentist is required for every child in accordance with the periodicity schedule set by a state.

Dental services for children must minimally include:

- Relief of pain and infections
- Restoration of teeth
- Maintenance of dental health

Adult
States have flexibility to determine what dental benefits are provided to adult Medicaid enrollees. There are no minimum requirements for adult dental coverage.

Medicaid Waiver	Comment Process	Approval Periods
1915(c) [17]	States are required to provide at least a 30-day notice and comment period prior to submission of the waiver application to CMS.	Initial: 3 years Extension: up to 5 years
1115[18]	States are required to provide at least a 30-day public notice and comment period for applications for both new 1115 demonstrations and for extensions and amendments to existing demonstrations. States also must conduct at least two public hearings on separate dates and at separate locations and accept public comment. After the application is submitted to CMS, CMS provides a second 30-day comment period.	Initial: 5 years Extension: 3-5 years
1915(b)[19]	States are required to provide at least a 30-day notice and comment period prior to submission of the waiver application to CMS.	Initial: 2 years Extension: 2 years

Dentist in GA serving IDD (or “special needs”) population

David Kurtzman – Marietta, GA
Autum Dental – Marietta, GA
DDD Foundation – Atlanta, GA
Steven Berwitz – Savannah, GA
Jacobs Pediatric Dentistry, Macon, GA

QUOTE

Access Dental Care
513 White Oak Street, Suite D
Asheboro, NC 27203
Phone: 336-626-7232

DATE December 3, 2024

EXPIRATION DATE 2/3/2025

TO Kevin Tanner
Commissioner of the Georgia Department of
Behavioral Health and Developmental Disabilities

QUANTITY	DESCRIPTION	UNIT PRICE	LINE TOTAL
1.00	**Custom Built Dental Delivery System**	**$ 252,500.00**	**$ 252,500.00**
1.00	Custom Delivery Truck with Lift		
2.00	Custom Mobile Adult Dental Chair		
2.00	Custom Mobile Dental Operating Unit		
1.00	Custom Supply Cart		
1.00	Custom Assistant's Cart		
1.00	Custom Ultrasonic Cart		
1.00	Custom Sterilization Cart		
2.00	Operator Stool		
1.00	Assistant's Stool		
1.00	Custom Technology Cart		
1.00	Ultrasonic Cleaner with basket		
1.00	Autoclave		
	Consultation Services (included in price)		
	Pre-program Consulting		
	On-site program planning		
	Mobile Program Implementation Support		
	Delivery Unit Support and Training		
	Post-delivery support for 1 year		
		SUBTOTAL	$ 252,500.00
		SALES TAX	
		TOTAL	**$ 252,500.00**

You will need to consider the additional purchase of a Nomad X-ray Unit, X-ray Sensor, Laptop Computers, Instruments, Ultrasonic Scaler, Small Equipment and Supplies

This is a quotation on the goods named, subject to the conditions noted below:
This is an estimate. If additional expenses are incurred during the fabrication of this equipment you will be notified and expected to cover the additional expense. At the time of sale applicable sales tax will be charged.

THANK YOU FOR YOUR BUSINESS!

APPENDIX I: ADVISORY SUBCOMMITTEE ON HOMELESSNESS

Georgia Behavioral Health Reform and Innovation Commission

Advisory Subcommittee on Homelessness

2024 Annual Report

Chair

Edward J. Hardin

Members

Representative Mary Margaret Oliver
Commissioner Christopher Nunn
Cathryn Vassel
Jennifer Dulong
Melanie Kagan
Philip Gilman
Katheryn Lawler

November 19, 2024

Report prepared with assistance from Georgia Health Policy Center

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas, and an additional five Advisory Subcommittees including the Homelessness Advisory Subcommittee chaired by Edward J. Hardin.

During 2024, the Advisory Subcommittee on Homelessness held 3 public meetings on the background of homelessness and behavioral health in Georgia, available services and

This report includes a summary of public meetings and the Advisory Subcommittee on Homelessness recommendations.

List of Presenters to the BHRIC Subcommittee on Homelessness Advisory Group 2024

BHRIC Subcommittee on Homelessness Advisory Group Edward J. Hardin, Chair Representative Mary Margaret Oliver, Commissioner Christopher Nunn, Cathryn Vassel Jennifer Dulong, Melanie Kagan, Phillip Gilman, Katheryn Lawler		
Support to the BHRIC Subcommittee on Homelessness Advisory Group Ana LaBoy, Georgia Health Policy Center, and Ashlie Oliver, Georgia Health Policy Center		
Presenters to the BHRIC Subcommittee on Homelessness Advisory Group 2024		
Date	**Topic**	**Presenter**
Date	Topic	**Presenter** Presenter's Title
June 26, 2024	Observations on Housing and Treatment for Unhoused Persons Facing Severe Mental Health and Substance Use Challenges	Sam Tsemberis, Founder and Executive Director Pathways to Homelessness Associate Clinical Professor in Psychiatry and Biobehavioral Sciences, University of Los Angeles, California
	Scope of the Problem of Homelessness and Mental Health	Christy Doyle, Georgia Health Policy Center
	Overview of DBHDD Services and Programs	Maxwell Rupersburg, Director, Office of Supportive Housing
	Olmstead Memo	Committee Discussion
August 29, 2024	Lesson from the Melody	Elizabeth Banks, Chief Program Officer HOPE Atlanta
	Report on Ongoing Research	Ana LaBoy, Georgia Health Policy Center
	Practical Applications of Access to Mental Health Services and Permanent Supportive Housing: The Front Line Worker Experience	Jennifer Dulong, Chief Executive Director, Chatham Savannah Authority for the Homeless
	Behavioral Health Outreach	Anne Hernandez, Vice President, Behavioral Health Marvin Blissett Housing Manager, Behavioral Health David Petty PATH Team Lead
October 25, 2024	Open Discussion and 2024 Final Recommendations for Homeless Workgroup	

Summary of Presentations to Subcommittee

July 26, 2024

Observations on Housing and Treatment for Unhoused Persons Facing Severe Mental Health and Substance Use Challenges

Sam Tsemberis, Founder and Executive Director Pathways to Homelessness,

Associate Clinical Professor in Psychiatry and Biobehavioral Sciences, University of Los Angeles, California

Dr. Tsemberis presented the "housing first" model, including a review of literature describing the problem, program models to address the need, and some evidence-based solutions. He emphasized the centrality of robust supportive behavioral health services to the success of the housing first mode. Key components included: landlord engagement, in which he emphasized the need for physical plant support and rapid response from service providers as key elements; and having a variety of housing supply options, to include permanent supportive housing, affordable housing, and public housing options, among others; having a comprehensive array of services available to individuals to help maintain stable housing. He provided examples of successful implementation of this model, including the HUD-Veterans Affairs Supportive Housing (HUD-VASH) partnership to reduce homelessness among the veterans population, and a review of Milwaukee County's successful housing program.

Scope of the Problem of Homelessness and Mental Health

Christy Doyle, Georgia Health Policy Center

Dr. Doyle overviewed the scope of Homelessness and Mental Health in Georgia. In the latest published Point in Time Count, there were 12,294 individuals experiencing homelessness in Georgia. Those who experience homelessness have a greater risk of experiencing behavioral health issues. Dr. Doyle reported that in Georgia, there were 21% of those who were experiencing homelessness reported having a mental illness, and 16% reported having a substance use disorder.

Overview of DBHDD Services and Programs

Maxwell Rupersburg, Director, Office of Supportive Housing

Mr. Rupersburg reported on the programs that are available through the Department for Behavioral Health and Developmental Disabilities including; Georgia Housing Voucher Program (GHVP), Housing Support Program (HSP), DBHDD Vital Records Partnership, SSI/SSDI Outreach, Access and Recovery (SOAR), and Project for Assistance in Transition from Homelessness (PATH).

DBHD is grounded in 4 statements 1) Housing is a right, 2) Housing Provides the necessary foundation for recovery, 3) Housing allows people to live with freedom, purpose and dignity, and 4) Housing signals a new beginning

July 26, 2024

Lesson from the Melody

Elizabeth Banks, Chief Program Officer HOPE Atlanta

Ms. Banks stated that HOPE Atlanta provides supportive services for The Melody, which is an integrated housing and behavioral health program supporting individuals with wrap around services 24/7 at their place of residence. The Melody is considered Permanent Supportive Housing and individuals can stay as long as they would like, but about half report the desire to move to a different level of care. The services at the Melody are always available to individuals, from the beginning of their stay, and they can choose to take part in the services that best meet their needs and desires. The Melody is part of a 500 tiny home rapid housing effort of the City of Atlanta led by Partners for HOME.

Report on Ongoing Research

Ana LaBoy, Georgia Health Policy Center

Dr. LaBoy reviewed a summary of conversations with outreach workers throughout Metro Atlanta about the needs of those they serve. Individuals face challenges to receiving services such as the length of time between assessment and placement, general mistrust of the system, active substance use, and co-morbid diagnosis of behavioral and substance use disorder. Service providers report that ideal services for these individuals involve consistent outreach and support, a broad variety of services including immediate available housing options, and a wide variety of types of providers to serve every population.

Practical Applications of Access to Mental Health Services and Permanent Supportive Housing: The Front-Line Worker Experience

Jennifer Dulong, Chief Executive Director, Chatham Savannah Authority for the Homeless

Ms. Dulong reported on the ways in which Chatham Savannah Authority for the Homeless serves those who experience homelessness with behavioral health challenges. She reports that there are barriers to available housing once individuals qualify for vouchers, and there is a lack of services that can serve individuals who may have behavioral health needs but do not qualify as having a severe mental illness by PATH standards. Additionally, Ms. Dulong points out that there is a lack of coordination between CSBs and homeless service providers. She believes there is a need for more flexibility in funding sources and mechanisms to serve this population.

Behavioral Health Outreach

Anne Hernandez, Vice President, Behavioral Health

Marvin Blissett Housing Manager, Behavioral Health

David Petty, PATH Team Lead

Ms. Hernandez, Mr. Blissett, and Mr. Petty reported on challenges they face to serve individuals experiencing homelessness with mental or behavioral health needs at Grady. Ms. Hernandez reports first on the need to expand housing with on-site case management in areas where individuals feel safe. Mr. Blissett reports that beyond services, those without housing for many years could also benefit from additional services, such as help with cleaning, budgeting, and other day-to-day tasks. All three report issues with getting individuals properly diagnosed and connected to services in a timely manner. For those whom they serve, they recommend a low-barrier day shelter, different kinds of emergency housing options, consistent outreach, and transitional housing to assist individuals in stabilizing.

Additional Content to Highlight

Background: Homelessness and Behavioral Health in Georgia

In the 2023 Annual Homeless Assessment Report (AHAR), there were 12,294 individuals experiencing homelessness in Georgia. 1,494 individuals qualified as chronically homeless. People who experience homelessness are at greater risk of experiencing behavioral health disorders. In a report from the Substance Use and Mental Health Administration (SAMSHA) using the 2022 Annual Homelessness Assessment Report (AHAR) to Congress, there were 21% of individuals nationally had a serious mental illness, and 16% had a substance use disorder. The most recent aggregate-level data from Georgia had similar responses. However, some of the local counts of individuals report higher levels of behavioral health in the homeless population, with 48% of the Atlanta homeless population reporting mental illness in the 2024 count, 40% reporting substance abuse, 62% of Athens-Clarke reporting mental illness, and 42% reporting substance abuse.

The homelessness system in Georgia functions out of 9 Continuums of Care (COCs) and manages federal and other dollars to fund homelessness programs throughout the state. The COCs have differing levels of collaboration with state-agencies serving behavioral health. COCs throughout the state face different challenges in serving and housing those who have mental and behavioral health challenges, and current funding streams need to account for the flexibility required for individuals throughout the state.

The Georgia Housing Voucher Program (GHVP) operated by DBHDD to secure compliance with the 2010 *Olmstead* Settlement Agreement with the federal Department of Justice requires the state to be able to provide housing and supportive services to people in the target population of 9,000 chronically homeless individuals with severe and persistent mental illness (SPMI) who are cycling through the criminal justice system, hospitals, and emergency rooms. At present, DBHDD is serving 2,300 people with the GHVP, but are exceeding funding limits due to a dramatic increase in the cost of rent, and a large demand for permanent supportive housing among this population.

Exiting Systems into Homelessness

The experience of homelessness often coincides with interactions with the justice and child welfare systems in childhood. Research around the interactions between these systems yields a correlation, but there is no consistent research on the number of individuals discharged from these systems directly into homelessness.

Foster care systems and jails/prisons may conduct screeners while individuals are in their care, but the data is often not systematically collected or required to be collected and distributed. The systems that serve foster care and jails/prisons are fragmented from the systems that serve behavioral health and housing. Additionally, the procedures and actions within each sector can vary by geographical and service region within the state. These fragmented and siloed systems cause difficulty between referral processes. Additionally, system-involved individuals frequently experience mistrust regarding becoming involved with yet another system and may be reluctant to receive and accept services.

Foster Care and Homelessness in Georgia

Welfare agencies sometimes do screenings for homelessness and behavioral health issues before discharge from state custody, but oftentimes the results are not systematically tracked. Additionally, individuals may be referred to services but may not decide to receive services. Conversely, they may be housed or stabilized but later face housing challenges due to lack of wraparound services. While the Social Security Act Title IV-E, Section 475(1)(D) and 475(5)(H) requires the Division of Family and Children Services (DFCS) to develop a written transition plan for youth exiting foster services, funding for DFCS is limited to youth who are within age limitations. DFCS cannot use their funding mechanism for youth who have aged out of the program.

There are two resources for data available to estimate the prevalence of foster care and housing difficulties, the National Youth in Transition Database and the Atlanta Youth Count 2018. Additionally, several housing authorities is Georgia are participating in the Foster Care to Youth Independence initiative, to help mediate experiences of homelessness for foster youth.

Atlanta Youth Count

The Atlanta Youth Count 2018 (AYC2018) was a National Institute of Justice study with the goal of estimating the prevalence of sex and labor trafficking among youth experiencing homelessness, documenting the needs of youth experiencing homelessness, and estimating the size of the homeless population in the metro-Atlanta area. Surveys were conducted in fall of 2018, with youth who were 14-25 years of age, without stable residence of their own in the past 30 days, and without consistent financial support from family. The AYC 2018 had 491 individuals who answered questions about foster care and homelessness. 38.1% of youth currently experiencing homelessness had a history of foster care involvement. About half of the sample (48.4%) of youth had been arrested before age 18, and 62.9% of youth reported being involved with either juvenile justice or foster care before they were 18 years of age.

National Youth in Transition Database

The National Youth in Transition Database is a survey of both youth who were in foster care at the time of the survey or have aged out of foster care. It collects outcomes concerning financial self-sufficiency, homelessness, educational attainment, positive connection with adults, high risk behaviors,

and access to health insurance. The Chafee Foster Care Program for Successful Transition to Adulthood requires the Administration for Children and Families to develop a data collection system to track data on youth who have exited foster care. Surveys are collected by cohorts and are aggregated nationally and by states. Information is available online for individuals in Cohort 3, collected in FY2017-2021, and for Cohort 4, collected in FY2018-2022. Individuals are surveyed when they are 17, 19 and 21 years old.

Table 1: National Youth in Transition Database: Georgia Data on Homelessness for Cohort 3 and Cohort 4

	Age	Cohort 3		Cohort 4	
		%	Total N	%	Total N
Experienced homelessness ever in your life	17 years old	12%	602	16%	622
Experienced homelessness in the past 2 years	19 years old	20%	200	23%	191
	21 years old	27%	173	*Collected in 2024*	

Note: Total N reported are individuals who responded to the survey questions. More information about the response rates, and other categories can be found on the linked Cohort reports above.

Foster Youth to Independence Initiative (FYI)

Foster Youth to Independence Initiative is housing assistance for individuals transitioning from foster care services. Individuals who are 18 to 24 years of age, who have left foster care are eligible to receive Housing Choice Vouchers alongside supportive services. Individuals can receive these services for up to 36 months. Each housing authority manages their choice voucher program, and must coordinate directly with the Department of Housing and Urban Development for receipt of these specific vouchers. The Georgia Department of Community Affairs and the Department of Families and Children are finalizing an agreement to expand the foster care to independence voucher throughout Georgia. There are six current programs, in Dekalb County, City of Atlanta, Savannah, Newnan, Carrollton and Jonesboro.

Justice Involvement and Homelessness:

According to the Bureau of Justice In 2019, there were a total of 594,056 individuals releases from jails or prisons in Georgia. Individuals who have experiences of homelessness have a high likelihood of contacts with the justice system, and interactions with the justice system correlates with housing and homelessness. The Urban Institute released a report in 2020 that included data explaining the intersection of homelessness and justice involvement. The following themes emerged as relevant to the goals of the Homelessness Advisory Group:

1. "People who are incarcerated once are 13 times more likely to experience homelessness than the general population"
2. "People experiencing unsheltered homelessness are more likely to interact with the justice system and emergency service than people in shelters"
3. "The homeless jail cycle is expensive for taxpayers"
4. "A housing first approach can break the homelessness-jail cycle"

Georgia Release Population

The Georgia Department of Corrections releases a report yearly that details demographic information, including the prison they are being released from, educational attainment, and psychological and physical information. In CY2023, the Georgia Department of Corrections Inmate Statistical Profile details information about 13,307 releases of both males and female inmates. Individuals had a mean age of 39.16, about half were black individuals (51.62%), and over half had children (60.73%). Of those who reported job status (N=5637), 10.11% had never had a job, 29.95% had been unemployed when they entered prison, and of those who responded (N=9012), 45.9% of individuals did not have a high school diploma or GED. At release, 13.07% of those whom information was collected on (N=12,995) had some kind of restriction on their ability to work. At release, more than half (59.6%) had not received a mental health evaluation while in prison, with 29% receiving some kind of mental health treatment and 16.08% requiring treatment. Additionally, 28.2% of individuals experienced some level of chronic disease. The majority (52.39%) of individuals had been incarcerated in Georgia previously.

Jail In-Reach Program

As part of a housing-first approach, DBHDD has funded a Pilot Jail In-Reach Program, which serves individuals in Hall, Dekalb, Lowndes, Chatham, and Walton County jails. The Jail In-Reach program was expanded to Fulton County this calendar year. At each site (except Walton, which does not yet have staff), a care coordinator and a forensic peer mentor serve individuals who are incarcerated and who have serious mental health diagnosis. Care coordinators and peer mentors then conduct the Need for Supportive Housing and Brief Jail Mental Health screener to help identify individuals who would benefit from connection to permanent supportive housing. The Jail In-Reach program aims to gather the necessary paperwork and information to obtain a housing voucher for qualified individuals. The program's success depends on the wrap-around services, resources, and permanent supportive housing beds available in each region. The Pilot Program has not yet expanded to rural areas in Georgia.

Recommendation Priorities

Homelessness is a housing problem, but it is also a human problem. The root causes of homelessness have been consistent for decades; poverty, criminal backgrounds, untreated mental illness, active substance abuse addiction. Poverty results in a general inability to maintain household expenses. These households are disproportionately impacted by rising housing costs and a general lack of affordable housing supply. For decades housing costs increases have outpaced household incomes. More particularly, as housing costs have soared in the post-pandemic era, the rate of homelessness has increased, both nationally and locally. For the sub-population of homeless that are also struggling with mental illnesses and substance use disorders, housing becomes even more unattainable. This population subset is what we have considered for the recommendations being brought forward.

Many of our unsheltered residents are uninsured and not accessing or not eligible for Medicaid benefits. There is a significant shortage of treatment capacity for patients with mental illnesses and substance use disorders. Other workgroups are more directly addressing these issues which also play a big role in addressing the needs of and stabilizing this population. We have been asked to focus on three questions related specifically to behavioral health and homelessness.

1. What can be done to increase the rate of acceptance of treatment by people experiencing homelessness and in need of behavioral health services?
2. What is the best way to house people who are homeless and experiencing behavioral health issues?
3. What is the appropriate array of services to provide formerly homeless individuals with behavioral health issues to strengthen their ability to remain successfully housed?

We feel the starting point to answering these questions and solving some of these ongoing challenges are imbedded in the specific recommendations detailed below. Simply stated, the workgroup answers the questions as follows:

For question 1 we are recommending significant expansion of investment in outreach workers and providing those outreach workers with access to enhanced behavioral health skills including ACT teams with specific experience with homeless populations. To be successful, the outreach workers need continuous contact to build trust, to be present when individuals have moments of clarity to choose help and when those moments of clarity come, the outreach workers need access to solutions that can be offered in real time. In that regard we are recommending a pilot for short term safe haven, harm reduction beds for severely ill individuals not well enough for mainstream supportive housing.

For questions 2 and 3 we are recommending a continuum of support services from intense to lighter touch depending on the needs of the individuals. Additionally, because supportive housing interventions critically rely on the “three-legged stool” of 1) housing supply, 2) rental support, and 3) support services, there is a need for a flexible funding source that can cut across all three areas of need. A “Georgia way” fund would have the ability to break down silos by filling whatever gap a local solution faces in order to maximize impact

These recommendations focus on promoting coordination, empowering communities, and providing flexible funding for homelessness solutions. Immediate action includes aligning resources and goals across agencies (DCA, DBHDD, DFCS, CoC’s, CSB etc.), improving data sharing, and supporting local collaboration and increased accountability of service delivery and outcomes. Significant investment in highly skilled outreach teams should be prioritized, along with state-funded supportive services. Flexible grant funding is essential for addressing specific local needs, allowing CoCs to tailor services such as permanent supportive housing, short-term solutions, and reentry programs. Ongoing monitoring, voucher expansion, and pilot programs for vulnerable populations further enhance the strategy.

The Homelessness Advisory Group Subcommittee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

1. Promote greater homelessness coordination, including: (DCA/DBHDD)
    a. We propose the coordination be implemented through an agreement among the 9 CoCs and DCA, and DBHDD and that the coordination prioritize the unsheltered homeless alignment of state resources among DBHDD, DCA, DFCS, DDS, DHS, and DoC, particularly related to the homeless population with behavioral health issues, mental illness, and substance use disorders, as well as individuals aging out of foster care or reentering society from jail/prison;
    b. Maximize utilization of Family Unification Program and Fostering Youth Initiative vouchers for families at risk and youth aging out of foster care including through partnerships with CoC's who shall provide referrals of people currently experiencing homelessness;
    c. Support data sharing and interoperability between state and local systems, including HMIS, that reduces duplication, streamlines processes, and eliminates unnecessary steps, including through GaHIN and Georgia Unify; and
    d. local collaboration among CoCs, CSBs, and Public Housing Authorities (ideally involving MOUs);
    e. Renew and expand existing Temporary Assistance for Needy Families program to divert and rapidly rehouse families experiencing homelessness and at risk of entering the child welfare system;
    f. DBHDD, DCA, and the CoCs shall provide a written report no later that December 1, 2025 to the Behavioral Commission outlining their efforts and resulting conclusions and agreements on improved procedures for coordination and possible additional recommendations

2. Contractually align existing outreach teams (e.g. PATH, ACT and ICM) to prioritize service to unsheltered individuals with behavioral health challenges and fund additional outreach teams where needed, specifically, fund four additional ACT teams in Atlanta which are dedicated to serving the unsheltered and coordinate with the Coc for referrals and priority locations at a cost of $750,000 per team totally in $3 million annually[1];

3. Provide state-funded supportive services in partnership with supportive housing providers, public housing authorities, and developers/providers, including housing navigation, case management, tenancy preservation, employment, and behavioral health.

4. Provide a continuing source of flexible grant funding to meet specific local needs (all CoCs, not just BoS) that align with each CoCs respective strategy, such as: (DCA/SHTF)
    a. Supportive services to complement permanent supportive housing to the extent funding recommended in item 3 is not sufficient to a local need;
    b. Funding for homeless solutions, e.g., the Melody, in other parts of the state;

[1] The cost of ACT teams is current as of the publication of this report, and may be re-evaluated in upcoming months, which would change the total cost.

    c. Support service provider capacity, especially in unserved/ under-served parts of the state;
    d. Housing vouchers and services for those who don't meet SPMI/PMI criteria required by GA Housing Voucher;
    e. Dedicated staff to provide inreach to jails and prisons to promote comprehensive re-entry plans ;
    f. New strategies that address specific, targeted needs;
    g. Shelter operations
    h. Diversion funding facilitating quick exits from homelessness; and
    i. Specifically, provide annual funding for supportive services for 500 units in development in the City of Atlanta which will service people experiencing homelessness with severe behavioral health challenges at approximately $6.5 million annually;

5. Monitor and evaluate CSBs and hold them accountable to specific performance criteria including working with CoCs, prioritization of unsheltered persons, and proactive partnerships with organizations that to serve the homeless population with behavioral health issues. (DBHDD)

6. Expand the availability of GHVP and address barriers to GHVP utilization across the state. (DBHDD)

7. Pilot a temporary, intensive harm reduction Safe Haven model to serve a population too ill for congregate housing or immediate entry in traditional supportive housing. (TBD)

8. Implement behavioral health screening and connection to treatment in conjunction with youth aging out of the foster care system (i.e., 533 individuals in 2024). (DFCS) and releasees from incarceration (DoC, Local Sheriffs)

9. Prioritize unsheltered populations for housing vouchers. (DCA)

10. Ensure the effectiveness of highly skilled outreach teams (e.g., ACT, ICM) and fund additional outreach teams, where needed. (DBHDD)

Scope of Homelessness and Behavioral Health in Georgia

Georgia Health Policy Center




Georgia Health Policy Center

1

Mental Health in Georgia

- Diagnosis
  - 8.47% had a major depressive episode
  - 4.7% had thoughts of suicide
  - 1.45% have made suicide plans
- 29.4% of individuals reported symptoms of anxiety or depression
- 28.3% unable to access counseling or therapy
  - Those in rural areas were more likely to reach out to 988 for care

2

GA Mental Health Information

- Access to care overall is an ongoing issue for all Georgians
  - America Health Rankings list at 47 out of 50 in access to care based on number of mental health providers
    - 185.9 per 100,000 Georgia
    - 324.9 per 100,000 US average
  - Ranks 48 out of 50 for access to care based on the percentage of uninsured folks in GA
    - 11.7% uninsured in GA
    - 8.00% US average
- According to Kaiser Family Foundation 58% of those who have mental illness have private insurance coverage

3

Mental Health and Homelessness

- People who experience homelessness are at greater risk of experiencing behavioral health disorders
  - 21% of individuals experiencing homelessness report having a serious mental illness*
  - 16% report having a substance use disorder

4

Homelessness Information

COC- Continuum of Care-

- 9 COCS in Georgia:
  - Atlanta
  - Georgia Balance of State
  - Fulton County
  - Athens-Clarke County
  - Augusta-Richmond County
  - Columbus-Muscogee
  - Marietta/Cobb County
  - Savannah Chatham County
  - Dekalb

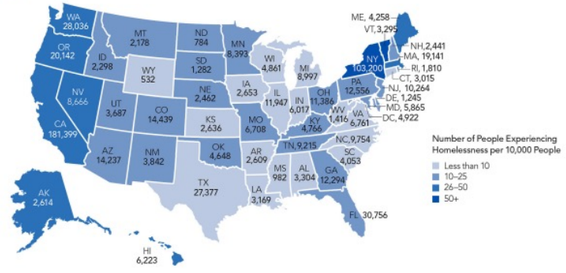
Point-in-time counts conducted by COCs

- Biannual counts of individuals who experience homelessness per 24 CFR 578.7(c)(2)
- Includes Sheltered and Unsheltered
  - Does not include individuals in more permanent residence, such as Permeant Supportive Housing

5

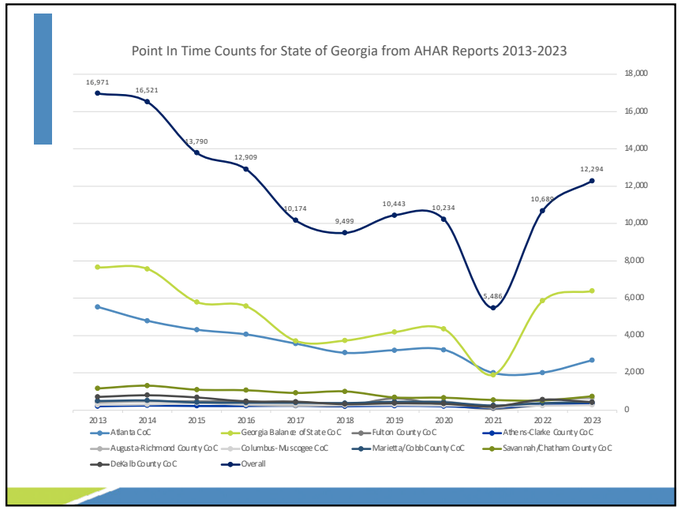
Scope of Problem Georgia

EXHIBIT 1.6: **Estimates of People Experiencing Homelessness**
By State, 2023



https://www.huduser.gov/portal/datasets/ahar/2023-ahar-part-1-pit-estimates-of-homelessness-in-the-us.html

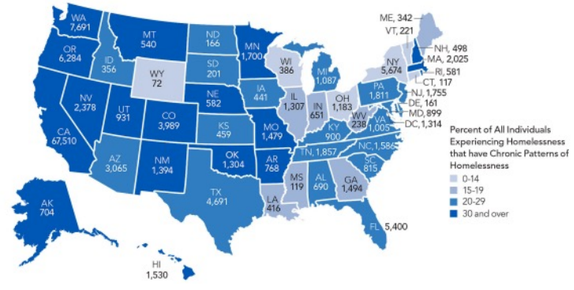
6



7

Chronic Homelessness

EXHIBIT 6.3: **Estimates of Individuals with Chronic Patterns of Homelessness**
By State, 2023



https://www.huduser.gov/portal/datasets/ahar/2023-ahar-part-1-pit-estimates-of-homelessness-in-the-us.html

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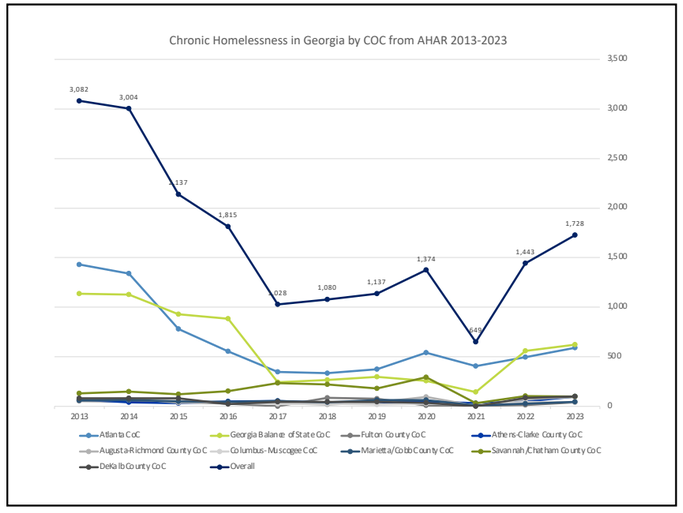

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Behavioral Health and Homelessness in Georgia

Athens Clarke (N=386)	• Mental Illness 62% • Substance Use 43%
Atlanta (N=2,867)	• Mental Illness: 48% • Substance Use: 40%

Cobb County	• Unsheltered (N=315)
	  • Severe Mental Illness 4.4%
	  • Chronic Substance use 20.6%

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Mental Health Housing Services

- *Olmstead* Decision
- DBHDD Office of Supportive Housing
  - Georgia Housing Voucher Program (GHVP)
    - Permanent supportive housing that help individuals with behavioral health needs integrate into the community
  - Bridge Funding
    - Financial support to GHVP recipients to help them transition to permanent housing
  - To qualify for either funding
    - Serious and persistent mental illness AND Served in state hospital OR frequently admitted to state hospital, OR frequently seen in the ER or Chronically homeless OR has history of incarceration or forensic status AND
    - Identified in transitional planning for individual's on the American with Disabilities (ADA) ready to discharge

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Thank You

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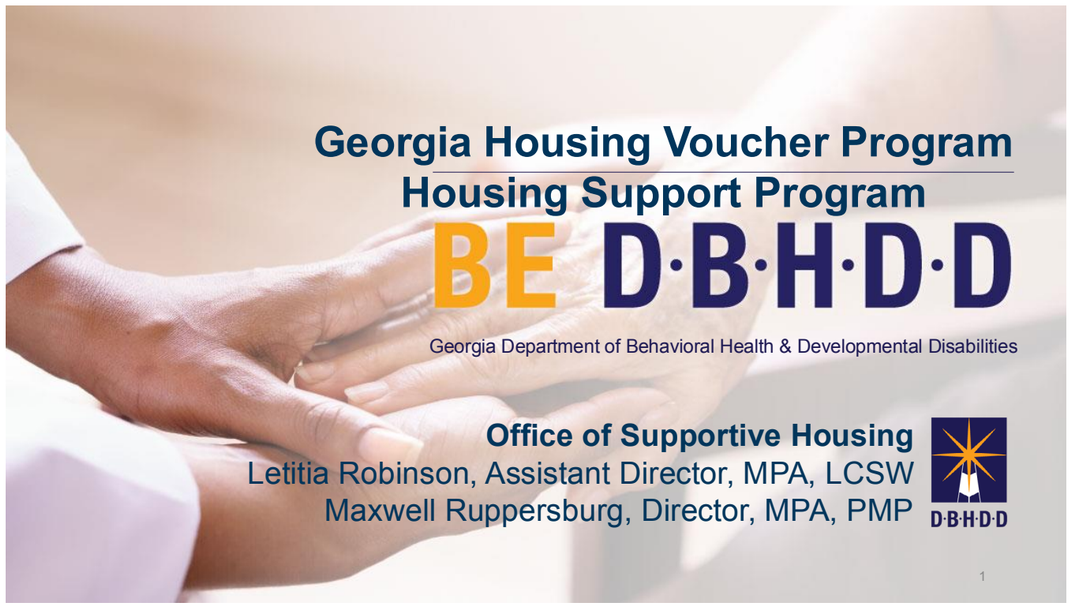


Georgia Housing Voucher Program
Housing Support Program

BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities

Office of Supportive Housing
Letitia Robinson, Assistant Director, MPA, LCSW
Maxwell Ruppersburg, Director, MPA, PMP

Contents

Evidence-Based Practices: Housing First and Permanent Supportive Housing

GHVP

Understanding the Housing First model

"Recovery needs a ***home***."

- Person-centered, recovery-oriented, harm reduction approach
- Addressing basic survival before seeking to address underlying behavioral health or other challenges
- Client choice is critical in both housing and service selection
- Clinical treatment is optional → There is no requirement for treatment, medication, or sobriety to access housing
- Supportive services are still required and critical to success!
  - Ongoing wellness visits and adjustable to individual needs

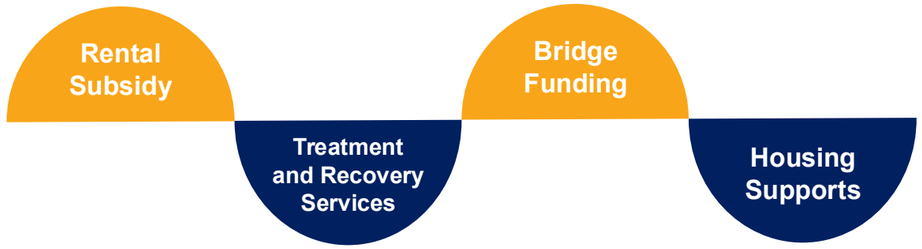
GHVP

What is Permanent Supportive Housing (PSH)?

GHVP

What does DBHDD PSH look like?

Georgia Housing Voucher Program (GHVP)



GHVP

Housing Value Statements

In addition to being evidence-based, the work we do is for the benefit of our fellow Georgians. DBHDD housing providers helped to develop these housing value statements in which our work is grounded.

1. Housing is a right.
2. Housing provides the necessary foundation for recovery.
3. Housing allows people to live with freedom, purpose, and dignity.
4. Housing signals a new beginning.

GHVP

HOUSING IS HEALTHCARE.

GHVP

Georgia Housing Voucher Program (GHVP)

HOUSING IS HEALTHCARE.

9

Steps in the DBHDD Supportive Housing process

10

GHVP Program

- Tenant-based voucher program providing independent Permanent Supportive Housing to individuals living with a psychiatric disability who are experiencing homelessness or at imminent risk.
- Born out of ADA settlement agreement between Georgia and DOJ.
- GHVP is accessed by assessment and referral via DBHDD provider.
- Participant not intended to pay more than 30% of income.
  - GHVP pays rent directly to landlord.
  - Some participants have no income and GHVP pays 100% of the rent.
  - GHVP does not cover ongoing utility costs unless built into rent.
- Housing First model:
  - Lease in participant's name. Participants maintain tenancy rights.
  - No requirement for treatment nor sobriety. No housing "readiness".

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GHVP Eligibility

- Adults (18+)
- Diagnosis of Serious and Persistent Mental Illness (SPMI)
- Currently experiencing homelessness or in a residential program
- Meets one of below criteria
  - Chronically homeless (HUD definition)
  - Currently being served in DBHDD state hospital
  - 3 or more hospitalizations or residential program visits in last 12 mos.
  - 3 or more ER visits in last 12 mos.
  - Exiting correctional system in last 90 days
  - Has a forensic status w/ DBHDD (incarcerated, preparing to be released)

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GHVP Bridge Funding

- Bridge Funding Program available to GHVP participants once they are approved for a voucher and begin housing search.
  - $3,000 in one-time “startup” funding for each household to cover application fees, deposits, furniture, household goods, clothes, etc.
  - $1,500 in Temporary Shelter (hotel/motel) while in search phase.
  - $1,000 in Eviction Prevention in case tenant damages/debts occur.
  - $2,500 security deposit budget
  - $1,500 in landlord incentives
  - $1,500 to cover property repairs if failing HQS inspection
- Bridge payments made via DBHDD provider on behalf of individual and DBHDD reimburses provider agencies.

GHVP

GHVP State Budget

- GHVP is fully state-funded and administered by DBHDD.
- GHVP funding supports Bridge Funding and the Housing Support Program service contracts.
- GHVP began exceeding its budget in FY23 and continued to grow.
- Fiscal Year Budgets:
  - FY20:~$27,000,000
  - FY21: $20,637,457.00 (COVID related budget cuts targeting unutilized funds)
  - FY22: $20,637,457.00 (no change)
  - FY23: $24,019,311.00 (~$3.5M increase following advocacy)
  - FY24: $25,919,311.00 ($1.9M released after initial Gov disregard)
  - FY25: $25,919,311.00 (no change)

HCV Preferential Access and FY24 GHVP Access Policy Change

- Individuals belonging to the ADA Settlement Population have preferential access to DCA's Housing Choice Voucher, meaning priority access for 1 of every 2 that become available through attrition. This is exclusively within DCA's HCV territory, which excludes local PHAs where population density is highest.
- DeKalb Housing Authority also offers this preferential access. No other PHAs have this preferential access in place.
- In 2020 during COVID, GHVP was made the resource of first resort instead of federal resources, achieving a reduction in resource access from over 100 days to under 5 days.
- Effective April 1, 2024, all referrals to supportive housing to DBHDD began to be diverted toward the Housing Choice Voucher Program. GHVP is now operating a waitlist.

Housing Support Program Summary

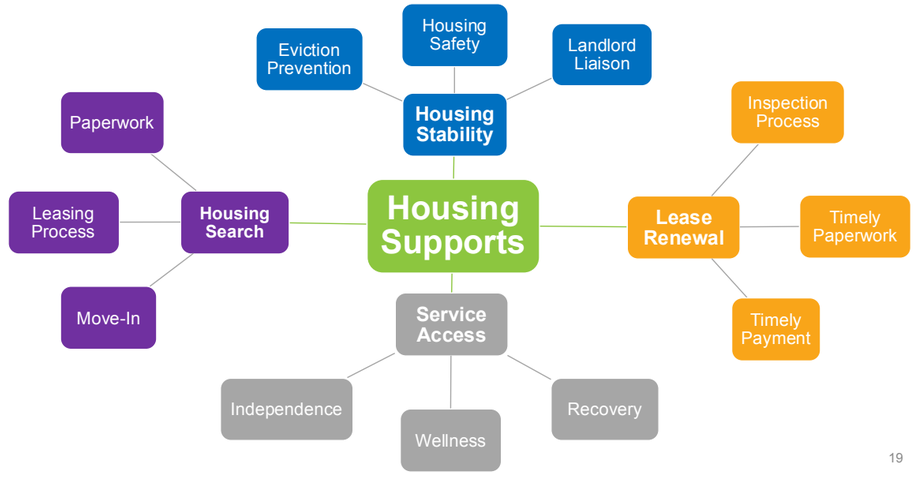
DBHDD Permanent Supportive Housing

Housing Support Program Description

- Ensures **all** GHVP program participants receive ongoing housing support to maintain their housing stability and to promote their individual recovery, wellness, and independence.
- Ensures all ADA settlement population individuals (see GHVP eligibility) can receive assistance with obtaining housing with their state or federally funded PSH voucher.
  - HSP Program was expanded to cover individuals going to HCV and HUD 811 in 2024.
- Ensures regular wellness visits and continued access to behavioral health services to meet program participants' needs and preferences.
- Comprised of multiple recovery supports and Medicaid-billable services.
- HSP is a required component of GHVP. Optional for other programs.
- Program is considered non-clinical at its core but providers are required to maintain clinical oversight of program.
- While clinical care is not required, periodic clinician engagement is critical to support ongoing authorization for supportive services.

GHVP

Systemic Need and Impact of HSP

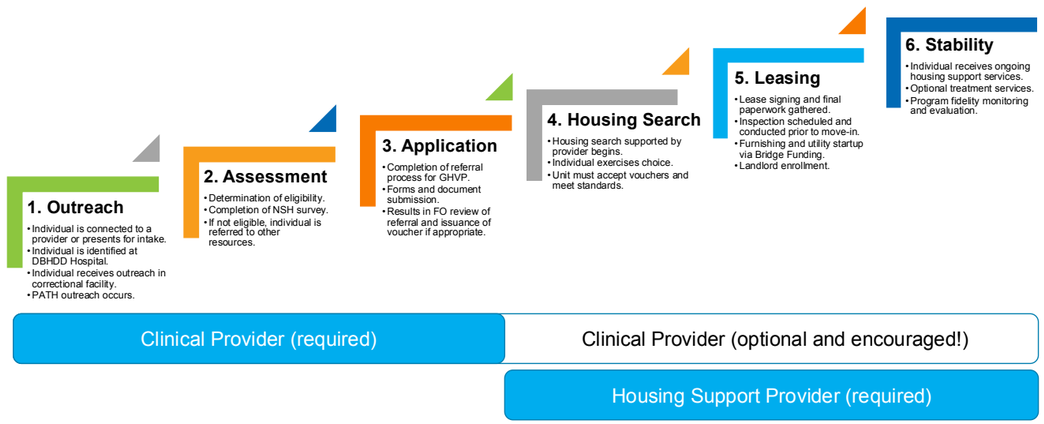


Housing Support Program Priorities

Supporting individuals in:

1. Recovery, wellness, and independence.
2. Obtaining safe housing with their vouchers.
3. Remaining stably housed and connected to benefits.
4. Transitioning eligible and stabilized individuals from the state voucher to other permanent housing programs to maximize resources.

When does Housing Supports enter the picture?



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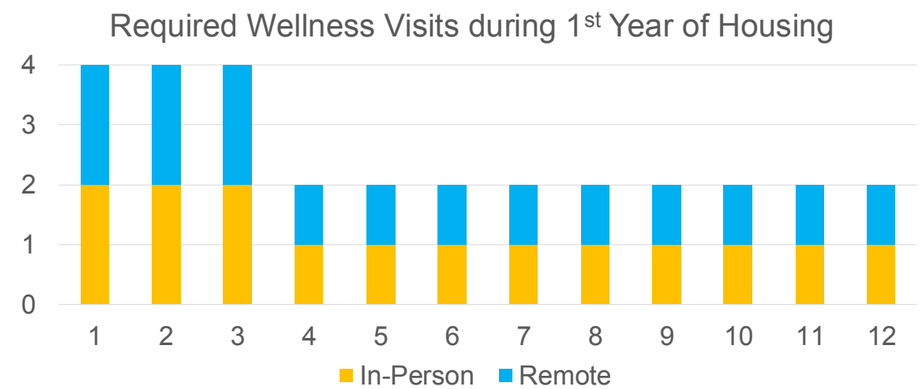
Minimum Wellness Visit Frequency once Housed



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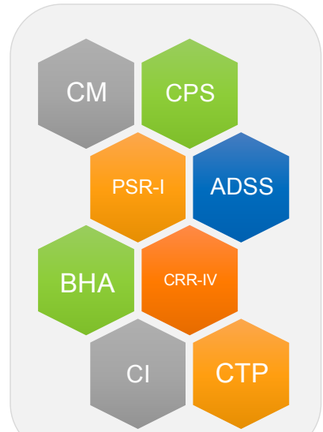
Housing Support Program Medicaid-Billable Activities

- Program consists of a combination of unbundled Medicaid-billable services.
- Providers can bill for the following:
  - Behavioral Health Assessment (BHA) and Service Plan Development
  - Case Management (CM)
  - MH and/or SUD Peer Supports (PS)
  - Psychosocial Rehabilitation – Individual (PSR-I)
  - Addictive Disease Support Services (ADSS)
  - Crisis Intervention
  - Community Residential Rehabilitation (CRR-IV)
  - Community Transition Planning (CTP)



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Housing Supports – Service Authorization/Billing

- DBHDD created a new Type of Care for GHVP Housing Supports that providers can use to request authorization for services and bill against for any of the 8 services below.
- This design means that a single authorization can approve someone for any of the 8 services.
- Each service must still be delivered and billed in accordance with the regular service guidelines.
- HSP Teams have been given a unique exception to be able to authorize someone with clinical documentation provided by another provider, since the idea is that this team is coming into the picture after the primary clinical provider has made the successful referral to GHVP.

Level of Service	Type of Service	Level of Care	Type of Care Code	Type of Care Description	Service Class Code	Service Description	Initial Auth		Concurrent Auth		Max Daily Units	Place of Service
							Max Auth Length	Max Units Auth'd	Max Auth Length	Max Units Auth'd		
OP	MH, SU, MHSU	OP	HSUP	Housing Supports	BHA	BH Assessment & Service Plan Development	180	8	275	8	8	11, 12, 53, 99
					CMS	Case Management	180	140	275	140	24	11, 12, 53, 99
					PSI	Peer Support - Adult - Individual	180	520	275	520	48	11, 12, 53, 99
					PSR	Psychosocial Rehabilitation - Individual	180	300	275	300	48	11, 12, 53, 99
					ADS	Addictive Disease Support Services	180	100	275	100	48	11, 12, 53, 99
					CIN	Crisis Intervention	180	64	275	64	16	11, 12, 53, 99
					CT1	Community Transition Planning	180	32	275	32	24	11, 12, 53, 99
					CL4	Community Residential Rehab 4	180	36	275	36	8	11, 12, 53, 99

DBHDD Vital Records Partnership Creates Free Access to Birth Certificates

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DBHDD Vital Records Partnership

- Partnership with DPH Vital Records Office and DBHDD.
- Georgia birth certificates for individuals experiencing homelessness can be requested from DBHDD directly for individuals that are enrolled in any DBHDD service.
- Free for the individual AND free for the provider.
- No requirement to submit unexpired ID document.
- Certificates will be mailed directly to secure agency addresses.
- All DBHDD agencies can utilize this resource.
- Turnaround time from current 8-10 weeks to 1 week target.

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SSI/SSDI Outreach, Access, and Recovery (SOAR)

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SOAR Program Overview

- SOAR is a SAMHHSA program model which supports individuals with severe mental illness experiencing homelessness with their application for SSI/SSDI benefits to Social Security Administration.
- Approval for SSI/SSDI means automatic approval for Medicaid.
- DBHDD employs 15-person SOAR team, funded partly by Medicaid.
- SOAR-designated applications are supposed to be processed in expedited fashion by SSA, with an identified target of 90 days, which was realistic prior to COVID.
- Currently, SSA decisions in Georgia take almost 12 months, due to SSA staff shortages in Georgia. Only Hawaii reported a longer decision timeframe in 2023.
- DBHDD is experimenting with direct application to Medicaid through Georgia Gateway portal operated by DHS.

Projects for Assistance in Transition from Homelessness (PATH)

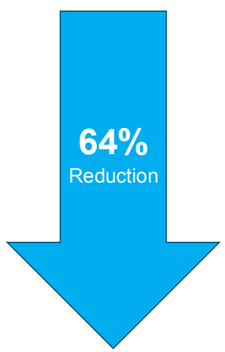
PATH Program

- Outreach and engagement teams that meet people where they are.
- Teams provide short-term (90-day) case management to make referrals and linkage to long-term service providers and housing resources for individuals who are experiencing homelessness and living with severe mental illness.
- **Eligibility**:
  - Adults (18+)
  - Currently experiencing homelessness
  - Severe mental illness (SMI)
- 9 teams of 2-5 staff, each operating around the state.
  - Four teams cover Region 3. One team in Regions 2, 4, 5, & 6. No Region 1 team.
  - Each team covers local areas, not full region.
- Not emergency/crisis response, requires appointments/scheduling.
- Accessed by contacting DBHDD BH Regional Field Offices.

DBHDD Research on Impact of GHVP on Service Utilization

Impact of Supportive Housing on Crisis Service Utilization

- For those who entered housing with a GHVP voucher during FY22, comparisons were made between the six-month period before households became housed and the six-month period after they became housed.



In the first six months of housing, there was an overall **64.3% decrease in the number of days of crisis services utilized** by the housed group compared to the six months before they entered supportive housing.

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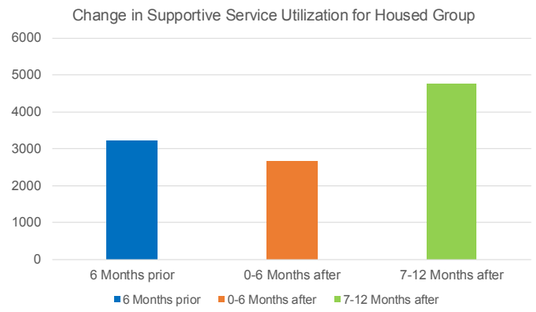
Use of Supportive Services following successful Housing Intervention

For the housed group, there was an initial **20.3% decrease** in the usage of supportive services during the first six months in housing.

The same group experienced a **78.2% increase in utilization** of supportive services in the 6-12 months of their first year in housing.



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GA Behavioral Health and Developmental Disabilities

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) was created by the General Assembly and Governor in 2009. DBHDD is responsible for operating state hospitals and community-based services for individuals who are uninsured, and also individuals who are on Medicaid.

DBHDD Behavioral Health Services are divided into three tiers of work[1]:

> TIER 1: Comprehensive Community Providers are DBHDD's community service boards, which serve as the public safety net and offer a core benefit package, as well as additional specialty services.
>
> TIER 2: Community Medicaid Providers ensure choice for individuals receiving Medicaid and offer a core benefit package.
>
> TIER 3: Specialty Providers offer an array of specialty treatment and support needed in the continuum of care.

There are six Regional Field Office that DBHDD serves based on geographical location. DBHDD has a an interactive Regional Map that individuals can find on their website. The field offices do the following[2]

- Locate and coordinate services and support
- Monitor the services being received by consumers to ensure quality and access
- Develop new services and expand existing services as needed
- Investigate and resolve complaints
- Conduct special investigations and reviews when warranted
- Oversee statewide initiatives

Alongside providing services, DBHDD has five hospitals in their continuum of care. The hospitals provides comprehensive treatment and assessment for those who have behavioral and mental health needs.

DBHDD also monitors GCAL (Georgia Crisis and Access line) which connects individuals in crisis for mental health, substance abuse, or intellectual/developmental disability to services.

Individuals with Intellectual and Developmental Disability are supported by DBHDD and are funded by two Medicaid Waivers: New Options Waiver and Comprehensive Waiver (COMP).

DBHDD also has several boards that they support, which work to address policy, funding, and care and services.

- The Georgia Behavioral Health Coordinating Council created by the Georgia General Assembly supports behavioral health agencies and partners and is chaired by Commissioner Kevin Tanner.
- Board of Behavioral Health and Developmental Disabilities establishes policy that DBHDD follows. The board is appointed by the Governor
- Intellectual and Developmental Disabilities Advisory Council advises DBHDD on issues pertaining to supporting individuals with intellectual and developmental disabilities.

DBHDD and BHRIC

The Commissioner of DBHDD, Commissioner Kevin Tanner, serves as the chair of the BHRIC work from the inception in the 2019 legislative session. Previous to his role at DBHDD which began in December 2022, he served as a State Representative in District 9. The BHRIC recommendations and work contributed to $1.6 bilion in state funds in the FY2025 budget.

The following reports from DBHDD correlate to recommendations from BHRIC:

Georgia DBHDD Bed Capacity Study and Strategic Plan

HB 1013 Compliance Reports

[1] Copied directly from the website found at https://dbhdd.georgia.gov/be-dbhdd/be-supported
[2]Copied directly from the website found at https://dbhdd.georgia.gov/regional-field-offices

DBHDD Vital Records Partnership

What is the DBHDD Vital Records partnership?

The DBHDD Vital Records Partnership is a collaboration between the DBHDD Office of Supportive Housing with the Vital Records Office (VRO) in the Department of Public Health (DPH). It allows DBHDD-contracted agencies and hospitals to quickly request birth certificate documents for Georgia-born individuals receiving services who are experiencing homelessness, at no cost to individual/provider.

How does the service work?

1. Once an agency has signed up for this program, staff can submit requests online through a ZenDesk form. Staff will have to log in to view messages, respond to messages, and access emailed documents.

2. Unlike the traditional request process, an unexpired identification document is not required to submit a request through this partnership, meaning there's no need to delay a request.

3. The Office of Supportive Housing will respond to the request, usually within 5 business days.

4. Records are mailed to a designated staff person at one of the agency's approved addresses for the requesting agency in a Vital Records envelope.

5. The agency should scan and upload the physical certified copy into an appropriate electronic record for preservation. The agency can/should continue to store the document until the household can keep it secure.

What are the limitations?

- Participating agencies and all requests must comply with DBHDD Policy 01-506 "Birth Certificate Request." **https://gadbhdd.policystat.com/policy/13956638/**
- Requests can only be submitted for individuals born in Georgia.
- Birth certificates must be sent to a secure address and stored using a double-lock rule, i.e. behind a locked door and within a locked container.
- The records can only be sent to approved staff and locations chosen by your agency, for security.

How do we sign up?

DBHDD Behavioral Health Providers can sign up to utilize this service by having an authorized representative fill out the following form: **https://forms.office.com/g/AB4djZdiT5**

After an agency has been approved to utilize this service, certificate requests can be submitted on ZenDesk at the following link: **https://DBHDDVR.zendesk.com/hc/en-us/requests/new**

To: Department of Community Affairs
From: Georgia Supportive Housing Association (GSHA)
Re: Olmstead Integration Mandate
Date: 8/19/22

Introduction

GSHA is a 501(c)(3) organization dedicated to the creation and preservation of quality supportive housing in Georgia for vulnerable individuals and families.

This memo provides background information on the landmark *Olmstead* decision of the Supreme Court, as well as the agreements and litigation in Georgia that followed Olmstead, seeking compliance with its tenets. It clarifies federal and state limitations on density of permanent supportive housing (PSH) units for individuals with disabilities experiencing homelessness and for individuals experiencing homelessness. This memo seeks to identify current challenges in the creation of supportive housing units and provides recommendations to increase the supply of needed PSH units.

History of the Olmstead Integration Mandate

In 1999 the Supreme Court of the United States decided in *Olmstead v. L.C.* that two women confined for psychiatric treatment at Georgia Regional Hospital in Atlanta should receive placement in community care, finding that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act.[1]

The Court held that public entities must provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others who are receiving disability services from the entity. The decision held that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

This landmark decision held that certain people with disabilities currently living in "more restrictive settings," such as public institutions and nursing homes, as well as people at risk of living in such settings, should be offered housing and community-based supports that are consistent with the integration mandate of the Americans with Disabilities Act (ADA). The Olmstead decision recommended that states develop "comprehensive, effectively working plans" to ensure community integration with the provision of permanent, affordable, accessible, and integrated housing.

[1] Olmstead v. L.C. (98-536) 527 U.S. 581 (1999) https://www.law.cornell.edu/supct/html/98-536.ZS.html

In 2008, Georgia entered into a Voluntary Compliance Agreement with the US Department of Health and Human Services Office of Civil Rights (HHR OCR) regarding people confined in institutions. This was spurred by a 2001 HHS OCR complaint filed by the Atlanta Legal Aid Society, Georgia Advocacy Office, the Disability Law and Policy Center of Georgia, and Georgia Legal Services Program. The Complaint alleged that Georgia violated the ADA by failing to treat qualified individuals with mental retardation, developmental disabilities, and mental health disabilities in the most integrated setting appropriate to their needs.

In 2009, on the tenth anniversary of the Supreme Court's decision in *Olmstead*, President Obama launched "The Year of Community Living" and directed federal agencies to make enforcement of *Olmstead* a top priority.[2] A federal court case litigated by the Department of Justice (DOJ) against the State of Georgia ensued. A Settlement Agreement was signed in 2010 to expand community alternatives to institutionalization for individuals with disabilities. In addition to many other requirements, the settlement agreement requires Georgia to have the capacity to provide Supported Housing to any of the approximately 9,000 persons with severe and persistent mental illness (SPMI) in the "Target Population" who need such support.[3] The Target Population includes subgroups of people with SPMI, including: (1) those currently being served in the State Hospitals; (2) those who are frequently readmitted to the State Hospitals; (3) those who are frequently seen in Emergency Rooms; (4) those who are chronically homeless; and (5) those who are being released from jails or prisons.[4]

Under the terms of the Settlement Agreement, by June 30, 2015, the State was required to have the capacity to provide Supported Housing to any of the individuals in the Target Population who need such support. In Provision 36, Supported Housing is defined as "assistance, including psychosocial supports, provided to persons with SPMI to assist them in attaining and maintaining safe and affordable housing and support their integration into the community. Supported Housing includes integrated permanent housing with tenancy rights, linked with flexible community-based services that are available to consumers when they need them, but are not mandated as a condition of tenancy. Supported Housing is available to anyone in the Target Population, even if he or she is not receiving services through DBHDD [Georgia Department of Behavioral Health and Developmental Disabilities]."[5]

An Extension Agreement between Georgia and DOJ was signed in 2016 and the case remains open in significant part because of the State's failure to meet the obligations of providing supportive housing to the target population. As of March 2022, the State serves 1,853 recipients of the Georgia Housing Voucher Program.[6]

Limitations on Density of PSH Units for Individuals with Disabilities

[2] Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. (June 22, 2011) https://www.ada.gov/olmstead/q&a_olmstead.htm#_ftnref11

[3] United States of America v. State of Georgia, Civil Action No. 1:10-CV-249-CAP https://drive.google.com/file/d/1ZGqEgxbW_11CjAp5w8bKeHVQBU2dle8e/view?usp=sharing

[4] Definition of "Target Population" GA DBHDD policy https://gadbhdd.policystat.com/policy/8675761/latest#autoid-94p33

[5] Supplemental Report of the Independent Reviewer, In the Matter of United States v. Georgia, Civil Action No. 1:10-CV-249-CAP https://drive.google.com/file/d/0B3BBI3fWo7UQZjFEWmd0Mzk3Y2JmM2o2cFQxV3NCQlVyU1Ij/view?usp=sharing&resourcekey=0-meXNnWmzhdIToByRCh7XUw

[6] March 2022 Office of Supportive Housing Report for SHARE, https://drive.google.com/file/d/1E_HS8J_A6Kr4olO3borU1clrS71TUVoh/view

Federal law, including the ADA, does not limit PSH units in a development or set a maximum percentage of PSH units in order for it to be considered "integrated." The only federal law enumerating a limit on PSH development is the Frank Melville Supportive Housing Investment Act of 2010, which restricts new Section 811-financed multi-family projects, including condominiums or cooperative housing, to have an occupancy preference of no more than 25% of the units for people with disabilities. There is no "Olmstead" limitation on the development of thoughtfully designed, non-scattered site supportive housing.

The ADA requires state and local governments to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[7] It forbids the needless segregation of people with disabilities. The "most integrated setting" is a setting that "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[8] The ADA's integration mandate is implicated where a public entity administers its programs in a manner that results in unjustified segregation of persons with disabilities. More specifically, a public entity may violate the ADA's integration mandate when it: (1) directly or indirectly operates facilities and or/programs that segregate individuals with disabilities; (2) finances the segregation of individuals with disabilities in private facilities; and/or (3) through its planning, service system design, funding choices, or service implementation practices, promotes or relies upon the segregation of individuals with disabilities in private facilities or programs.[9]

There is a Georgia-specific limitation on the development of supportive housing set forth in the 2010 Settlement Agreement between the State and the DOJ. It provides, in Section III.B.2.c.i.(A), that "[s]upported housing includes scattered-site housing as well as apartments clustered in a single building. By July 1, 2015, 50% of Supported Housing units shall be provided in scattered-site housing, which requires that no more than 20% of the units in one building, or no more than two units in one building (whichever is greater) may be used to provide Supported Housing under this agreement. Personal care homes shall not qualify as scattered-site housing."[10] The Extension Agreement in 2016 includes this provision in paragraph 37.[11]

The 2010 Agreement provides that "[t]he Supported Housing required by this provision may be in the form of assistance from the Georgia Department of Community Affairs (DCA), the federal Department of Housing and Urban Development, and from any other governmental or private source."[12]

Georgia has no limitation on the development of supportive housing units for individuals and families outside of the Target Population of the Settlement Agreement. There is no limitation on the development of units for special needs categories, such as domestic violence survivors,

[7] 3 28 C.F.R. § 35.130(d)

[8] 28 C.F.R. pt. 35 app. A

[9] Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. (June 22, 2011) (Q+A #2) https://www.ada.gov/olmstead/q&a_olmstead.htm#_ftnref11

[10] United States of America v. State of Georgia, Civil Action No. 1:10-CV-249-CAP, Section III.B.2.c.i.(A), p.19 of 40 https://drive.google.com/file/d/1ZGqEgxbW_11CjAp5w8bKeHVQBU2dle8e/view?usp=sharing

[11] Joint Motion to Enter Into Extension of Settlement Agreement, United States of America v. State of Georgia, Civil Action No. 1:10-CV-249-CAP #37 , p. 13 https://drive.google.com/file/d/1SgPKhs8wb6WE5hs73Nn6GCR6u3lXLw3c/view?usp=sharing

[12] United States of America v. State of Georgia, Civil Action No. 1:10-CV-249-CAP, Section III.B.2.c.ii.(A), p.19 of 40 (Of interest for development purposes: the 2010 Agreement provides the parties' intent that 60% of the scattered site apartments will be two-bedroom units and 40% will be one-bedroom apartments. Id. Section III.B.2.c.i.(B), p.19 of 40.

returning citizens, veterans, individuals with I/DD, individuals with physical disabilities and/or mental disabilities that do not meet Target Population criteria, seniors, young adults, etc.

Georgia Needs to Produce More Dedicated PSH Units to Meet Substantial Unmet Need

While the Settlement Agreement provides 50% of units provided or generated by state funding shall be scattered site and limited to 20% of units in any one building serving the Target Population, the remainder 50% of units in the state's portfolio is not limited and should be used for as many supportive housing units as possible.

While some disability advocates want the development of only scattered site supportive housing, the reality is that Georgia has a shortage of landlords receptive to scattered site vouchers and has developed few dedicated PSH units in recent years. Georgia has a growing need for supportive housing units for varied demographics of special needs populations, and they vie for the limited quantity of existing dedicated PSH units. Research indicates that some of these subpopulations benefit more from single- site versus scattered- site PSH.[13]

Also, Georgia does not yet have adequate Medicaid infrastructure to sustain only scattered-site community-based services. Georgia has a dearth of community-based service providers that can visit households in scattered site locations. This is an impediment to the success of DCA's Permanent Supportive Housing Program and HUD 811 program. And, as Georgia has not fully "expanded" Medicaid, many homeless consumers do not have Medicaid or other insurance, and providers with Medicaid accreditation cannot bill Medicaid for services.

Data indicates that Georgia cannot rely upon only scattered site units to house vulnerable people. The Georgia Housing Voucher Program (GHVP), for example, which relies upon a state appropriation for the vouchers and to fund housing supports for consumers living in the community, has private market challenges. Of 355 new vouchers issued as of March of 2022, 116 achieved housing.[14]

It must be recognized that a compromise has been achieved between advocates for the development of only scattered-site supportive housing and those seeking more density to create more units. A compromise was achieved in the Settlement Agreement, and it provides that 50% of units provided or generated by state funding shall be scattered site and limited to 20% of units in any one building serving the Target Population. This allows 50% of the state's supported housing portfolio to be "apartments clustered in one building."

There is a need for the development of more dense supportive housing. It is not problematic if the state does not have data on its portfolio to know when it meets the 50% of the portfolio cut-off for scattered site or congregate units, because there is not enough housing. If Georgia ever experiences a period of vacancies of supportive housing units, then it becomes relevant.

While very few units of supportive housing have been developed in Georgia in the past years, DBHDD continues to create scattered-site locations with GHVP. In 2017, data from DBHDD

[13] "Outcomes in Single-Site and Scattered-Site Permanent Supportive Housing," Homelessness Policy Research Institute (April 1, 2019) https://socialinnovation.usc.edu/wp-content/uploads/2019/04/Scattered-vs.-Single-Site-PSH-Literature-Review.pdf

[14] DBHDD Office of Supportive Housing, Supportive Housing Report for SHARE, March 2022 (link)

indicated that the percentage of scattered sites per Region ranged from 78% in Region 6 to 96% in Region 5.[15] There was no update of data in 2021.[16]

DCA should maximize the ability to develop 50% of its portfolio to meet the need, and that means the development of thoughtfully designed projects with greater set aside density.

Supportive Housing in almost every instance, incorporates the Supreme Court's defined key elements for 'integrated settings"

In contrast to institutionalized group homes, supportive housing is designed to allow people with disabilities to live in the most integrated setting appropriate to meet their needs.[17] Tenants have their own apartments with their own bathrooms and kitchens. It is located near community services, transportation, employment opportunities and other housing and is not segregated from the larger community. It employs best practice in service paradigms/modalities, promoting choice and voluntary services. Residents living in permanent supportive housing are free to come and go as they choose, and they can move out. They can leave at any time for other housing options of their choice. Not all supportive housing is targeted to people with disabilities. It may target homeless households with children, at-risk subpopulations such as youth exiting the foster care system, victims of domestic violence, people exiting correctional systems after years of incarceration, and families involved with the child welfare system, amongst other demographics.

An example of supportive housing providing integrated living is The Commons at Imperial, a single-site supportive housing development located in downtown Atlanta.[18] Tenants select to live there, sign a lease in their names for private units with a bedroom, bathroom, and kitchen, and enjoy the protections provided by Fair Housing protections. The lease is renewable at both the tenants' and owners' option. Tenants have freedoms all multifamily residents enjoy: to control their schedules and activities, make and eat food at any time, have roommates only by their choice, have visitors on their schedule, etc. Critically important, they have a choice in the support services that they receive and using the Housing First approach, the services are voluntary.

The United States Interagency Council on Homelessness (USICH) provides that the shared values and goals of the Olmstead Mandate include "Housing as a foundation for life in the community, not a bed in a hospital, treatment facility, or nursing facility. Housing that is integrated in the community and offers privacy, stability, safety, self-determination, and hope—not a tent, or mat on a shelter floor. Opportunities to interact with family members, friends, and social contacts that include neighbors who do not have disabilities, and an end to unnecessary segregation and isolation. Meaningful choices among available housing options and about how and from whom to receive supportive services. Availability of supportive services that are not required as a condition

[15] Report of the Independent Reviewer, In The Matter of United States of America v. The State of Georgia, Civil Action No. 1:10-CV-249-CAP p. 38 of 45.(March 26, 2018)

[16] Review of Supported Housing Obligations, In The Matter of United States of America v. The State of Georgia, Civil Action No. 1:10-CV-249-CAP p.12 of 20.(August 4, 2021)

[17] CSH: Supportive Housing & Olmstead, The Dialogue (March 2016) p. 6 https://drive.google.com/file/d/12DTWLjIosnAB_1wBt88-8nFu6LomQSPi/view?usp=sharing

[18] https://www.columbiares.com/downtown-atlanta-apartments/commons-at-imperial-hotel/

of tenancy that help individuals to maintain housing stability."[19] Supportive housing meets all of these criteria, even where the density of residents is higher than scattered-site.[20]

According to national supportive housing leader CSH, "[s]upportive housing, in almost every instance, incorporates the Supreme Court's defined key elements for 'integrated settings.' In fact, courts have recognized supportive housing as advancing the right of people with disabilities to live independently in integrated settings. It is the case that some supportive housing buildings are occupied primarily by people with disabilities; however, these supportive housing providers still meet all of the central tenets of integrated settings, and do not fall under the federal definition of 'congregate setting.'"[21]

"Integrated settings are those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities. Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible."[22] As per CSH, "it should be the quality of the tenancy experience that is important, not the configuration or number of units."[23]

Largely, concern about projects dense with supportive housing units is from research and litigation focused upon the I/DD community.[24] "[S]egregated settings are occupied exclusively or primarily by individuals with disabilities. Segregated settings sometimes have qualities of an institutional nature, including, but not limited to, regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, limits on individuals' ability to engage freely in community activities and manage their own activities of daily living, or daytime activities primarily with other individuals with disabilities."[25] An example of a poorly integrated setting is a group home housing people with mental illnesses who do not have contact with people outside of other residents and staff of the facility or at segregated day programs, who are required to attend programs or activities, may lack privacy and the ability to manage their activities of daily living.[26]

Georgians for a Healthy Future is currently working in partnership with the Georgia Council on Developmental Disabilities (GCDD) to assess the barriers to housing that Georgians with developmental disabilities face, and DCA may be able to utilize the findings to identify ideal housing projects for the I/DD population that best meets the goals of the Olmstead Mandate.

[19] United States Interagency Council on Homelessness (USICH): Fulfilling the Dream: Aligning State Efforts to Implement Olmstead and End Chronic Homelessness (February 2016) p. 4 https://www.usich.gov/resources/uploads/asset_library/Olmstead_Brief_02_2016_Final.pdf

[20] CSH: Supportive Housing & Olmstead, The Dialogue (March 2016) p. 3-4 https://drive.google.com/file/d/12DTWLjIosnAB_1wBt88-8nFu6LomQSPi/view?usp=sharing

[21] CSH: Supportive Housing & Olmstead, The Dialogue (March 2016) p. 6 and fn cited there https://drive.google.com/file/d/12DTWLjIosnAB_1wBt88-8nFu6LomQSPi/view?usp=sharing

[22] Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. (June 22, 2011) (Q+A #1) https://www.ada.gov/olmstead/q&a_olmstead.htm#_ftnref11

[23] Id. p. 4 https://drive.google.com/file/d/12DTWLjIosnAB_1wBt88-8nFu6LomQSPi/view?usp=sharing

[24] Doe v. Zucker et al, No. 1:2017cv01005 - Document 81 (N.D.N.Y 2019), https://law.justia.com/cases/federal/district-courts/new-york/nyndce/1:2017cv01005/111467/81/; see also Statement of Interest by the United States in Z.S. v. Durham County, 1:21-cv-663 (M.D.NC), (October 25, 2021) https://www.justice.gov/crt/page/file/1446341/download

[25] Statement of the Department of Housing and Urban Development on the Role of Housing in Accomplishing the Goals of Olmstead (June 4, 2013) Q+A #1, p.6 https://www.hud.gov/sites/documents/OLMSTEADGUIDNC060413.PDF

[26] Statement of Interest by the United States in John Doe v. Howard Zucker, M.D., 1:17-cv-01005 – (N.D.N.Y.), (January 10, 2022) https://www.ada.gov/doe_soi.pdf

Simultaneously, I/DD advocates Better Living Together are requesting DCA create supportive housing projects with higher densities of units for individuals with I/DD to improve the cost-effectiveness of service provision when caregivers and services can be shared, and, because individuals with I/DD may want to live in a development with friends with I/DD.

Recommendations

Currently, outside of the LIHTC program, there is only one state program developing *new* units of supportive housing, the HUD Section 811 program. This is a resource for the Target Population of the Settlement Agreement. It is believed there are about 160 households with a disability in the HUD 811 program, though more than 340 units have been developed for PSH set-aside. We recommend DCA expand the set-aside for PSH units in Section HUD 811 to 25%, as each new unit created is critically needed.

In the LIHTC program, we recommend DCA align Project Based Voucher (PBV) RFP rounds with the GA HFA 9% LIHTC round deadline. Aligning these rounds will enable developers/owners coming to the 9% round to receive a commitment for new PBV funding. Further, it is our understanding that a significant tranche of this PBV is targeted to special needs populations, for example Veterans Affairs Supportive Housing (VASH) and GHVP. DCA can partner with these programs for the issuance of subsidy to owners in advance of the 9% round deadline.

Also, we recommend that DCA create a program similar to the Indiana QAP, wherein there is a Community Integration set-aside incentive with a limit on density of supportive housing units for disabled households, and also rounds without these limits.[27]

DCA is in a position to support the development of projects that will accept tenant-based vouchers. Presently, multi-family housing projects developed using LIHTC are not required to accept vouchers and can turn away voucher holders. At the same time, there are a proliferation of voucher subsidies in the community in need of receptive landlords, such as GHVP, Housing Opportunities for Persons with Aids (HOPWA), VASH, and Mainstream vouchers. Even the the McKinney-Vento Shelter Plus Care (SPC) program, now called GHFA Permanent Supportive Housing Program, is currently a form of rental assistance.

DCA can also encourage developers to utilize project based rental assistance and tenant based rental assistance in LIHTC properties. We recommend that DCA encourage developers to use HOME, National Housing Trust Funds, and low income housing tax credits to develop new, dedicated units of supportive housing that are 25% set aside, 30% set aside, or even 100% set aside. DCA is in a position to develop projects with these subsidies included in the underwriting or incentivized to accept TBRA as landlords.

Summation

While we eagerly await the data of Georgia's current inventory of supportive housing and current and future needs for PSH units from the Statewide Housing Needs Assessment contracted to

[27] State of Indiana 2022 Qualified Allocation Plan https://www.in.gov/ihcda/files/2022-QAP-FINAL-6-28.pdf

Mullin Lonergan & Associates, we know that supportive housing units are vitally needed.[28] This is evidenced in the annual Point In Time Count of sheltered and unsheltered homelessness and the reports of the Independent Reviewer in the state's court case. DCA's core mission includes the creation of safe and affordable housing to meet this need. Changes to DCA policies to allow and actively encourage more dense developments of SH and PSH are allowed under federal and state law and the Settlement Agreement, and will enable housing for more of Georgia's most vulnerable households.

Sincerely,

Mariel Risner Sivley

Mariel Risner Sivley, Esq.
Executive Director, GSHA

Sign on:

[28] DCA's Agreement for Statewide Housing Needs Assessment with contractor Mullin Lonergan & Associates includes the deliverable: Assess the population characteristics of those associated with supportive housing needs, including analysis of subpopulation health data, gather information on the current inventory of supportive housing, and estimate the current and future needs for supportive housing units through Monte Carlo simulation or other methodology as deemed appropriate. (D)(4)(e) p. 24 of 27.

APPENDIX J: ADVISORY SUBCOMMITTEE ON INSTITUTIONS FOR MENTAL DISEASE WAIVERS

Georgia Behavioral Health Reform and Innovation Commission

Advisory Subcommittee on Institutions for Mental Disease (IMD) Waivers

2024 Annual Report

Chair

Dr. Brenda Fitzgerald

Members

Commissioner Russel Carlson
Kim Jones
Donna Hyland

November 20, 2024

Report prepared with assistance from Georgia Health Policy Center

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas, and an additional five Advisory Subcommittees including the Institutions for Mental Disease (IMD) Waiver Advisory Subcommittee chaired by Dr. Brenda Fitzgerlad.

During 2024, the Advisory Subcommittee on IMD Waivers held two public meetings on the topics of Medicaid coverage for enrollees in IMDs and an overview of IMDs in Georgia.

This report includes a summary of public meetings and the Advisory Subcommittee on IMD Waivers recommendations.

List of Presenters to the BHRIC Advisory Subcommittee on IMD Waivers 2024

BHRIC Advisory Subcommittee on IMD Waivers Dr. Brenda Fitzgerald, Chair Commissioner Russel Carlson, Kim Jones, Donna Hyland
Support to the BHRIC Advisory Subcommittee on IMD Waivers Dr. Ana LaBoy, Georgia Health Policy Center, Ashlie Oliver, Georgia Health Policy Center, Courtnee King, Georgia Health Policy Center

Presenters to the BHRIC Advisory Subcommittee on IMD Waivers 2024

Date	Topic	Presenter
Date	Topic	**Presenter** Presenter's Title
9.3.24	Medicaid Coverage for Enrollees in Institutions for Mental Diseases	Melinda Becker Roach, Principal Analyst, MACPAC Melissa Schobe, Principal Analyst, MACPAC
10.30.24	Institution for Mental Diseases Overview	Stuart Portman, Executive Director, Division of Medical Assistance Plans, Georgia Department of Community Health

Summary of Presentations to Subcommittee

Medicaid Coverage for Enrollees in Institutions for Mental Diseases

Melinda Becker Roach, Melissa Schobe, Principal Analysts for MACPAC (Medicaid and CHIP Payment Access Commission)

Melinda Becker Roach and Melissa Schobe presented to the advisory committee on behalf of MACPAC, a non-partisan legislative branch agency with 17 commissioners.

The IMD exclusion is a policy that states that individuals who are Medicaid eligible cannot be provided Medicaid funds for services received in an IMD. The federal definition of an IMD is, "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services."

There are exceptions to the IMD exclusion that states may use to cover services for enrollees in IMDs. Medical assistance for IMDs can be covered first for adults age 65 and over. Non-elderly adults with substance use disorder (SUD) can be covered, but IMDs must provide at least two forms of medications for opioid use disorder and states must cover a continuum of SUD care and maintain prior funding for outpatient and community-based services. Only two states currently use this option including South Dakota and Tennessee, however, Congress made this preeminent so it is possible that more states will use this option. Next children under the age of 21 can be covered if they are in psychiatric hospitals, psychiatric units of a general hospital, or a psychiatric residential treatment facility (PRTF). This is commonly known as the "psych under 21" benefit. PRTFs are non hospital-based facilities that provide the psych under 21 benefit and meet federal requirements although it is not present in all states. Though unlikely, becoming certified as a PRTF is a way for qualified residential treatment programs (QRTPs) to be exempt from the IMD exclusion.

Section 1115 of the Social Security Act is a provision that allows Medicaid state plan requirements to be waived in the case of demonstration projects that aim to promote the Medicaid program.

Regarding substance use disorder (SUD) demonstrations, states may receive federal matching funds for enrollees receiving SUD treatment in IMDs. To receive this, states must meet milestones such as ensuring access to a full continuum of care for SUD, use of evidence-based placement criteria, and improved transitions between levels of care. Demonstrations must be budget neutral and are subject to monitoring and evaluation requirements. Specifically, they cannot cost the federal government more than if it was not in place.

For mental health demonstrations, states may receive federal matching funds for IMD stays if they meet milestones such as ensuring quality of care in psychiatric hospitals and residential settings, improved transitions to community-based care, and increased access to a continuum of care including crisis stabilization. These demonstrations must also be budget neutral and are subject to monitoring and evaluation requirements.

Some considerations include that the Medicaid state plan option includes a maintenance of efforts. Additionally, states may need to weigh the length of stay with IMDs varies. There are also efforts to treat patients in ways that are not as restricting. It should be considered how

maintenance of effort requirements compare to continuum of care requirements. There may be a need to look at the language to see what the guidance suggested for specific details on funding. CMS regional offices are typically where advice and guidance are available. It is recommended that the committee connects with other states to see what their firsthand experience with this process was. Oklahoma is a suggestion. Each state's plan is available on the CMS website.

Institution for Mental Diseases Overview

Stuart Portman, Executive Director, Division of Medical Assistance Plans, Georgia Department of Community Health

Stuart Portman provided an overview of IMDs to the committee. IMDs are "hospitals, hospital, nursing facilities, or other institutions of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases." Beds may be counted cumulatively across multiple facilities, locations and programs if they are owned or governed by the same entity. An entity is considered an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental health needs, meaning that more than 50% of the population has a mental health diagnosis.

States must ensure that placement of beneficiaries in an IMD will allow for their successful transition to the community, considering factors such as the proximity to their support network. To ensure an appropriate transition from IMD to community, states must provide services at lower levels of clinical intensity or establish relationships with Medicaid enrolled providers offering care at lower levels. As beneficiaries transition between levels of care, they must generally be able to receive covered services from any Medicaid provider who agrees to furnish services to them. CMS encourages states to ensure seamless transitions across the continuum of care and collaboration between different types of health care.

There are some Medicaid opportunities to access IMDs including a QRTP with fewer than 16 beds, CSUs with fewer than 16 beds and average length of stay of fewer than 23 hours, and 1115 IMD waivers, which are focused waivers for individuals with SMI or SED for short stays in IMDs. Currently, 35 states have an 1115 waiver for mental health, SUD, or both. The normal requirements for 1115 waivers such as budget neutrality and evaluations apply. Another opportunity is the State Plan Option to provide Medicaid coverage of enrollees aged 21 through 64 with at least one SUD who are patients in an eligible IMD for no more than a period of 30 days during a 12-month period. The conditions include that the IMD follows evidence-based practices and offers two forms of MAT for SUDs on site. There is an MOE on state expenditures in IMDs and in the community, and there are continuum of care requirements, as outlined by the ASAM levels of care. Lastly, there is the opportunity to access IMDs for 15-day short stays which are covered as an "in lieu of service" in managed care plans.

Additional Information to Highlight

The IMD exclusion prohibits states from claiming Federal Financial Participation for individuals under the age of 65 who are patients in IMDs, with only a few exceptions to this rule. In turn, this exclusion has left states with limited pathways to pay for these services. As of 2019, 26 states had received approval for IMD waivers for substance use disorder services, and states are also exploring IMD waivers for mental health services. In the 2022 legislative session, the Georgia General Assembly passed Senate Bill 610, which called on DCH to submit an IMD waiver for both mental health and substance use disorder treatment. Following this in the 2023 report, the Commission recommended that an IMD Waiver Advisory Subcommittee be established in collaboration with DCH leadership to identify funding and identify additional barriers that may prevent DCH from following the directive prescribed to the agency in SB610.

When identifying barriers to the IMD waiver the current capacity of the continuum of care was discussed. In 2019, the Department of Community Health (DCH) contracted with Deloitte to study, review and analyze waiver opportunities[1]. From the Deloitte review, several recommendations were made for DCH to prepare them for a waiver opportunity in 2022. Alongside the study, in September of 2023, DCH began a procurement process, opening a request for proposals from Care Management Organizations (CMOs)[2].

DCH has been working internally to comply with recommendations from the internal Deloitte report to prepare for a waiver. To date, DCH has continued to expand its continuum of care and addresses additional recommendations provided in the Deloitte analysis. After testimony heard by the Advisory Subcommittee on IMD Waivers, the Commission recommends continued partnership with DCH to evaluate the best options moving forward to address the funding of additional behavioral health crisis services and to expand the crisis continuum of care, given the upcoming changing landscape of managed care in Georgia Medicaid. The Commission Recommends that DCH explore and assess alternative options to the IMD waiver to achieve similar goals, including but not limited to, 1115 waivers, 1915(s), and utilize in lieu of services, and state plan amendments.

[1] https://dch.georgia.gov/announcement/2019-06-10/dch-selects-deloitte-consulting-assist-1115-and-1332-waiver-development
[2] For more infomrtion on rocurement process please visit https://dch.georgia.gov/divisionsoffices/office-procurement-services

Recommendation Priorities

The IMD Waiver Advisory Subcommittee identified the following recommendations from the testimony heard over the past 5 months as priorities for immediate action.

1. Continued partnership with DCH to assess milestones for establishing a fully robust continuum of care. Milestones Identified in DCH Deloitte Gap Analysis, DCH to share updates.
2. Evaluate and assess alternative options to the IMD Waiver.

APPENDIX K: ADVISORY SUBCOMMITTEE ON MEDICAID-SOCIAL DETERMINANTS OF HEALTH

Georgia Behavioral Health Reform and Innovation Commission

Advisory Subcommittee on Medicaid- Social Determinants of Health(SDoH)

2024 Annual Report

Chair

Dr. Brenda Fitzgerald

Members

Commissioner Russel Carlson

Dr. John Constantino

Dr. April Hartman

Dr. Dorothy Hahn

Dr. Stan Sonu

November 19, 2024

November 2024

Report prepared with assistance from Georgia Health Policy Center

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas, and an additional five Advisory Subcommittees including the Medicaid-Social Determinates of Health Advisory Subcommittee chaired by Dr. Brenda Fitzgerald.

During 2024, the Advisory Subcommittee on Medicaid-Social Determinants of Health held two public meetings on the impact of Social Determinants of Health on Adverse Childhood Experiences and Medicaid.

This report includes a summary of public meetings and the Advisory Subcommittee on Medicaid-Social Determinates of Health recommendations.

List of Presenters to the BHRIC Advisory Subcommittee on Medicaid-SDoH

BHRIC Advisory Subcommittee on Medicaid- Social Determinants of Health Dr. Brenda Fitzgerald Commissioner Russel Carlson, Dr. John Constantino, Dr. April Hartman, Dr. Dorothy Hahn, Dr. Stan Sonu
Support to the BHRIC Advisory Subcommittee on Medicaid- Social Determinants of Health Ana LaBoy, Georgia Health Policy Center & Ashlie Oliver, Georgia Health Policy Center
Presenters to the BHRIC Advisory Subcommittee on Medicaid- Social Determinants of Health 2024

Date	Topic	Presenter
Date	Topic	**Presenter** Presenter's Title
August 16, 2024	Social Determinants of Health (SDoH), Trauma/Adversity and Systemic Approaches	Dr. Stan Sonu Department of Medicine Assistant Professor
	SDoH and Medicaid: It's Complicated	Dr. April Hartman, Associate Professor and Vice Chair of Advocacy Department of Pediatrics, Medical College of Georgia, Augusta University Dorothy A. Hahn, MD Endowed Chair in Pediatrics Division Chief, General Pediatric & Adolescent Medicine Children's Hospital of Georgia
September 13, 2024	Georgia Health Information Network Updates	Dr. Denise Hines, DHA, PMP, FHIMSS Executive Director, Georgia Health Information Network

Summary of Presentations to Subcommittee

Social Determinants of Health (SDoH), Trauma/Adversity and Systemic Approaches

Dr. Stan Sonu, Department of Medicine Assistant Professor

Dr. Sonu presented to the advisory subcommittee, the implications of Social Determinants of Health (SDOH) and Adverse Childhood Experiences (ACEs) on the health and well-being of the population. Trauma and adversity that individuals experience over their life course leads to what Dr. Sonu called the five D's- dysregulation, social dysfunction, physical and mental disease, disability, and premature death. Dr. Sonu pointed to recommendations such as SDOH screenings in primary care and trauma-informed care to mediate these effects. These interventions would have long-lasting effects on both individual-level health, but also community well-being.

SDoH and Medicaid: It's Complicated

Dr. April Hartman, Associate Professor and Vice Chair of Advocacy

Department of Pediatrics, Medical College of Georgia, Augusta University

Dorothy A. Hahn, MD Endowed Chair in Pediatrics, Division Chief, General Pediatric & Adolescent Medicine, Children's Hospital of Georgia

Dr. Hartman and Dr. Hahn presented the implications of considering social drivers of health when assessing how Medicaid providers can deliver services and how Medicaid reimburses for services that specifically address social drivers of health. In the presentation, the presenters documented the difficulties that the Medicaid service population already faces, including documented workforce issues, provider availability, and limited provider network, which leads to access issues. Providers also face low reimbursement rates for serving the Medicaid population,

To address these and other issues, the presenters recommend the following:

1. Align Medicaid reimbursement rates with Medicare.
2. Medicaid insurance plans are required to update clinicians and member panels regularly.
3. Financial Penalties and fines for insurance plans that show non-compliance
4. Engage Medicaid providers to establish Community Care Coordinators

Georgia Health Information Network Updates

Dr. Denise Hines, DHA, PMP, FHIMSS

Executive Director, Georgia Health Information Network

Denise Hines from GaHIN presented information about the capabilities of the platform and how it has already been used with participating providers. She shared with the subcommittee that GaHIN is an information-sharing integrated platform that allows the sharing of patient-level information between various sources. The goal is to support whole-person care, build trust, engage service providers, and align and coordinate care.

GaHin combines Georgia ConnX with Georgia Unify. Georgia Connx gives providers and payers access to data from integrated hospitals, providers, state agencies, and care managers to lead care coordination. Georgia Unify has professional and individual access to community-based organizations, the education department, government agencies, and a resource director. With these services combined, providers and service providers can access longitudinal patient care information across the entire care ecosystem on patients receiving services.. In this way, providers can directly refer patients to other services such as housing, food, and transportation and also gain an understanding of previous encounters individuals may have had with other organizations. With this coordination of information, service providers can give full patient care that is specified to their unique geography and needs.

Beyond referral mechanisms, GaUnify provides a platform of built-out social screening forms. Specific coding guidelines can allow providers to receive reimbursement for those screenings, but as Dr. Hines and other members of the advisory subcommittee pointed out during discussions, there is room for expansion of these approved services. Additionally, GaUnify can pull real-time reports about specialized patient populations.

Additional Content to Highlight

Social Determinants of Health (SDOH) include a variety of non-medical factors that can influence individuals physical and mental health and can also impact an individuals ability to fully participate in their own healthcare. SDOH can include but are not limited to housing, transportation, accessibility of food, and employment. Healthcare providers have in recent years prioritized screening and referral mechanisms to better address health of patients. This effort requires extra time and effort for providers, to both maintain a regular list of accurate referrals. Systems to both incentivize providers and make referrals easy are needed within Georgia.

Recommendation Priorities

The Medicaid- Social Determinants of Health Subcommittee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

1. **Instate permanent funding for data system, staffing and referral system. Georgia is currently supporting the Georgia Health Information Network (GaHin).**

The Georgia Information Network (GaHIN) would allow for clinical services to be more judicially applied, by allowing for service providers to access existing longitudinal patient information. Providers would also have an ability to screen and refer patients directly to additional services that would allow them to better receive both mental and physical health services. Clinical data cites that in pediatric studies, if caregivers of young infants were screened for social needs, and then referred to appropriate services at clinical care, with warm hand offs, had better uptake that those who may be screened, but not provided additional resources during the referral process.[1]

GaHIN provides a pivotal service to allow for the best care for Georgians, allowing for not only Georgian's to have access to available services, but also for prevention of adverse experiences for youth.

GaHIN has available curriculum and marketing materials for webinars, presentations, etc., to educate clinicians on screening and documenting SDoH as part of the medical record.

GaHIN would also be an integral part of parity regulations plans, and would allow for there to be regular reporting to the Parity Reporting group

More specifically, as it pertains to SDOH, GaHIN would be able to report

- How many and which SDoH's are being documented on claims?
- What are the most common ones based on zip code?
- What percentage of physicians document SDoH diagnosis codes?
- Do clinicians use their EMR's to screen? (Epic and Athena have SDoH screeners that are built into their intake process and can be customized)
- How do demographics play a part in SDoH?
- What are the most common resources requested? How often are these requests followed up?

Longitudinal clinical and referral information would allow providers to better understand patients who are most at risk, including individuals who are exiting foster care systems, uninsured patients, and individuals who are frequent users of

[1] Garg A, Toy S, Tripodis Y, Silverstein M, Freeman E. Addressing social determinants of health at well child care visits: a cluster RCT. Pediatrics. Feb 2015;135(2):e296-304. doi:10.1542/peds.2014-2888

multiple systems. This would allow these patients to have the best chance at full participation in their healthcare. .

GaHIN provided an estimate of expanding GaHIN throughout the state, which is attached in the appendices of this subcommittee report. To create a fully integrated network, GaHIN would need $11,654,416.00 for year 1 and $11,654,416.00 year 2. The cost for the following years would depend on the progress.

2. **Include continued funding for CHADIS universal screening tools.**

CHADIS is a clinically recognized universal screening that can be utilized by providers to screen for SDOH needs. The Advisory Subcommittee on Medicaid Social Determinants of Health recommends that there would be continual funding for CHADIS to be incorporated into GaHIN, which would provide up to 600 questionnaires for providers to include in their work. CHADIS gives providers the ability to send screeners to patients before visits. It also would provide information for schools about behavioral problems that doctors may be managing. Additionally, access to these screening tools within GaHIN would provide data to pull reports about areas of highest need, what doctors are screening, what trends exist in patient outcomes, and referral information.

3. **Add additional reimbursement code approval for SDOH screenings by the Department of Community Health (DCH).**

In many circumstances, clinicians are required to screen for things like food insecurity, homelessness, and domestic violence and other social determinants of health, but there is no or low reimbursement beyond the payment from the insurance companies.

This places a burden on clinicians who are in areas with high need. Clinicians will either continue to screen large percentage of their patient population without additional reimbursement. Sometimes the clinicians are able to refer out to additional resources. In some low resources communities, clinicians screen without the ability to refer out, because of a lack of resources available. Other clinicians in areas of high need, will be hesitant to comply with screening requirements, without a solution to offer the patients.

The Georgia Department of Community Health (DCH) Medicaid currently reimburses for the following CPT codes at the rate listed:

96127 - Depression and other mental health screening, $4.55

96160 – health risk assessment (tobacco, substance use, etc), $3.95

96161 – Caregiver risk assessment (maternal depression, etc), $3.95

DCH has an opportunity to include additional screening CPT codes, using new CPT and diagnosis codes. CMS has designated the CPT code G0136 for SDoH screening. For Medicare patients the reimbursement is about $19, much higher than current

DCH reimbursement rates. The reimbursement would help to offset the amount of time for physicians to appropriately review and refer for SDOH mechanisms. DCH also has the opportunity to allow SDOH diagnosis to be included and reported to determine the extend of need, and reevaluate the reimbursement rates for referrals.

The Advisory Subcommittee of Medicaid SDOH recommends that DCH adds additional codes for SDOH screening and SDOH issues.

Additional Recommendations to Consider in the Future

1. Funding for additional education for providers on the importance of screening for SDOH, using physician champions and ambassadors. Funding should include travel for physician champions and ambassadors.
2. Additional build outs of GaHIN to different hospital groups and organizations, and additional referral links as necessary.

NATIONAL COUNCIL for Mental Wellbeing

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HEALTH RELATED SOCIAL NEEDS
MODULE 6

SEPTEMBER 2024

Acknowledgments

This module was written by Selina Hickman, principal, and Rachael Matulis, MPH, principal, Bowling Business Strategies. Contributions and advisory support were provided by Virna Little, PsyD, LCSW, co-founder and chief operating officer, Concert Health; Laura Gottlieb, MD, MPH, co-director, Social Interventions Research and Evaluation Network (SIREN) and professor, Department of Family and Community Medicine, University of California, San Francisco; and the National Council for Mental Wellbeing project staff.

Background

This module supports organizations to implement evidence-based integrated care approaches specific to identifying health-related social needs (HRSN), also called social determinants, or drivers, of health (SDOH). An unequal distribution of SDOH is the root cause of HRSN at the individual level. For example, a particular community may lack affordable housing options, but individuals may experience housing needs differently. For providers of physical and behavioral health care, HRSN describes specific barriers to individual treatment goals due to a person's unique social and environmental conditions. Consistent with terminology and intended use clarifications by the Department of Health and Human Services (HHS)[1] and others,[2] this module will primarily use the term "HRSN" unless using direct quotes with alternative terminology, such as when referencing billing code descriptions.

Notes on Terminology

Social determinants of health (SDOH) are the conditions in which people are born, live, learn, work, play, worship and age, which affect a wide range of health, functioning and quality-of-life outcomes. SDOH are fundamental social and structural factors that touch people's lives and impact their wellness and longevity.

Health-related social needs (HRSN) are social needs at the individual level, including affordable housing, healthy foods and transportation.

While most mental health and substance use care providers have experience navigating patients' HRSN in their practices, the content of this module is organized to support providers' efforts to implement new sustainable billing options for HRSN. This module should be used in tandem with the Integrated Care Financing Decision Support Tool and provides interactive billing, reimbursement and aggregate financial modeling insights to support implementation. Please contact the Center of Excellence for Integrated Health Solutions if you have any questions or concerns.

Contents

INTRODUCTION

The integrated care movement has long emphasized the importance of better integrating and collaborating care across mental health, substance use and physical health care to improve health outcomes and service delivery across the health care system. Ensuring that evidence-based integrated care approaches are widespread and accessible to all consumers hinges on sustainable financing strategies. This module provides information regarding emerging financing strategies for supporting HRSN assessments and follow-up services that can be used in multiple locations where physical health and/or behavioral health services are provided, as well as in nontraditional health care settings such as community-based organizations (CBOs).

Research tells us that social and structural factors play a critical role in driving disparate health outcomes. Depending on the source of the data, socioeconomic factors can drive 50%-80% of all health outcomes, while clinical care comes in at 10%-20%.[3,4] People with identified behavioral health needs are also more likely to have unmet or adverse HRSN.[5] Recognizing these significant drivers, in November 2023, HHS made a significant policy statement in its "Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation."[6] In this publication, HHS highlights multiple opportunities to address unmet HRSN through Medicaid, Medicare, the Administration for Community Living, the Centers for Disease Control and Prevention (CDC) and the Office of the National Coordinator for Health Information Technology.

Within this context of quickly evolving standards and opportunities, health care organizations and providers are critical partners and collaborators in implementing these new approaches to service delivery. Although it is not the focus of this module, a variety of data sources are available to health care organizations seeking to learn more about local social and environmental conditions.

Data Sources on Local Social and Environmental Conditions

- The Centers for Medicare and Medicaid Services (CMS) Office of Minority Health's Mapping Medicare Disparities Tool can help identify the areas of greatest need for populations served.
- The CDC's data tools and resources can help organizations identify and address SDOH at the system level.[7]
- The Data Set Directory of Social Determinants of Health at the Local Level lists a number of sources on various social, economic and environmental conditions.
- Providers can perform their own analyses by conducting a local needs assessment and may already be required to do so depending on their organization type, such as Certified Community Behavioral Health Clinics (CCBHCs). Needs assessments focused on SDOH are recommended to be conducted in partnership with local community care hubs and/or CBOs.[8]

Understanding local social and environmental conditions at the population level may assist providers when developing a framework to address HRSN at the individual level, including:

- Screening and assessment to identify individual social risk factors and adverse conditions.
- Identifying appropriate clinical adjustments and interventions.
- Establishing closed-loop referral pathways with social services providers and CBOs.
- Implementing data management and coding strategies to track identified needs and impact or resolution.
- Integrated staffing models to implement individual navigation, education and referral tasks related to identified needs.

A large array of social care IT platforms are also available to providers seeking to implement these frameworks at scale.

Supporting these strategies, health insurers are increasingly providing reimbursement for providers to tackle HRSN in their practices. While state-level Medicaid programs have long been able to pay for services to address HRSN of specific populations through coverage of home- and community-based waiver programs, non-emergency medical transportation and services like case management, recent changes in Medicaid policy options and Medicare reimbursement are paving the way to broader adoption and integration across physical health and behavioral health practices, as well as within CBOs.

Coverage Landscape

The national health care financing landscape is complex and variable, often informed by local factors, such as state policy decisions, allocation of categorical grant-based funding, health insurance coverage and payer priorities. The growing shift toward alternative payment models and value-based care has accelerated the interest in addressing HRSN, which can lower health care costs, improve health outcomes and increase the cost-effectiveness of health care services and interventions.[9]

Although this module is focused on fee-for-service financing considerations for HRSN, the insights are universally applicable to organization settings that are financed through alternative payment mechanisms such as cost-based, prospective and value-based payment arrangements, recognizing that fee-for-service cost considerations are often the financial benchmark to structure alternative payment mechanisms. Additional guidance on how to adapt services across various health care settings is highlighted in the "Billing Medicare for New HRSN codes in Different Health Care Settings" subsection and focuses primarily on standards applied to new Medicare billable services for addressing HRSN, as other payer standards lack comparable uniformity.

The national landscape for coverage of services to address HRSN is rapidly evolving, with varying reimbursement opportunities across state-level Medicaid programs, Medicare plans, and qualified health plans offered through state health insurance marketplaces. Despite a general lack of standardization, health care policymakers are making progress on rapidly expanding reimbursement options for organizations looking to implement sustainable HRSN service offerings.

MEDICAID

Coverage of services to address HRSN has historically been limited to state Medicaid programs, particularly for home- and community-based service (HCBS) waiver programs. However, in recent years there has been increased standardization and expansion of Medicaid coverage and billing options.

A series of policy documents have been published by CMS and the Children's Health Insurance Program (CHIP) since 2021 that together clarify, emphasize and support state coverage of services to address health-related social needs in ways that move beyond traditional HCBS waiver approaches and populations. Although not uniformly adopted in all states, these options represent an important shift in federal policy and promote service delivery approaches for new provider types, including physical and behavioral health providers and organizations, to address HRSN.

Recent Medicaid Policy Communications

- The Center for Medicaid and CHIP Services (CMCS) Informational Bulletin: Coverage of Services and Supports to Address Health-related Social Needs in Medicaid and the Children's Health Insurance Program (November 2023). This bulletin compiles recent guidance into a high-level compliance framework for states, with available coverage authorities to address HRSN.
- Medicaid managed care. CMS published a State Medicaid Director Letter in January 2023, describing innovative options states may consider employing in Medicaid managed care programs to address HRSN using a service or setting that is provided to an enrollee "in lieu of" an authorized service or setting (known as an "in lieu of" service or ILOS) covered under the Medicaid state plan. This Medicaid managed care approach allows states to expand HRSN support to populations that don't receive HCBS.
- Since November 2022, a new Medicaid 1115 (innovation) waiver opportunity has also been made available that standardizes expectations for approved states to provide evidence-based housing and nutritional services designed to mitigate the negative health impacts of unmet HRSN. KFF[10] provides a helpful compendium of up-to-date information about states with approved and pending SDOH provisions.

MEDICARE

In Medicare, HRSN historically have been addressed through supplemental benefits in Medicare Advantage and through the Merit-based Incentive Payment System and the Medicare Shared Savings Program in the traditional Medicare program.[11]

This module highlights new Medicare coding and financially sustainable service options to address HRSN, which were finalized by CMS in late 2023 and early 2024. The new covered services under Medicare Part B are expected to be included in Medicare Advantage and Special Needs Plans annual coverage and fee schedule updates by September 30, 2024, and made effective by January 1, 2025. These new options are available for billing practitioners who are eligible to bill under the Medicare physician fee schedule.

New Place of Service (POS) 27 — Outreach Site/Street. CMS created this new POS code, effective in October 2023, to indicate when a service is provided in a nonpermanent location on the street or found environment, not described by any other POS code, where preventive, screening, diagnostic or treatment services are provided to unsheltered, homeless patients.[12]

New Covered Codes — In January 2024, Medicare finalized new rules[13] that expand service options to support both HRSN assessments and services to mitigate and/or address identified needs. The codes are summarized here and are defined in greater detail in the "New Medicare Codes and Specifications" section of this module.

- G0019, G0022: Community health integration
- G0136: SDOH risk assessment
- G0023, G0024: Principal illness navigation
- G0140, G0146: Principal illness navigation — peer support

QUALIFIED HEALTH PLANS

A qualified health plan is an insurance plan that is certified by the Health Insurance Marketplace® and meets the Affordable Care Act requirement for providing "minimum essential coverage."[14] All plans offered in the Marketplace cover 10 essential health benefits;[15] however, specific services covered in each broad benefit category can vary based on each state's requirements. Plans may also offer additional benefits that are not mandated, such as dental coverage, vision coverage and medical management programs (for specific needs like weight management, back pain and diabetes). HRSN services and supports may be included under multiple essential health benefit categories but are not required to be offered. Plan-by-plan adoption will vary, requiring local plan-by-plan outreach efforts to determine if specific reimbursement options exist for enrolled providers and members.

Screening and Assessment for HRSN

There are multiple standardized, evidence-based screening and assessment tools to identify HRSN. Frequently, provider electronic health record (EHR) platforms will also have options to add standardized HRSN questions. Although there is no national consensus around one specific tool for screening or assessment of HRSN, prominent examples include the following:

- The Accountable Health Communities (AHC) Screening Tool is promoted by CMS as part of the AHC model and is appropriate for use in a wide range of clinical settings, including primary care practices, emergency departments, labor and delivery units, inpatient psychiatric units, behavioral health clinics and other places where people access clinical care.
- The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) Screening Tool consists of a set of national core measures, as well as a set of optional measures for community priorities.

While many other screening tools are available, these two are also identified by CMS in the recent 2024 Medicare rulemaking[16] as appropriate for use when billing the new G-code, SDOH risk assessment (G0136), which requires clinical practices to use a standardized, evidence-based SDOH risk assessment tool that has been tested and validated through research. The tool is also required to include the domains of food insecurity, housing insecurity, transportation needs and utility difficulties.

Additional resources to evaluate choice of screening tools include the following:

- The Gravity Project[17] provides a downloadable comparison table[18] of social risk screening assessment instruments and their associated SDOH domains, web links where readily available and the status of Logical Observation Identifiers Names and Codes (LOINC) encoding.

- The Social Interventions Research and Evaluation Network[19] provides a downloadable comparison table[20] of social risk screening tools that can support selection decisions. It includes information about each tool's length, target populations, reading level, translations and cost, among other considerations.

Service Delivery Adjustments and Interventions

There are multiple ways for providers to respond when a patient identifies an adverse social or environmental condition as a need. Although health care providers are typically not positioned to "solve" the wide range of social barriers to health, they are often able to take actions in creating care plans that may account for social conditions and help patients access key social services. Examples of adjustments to routine clinical care that seek to accommodate identified social barriers include:[21]

- Providing language- and literacy-appropriate services.
- Reducing the patient panel size for clinicians serving people with socially complex needs.
- Offering open-access scheduling or evening and weekend clinic access.
- Providing telehealth services.

These examples are not interventions focused on changing underlying social risk; they are adaptations to traditional care designed to accommodate patients' social contexts.

In the new 2023 Social Need Screening and Intervention, an improved Healthcare Effectiveness Data and Information Set (HEDIS) measure, the National Committee for Quality Assurance (NCQA) also identified eight categories of appropriate clinical response to identified social risk factors.[22]

INTERVENTION TYPE	INTERVENTION EXAMPLE[23]
Assessment	Discussed in the prior section, "Screening and Assessment for HRSN"
Assistance	Assistance with an application to a homelessness prevention program.
Coordination	Coordination of a care plan.
Counseling	Counseling for readiness to implement a food insecurity care plan.
Education	Education about an area agency on aging (AAA) program.
Evaluation	Evaluation of eligibility for a fuel voucher program.
Referral	Connections to relevant social care resources, such as referral to an AAA.
Provision	Providing needed resources, such as home-delivered meals.
Interventions are captured via Current Procedural Terminology (CPT), Systematized Nomenclature of Medicine (SNOMED) and Healthcare Common Procedure Coding System (HCPCS) codes.	

The National Council for Mental Wellbeing's Toolkit for Designing and Implementing Care Pathways is a useful resource for providers looking to design and implement new care pathways.

Data Management

Data management and tracking for HRSNs includes the following key activities: the ability to capture screening results and to identify clinical adjustments and interventions; the ability to manage needed service referrals; and the ability to receive referral feedback and track outcomes. This section focuses primarily on Z-codes used to support service documentation, recognizing that new codes to document interventions may be available in the future. Additional provider resources from the Office of the National Coordinator for Health Information Technology on HRSN data management include:

- Social Determinants of Health Information Exchange Toolkit (HealthIT.gov)
- Social Determinants of Health (HealthIT.gov)

Z-CODES FOR USE WITH HRSN SCREENING

Z-codes are a set of ICD-10-CM codes used to report social, economic and environmental determinants known to affect health and health-related outcomes. Z-codes are a tool for identifying a range of issues related to education and literacy, employment, housing, ability to obtain adequate amounts of food or safe drinking water, occupational exposure to toxic agents, dust or radiation, and other conditions. Z-codes can be used in any health setting (e.g., doctor's office, hospital, skilled nursing facility) and by any provider (e.g., physician, nurse practitioner). Nine broad categories of Z-codes represent various hazardous social, economic and environmental conditions, each with several sub-codes. These codes should be assigned only when the documentation specifies that the patient has an associated problem or risk factor that influences their health.

New HRSN billing options under Medicare require documentation in the medical record, and Medicare calls out Z-codes (Z55-Z65) as an appropriate documentation method to facilitate high-quality communication between providers and better understand the needs of beneficiaries.

Providers can use the CDC's National Center for Health Statistics ICD-10-CM Browser tool[24] to search for all the current Z-codes. The CMS Health Equity Assistance Program's infographic on how to use Z-codes provides summary level information and does not include the subsets of codes available within each category.

- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z58 – Problems related to physical environment
- Z59 – Problems related to housing and economic circumstances
- Z60 – Problems related to social environment
- Z62 – Problems related to upbringing
- Z63 – Other problems related to primary support group, including family circumstances
- Z64 – Problems related to certain psychosocial circumstance
- Z65 – Problems related to other psychosocial circumstance

New Medicaid Service Types and Definitions

This section briefly touches on newly available Medicaid coverage options at the federal level, as coding strategies currently have significant variation on a state-by-state basis depending on specifications developed by individual state Medicaid programs and their implementation through Medicaid managed care plans. At the federal level, CMCS has provided new guidance and standards for nutrition and housing HRSN services and supports considered allowable under specific Medicaid and CHIP authorities. This table is adapted from Coverage of Health-related Social Needs Services in Medicaid and CHIP.

HRSN CATEGORY	SERVICE DESCRIPTIONS	MEDICAID COVERAGE AUTHORITY
Nutrition	1. Case management services for access to food/nutrition (e.g., outreach and education and linkages to other state and federal benefit programs, benefit program application assistance and benefit program application fees).	■ Medicaid/CHIP managed care in lieu of service or setting (ILOS) ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*)
	2. Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions and/or demonstrated outcome improvement (e.g., guidance on selecting healthy food and healthy meal preparation).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives
	3. Home-delivered meals or pantry stocking tailored to health risk and eligibility criteria, certain nutrition-sensitive health conditions and/or specifically for children or pregnant people (e.g., meals medically tailored to high-risk expectant people at risk of or diagnosed with diabetes).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*) *Limitations on # of meals and coverage duration apply.*

HRSN CATEGORY	SERVICE DESCRIPTIONS	MEDICAID COVERAGE AUTHORITY
Nutrition	4. Nutrition prescriptions tailored to health risk, certain nutrition-sensitive health conditions and/or demonstrated outcome improvement (e.g., fruit and vegetable prescriptions, protein boxes, food pharmacies and healthy food vouchers).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*) *Limitations on # of meals and coverage duration apply.*
	5. Grocery provisions for high-risk people to avoid unnecessary acute care admission or institutionalization.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*) *Limitations on # of meals and coverage duration apply.*
Housing	1. Housing supports without room and board, such as housing transition and navigation services (e.g., finding and securing housing), pre-tenancy navigation services, one-time transition and moving costs (e.g., security deposits, application and inspection fees, utilities activation fees and payment in arrears, movers), tenancy and sustaining services and individualized case management (e.g., linkages to state and federal benefit programs, benefit program application assistance and fees, eviction prevention, tenant rights education).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives
	2. First month's rent as a transitional service.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) (1915(k) only and via ARP 9817) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives

HRSN CATEGORY	SERVICE DESCRIPTIONS	MEDICAID COVERAGE AUTHORITY
Housing	3. Short-term pre-procedure and/or post-hospitalization housing with room and board, only where integrated, clinically oriented recuperative or rehabilitative services and supports are provided. Pre-procedure and post-hospitalization housing are limited to a clinically appropriate amount of time.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations (time limits apply) ■ CHIP Health Services Initiatives (*not previously approved*)
	4. Caregiver respite with or without room and board.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*also available under CHIP state plan*)
	5. Short-term post-transition housing with room and board where clinically oriented rehab services and supports may or may not be integrated, following allowable transitions and limited to a clinically appropriate amount of time.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) *MFP only for HCBS authorities ■ Section 1115 demonstrations (*time limits apply*) ■ CHIP Health Services Initiatives (*not previously approved*)
	6. Utility assistance.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ MFP only for HCBS authorities ■ Section 1115 demonstrations (*time limits apply*) ■ CHIP Health Services Initiatives (*not previously approved*)

HRSN CATEGORY	SERVICE DESCRIPTIONS	MEDICAID COVERAGE AUTHORITY
Housing	7. Day habilitation programs without room and board.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*)
	8. Sobering centers (<24 hour stay) without room and board.	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*not previously approved*)
	9. Home remediations that are medically necessary (e.g., air filtration, air conditioning or ventilation improvements; refrigeration for medications; carpet replacement; mold and pest removal; housing safety inspections).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives
	10. Home/environmental accessibility modifications (e.g., wheelchair accessibility ramps, handrails, grab bars).	■ Medicaid/CHIP managed care ILOS ■ HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k) ■ Section 1115 demonstrations ■ CHIP Health Services Initiatives (*Also available under CHIP state plan*)

New Medicare Codes

As mentioned in the earlier section on Coverage Landscape Considerations, starting in January 2024 Medicare established new billing codes to address HRSN, available under the Physician Fee Schedule. The new codes support payment for the administration of SDOH risk assessments, community health integration (CHI) and principal illness navigation (PIN) services provided by certified auxiliary personnel, including community health workers, care navigators and peer support specialists. These changes are the first specifically designed to account for the the involvement of auxiliary personnel in service provision, which in turn encourages their inclusion and reduces the burden on clinicians to expand access to needed services.[25]

SDOH Risk Assessments

CMS has published coding specifications and payment for SDOH risk assessments, to recognize the time and resources providers spend assessing social factors that may impact patient care. The risk assessment is a standard evidence-based tool tailored for a patient's health literacy level, as well as educational, developmental, cultural and linguistic background. With these new codes, Medicare will separately pay for an SDOH risk assessment once every six months. The visit can be on the same day as an in-person or telehealth evaluation and management visit or during a Medicare annual wellness visit.

CHI and PIN Services

CHI services address unmet HRSN that affect the diagnosis and treatment of a patient's medical conditions, while PIN services help people who are diagnosed with high-risk conditions (including mental health and substance use disorders) identify and connect with appropriate clinical and HRSN support resources. Medicare has added coding and payment for both CHI and PIN services to reimburse auxiliary personnel for the time and resources required to connect beneficiaries with the additional HRSN support they need to produce positive health outcomes.

Health Equity and PIN

The Medicare final rulemaking also discusses the important implications that PIN has for health equity. For example, members of historically disadvantaged communities and communities of color often receive lower rates of patient navigation, are often diagnosed with serious, high-risk illnesses like cancer at later stages, and have longer times between suspicion and definitive diagnosis for conditions like cancer. It is hoped that PIN services will fill a critical gap in navigation services, noting that many navigation programs are currently grant funded and unable to serve all patients that might benefit.

BILLING MEDICARE FOR NEW HRSN CODES IN DIFFERENT HEALTH CARE SETTINGS

As stated previously, most Medicare-reimbursed HRSN services may be provided across different health care settings as long as qualified providers furnish the service. CHI services are geared toward physical health care delivery settings, while PIN and peer support services specifically include behavioral health settings and the services furnished by qualified clinical psychologists and certified peers.

Specific to the national movement to address HRSN, HHS also encourages contracts with third-party entities, specifically community care hubs[26] and community-based organizations (CBOs), so each of these new services can be embedded into new locations where qualified auxiliary staff are employed under the general supervision of a qualified billing provider. Auxiliary staff employed through third parties are not limited to CBOs and may include other behavioral health personnel, such as community health workers, certified peers, licensed clinical social workers and nurses (RN or LPN).

Medicare references to CBOs includes public or private not-for-profit entities that provide specific services to the community, or targeted populations in the community, to address the HRSN of those populations. They may include community action agencies, housing agencies, area agencies on aging, centers for independent living, aging and disability resource centers or other nonprofits that apply for grants or contract with health care entities to perform social services. CBOs may receive grants from other agencies in HHS or receive state-funded grants to provide social services.

In late 2023, CMS created POS code 27 to indicate when a preventive, screening, diagnostic or treatment service is provided to unsheltered individuals. The new POS code is used on professional claims to specify the location where service(s) were rendered. This change aligns with broader CMS efforts to address economic, social and other obstacles impacting Medicare beneficiary health care access, by helping identify services provided to those who may be unable to access brick-and-mortar settings, as well as potentially allow tracking of care that is provided through outreach sites. Individual payers will have different reimbursement policies for use of this code, requiring local outreach to determine available use for each provider.[27]

New Medicare Code Specifications

The following tables provide specification for each of the new Medicare codes based on information provided by Medicare in its January 2024 Physician Fee Schedule final rulemaking.[28]

SDOH RISK ASSESSMENT (G0136)

Full code description: Administration of a standardized, evidence-based SDOH assessment, 5-15 minutes, not more often than every six months.

SDOH RISK ASSESSMENT (G0136) SPECIFICATIONS		
Category	**Specifications**	**Notes**
Qualified practitioner	Physicians and qualified practitioners. Behavioral health practitioners may furnish the SDOH risk assessment in conjunction with the behavioral health office visits they use to diagnose and treat mental illnesses and substance use disorders.	Physicians include doctors of medicine, osteopathy, dental surgery or dental medicine, podiatric medicine, optometry and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a state where they perform this function. Services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice. "The following practitioners may deliver services without direct physician supervision: nurse practitioners and physician assistants in rural health clinics, designated manpower shortage area or HMOs, qualified clinical psychologists, clinical social worker, certified nurse midwives, and certified registered nurse anesthetists."[29]
Auxiliary personnel	Allowed according to Medicare "incident to" billing guidelines.	"Auxiliary personnel means any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner), has not been excluded from the Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his or her Medicare enrollment revoked, and meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished."[30]
Workflow	The SDOH risk assessment is meant to be furnished in conjunction with: ■ An evaluation and management (E/M) visit, which can include hospital discharge or transitional care management services. ■ Behavioral health office visits, such as psychiatric diagnostic evaluation and health behavior assessment and intervention. ■ The Medicare Annual Wellness Visit (AWV). In addition to an outpatient E/M visit (other than a Level 1 visit by clinical staff), SDOH risk assessment can also be furnished with CPT code 90791 (psychiatric diagnostic evaluation) and the health behavior assessment and intervention services, described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167 and 96168.	The SDOH risk assessment may be performed on the same date as the associated E/M or behavioral health visit, but it is not required. This also aligns with when the SDOH risk assessment is performed in conjunction with an AWV, as the AWV may be split over two visits. In most cases, the SDOH risk assessment would not be performed in advance of the associated E/M or behavioral health visit. The SDOH risk assessment is not designed to be a screening. The assessment should be tied to one or more known or suspected SDOH needs that may interfere with the practitioners' diagnosis or treatment of the patient.
Locations	The SDOH risk assessment can be billed in outpatient settings, including physical health and behavioral health. CMS has expressed interest in learning more about the ideal settings for this service and intends to continue examining this issue in future rulemaking.	
Frequency	The SDOH risk assessment may also be furnished with hospital discharge visits, to remain consistent with other CMS policies promoting assessment of SDOH as an indicator of quality care and to promote safe discharge planning.	

Example[31]	A patient who hasn't been seen recently requests an appointment at a specific time or on a specific date due to limited availability of transportation to or from the visit, or they request a refill of refrigerated medication that went bad when the electricity was terminated at their home. If the patient hasn't received an SDOH risk assessment in the past six months, the patient can fill out an SDOH risk assessment 7-10 days in advance of an appointment as part of intake, to ensure that there is enough information to appropriately treat them.
Concurrent services	**Risk assessment, CHI and PIN**: SDOH risk assessment is related to CHI and PIN services, and time spent performing the SDOH risk assessment that is not otherwise billed counts toward the 60 minutes per month spent in the performance of PIN or CHI services. SDOH risk assessments may also be furnished as an optional element of the AWV, in which case it is a preventive service and cost sharing won't apply.
Documentation	The SDOH needs identified through the risk assessment must be documented in the medical record and may be documented using a set of ICD-10-CM codes known as Z-codes (Z55-Z65), which are used to document SDOH data to facilitate high-quality communication between providers. Post risk assessment referral — Medicare expects the practitioner furnishing an SDOH risk assessment to, at a minimum, refer the patient to relevant resources and consider the results of the assessment in their medical decision-making or their diagnosis and treatment plan for the visit. SDOH risk assessment refers to a review of the individual's SDOH needs or identified social risk factors influencing the diagnosis and treatment of medical conditions. Use a standardized, evidence-based SDOH risk assessment tool to assess for: ■ Housing insecurity ■ Food insecurity ■ Transportation needs ■ Utility difficulty
Telehealth	Allowed.

COMMUNITY HEALTH INTEGRATION (G0019, G0022)

Full code description

G0019 — Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address SDOH need(s) that significantly limit the ability to diagnose or treat problem(s) addressed in an initiating visit:

- Person-centered assessment performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit.
  - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and unmet SDOH needs (that aren't separately billed).
  - Facilitating patient-driven goal setting and establishing an action plan.
  - Providing tailored support to the patient, as needed, to accomplish the practitioner's treatment plan.
- Practitioner, home- and community-based care coordination.
  - Coordinating receipt of needed services from health care practitioners, providers and facilities and from home- and community-based service providers, social service providers and caregivers (if applicable).
  - Communication with practitioners, home- and community-based service providers, hospitals and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences and desired outcomes, including cultural and linguistic factors.
  - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians, follow-up after an emergency department visit or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. wFacilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s).
- Health education: Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals and preferences in the context of SDOH need(s), and educating the patient on how to best participate in medical decision-making.

- Building patient self-advocacy skills, so the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s) in ways that are more likely to promote personalized and effective diagnosis or treatment.
- Health care access/health system navigation: Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.
- Facilitating behavioral change as necessary to meet diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
- Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s) and adjust daily routines to better meet diagnosis and treatment goals.
- Leveraging lived experience, when applicable, to provide support, mentorship or inspiration to meet treatment goals.

G0022 — Community health integration services, each additional 30 minutes per calendar month. (List separately in addition to G0019.)

COMMUNITY HEALTH INTEGRATION (G0019, G0022) SPECIFICATIONS		
Category	**Specifications**	**Notes**
Qualified healthcare professional	The community health integration services must be provided "incident to" the professional service of a physician or other statutorily qualified practitioner, who must bill for those services.	Services provided by clinical psychologists (CPT codes 90791 and 96156) are not currently services that could serve as an initiating visit for CHI services. However, these services are captured under the PIN service described later in this section.
Auxiliary personnel	These codes were specifically designed to capture services commonly performed by community health workers, which are a type of auxiliary personnel. However, the codes do not limit the types of other health care professionals (e.g., registered nurses and social workers) who can perform CHI services (and PIN services) incident to the billing practitioner's professional services, provided they meet the requirements to provide all elements of the service included in the code, consistent with the definition of auxiliary personnel at Title 42 Code of Federal Regulations § 410.26(a)(1). Auxiliary personnel who provide these services must be under supervision of the billing physician (or other practitioner), and the provided services must be reasonable and necessary for diagnosis and treatment of illness or injury.	**Supervision:** "Incident to" policy requires that the billing practitioner maintains active participation in and management of the course of treatment. Medicare allows for the broadest possible level of supervision of auxiliary personnel (general supervision), and contracting with third parties (such as CBOs) to furnish CHI services is allowable, however this must be part of clinical care and treatment by the billing practitioner. **Example:** It would not be in the scope of practice of the auxiliary personnel to determine that a given HRSN is impacting the billing practitioner's ability to diagnose or treat problems addressed in an initiating visit. Auxiliary personnel must review all unmet HRSN needs they find so they can be addressed by the billing practitioners in the CHI services. CHI service codes were created for auxiliary personnel, including community health workers, to provide tailored support and system navigation to help address unmet social needs that significantly limit a practitioner's ability to carry out a medically necessary treatment plan. CHI services include items like: - Person-centered planning - Health system navigation - Facilitating access to community-based resources - Practitioner, home and community-based care coordination - Patient self-advocacy promotion Group CHI services are not allowed.

Workflow	The billing practitioner initiates CHI services during an initiating visit where the practitioner identifies unmet SDOH needs that significantly limit the ability to diagnose or treat the patient. Initiating visits are personally performed by the practitioner and include: ■ An E/M visit ■ A Medicare AWV Additional CHI services: The same practitioner bills for the subsequent CHI services provided by the auxiliary personnel. The same practitioner furnishes and bills for the CHI initiating visit and the CHI services. CHI services must be furnished in accordance with the "incident to" regulation at Title 42 Code of Federal Regulations § 410.26.	During the initiating visit, the billing practitioner establishes the treatment plan, specifies how addressing the unmet SDOH needs would help accomplish that plan and establishes the CHI services as incidental to their professional services. Auxiliary personnel can perform the subsequent CHI services. The Medicare AWV can be a CHI initiating visit when the furnishing practitioner identifies an unmet HRSN that will prevent the patient from carrying out the recommended personalized prevention plan. However, practitioners may bill an E/M visit in addition to the AWV when medical problems are addressed in the course of an AWV encounter.[32] The AWV is not a CHI initiating visit if it is provided by a type of health care professional who does not have an "incident to" benefit for their services under the Medicare program (e.g., a health educator, a registered dietitian or nutrition professional), because they could not then furnish and bill for CHI services incident to their professional services. The initiating visit can also be an E/M visit provided as part of transitional care management services. A patient must be seen for a CHI initiating visit prior to furnishing and billing CHI services. Certain types of E/M visits, such as inpatient and observation visits, emergency department visits and skilled nursing facility visits, do not serve as CHI initiating visits because the practitioners providing the E/M visit wouldn't typically be the one providing continuing care to the patient, including providing necessary CHI services in the subsequent months. Medicare does not require an initiating E/M visit every month that CHI services are billed, but only before commencing CHI services, to establish the treatment plan, specify how addressing the unmet SDOH need(s) would help accomplish that plan and establish the CHI services as "incident to" the billing practitioner's service. **Tip:** This framework is similar to the current requirements for billing care management services, such as chronic care management services.

Example	**Case study**: Tailored support could be provided through CHI services to a patient experiencing homelessness with signs of potential cognitive impairment and a history of frequent emergency department admissions for uncontrolled diabetes. The patient's primary care practitioner learns, during a clinic visit after discharge from the emergency department, that the patient has been able to reliably fill their prescriptions for diabetes medication but frequently loses the medication (or access to it) while transitioning between homeless shelters and a local friend's home. ■ In the medical record, the primary care practitioner documents SDOH needs of housing insecurity and transportation insecurity contributing to medication noncompliance, resulting in inadequate insulin control and a recent emergency department visit for hypoglycemia. ■ The primary care practitioner's treatment plan is daily diabetes medication, with the goal of maintaining hemoglobin A1c within appropriate levels. ■ To accomplish the treatment plan, the primary care practitioner orders CHI services to develop an individualized plan for daily medication adherence/access while applying for local housing assistance, and orders a follow-up visit for cognitive impairment assessment and care planning to further evaluate the potential contribution of cognitive impairment. ■ The primary care practitioner's auxiliary personnel provide tailored support, composed of facilitating communication between the patient, local shelters and their friend to help the patient identify a single location to reliably store their medication while applying for local housing assistance. ■ The auxiliary personnel also help the patient identify a reliable means of daily transportation to that location for their medication and show the patient how to create a daily automated phone reminder to take the diabetes medication. ■ The auxiliary personnel document these activities (including the amount of time spent) in the medical record at the primary care practitioner's office, along with periodic updates regarding the status of the patient's housing assistance application.	
Consent	The billing practitioner or the auxiliary personnel under supervision must get advance patient consent before furnishing CHI services.	Consent can be written or verbal, as long as it is documented in the patient's medical record. As part of consent, providers must explain to the patient that cost sharing applies and that only one practitioner may furnish and bill the services in each month. Consent is not required again, unless the practitioner furnishing and billing CHI changes.

Community health worker training	According to the new Medicare rules, all auxiliary personnel who provide CHI services must be certified or trained to perform all included service elements and authorized to perform them under applicable state laws and regulations. For CHI services, as with all "incident to" services, it is the billing practitioner's responsibility to ensure that the Medicare criteria for billing and payment of CHI services are met, including applicable state requirements regarding licensure, certification and/or training. Medicare defers to state rules, where they have been established, for training content and hours. For states that do not have applicable rules, Medicare has established that training to provide CHI services must include the competencies of patient and family communication, interpersonal and relationship building, patient and family capacity building, service coordination and system navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and development of an appropriate knowledge base, including of local community-based resources. Specific training hours are not specified.
Concurrent services	**Medicare** — Only one practitioner can bill for CHI services per month. This helps ensure a single point of contact to address social needs that may span other health care needs. It helps avoid a fragmented approach and duplicated services. Medicare currently makes separate payments under the physician fee schedule for a number of care management and other services that may include aspects of CHI services. Those care management services focus heavily on clinical, rather than social, aspects of care. CHI services can be furnished in addition to other care management services if the practitioner: ■ Doesn't count time and effort more than once. ■ Meets requirements to bill the other care management services. ■ Performs services that are medically reasonable and necessary. **Home health, Medicare Part B** — CHI services may not be billed while the patient is under a home health plan of care under Medicare Part B. **Medicaid** — According the Medicare rulemaking, CHI services are meant to resolve specific concerns to facilitate a patient's medical care, which distinguishes CHI from other social services and programs that may be available through Medicaid state plans or other state or community programs.

Documentation	The patient's unmet social needs that CHI services address must be documented in the medical record. Documenting ICD-10-CM Z-codes can count as the appropriate documentation. Auxiliary staff of third-party organizations — Medicare policy regarding medical record documentation allows any individual who is authorized under Medicare law to furnish and bill for their professional services, whether or not they are acting in a teaching role, may review and verify (sign and date) the medical record for the services they bill, rather than re-document notes in the medical record made by physicians, residents, nurses, students (including students in therapy or other clinical disciplines) or other members of the medical team.[33] Ultimately, documentation is the responsibility of the billing practitioner. CBOs and other contracted entities for auxiliary personnel services may enter data following this general policy, as long as the biller reviews and verifies the documentation.
Frequency	CHI services can be billed monthly as medically reasonable and necessary, billing for the first 60 minutes of CHI services (G0019) and then each additional 30 minutes thereafter (G0022). Also, document the amount of time spent with the patient and the nature of the activities. There is no frequency limitation for the add-on HCPCS code G0022, to allow for flexibility when practitioners do spend more than 60 minutes on CHI services in the month. As long as the time spent by auxiliary personnel is reasonable and necessary for the diagnosis and treatment of injury or illness, Medicare will allow it to be billed.
Telehealth	Combination of in-person and virtual expected.[34]

PRINCIPAL ILLNESS NAVIGATION (G0023, G0024)

Full code description

G0023 — PIN services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month in the following activities:

- Person-centered assessment performed to better understand the individual context of the serious, high-risk condition.
  - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and unmet SDOH needs (that aren't separately billed).
  - Facilitating patient-driven goal setting and establishing an action plan.
  - Providing tailored support, as needed, to accomplish the practitioner's treatment plan.
- Identifying or referring the patient (and caregiver or family, if applicable) to appropriate supportive services.
- Practitioner, home- and community-based care communication.
  - Coordinating receipt of needed services from health care practitioners, providers and facilities; home- and community-based service providers; and caregiver (if applicable).
  - Communicating with practitioners, home- and community-based service providers, hospitals and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences and desired outcomes, including cultural and linguistic factors.
  - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians, follow-up after an emergency department visit or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.
  - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance), as needed, to address SDOH need(s).
- Health education — Helping the patient contextualize health education provided by their treatment team with the patient's individual needs, goals, preferences and SDOH need(s), and educating the patient (and caregiver, if applicable) on how to best participate in medical decision-making.
- Building patient self-advocacy skills so that the patient can interact with members of the health care team and related community-based services, as needed, in ways that are more likely to promote personalized and effective treatment of their condition.

- Health care access/health system navigation.
  - Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.
  - Providing the patient with information/resources to consider participation in clinical trials or clinical research, as applicable.
- Facilitating behavioral change, as necessary, to meet diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
- Facilitating and providing social and emotional support to help the patient cope with the condition and their SDOH need(s) and adjust daily routines to better meet diagnosis and treatment goals.
- Leveraging knowledge of the serious, high-risk condition and/or lived experience, when applicable, to provide support, mentorship or inspiration to meet treatment goals.

G0024 — PIN services, additional 30 minutes per calendar month. (List separately in addition to G0023.)

PRINCIPAL ILLNESS NAVIGATION (G0023, G0024) SPECIFICATIONS

Category	Specifications	Notes
Qualified practitioner	Practitioners are physicians or other qualified health care professionals, including clinical psychologists.	
Auxiliary personnel	Certified or trained auxiliary personnel under the direction of a billing practitioner who are involved in the patient's health care navigation. Auxiliary personnel may include a care navigator or certified peer specialist.	Since there isn't a Medicare benefit for paying navigators and peer support specialists directly, Medicare pays for their services as incidental to the services of the health care practitioner who directly bills Medicare. The auxiliary personnel may be external to and under contract with the practitioner or their practice, such as through a CBO that employs navigators, peer support specialists or other auxiliary personnel, if they meet all "incident to" requirements and conditions for payment of PIN services.

PRINCIPAL ILLNESS NAVIGATION (G0023, G0024) SPECIFICATIONS		
Category	**Specifications**	**Notes**
Auxiliary personnel		Supervision — Same as CHI. PIN services are considered care management services that may be furnished under general supervision under Title 42 Code of Federal Regulations § 410.26(b)(5). General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required when performing the service (Title 42 Code of Federal Regulations § 410.26(a)(3)).
Workflow	1. Initiating visits: The billing practitioner initiates PIN services during an initiating visit addressing a serious high-risk condition, illness or disease (included severe mental illness and substance use disorder). The billing practitioner personally performs initiating visits including: • An E/M visit, other than a low-level E/M visit done by clinical staff. • A Medicare AWV provided by a practitioner who meets the requirements to furnish subsequent PIN services.	The initiating visit includes identifying the medical necessity of PIN services and establishing an appropriate treatment plan. For PIN, a serious high-risk condition, illness or disease has these characteristics: ■ One serious, high-risk condition that places the patient at significant risk of: • Hospitalization • Nursing home placement • Acute exacerbation or decompensation • Functional decline or death ■ A condition that requires development, monitoring or revision of a disease-specific care plan and may require frequent adjustment in the medication or treatment regimen or substantial assistance from a caregiver.

Workflow	• E/M visit done as part of transitional care management services could serve as an initiating visit for PIN services because it includes a high-level office/outpatient E/M visit furnished by a physician or nonphysician practitioner managing the patient in the community after discharge. • CPT code 90791 (psychiatric diagnostic evaluation) or the health behavior assessment and intervention services that CPT codes 96156, 96158, 96159, 96164, 96165, 96167 and 96168 describe. 2. The same practitioner bills for the subsequent PIN services that auxiliary personnel provide. • Auxiliary personnel like patient navigators and peer support specialists to provide navigation when treating a serious, high-risk condition or illness. These services help guide the patient through their course of care, including addressing any unmet social needs that significantly limit the practitioner's ability to diagnose or treat the condition. PIN services include items like: • Health system navigation • Person-centered planning • Identifying or referring patient and caregiver or family, if applicable, to supportive services • Practitioner, home- and community-based care coordination or communication • Patient self-advocacy promotion • Community-based resources access facilitation	■ Examples of a serious, high-risk condition, illness or disease include: • Cancer • Chronic obstructive pulmonary disease • Congestive heart failure • Dementia • HIV/AIDS • Severe mental illness • Substance use disorder Navigation and referral — PIN includes identifying or referring to appropriate supportive services and is especially relevant when a patient is first undergoing treatment for a high-risk illness, condition or disease, due to the extensive need to access and coordinate care from different specialties or service providers for different aspects of the diagnosis or treatment and, in some cases, related social services. Examples: • Cancer — Surgery, imaging and radiation therapy, chemotherapy • Serious mental illness — Psychiatry, psychology, vocational rehabilitation • Substance use disorder — Psychiatry, psychology, vocational rehabilitation, rehabilitation, recovery programs • HIV — Infectious disease, neurology, immunology The definition of a serious, high-risk condition depends on clinical judgment, and the example list of conditions provided by Medicare is not exhaustive. A three-month duration is set as a benchmark for the use of PIN services, as they are considered necessary to treat serious, high-risk conditions that require navigation over the course of several months. HRSN addressed through PIN may include food insecurity, transportation insecurity, housing insecurity and unreliable access to public utilities when they significantly limit the practitioner's ability to diagnose or treat the serious, high-risk illness, condition or disease.

Consent	Consent must be obtained annually and may be obtained by the auxiliary personnel either before or at the same time they begin performing PIN services for the patient.	Consent can be written or verbal, as long as it is documented in the patient's medical record.
Auxiliary staff training	Same as for CHI, all auxiliary personnel who provide PIN services must be certified or trained to perform all included service elements and authorized to perform them under applicable state laws and regulations. It is the billing practitioner's responsibility to ensure that the Medicare criteria for billing and payment of CHI services are met, including applicable state requirements regarding licensure, certification and/or training. Medicare defers to state rules, where they have been established, for training content and hours. For states that do not have applicable rules, Medicare has established that training and certification for auxiliary personnel providing HCPCS codes G0023 and G0024 include the competencies of patient and family communication, interpersonal and relationship building, patient and family capacity building, service coordination and systems navigation, patient advocacy, facilitation, individual and community assessment, professionalism and ethical conduct, and development of an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness or disease addressed in the initiating visit. Note — Forty-eight states have established state rules for peer supports, and those rules will apply in those states.	

Concurrent services	**Medicare** — The billing practitioner can't furnish PIN services more than once per practitioner per month for any single serious high-risk condition. This avoids duplication of PIN service elements when using the same navigator or billing practitioner. PIN is best suited for situations in which the navigator can serve as a point of contact for the patient. A patient should not require multiple PIN services for a prolonged period, except in circumstances in which a patient is receiving PIN services for highly specialized navigation, such as for mental health, substance use, or oncology. PIN and PIN peer support should not be billed concurrently for the same serious, high-risk condition. However, practitioners furnishing PIN services may bill care management services, as appropriate, for managing and treating a patient's illness. PIN services can be furnished in addition to other care management services, as long as time and effort are not counted more than once, requirements to bill the other care management services are met and the services are medically reasonable and necessary. Behavioral health integration codes and office-based substance use disorder bundled codes also describe care management services and are considered to be duplicative of PIN, as they also require an initiating visit, but that is specified for those services. **Medicaid** — Similar to CHI services, there are aspects of PIN services, or PIN services for certain conditions, that may be covered under a Medicaid state plan. When Medicare and Medicaid cover the same services for patients eligible for both programs, Medicare generally is the primary payer in accordance with section 1902(a)(25) of the Social Security Act.
Documentation	A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient choice. Notation in patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination or diagnostic study/studies) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Definitive diagnosis — A definitive diagnosis is not required before the practitioner makes a clinical determination that the patient has a serious high-risk condition, as the length of time between suspicion (such as a positive screening test) and definitive diagnosis can stretch into weeks for some conditions, and navigation services may be medically necessary to ensure full diagnosis and treatment of that condition.

Frequency	G0023 — 60 minutes per calendar month. G0024 — Additional 30 minutes per calendar month, as required, no frequency limitation.
Telehealth	Combination of in-person and virtual expected.[35]

PRINCIPAL ILLNESS NAVIGATION — PEER SUPPORTS (G0140, G0146)

Full code description

G0140 — Peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:

- Person-centered interview, performed to better understand the individual context of the serious, high-risk condition.
  - Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and unmet SDOH needs that aren't billed separately.
  - Facilitating patient-driven goal setting and establishing an action plan.
  - Providing tailored support, as needed, to accomplish the person-centered goals in the practitioner's treatment plan.
- Identifying or referring the patient (and caregiver or family, if applicable) to appropriate supportive services.
- Practitioner, home- and community-based care communication.
  - Assisting the patient to communicate with their practitioners, home- and community-based service providers, hospitals and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences and desired outcomes, including cultural and linguistic factors.
  - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance), as needed, to address SDOH need(s).
- Health education — Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences and SDOH need(s), and educating the patient (and caregiver, if applicable) on how to best participate in medical decision-making.
- Building patient self-advocacy skills so the patient can interact with members of the health care team and related community-based services, as needed, in ways that are more likely to promote personalized and effective treatment of their condition.
- Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals.

- Facilitating and providing social and emotional support to help the patient cope with the condition and SDOH need(s) and adjust daily routines to better meet person-centered diagnosis and treatment goals.
- Leveraging knowledge of the serious high-risk condition and/or lived experience, when applicable, to provide support, mentorship or inspiration to meet treatment goals.

G0146 — Peer support, additional 30 minutes per calendar month. (List separately in addition to G0140.)

PRINCIPAL ILLNESS NAVIGATION — PEER SUPPORTS (G0140, G0146) SPECIFICATIONS		
Category	**Specifications**	**Notes**
Qualified practitioner	Same as for PIN, requires the direction of a billing practitioner who is a physician or other qualified health care professional, including clinical psychologists.	
Auxiliary personnel	PIN peer support is provided by certified or trained auxiliary personnel directed by a billing practitioner. These auxiliary personnel are involved in the patient's health care navigation specifically for treatment of behavioral health conditions. Auxiliary personnel include certified peer specialists.	**Supervision** — Same as CHI. PIN services are considered care management services that may be furnished under general supervision under Title 42 Code of Federal Regulations § 410.26(b)(5). General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service (Title 42 Code of Federal Regulations § 410.26(a)(3)).

PRINCIPAL ILLNESS NAVIGATION — PEER SUPPORTS (G0140, G0146) SPECIFICATIONS		
Category	**Specifications**	**Notes**
Consent	Consent must be obtained annually and may be obtained by the auxiliary personnel before or while they perform PIN services for the patient.	Consent can be written or verbal, as long as it is documented in the patient's medical record.
Auxiliary staff training	Forty-eight states have established state rules for peer support, and those rules will apply in those states. If no applicable state requirements exist, this PIN peer support requires that training must be consistent with the National Model Standards for Peer Support Certification published by the Substance Abuse and Mental Health Services Administration.[36]	
Choice of PIN or PIN peer support	The list of activities described for PIN peer support are slightly modified from the list of activities associated with PIN. PIN peer support services are more closely aligned with the scope of a peer support specialist.	Patients with behavioral health conditions can receive either PIN or PIN peer support services, so long as the auxiliary staff providing them are trained and certified in all parts of those code descriptors.
Concurrent services	**Medicare** — PIN services cannot be provided more than once per practitioner per month for any single serious, high-risk condition, to avoid duplication of PIN service elements when using the same navigator or billing practitioner. Medicare does not expect a patient to require multiple PIN services for a prolonged period, except in circumstances in which a patient is receiving PIN services for highly specialized navigation, such as for mental health, substance use, or oncology. PIN services can be furnished in addition to other care management services, as long as time and effort are not counted more than once, requirements to bill the other care management services are met and the services are medically reasonable and necessary. Behavioral health integration codes and office-based substance use disorder bundled codes also describe care management services and are considered to be duplicative of PIN, as they also require an initiating visit, but that is specified for those services. PIN and PIN peer support should not be billed concurrently for the same serious, high-risk condition. However, practitioners furnishing PIN services may bill care management services as appropriate for managing and treating a patient's illness.	

Documentation	Time spent furnishing PIN services must be documented in the medical record in relationship to the serious, high-risk illness. The activities performed by the auxiliary personnel and how they are related to the treatment plan for the serious, high-risk condition should be described in the medical record, just as all clinical care is documented in the medical record. Medicare requires identified SDOH needs, if present, to be recorded in the medical record, and for data standardization practitioners would be encouraged to record the associated ICD-10-CM Z-codes (Z55-Z65) in the medical record and on the claim.
Frequency	G0140 — 60 minutes per calendar month. G0146 — Additional 30 minutes per calendar month, no frequency limitation.
Telehealth	Combination of in-person and virtual expected. [37]

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Diagnosis Codes for Health Hazards Related to Socioeconomic and Psychosocial Circumstances

Z55 Problems Related to Education & Literacy
Z55.0 Illiteracy and low-level literacy*
Z55.1 Schooling unavailable and unattainable
Z55.2 Failed school examinations
Z55.3 Underachievement in school
Z55.4 Educational maladjustment and discord with teachers and classmates
Z55.5 Less than a high school diploma
Z55.6 Problems related to health literacy
Z55.8 Other problems related to education and literacy
Z55.9 Problems related to education and literacy, unspecified

Z56 Problems Related to Employment & Unemployment
Z56.0 Unemployment, unspecified
Z56.1 Change of job
Z56.2 Threat of job loss
Z56.3 Stressful work schedule
Z56.4 Discord with boss and workmates
Z56.5 Uncongenial work environment
Z56.6 Other physical and mental strain related to work
Z56.8 Other problems related to employment
Z56.81 Sexual harassment on the job
Z56.82 Military deployment status
Z56.89 Other problems related to employment
Z56.9 Unspecified problems related to employment

Z57 Occupational Exposure to Risk Factors
Z57.0 Occupational exposure to noise
Z57.1 Occupational exposure to radiation
Z57.2 Occupational exposure to dust
Z57.3 Occupational exposure to other air contaminants
Z57.31 Occupational exp., environmental tobacco smoke
Z57.39 Occupational exposure to other air contaminants
Z57.4 Occupational exposure to toxic agents in agriculture
Z57.5 Occupational exp. to toxic agents in other industries
Z57.6 Occupational exposure to extreme temperature
Z57.7 Occupational exposure to vibration
Z57.8 Occupational exposure to other risk factors
Z57.9 Occupational exposure to unspecified risk factor

Z58 Problems Related to Physical Environment
Z58.6 Inadequate drinking-water supply
Z58.81 Basic services unavailable in physical environment
Z58.89 Other problems related to physical environment

Z59 Problems Related to Housing & Economic Circumstances
Z59.0 Homelessness
Z59.00 Homelessness unspecified
Z59.01 Sheltered homelessness
Z59.02 Unsheltered homelessness
Z59.1 Inadequate housing
Z59.10 Inadequate housing unspecified
Z59.11 Inadequate housing environmental temperature
Z59.12 Inadequate housing utilities
Z59.19 Other inadequate housing
Z59.2 Discord with neighbors, lodgers and landlord
Z59.3 Problems related to living in residential institution
Z59.4 Lack of adequate food
Z59.41 Food insecurity
Z59.48 Other specified lack of adequate food
Z59.5 Extreme poverty
Z59.6 Low income
Z59.7 Insufficient social insurance and welfare support
Z59.8 Other problems related to housing and economic circumstances
Z59.81 Housing instability, housed
Z59.811 Housing instability, housed, with risk of homelessness
Z59.812 Housing instability, housed, homelessness in past 12 months
Z59.819 Housing instability, housed, unspecified
Z59.82 Transportation insecurity
Z59.86 Financial insecurity
Z59.87 Material hardship due to limited financial resources, not elsewhere classified
Z59.89 Other problems related to housing and economic circumstances
Z59.9 Problem related to housing and economic circumstances, unspecified

Z60 Problems Related to Social Environment
Z60.0 Problems of adjustment to life-cycle transitions
Z60.2 Problems related to living alone
Z60.3 Acculturation difficulty
Z60.4 Social exclusion and rejection
Z60.5 Target of (perceived) adverse discrimination and persecution
Z60.8 Other problems related to social environment
Z60.9 Problem related to social environment, unspecified

Z62 Problems Related to Upbringing
Z62.0 Inadequate parental supervision and control
Z62.1 Parental overprotection
Z62.2 Upbringing away from parents
Z62.21 Child in welfare custody
Z62.22 Institutional upbringing
Z62.23 Child in custody of non-parental relative
Z62.24 Child in custody of non-relative guardian
Z62.29 Other upbringing away from parents
Z62.3 Hostility towards and scapegoating of child
Z62.6 Inappropriate (excessive) parental pressure
Z62.8 Other specified problems related to upbringing
Z62.81 Personal history of abuse in childhood
Z62.810 Personal history of physical and sexual abuse in childhood
Z62.811 Personal history of psychological abuse in childhood
Z62.812 Personal history of neglect in childhood
Z62.813 Personal history of forced labor or sexual exploitation in childhood
Z62.814 Personal history of child financial abuse
Z62.815 Personal history of intimate partner abuse in childhood
Z62.819 Personal history of unspecified abuse in childhood
Z62.82 Parent-child conflict
Z62.820 Parent-biological child conflict
Z62.821 Parent-adopted child conflict
Z62.822 Parent-foster child conflict
Z62.823 Parent-step child conflict

Z62.83 Non-parental relative or guardian-child conflict
Z62.831 Non-parental relative-child conflict
Z62.832 Non-relative guardian-child conflict
Z62.833 Group home staff-child conflict
Z62.89 Other specified problems related to upbringing
Z62.890 Parent-child estrangement NEC
Z62.891 Sibling rivalry
Z62.892 Runaway [from current living environment]
Z62.898 Other specified problems related to upbringing
Z62.9 Problem related to upbringing, unspecified

Z63 Other Problems Related to Primary Support Group, Including Family Circumstances

Z63.0 Problems in relationship with spouse or partner
Z63.1 Problems in relationship with in-laws
Z63.3 Absence of family member
Z63.31 Absence of family member due to military deployment
Z63.32 Other absence of family member
Z63.4 Disappearance and death of family member
Z63.5 Disruption of family by separation and divorce
Z63.6 Dependent relative needing care at home
Z63.7 Other stressful life events affecting family and household
Z63.71 Stress on family due to return of family member from military deployment
Z63.72 Alcoholism and drug addiction in family
Z63.79 Other stressful life events affecting family and household
Z63.8 Other specified problems related to primary support group
Z63.9 Problem related to primary support group, unspecified

Z64 Problems Related to Certain Psychosocial Circumstances

Z64.0 Problems related to unwanted pregnancy
Z64.1 Problems related to multiparity
Z64.4 Discord with counselors

Z65 Problems Related to Other Psychosocial Circumstances

Z65.0 Conviction in civil and criminal proceedings without imprisonment
Z65.1 Imprisonment and other incarceration
Z65.2 Problems related to release from prison
Z65.3 Problems related to other legal circumstances
Z65.4 Victim of crime and terrorism
Z65.5 Exposure to disaster, war and other hostilities
Z65.8 Other specified problems related to psychosocial circumstances
Z65.9 Problem related to unspecified psychosocial circumstances
Z77.22 Exposure to environmental tobacco smoke

Z81 Family History of Mental and Behavioral Disorders

Z81.0 Family history of intellectual disabilities
Z81.1 Family history of alcohol abuse and dependence
Z81.2 Family history of tobacco abuse and dependence
Z81.3 Family history of other psychoactive substance abuse and dependence
Z81.4 Family history of other substance abuse and dependence
Z81.8 Family history of other mental and behavioral disorders

Z91 Personal Risk Factors, Not Elsewhere Classified

Z91.1 Patient's noncompliance with medical treatment and regimen
Z91.11 Patient's noncompliance with dietary regimen
Z91.110 Patient's noncompliance with dietary regimen due to financial hardship
Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship
Z91.13 Patient's unintentional underdosing of medication regimen
Z91.130 Patient's unintentional underdosing of medication regimen due to age-related debility
Z91.138 Patient's unintentional underdosing of medication regimen for other reason
Z91.141 Patient's other noncompliance with medication regimen due to financial hardship
Z91.151 Patient's noncompliance with renal dialysis due to financial hardship
Z91.190 Patient's noncompliance with other medical treatment and regimen due to financial hardship
Z91.A10 Caregiver's noncompliance with patient's dietary regimen due to financial hardship
Z91.A20 Caregiver's intentional underdosing of patient's medication regimen due to financial hardship
Z91.A41 Caregiver's other noncompliance with patient's medication regimen due to financial hardship
Z91.A51 Caregiver's noncompliance with patient's renal dialysis due to financial hardship
Z91.A91 Caregiver's noncompliance with patient's other medical treatment and regimen due to financial hardship
Z91.4 Personal history of psychological trauma, not elsewhere classified
Z91.41 Personal history of adult abuse
Z91.410 Personal history of adult physical and sexual abuse
Z91.411 Personal history of adult psychological abuse
Z91.412 Personal history of adult neglect
Z91.413 Personal history of adult financial abuse
Z91.414 Personal history of adult intimate partner abuse
Z91.419 Personal history of unspecified adult abuse
Z91.42 Personal history of forced labor or sexual exploitation
Z91.49 Other personal history of psychological trauma, not elsewhere classified
Z91.5 Personal history of self-harm
Z91.51 Personal history of suicidal behavior
Z91.52 Personal history of nonsuicidal self-harm
Z91.8 Other specified personal risk factors, not elsewhere classified
Z91.82 Personal history of military deployment
Z91.85 Personal history of military service
Z91.89 Other specified personal risk factors, not elsewhere classified

**Blue print indicates pediatric focused diagnosis codes. May need to create one list for pediatrics and one that is adult focused in addition to one that is combined for specialties like family medicine.*

GEORGIA HEALTH INFORMATION NETWORK

Estimated Level of Effort and Cost

GaHIN's total cost each year for GeorgiaUnify is a combination of Technology costs and GaHIN Services costs.

GaHIN proposes the same funding amount for Year 1 ($11,654,416.00) and Year 2 ($11,654,416.00). The work of GaHIN is perpetual and will continue to advance at nearly the same rates for the first two years and perhaps into Year 3. The ongoing funding for each year's costs is needed to manage the new onboardings, conduct training, perform analytics and provide help desk support. GaHIN would work with each agency to design and develop their multi-year connectivity strategy. Year 1 would be comprised of connectivity to the platform using the designed plan to ramp up as efficiently as possible including reporting, user training. Exchange services include alerting, access to cohorts and the ability to perform social care referrals. Year 2 would build onto their use case by adding more users, defining additional data needs, then outreaching to identified social care or community-based organizations to continue to enhance and grow the use of GaHIN.

Each year includes the onboarding of the clinical users to GeorgiaConnX and simultaneously, onboarding Users to the social care platform, GeorgiaUnify. For example, GaHIN will identify and design the use case and workflows with each user organization, develop the onboarding plan including technical connectivity options, create the project management approach and plan, then start the onboarding. Onboarding will include system functionality demonstrations and user training. User Training will be offered in a variety of methods such as onsite, virtual sessions, and access to reference guides and portals. GaHIN has factored in onsite outreach and education, onsite technical onboarding support such as providing onsite or remote technical connectivity resources or technical staff augmentation as needed to ensure technical connectivity is performed in a timely and correct manner.

Costs for GaHIN include onboarding new users and new functionality for existing users. The types of onboardings consist of:

- Onboarding new clinicians to GeorgiaConnX to create, and view and retrieve the longitudinal, whole person care record
- Onboarding new community based/social care organizations to GeorgiaUnify
- Onboarding new clinical community-based organizations to support closed-loop for referrals with clinical and social care providers
- Onboarding existing provider members with new community-based/social care organization in GeorgiaUnify to conduct social care referrals.
- Onboarding new community-based/social care organizations to populate and maintain the community resource directory
- Onboarding existing clinicians and community-based/social care organizations to new functionality to support new use cases.
- Establishing and integrating new sources of data to contribute to the whole-person care record.
- Identifying and creating analytics and reports specific to the user organization.

GaHIN will work with all members to create the most efficient and impactful on-boarding and use of GaHIN. The use of GaHIN will include the member organization's connectivity and will also support the most complex use-cases and workflows that require multiple providers and users across the full spectrum of connected members. GaHIN offers full integration and connectivity services and functionality across all members using sophisticated technology and data matching and management tools. GaHIN will work with identified members and stakeholders to create the fully integrated exchange network including:

- Health systems, hospitals, providers
- Care Management Organizations (CMO)
- Department of Community Health (DCH)
- Department of Public Health (DPH)
- Department of Human Services- Division of Family and Children Services (DFCS)
- Department of Juvenile Justice (DJJ)
- Department of Behavioral Health and Developmental Disabilities (DBHDD)
- Department of Corrections (GDC)
- Department of Community Supervision (DCS)
- Department of Community Affairs (DCA)
- Department of Education (DOE)-School Based Clinics

GaHIN COSTS (Year 1 and Year 2)

TECHNOLOGY & SERVICES	ITEM	TOTAL
Year 1 Costs *(300,000 Active/New Referrals Per Year)*		
Technology	Hosting	$386,040
	Licensing	$2,754,524.00
	Services	$681,534.00
		$3,822,098.00
GaHIN Services	Project Management	$2,080,000.00
	Outreach, Onboarding & Training	$3,338,190.00
	Reporting & Analytics	$1,324,128.00
	Support - Engagement & Help Desk	$764,400.00
		$6,742,318.00
	TOTAL Year 1 COST	**$10,654,416.00**
	INTERMEDIARY FUNDING	**$1,000,000.00**
	TOTAL	**$11,654,416.00**

Intermediary Funding: GaHIN will also seek additional funding to serve as an intermediary to pass through funding to assist provider with related technology costs. Although GaHIN does not charge fees to providers nor community based /social care organizations to connect; providers may incur

fees from their technical vendor or may need assistance purchasing or upgrading their technology such as new interfaces, or computers. Some providers and community-based organizations may need to update their security infrastructure to meet the advanced security requirements of exchanging protected health information. Additionally, some providers may need additional support services to help with data entry or data uploads.

GaHIN

Social Care Integration Update

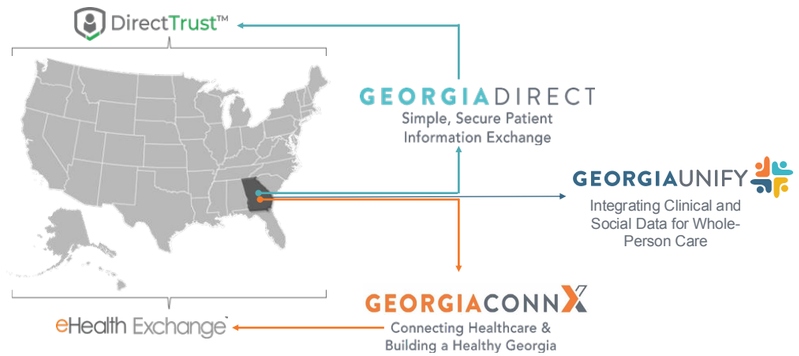
GEORGIA HEALTH INFORMATION NETWORK

GA BHRIC Medicaid SDOH Workgroup

September 13, 2024

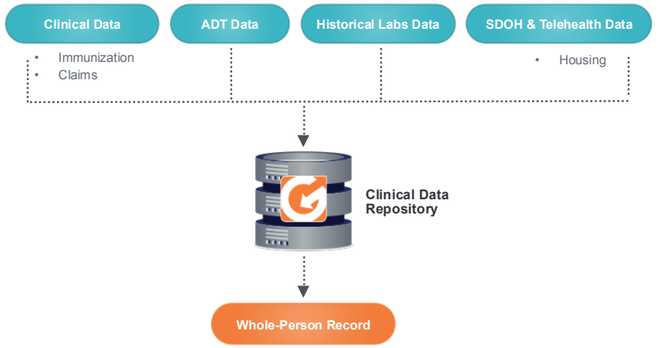
About GaHIN

Georgia Health Information Network is the state-designed HIE for Georgia that helps health systems across the state and nationwide share vital clinical and social data.



Transition to GaHIN's Integrated Platform

Building a robust data repository



GaHIN recently transitioned to intersystems HealthShare® platform to:

- Build a repository of clinical, behavioral, and social data
- Support QHIN and TEFCA requirements
- Create specialty cohorts/ registries, services, use advanced technology such as APIs, FHIR
- Take advantage of national networks (eHealth Exchange and Carequality)
- Accelerate ability to connect with different types of organizations (state agencies, CBOs, CMOs)
- Explore advanced interoperability use cases with our members

Social Care Integration Strategy

GaHIN's New Social Care Integration Initiative

Vision

Support whole person care by integrating social care data with clinical data to better enable access to services and improve care outcomes.

Aims

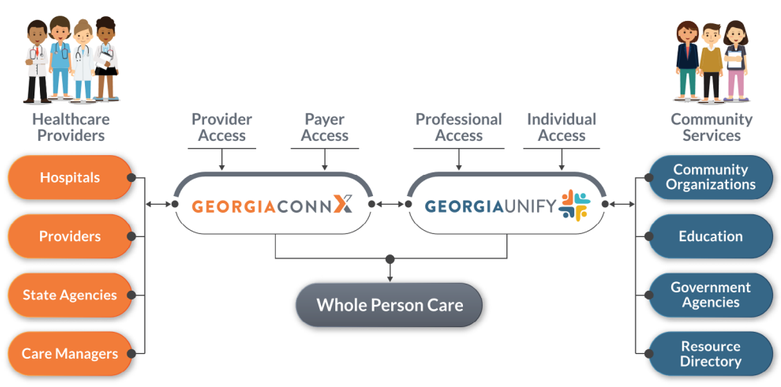
Build trust and align community stakeholders on the mission, purpose, and decision-making processes of the initiative.

Engage both health and social care stakeholders in a collaborative process to identify and prioritize use cases and services to be delivered by GaHIN.

Align and coordinate across local/regional social care integration and health equity initiatives.

GEORGIA HEALTH INFORMATION NETWORK

GeorgiaUnify Enables Whole Person Care



GEORGIA HEALTH INFORMATION NETWORK GEORGIAUNIFY

GEORGIAUNIFY

GaHIN's social care integration platform facilitates referrals and coordination of services for effective whole person care throughout the community.

Use cases include:

- Medical Providers
- Community Based Organizations (CBO)
- Non-emergency Medical Transportation
- Safe and Affordable Housing
- Education / Employment Programs
- Correctional Facilities
- Other Social Care Organizations

GEORGIA HEALTH INFORMATION NETWORK

Capabilities GeorgiaUnify Provides

GEORGIAUNIFY

Social Risk Screenings

GaHIN helps organizations capture, aggregate, link and share SDOH screening data.

Resource Directory

GaHIN works with social care stakeholders to build out and maintain a resource directory.

Reporting and Analytics

GaHIN collaborates to develop reporting and analytics capabilities for social care stakeholders.

Longitudinal Whole Person Records

GaHIN integrates cross-sector data on an individual for whole-person care.

Closed-Loop Referral Management

GaHIN supports interoperability of referrals and connects referral platforms for stakeholders in the state.

GEORGIA HEALTH INFORMATION NETWORK

Reference: https://sirenetwork.ucsf.edu/sites/default/files/wysiwyg/Community-Resource-Referral-Platforms-Guide.pdf

Why Social Determinants of Health are Important

There is growing awareness that social determinants of health (SDOH) information improves whole person care and lowers cost. Unmet social needs negatively impact health outcomes.

- **Food insecurity** correlates to higher levels of diabetes, hypertension, and heart failure.
- **Housing instability** factors into lower treatment adherence.
- **Transportation barriers** result in missed appointments, delayed care, and lower medication compliance.

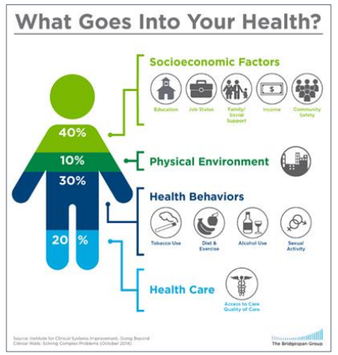
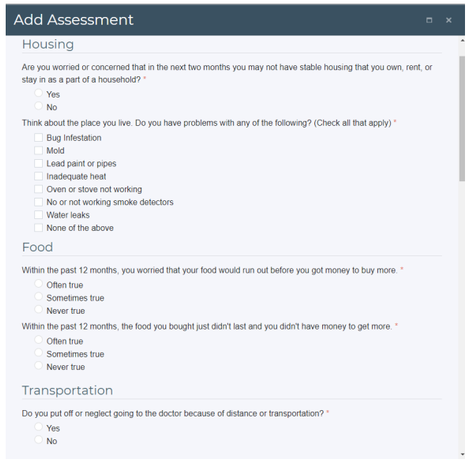


Image source: https://www.bridgespan.org/insights/the-community-cure-for-health-care



Housing

Z59 Problems related to housing and economic circumstances
Z59.0 Homelessness
Z59.1 Inadequate housing

Food

Z59.4 Lack of adequate food
Z59.41 Food insecurity
Z59.48 Other specified lack of adequate food

Transportation

Z59.82 Transportation insecurity

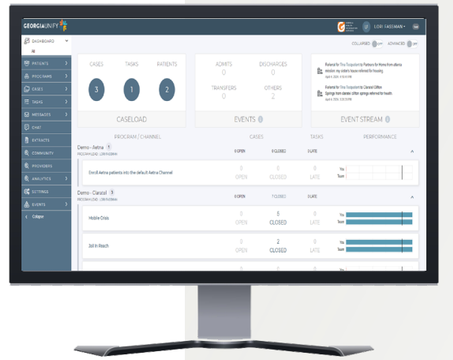
Example Referral Assessments

Example CBO Intake Form

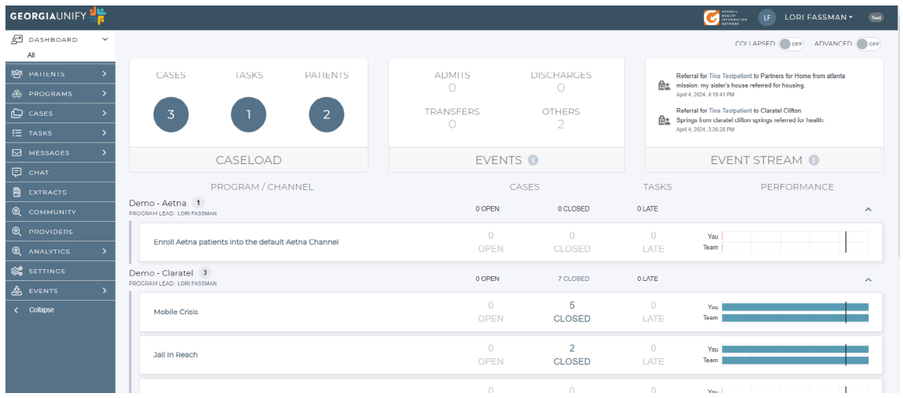
Food Bank Intake Form

Current information collected:
- Name
- Address
- Number of people in the household

Additional requested information:
- Health insurance information
- Referral information



GeorgiaUnify Environment



GeorgiaUnify Service Types and Categories

GeorgiaUnify Service Type	GeorgiaUnify Service Category
Baby Supplies	Baby Supplies (Diapers, Formula, Stroller etc)
Clothing	Clothing/Shoes
Clothing	Maternity Clothing
Counseling/Crisis Services	AA/NA Classes
Counseling/Crisis Services	Domestic Violence
Counseling/Crisis Services	Family Counseling
Counseling/Crisis Services	Group/Peer Counseling
Counseling/Crisis Services	Legal Counseling
Counseling/Crisis Services	Mental Health Counseling
Counseling/Crisis Services	One-on-One Counseling
Counseling/Crisis Services	Substance Abuse Counseling
Family/Community Services	Adult Daycare
Family/Community Services	Child Care
Family/Community Services	After School Program
Family/Community Services	Child Tutoring
Family/Community Services	Youth Mentoring Program
Financial	Eviction Support
Financial	Income Assistance
Financial	Rental Assistance
Financial	Utilities Assistance
Food	Food Stamp Assistance
Food	Food/Food Pantry
Food	Meals
Furniture/Household Goods	Bedding/Blankets
Furniture/Household Goods	Furniture
Furniture/Household Goods	Household Goods

GeorgiaUnify Service Type	GeorgiaUnify Service Category
Homeless Services	Laundry Services
Homeless Services	Showers
Housing	Housing Placement
Housing	Housing Services
Housing	Moving
Housing	Overnight Stay
Housing	Permanent Supportive Housing
Housing	Temporary Housing
Housing	Transistional Housing
Recreational	Community Recreational Center
Transportation	Employment Interviews
Transportation	MARTA Cards for Medical Transportation
Transportation	Non-Emergency Transportation
Transportation	Senior Care Transportation
Veterans Services	Veterans Assistance
Work/Education	College Admissions Support
Work/Education	Digital Skills Certificate / Technology Training
Work/Education	Educational Services
Work/Education	Educational Supplies
Work/Education	Employment Assistance
Work/Education	Employment Services
Work/Education	Financial Literacy
Work/Education	GED Support
Work/Education	Job Placement
Work/Education	Job Readiness
Work/Education	Life Skill Classes
Work/Education	Literacy Assistance
Work/Education	Vocational Training

GEORGIA HEALTH INFORMATION NETWORK

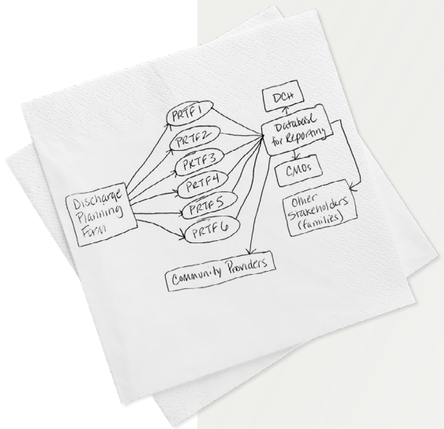
GeorgiaUnify Outreach

CURRENT Engagement & Prioritization	Demo Provided
Behavioral Health • DBHDD – Psychiatric Inpatient Hospitals – Office of Supportive Housing – PATH o Grady Health Systems o Advantage BHS o Legacy BHS o Serenity BHS o Mercy Care (St. Joe's) o Community Friendship, Inc. o Intown Collaborative Ministries • Georgia Alliance of Therapeutic Services (GATS) **Follow-up** • Psychiatric Residential Treatment Facilities (PRTF) • United Way 211 • VA Atlanta Health System (Fort McPherson VA Clinic) • Georgia Dept. of Corrections **Members** • HealthIE Georgia & Unite Us. • CHOA • Amerigroup • CareSource • Peach State • DPH • Wellstar • DHS-DFCS • Northeast Georgia Health System • HI-BRIDGE HIE	• DBHDD – Office of Children Youth & Families – Office of Supportive Housing – Office of Recovery Transformation – Multi-Agency Treatment for Children (MATCH) – Hospital Social Work Chiefs – Behavioral Health – PATH Leadership – Fulton County DBHDD • Dekalb CSB • Partners For Home • Department of Community Affairs (DCA) • Aetna • United Way 211 • VA Atlanta Health System (Fort McPherson VA Clinic) • Criminal Justice Coordinating Council • VP Health (PRTF) • Amerigroup • CHOA • Wellstar • HI-BRIDGE HIE • Emanuel Medical Center • ARCHI • GAPHC • White's Pediatrics • City of Refuge • The Salvation Army • Grady Health

GEORGIA HEALTH INFORMATION NETWORK GEORGIAUNIFY

CMO-DCH-Provider Access to the Discharge Planning

DCH asked GaHIN for help capturing and securely exchanging documentation between the 6 pediatric psychiatric residential treatment facilities (PRTFs) and the CMOs responsible for managing these patient populations

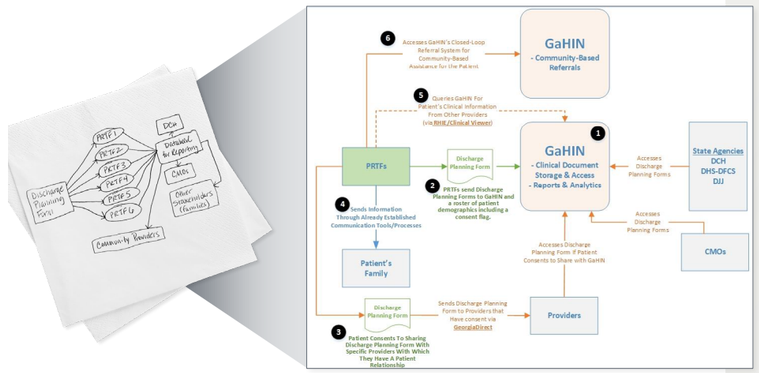


Challenges:

- CMOs need discharge planning data to ensure proper follow-on care occurs and services are rendered
- DCH needs discharge planning data to gain care utilization insights and facilitate program oversight
- Data exchanges need to be secure and more easily accessible by all authorized stakeholders

GEORGIA HEALTH INFORMATION NETWORK

Progress Report



GEORGIA HEALTH INFORMATION NETWORK

Milestones to Date

- Developed single-page discharge online form (5 pages down to 1)
- Architected workflows to enable auto-population of data and patient matching from GaHIN
- Option to implement GaDirect to support secure connectivity in the near term

Benefits

- Reduce keystrokes and room for human error
- Increase access for authorized clinical and social needs network
- Enable secure exchange of discharge planning data

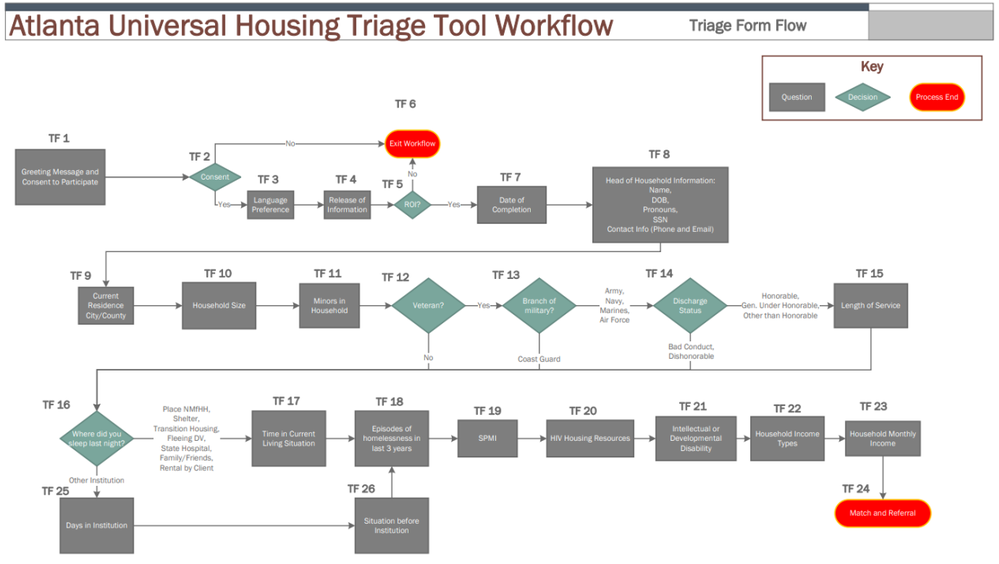
SAFETY+JUSTICE CHALLENGE

SJC is a national initiative focused on reducing the misuse and overuse of jails and advancing racial equity.

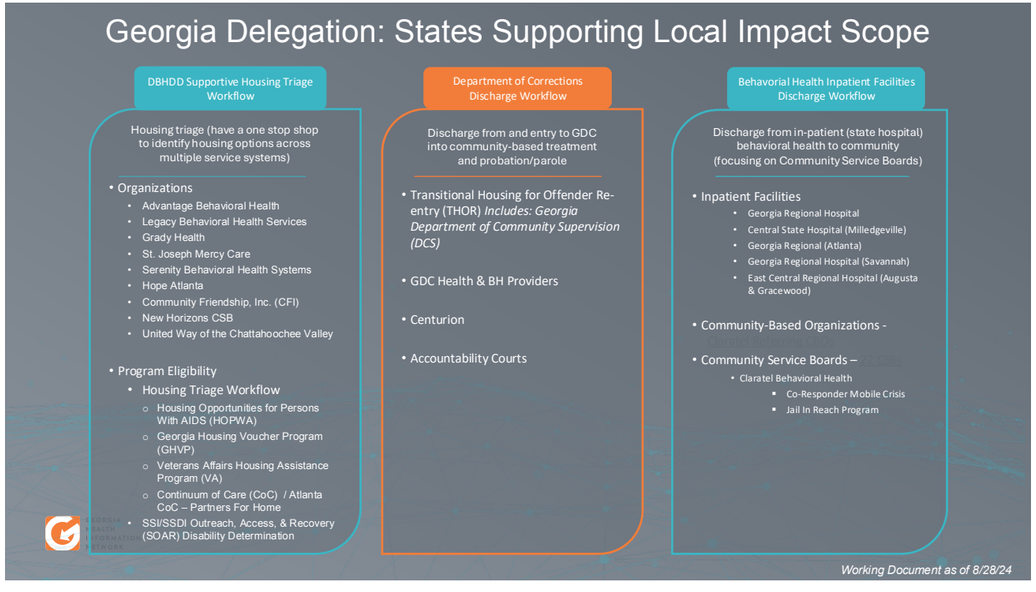
GEORGIA HEALTH INFORMATION NETWORK

Social Justice Challenge Award

- The Council of State Governments (CSG) Justice Center recently invited Georgia to participate in a new project and TA opportunity through the MacArthur Foundation's Safety and Justice Challenge (SJC).
- The CSG Justice Center, the Corporation for Supportive Housing (CSH), and the Center for Health Care Strategies (CHCS) to tackle a specific policy goal in health, housing, data, or funding. (Fabio Van Der Merwe presented GaHIN).
- Participating States Receive Technical Assistance: To sustain local efforts to reduce overrepresentation of people with behavioral health needs in local jails.
- Georgia Delegation TA Project: ***Connecting local and state data around criminal justice, homelessness, and behavioral health to GeorgiaUnify, the Social Determinants of Health, a closed-loop referral system that is the counterpart to the state health data exchange. State-level datasets identified as potential "low-hanging fruit"***: SCRIBE (GDC), The Portal (DCS), Avatar (State BH Hospital), and HMIS (DCA).
    - Proposed Project Scope:
        - BH Inpatient Discharge Workflow
        - Homeless/Housing Triage Workflow
        - DOC/Jail Discharge Workflow to include CSB Jail In-Reach Program



November 19, 2021



Claratel Behavioral Health – Jail-In Reach Program

Jail In-Reach Program Staff Member

Community Assessment

- Supportive Service Needs
- Housing/Living Situation
- Income
- Insurance
- Medical
- Social/Cultural & Safety
- Substance Use
- Mental Health
- Disabilities
- Psychiatric Rehabilitation
- Education
- Other Agency Involvement

Social Assessment

- Housing
- Food
- Transportation
- Utilities
- Personal Safety

Approx. 200+ Referrals Per Year

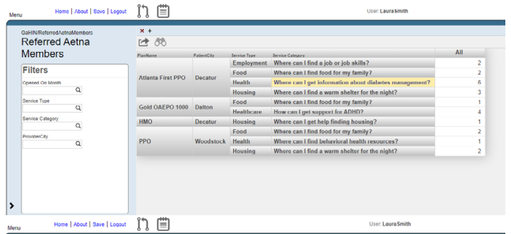
Most frequently refer to:

- Grady
- Community Friendship
- Other CSBs
- Atlanta Mission
- Salvation Army
- Mercy Care
- St. Jude's
- MedCura (Oakhurst)
- West End Medical Centers
- City of Refuge
- Hope Atlanta
- Worksource Dekalb
- Atlanta Food Bank
- Atlanta Furniture Bank

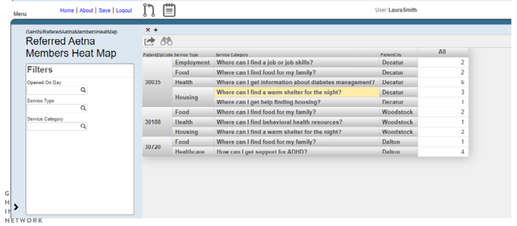
GEORGIA HEALTH INFORMATION NETWORK

GEORGIAUNIFY

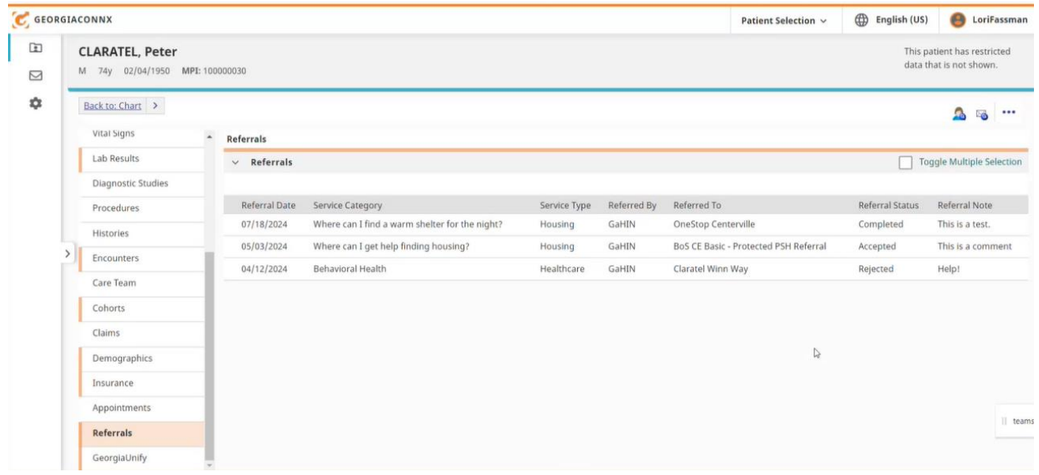
Sample Reports



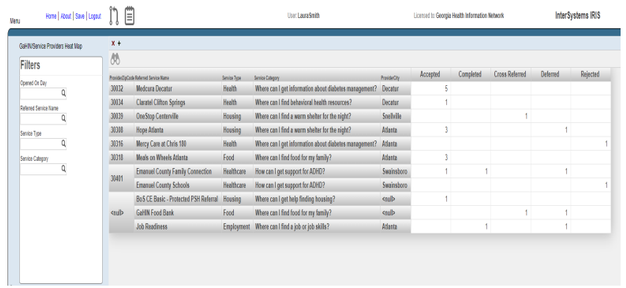
Show me what services Aetna Members are receiving, sorted by the Plan and City that they live in.
The user can filter the report by date of the referral, service type, service category and city (Member's location). Report results can be exported to Excel.



Show me what services Aetna Members are receiving, sorted by the Zip Code that they live in. This information could be put into a heat map to visually show the services being provided to Aetna Members across the state or a region.



Sample Reports



Show me what services are available to Aetna Members, sorted by Zip Code of the service provider.
This information could be put into a heat map to visually show the coverage/gaps in services across the state or a region.

The user can filter the report by date of the referral, service provider name, service type and service category. Report results can be exported to Excel.

GEORGIA HEALTH INFORMATION NETWORK

Thank You!

Stay connected with GaHIN all year round!

Social Media

Monthly Newsletters

Contact Us

www.gahin.org

Support@gahin.org

GEORGIAUNIFY

Housing Data is received and matched in the clinical data repository

Georgia Department of Community Affairs
HIMS Client Roster

Patient records with demographics and housing status for matching across clinical and social data

GEORGIA HEALTH INFORMATION NETWORK

Living Situation Option List

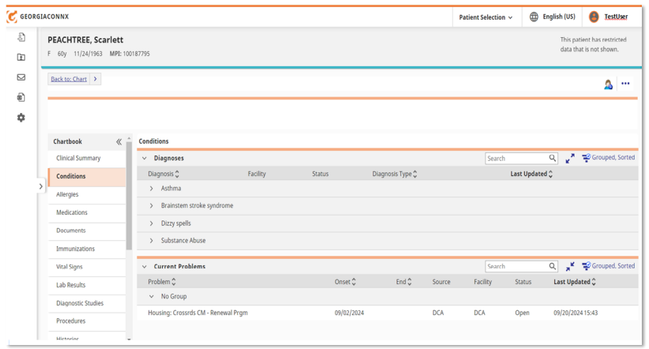
Appendix A – Living Situation Information

Living Situation Option List

Field #	Response	Prior Living Situation (3.917)	Current Living Situation (4.12)	Destination (3.12)
Header	Homeless Situations (100-199)			
116	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	X	X	X
101	Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter	X	X	X
118	Safe Haven	X	X	X
Header	Institutional Situations (200-299)			
215	Foster care home or foster care group home	X	X	X
206	Hospital or other residential non-psychiatric medical facility	X	X	X
207	Jail, prison, or juvenile detention facility	X	X	X
225	Long-term care facility or nursing home	X	X	X
204	Psychiatric hospital or other psychiatric facility	X	X	X
205	Substance abuse treatment facility or detox center	X	X	X
Header	Temporary Housing Situations (300-399)			
302	Transitional housing for homeless persons (including homeless youth)	X	X	X
329	Residential project or halfway house with no homeless criteria	X	X	X
314	Hotel or motel paid for without emergency shelter voucher	X	X	X
332	Host Home (non-crisis)	X	X	X
312	Staying or living with family, temporary tenure (e.g., room, apartment, or house)			X
313	Staying or living with friends, temporary tenure (e.g., room, apartment, or house)			X
327	Moved from one HOPWA funded project to HOPWA TH			X
336	Staying or living in a friend's room, apartment, or house	X	X	
335	Staying or living in a family member's room, apartment, or house	X	X	
Header	Permanent Housing situation (400 -499)			
422	Staying or living with family, permanent tenure			X
423	Staying or living with friends, permanent tenure			X

Populating the Central Data Repository for Matching Client Records with Housing Data

Georgia Department of Community Affairs
Homeless Client Roster

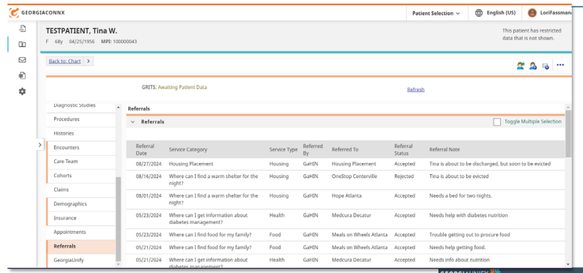


Client records with
- Demographics
- Housing status
- Housing program participation status

for matching across clinical and social data.

GEORGIA HEALTH INFORMATION NETWORK

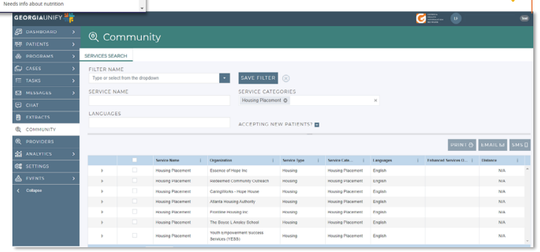
Leveraging the Integrated Platform



GEORGIACONNX

Clinical providers can now see social care referrals through the clinical viewer.

GEORGIAUNIFY



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