Georgia Behavioral Health Reform and Innovation Commission

Data Sharing Progress in Georgia

BHRIC Commission Meeting

Ana LaBoy

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November 2024

Georgia Health Policy Center

The Georgia Data Analytics Center (GDAC)

- Established in 2019- HB 197
  - Improve “public health and safety, security and wellbeing of Georgia residents” through data analytics
- Address state challenges of data sharing between and across agencies
  - Data dictionaries, administrative process, inadequate resources
- Review data access, retention, and publication policies and procedures

Governor’s Executive Order on Data Sharing Between State Agencies

- Governor's Executive Order signed September 2023
- GDAC
  - establish a data sharing request, data sharing agreement and data format for agency data
  - houses the data sharing requests
  - Assist agencies with making requests and executing agreements
- FY2025- $1,999,667 allocated in the budget

GDAC

- HB1013 reporting requirements- annual unified report related to complaints for violations of mental health parity
  - Annual Reporting of Mental Health Parity
- GDAC Dashboards
  - Health
  - State Financials
  - American Rescue Plan Act (ARPA)
  - Census
  - Education

Georgia All-Payer Claims Database (APCD)

- Senate Bill 482 (O.C.G.A 31-53-40)
  - "GAPCD shall be to facilitate data-driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve public health through the understanding of health care expenditure patterns and operation and performance of the health care system"
- Office of Health Strategy and Coordination (OHSC) creating and implementing database
  - Georgia Tech Research Institute's Center for Health Analytics and Informatics
- APCD repository of health claims across health care, pharmacy, and dental from private and public sources
  - Insurance companies, medical insurance plans, hospital plans, hospital medical service corporations, health maintenance organizations
    - Requirement of DCH and CMOs to submit

GAPCD Information

APCD Goals

Population Health

Assess population health

identify health disparities

Measure utilization of healthcare services

Healthcare Quality

Improve coordination of care

Informing consumers of the cost and quality of healthcare

Support the planning and evaluation of healthcare operations and care

Cost and Utilization

Establishing baseline healthcare cost information

Monitoring and analyzing healthcare costs

Enabling oversight of health insurance premium medical loss ratios

Conducting waste, fraud and abuse studies

Georgia Health Information Network (GaHIN)

- Integrated data sharing platform with live data
  - Data from various agencies throughout the state including but not limited to:
    - DBHDD, DCH, DJJ, DPH, CMOS, Health systems, GAMMIS & FQHCs
  - Longitudinal whole person data shared across clinical and non-clinical care platforms
    - Varied data access restrictions based on personnel that would be accessing the data
- Closed loop referral processes

GaHIN Whole Person Care

Healthcare Providers

Provider Access

Payer Access

Professional Access

Individual Access

Community Services

- Hospitals
- Providers
- State Agencies
- Care Managers

GEORGIACONNX

GEORGIAUNIFY

Whole Person Care

- Community Organizations
- Education
- Government Agencies
- Resource Directory

Thank You

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Georgia Behavioral Health Reform and Innovation Commission

Aging Adults Workgroup

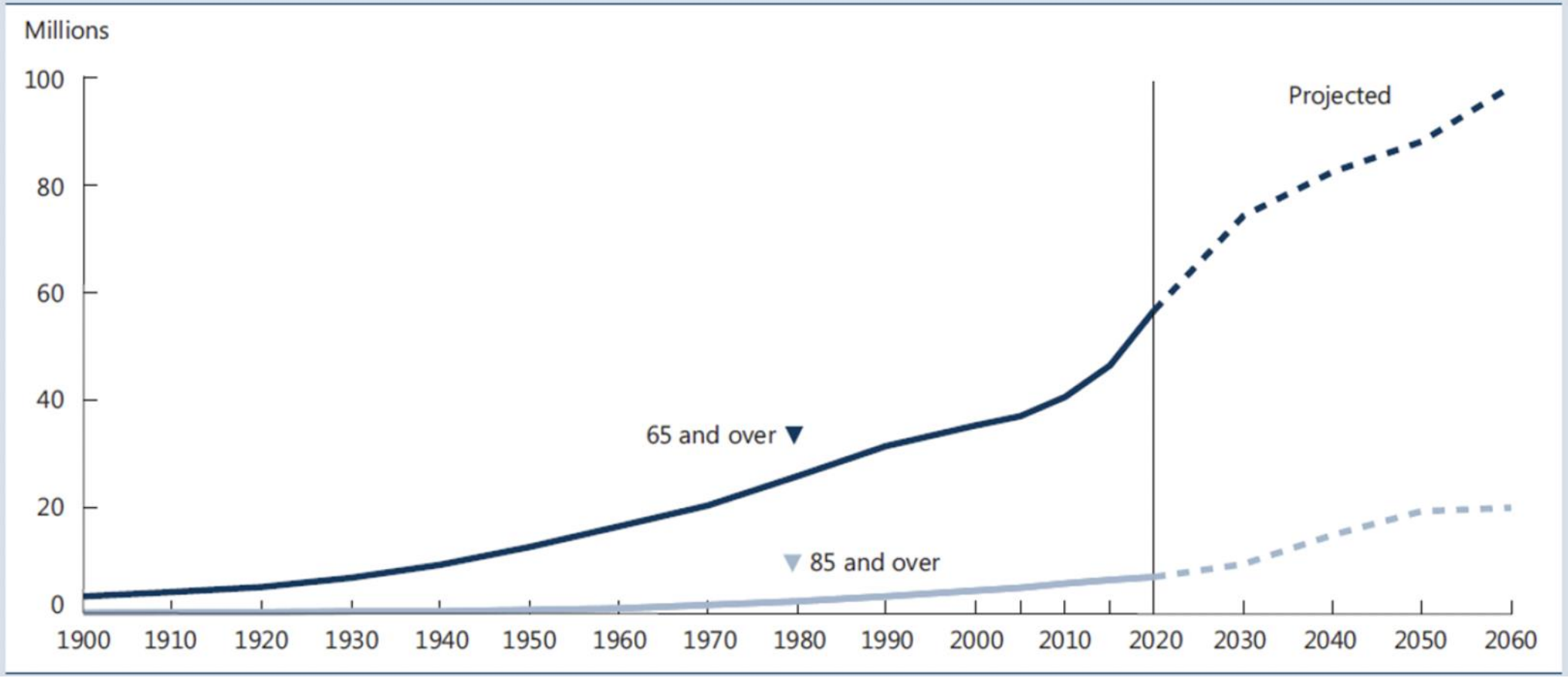
Subchair Debra L. Stokes,
Executive Director, Georgia Council on Aging

Georgia Aging Population

- 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]

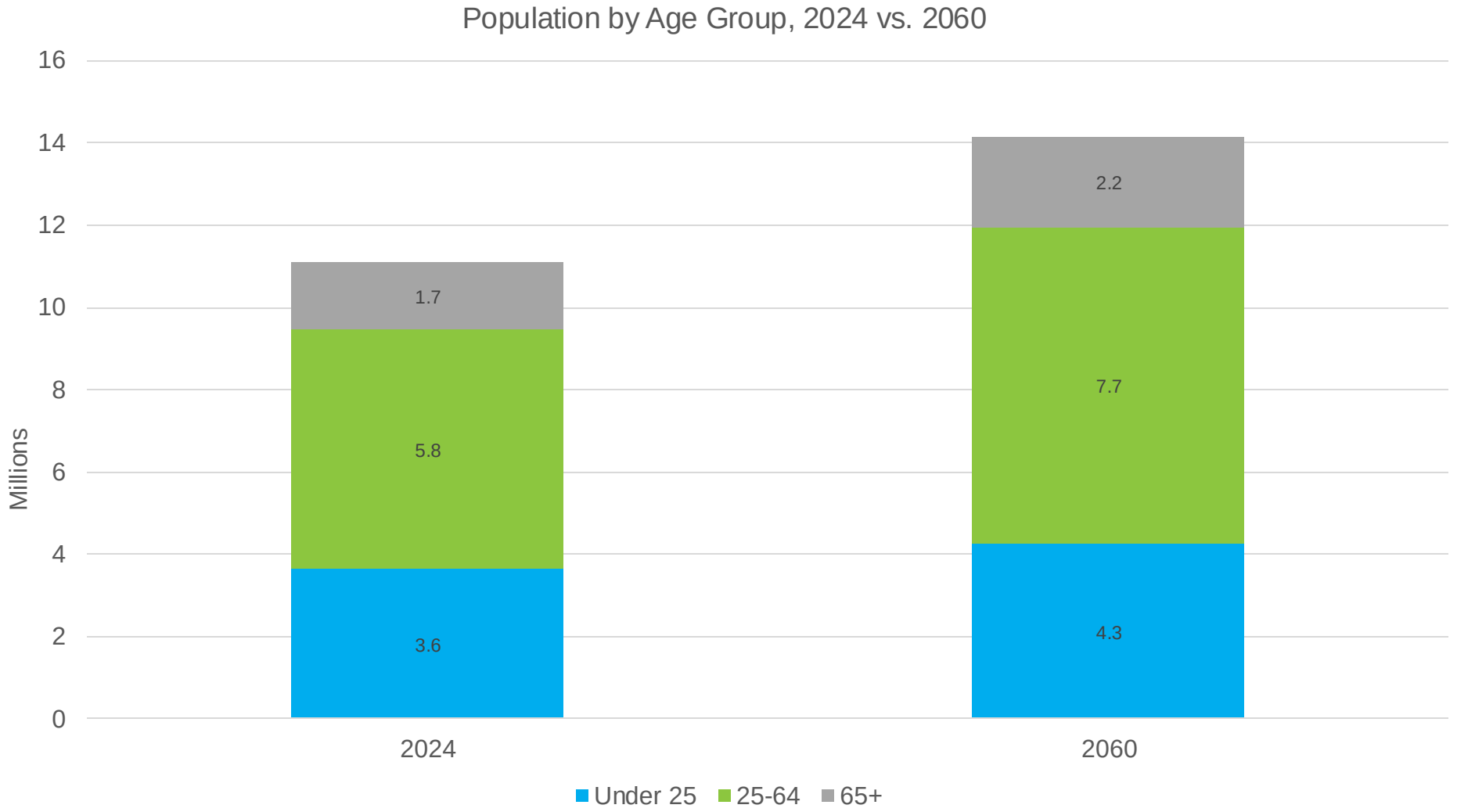
Rapidly-Changing Demographics

Population age 65 and over and age 85 and over, selected years, 1900–2014, and projected years, 2020–2060



Source: U.S. Census Bureau

Growth of Older Population in Georgia



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

Mental Health of Older Adults

- Loneliness and social isolation are 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
- 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
- 14% of adults 60+ live with a mental disorder[1]

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

Aging Adults in Georgia

- An estimated 35% of aging individuals had chronic psychiatric or mental health diagnosis
- Estimated 11% do not have family or friends who live with them
- 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

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

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.

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.

Georgia Behavioral Health Reform and Innovation Commission

Homelessness Advisory Group

Subchair Edward J. Hardin,

Background

- Housing costs have outpaced household incomes
- Unsheltered residents are often uninsured and not eligible for Medicaid benefits

Focused on three questions:

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?

Committee work

- Through the three meetings held by the subcommittee between June and October, the following themes were discussed:
  - Scope of the problem of mental and behavioral health care for unhoused folks
  - Available and successful services and programs
  - Barriers to receiving care for unhoused folks
- Recommendations focus on promoting coordination, empowering communities and providing flexible funding for homelessness sectors

Recommendations

- Promote greater homelessness coordination, including: (DCA/DBHDD)
  - 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, 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;
  - 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;
  - 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
  - local collaboration among CoCs, CSBs, and Public Housing Authorities (ideally involving MOUs);
  - 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;
  - 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

Recommendations

- 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

- 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.

Recommendations

- 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)
  - Supportive services to complement permanent supportive housing to extent funding recommended in item 3 is not sufficient to a local need ;
  - Funding for homeless solutions, e.g., the Melody, in other parts of the state;
  - Support service provider capacity, especially in unserved/ under-served parts of the state;
  - Housing vouchers and services for those who don't meet SPMI/PMI criteria required by GA Housing Voucher;
  - Dedicated staff to provide inreach to jails and prisons to promote comprehensive re-entry 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 which will service people experiencing homelessness with server behavioral health challenges at approximately $6.5 million annually

Recommendations

- 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)
- Expand the availability of GHVP and address barriers to GHVP utilization across the state. (DBHDD)
- 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)
- 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)
- Prioritize unsheltered populations for housing vouchers. (DCA)
- Ensure the effectiveness of highly skilled outreach teams (e.g., ACT, ICM) and fund additional outreach teams, where needed. (DBHDD)

Dental Advisory Subcommittee
Behavioral Health Reform and Innovation Commission

Members: Dr. David Bradley, Dr. Kim Cole, Dr. David Reznik, Dr. Nancy Young

Chair: Dr. Srinivas Challa

Commissioner Kevin Tanner

Contents

Objective

On June 10th, 2024, Commissioner Tanner established the Dental Advisory Subcommittee to

a) identify the core problems facing I/DD individuals in obtaining dental services,

b) improve dental access and care in the community and agency hospitals, and

c) explore long-term solutions to care for our I/DD individuals in Georgia.

History: How did the problem begin?

- 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 at DBHDD institutions to seek similar services in the community.
  - The I/DD population, about 220,000 individuals in Georgia, may require specialized dental care that is not readily available in the community.

Problems Faced by the I/DD Population

- I/DD individuals tend to have greater oral health problems compared to those without disabilities as they face unique barriers to care.
- I/DD individuals visit the dentist less frequently compared to individuals 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 individuals not experiencing disability.

Common Access and Care Challenges Faced by IDD Individuals & Families in GA

- Finding a dentist who will accept Medicaid
- Finding a dental practice with experience or willingness to treat people with I/DD
- Transportation

Common Reasons Dentists Choose Not to Treat I/DD

- Lack of recognition of need for this underserved patient population
- Lack of expertise to treat and manage patients with special needs
- Behavioral challenges 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
  - Transportation to dental appointments is not covered by Medicaid
- 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
- Dentists do not feel they are compensated enough for the lengthy procedures
- 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

Medicaid Dental Adult Coverage

- As of Oct 1st, 2024: Medicaid in GA covers adult dental services similarly to pediatric dental services.
- Medicaid reimbursement in Georgia is about 35% of fair market value.
- Sedation services are covered for adult I/DD patients with Medicaid.

Cost of Dental Treatment for I/DD Patients

- The cost for a dentist to take care of the I/DD population is approximately 4x 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.
- For the more medically and/or behaviorally complex individuals, the cost of providing transdisciplinary care is roughly eight to ten times the cost of providing care to a patient without a disability patient. This subsect I/DD patients represents the top 30% of the I/DD cost curve.
- Medicaid reimburses at 35% compared to the average dental office overhead of 62%. The financial barrier is one of the reasons that many dentists choose not to treat I/DD individuals.

What are other states doing for their I/DD population?

- Mobile Dentistry
- Teledentistry
  - Teledentistry is not currently legal in GA
- 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

Mobile Dentistry

Access Dental Care was established in 2000 as a non-profit organization to support the special care population in North Carolina.

- Access Dental Care has developed and mastered a unique mobile delivery system that can help overcome the barriers to delivering oral healthcare inside schools, health facilities and other locations.
- Custom designed trucks help transport all operatory equipment to any location. The dental equipment is designed to be easily rolled into an alternate location, so that patients can be treated where they are.

Role of DBHDD

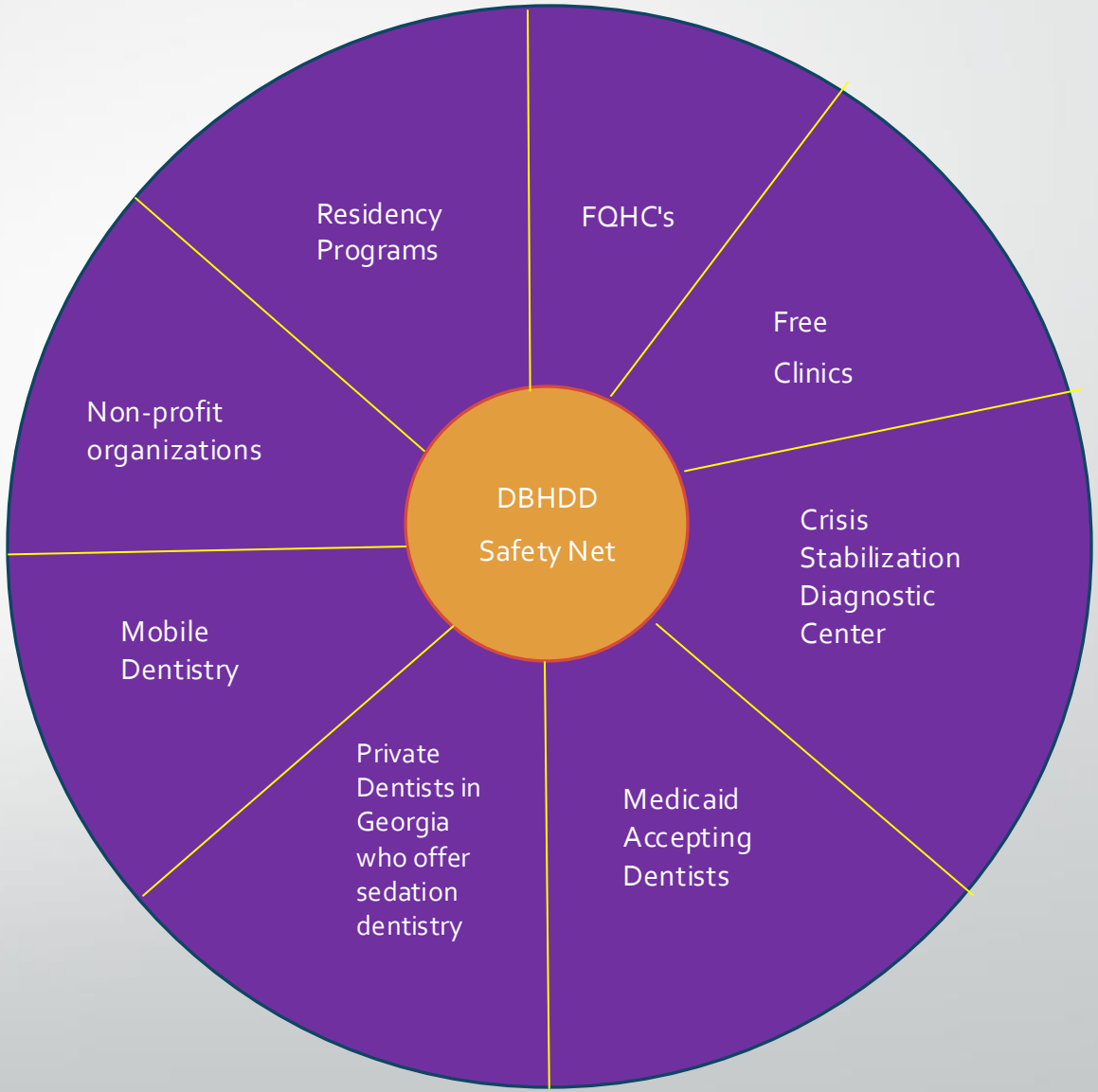
Vision

Easy access to high-quality care that leads to a life of recovery and independence for the people we serve.

Mission

Leading an accountable and effective continuum of care to support people with behavioral health challenges, and intellectual and developmental disabilities **in a dynamic health care environment**.

6 Regions (4 full-time and 6 part-time dentists)



Crisis Stabilization Diagnostic Center

- Crisis Stabilization Diagnostic Center (Macon Downtown Corridor) will open in 2025.
- Collaboration of DBHDD, Mercer University, and River Edge Behavioral Health.
- Comprehensive dental services will be provided on the clinic side.
- CSDC will be a referral option for our dental community.
- The CSDC will have five dental chairs, with one of those chairs closed off for more privacy. The space *could* be used for more intensive dental care.

CODA - Accreditation Standards For Dental Education Programs

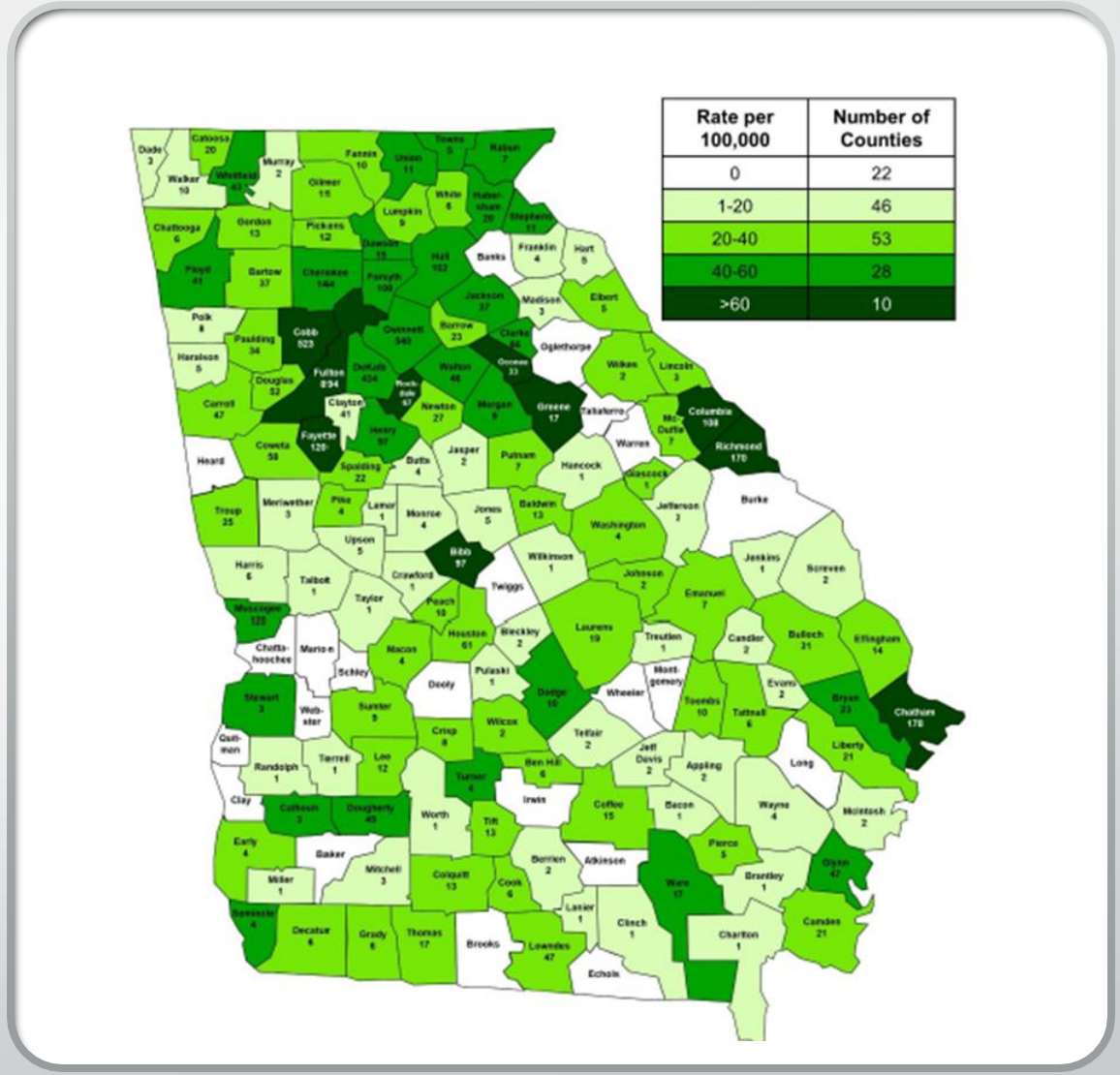
2-25: Graduates must be competent in assessing and managing the treatment of patients with special needs.

Intent:

An appropriate patient pool should be available to provide experiences that may include patients whose medical, physical, psychological, or social situations make it necessary to consider a wide range of assessment and care options. As defined by the school, these individuals may include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly. Clinical instruction and experience with the patients with special needs should include instruction in proper communication techniques including the use of respectful nomenclature, assessing the treatment needs compatible with the special need, and providing services or referral as appropriate.

Distribution of Dentists in Georgia

- As of 2024, there are 6,429 active dental licenses in Georgia.
  - All active dental licenses are not practicing dentists.
- 22 counties in Georgia do not have a dentist.

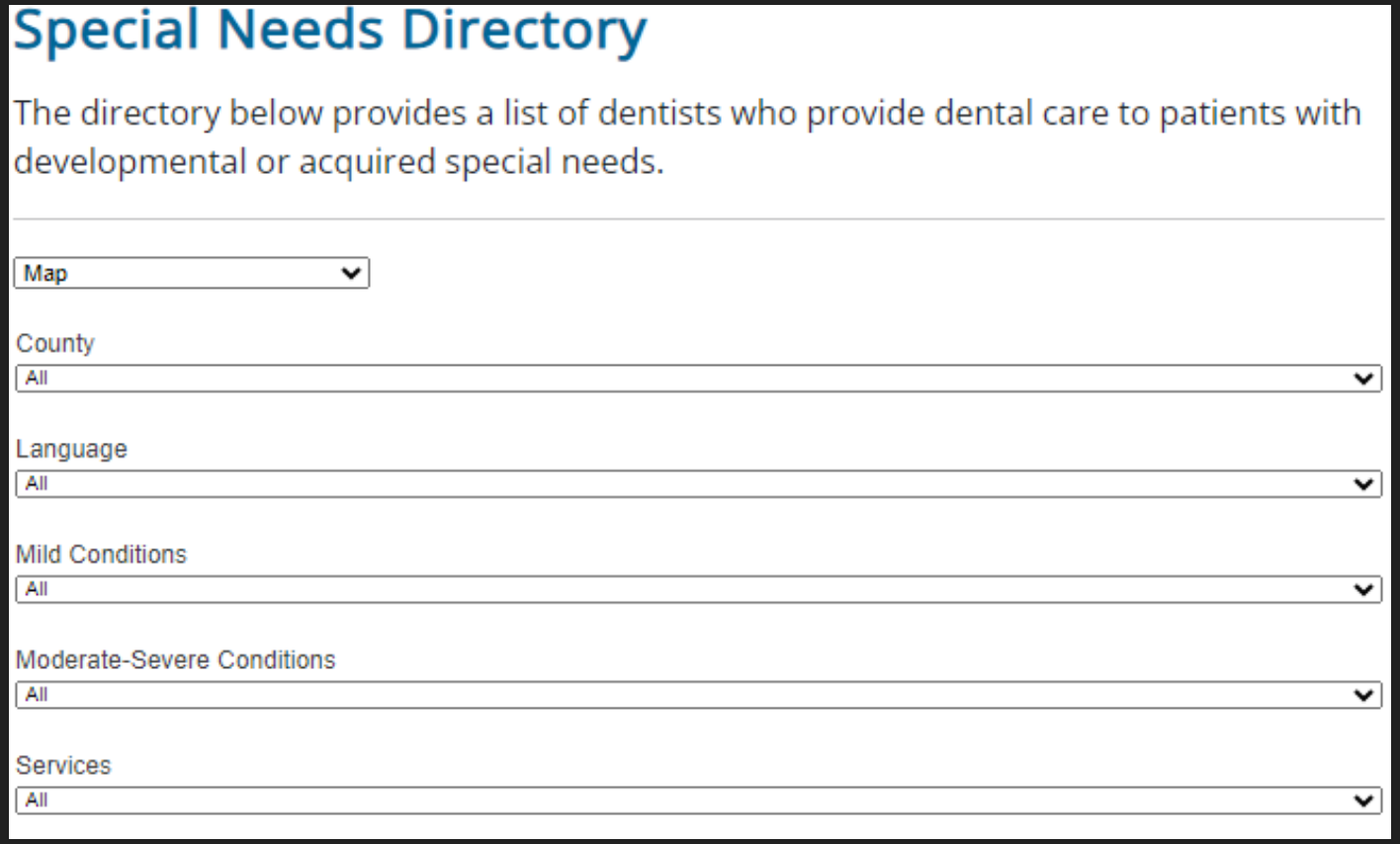


Create a Special Needs Dental Directory

- Evaluate integration of I/DD dental population resources and providers into GA Health Information Network. Recommend I/DD specific referral mechanisms and identify gaps.
- The directory should include search strategies that include:
  - 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

A list of specific qualifying conditions including but not limited to:

- Autism Spectrum Disorders
- Behavior/Learning Disorders
- Cerebral Palsy
- Down Syndrome/Intellectual disability
- Medically complex



Initial Recommendations

1. Create a Special Needs Dental directory.
2. Pilot a mobile dentistry program within DBHDD modeled after the successful Access Dental Care program in North Carolina.
3. Increase collaboration between DBHDD and DCG to ensure the exposure of dental students and residents 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 to receive continuing education credits for providing dental 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/Medicaid and DBHDD in assessing reimbursement avenues.
8. Recommend Medicaid reimbursement rates to be evaluated annually.

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Georgia Behavioral Health Reform and Innovation Commission

Medicaid – Social Determinants of Health Workgroup

Subchair Dr. Brenda Fitzgerald, M.D.,
Board Chair of Resilient Georgia

Social Determinates of Health (SDoH)

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 individual's 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.

Committee work

Through the five meetings held by the subcommittee between August and September, the following themes were discussed:

- Need for SDOH screenings in primary care
- Limited provider network for Medicare
- Need for Medicare to reimburse services that address SDOH
- Support for GHin

Recommendations

- Instate permanent funding for data system, staffing and referral system. Georgia is currently supporting the Georgia Health Information Network (GaHin).
- Include continued funding for CHADIS universal screening tools.
- Add additional reimbursement code approval for SDOH screenings by the Department of Community Health (DCH).

Georgia Behavioral Health Reform and Innovation Commission

IMD Waiver Workgroup

Subchair Dr. Brenda Fitzgerald, M.D.,

Board Chair of Resilient Georgia

Committee work

- Through the two meetings held by the subcommittee between August and October, the following themes were discussed:
  - Medicaid coverage for enrollees in Institutions for Mental Diseases
  - Overview of Institution for Mental Diseases in Georgia

Recommendations

- 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.

- Evaluate and assess alternative options to the IMD Waiver.

Georgia Behavioral Health Reform and Innovation Commission

Hospital and Short-Term Care Facilities Subcommittee

Subchair Dr. Brenda Fitzgerald, M.D.,
Board Chair of Resilient Georgia

Committee work

- Through the five meetings held by the subcommittee between June and October, the following themes were discussed:
  - Need for short-term treatment outside of immediate stabilization
  - Need for proper documentation
  - Insurance issues including coverage limits, authorizations, and network adequacy
  - Increase in discussion and advocacy for parity issues in the state

Mental Health Parity

- 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 years experts indicate that there are far greater parity violations than is currently being reported to the Insurance Commissioners Office or Department of Community Health.

Recommendations

- Create a third-party committee that helps to oversee parity violations.
- Allow providers and employers to report parity compliance issues.
- Mandate providers report parity compliance issues regularly to third party commission.
- Regular reporting on parity compliance should be made available on an accessible portal for patients, providers, and employers.
- Require regular patient and provider parity education.
- Create a more accessible process to report parity violations, including a qualifying assessment process.
- Create a client service position to assist individuals with reporting parity compliance issues.
- Create agency staffing assigned specifically for parity compliance.

Georgia Behavioral Health Reform and Innovation Commission

Children and Adolescent Behavioral Health Subcommittee

Subchair Dr. Eric Lewkowiez, M.D., M.S., DFAPA,
DFAACAP, Medical College of Georgia -Augusta University

Child and Adolescent Subcommittee Work

- Six meetings were held by the subcommittee between June 20th and November 7th, 2024, with the following themes discussed:
  - An update from the Georgia Department of Behavioral Health and Developmental Disabilities including updates on the Georgia APEX program, the MATCH program, and CCBHCs
  - Network adequacy and parity within the context of Children's Healthcare of Atlanta's Comprehensive Behavioral Healthcare plan
  - Addressing Children with Developmental Disabilities and Multiple Needs
  - Increasing Access to Mental Health Services at the Community Level
  - Mental Health Systems; Infant and Maternal Mental Health; Psychological Services for Medicaid Children and Families
  - Youth Mental Health Systems Change; School-Based Behavioral Health; Addressing Gaps in Therapeutic Care for Children and Adolescents

BHRIC Subcommittee on Children and Adolescents 2024 Recommendations

Addressing Children with Developmental Disabilities and Multiple Needs

- After hearing testimony from experts from DBHDD's MATCH Clinical Team, and residential treatment facilities in Georgia including Youth Villages and Devereaux, the committee identified 30 recommendations to address children with developmental disabilities such as Autism Spectrum Disorder, and co-occurring diagnoses. These recommendations address various ways to improve existing systems and programs in Georgia that serve children with multiple needs and aim to address all levels of intervention including prevention, early intervention, intervention, and late intervention.

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 contacted for services by state agencies.
- Allow approved DFCS foster families serving DD 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 the 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/or educational background.
- 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.
- Replicate what DBHDD is doing to professionalize DD 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.
- Add planned respite as an option for outpatient services.

Addressing Children with Developmental Disabilities and Multiple Needs (Cont.)

- Increase access to intense trauma focused care (residential and community-based) for 18 - 21 year-old adults and children in state.
- 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.
- Increase planned and crisis respite options for non DJJ/DFCS involved youth.
- Create/expand in state residential services for IDD/ASD diagnosed youth and/or those with co-occurring complex medical issues.
- Increase or expand intensive community-based therapeutic services; lack of availability of Intensive Family Interventions (IFI) across the footprint of the state.
- Expand minimum and maximum age ranges for PRTFs.
- Expand age ranges/services for ASD crisis services (CSU and crisis homes).
- Increase access to services for infant and early childhood especially as it pertains to Reactive Attachment Disorder (RAD) and attachment disorders.
- Increase access to specialized care for individuals exhibiting inappropriate sexual behaviors.
- Increase options to prove medical necessity for PRTF authorization when psychological evaluation is not available.
- Identify ways to increase housing/temporary shelter options for teens and families.

Addressing Children with Developmental Disabilities and Multiple Needs (Cont.)

- Identify ways to provide specialized childcare for families with children/teens with complex behavioral health concerns (BH/ASD/IDD).
- Develop a process for educating families on legal guardianship process for ASD/IDD individuals who are approaching 18.
- Identify and implement a follow-up process once recommendations are made at Match Clinical Team (MCT).
- Allow Match Clinical Team (MCT) the ability to access urgent care funds to create unique treatment options for complex individuals.
- Develop a process for an expedited contracting process for MATCH providers/pilots.
- Identify long-term capacity and sustainability for Match Clinical Team (MCT).
- Increase access to transportation to remove barriers to access healthcare.
- Provide family treatment while youth are in the PRTFs or CSUs.
- Create a system that includes intensive in-home services for families that need it the most.
- Continue to expand services under the state's Title IV-E Prevention Plan.
- Leverage existing mechanisms within the Medicaid system (flexibility under EPSDT or creation of ILOS definitions).
- Pursue a waiver (1115 or 1915b(3)) or a state plan amendment as a more long-term solution.

Network Adequacy and Parity

- The following three recommendations aim to address Georgia's compliance with HB 1013, to ensure the state is meeting parity requirements. These recommendations come to the subcommittee from the testimony of Children's Healthcare of Atlanta's (CHOA) Chief of Behavioral and Mental Health, Dr. John Constantino. They also align with recommendations from other subcommittees including the Hospital and Short-term Care committee.

Network Adequacy and Parity

- Shift reporting of parity violations from self-reporting to a mandatory reporting system that allows reporting of both individual and mass violations.
- Address reimbursement rate disparities for telehealth providers by a) subsidizing the implementation of tele-mental health services or b) working with partners to increase reimbursement rates.
- 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.

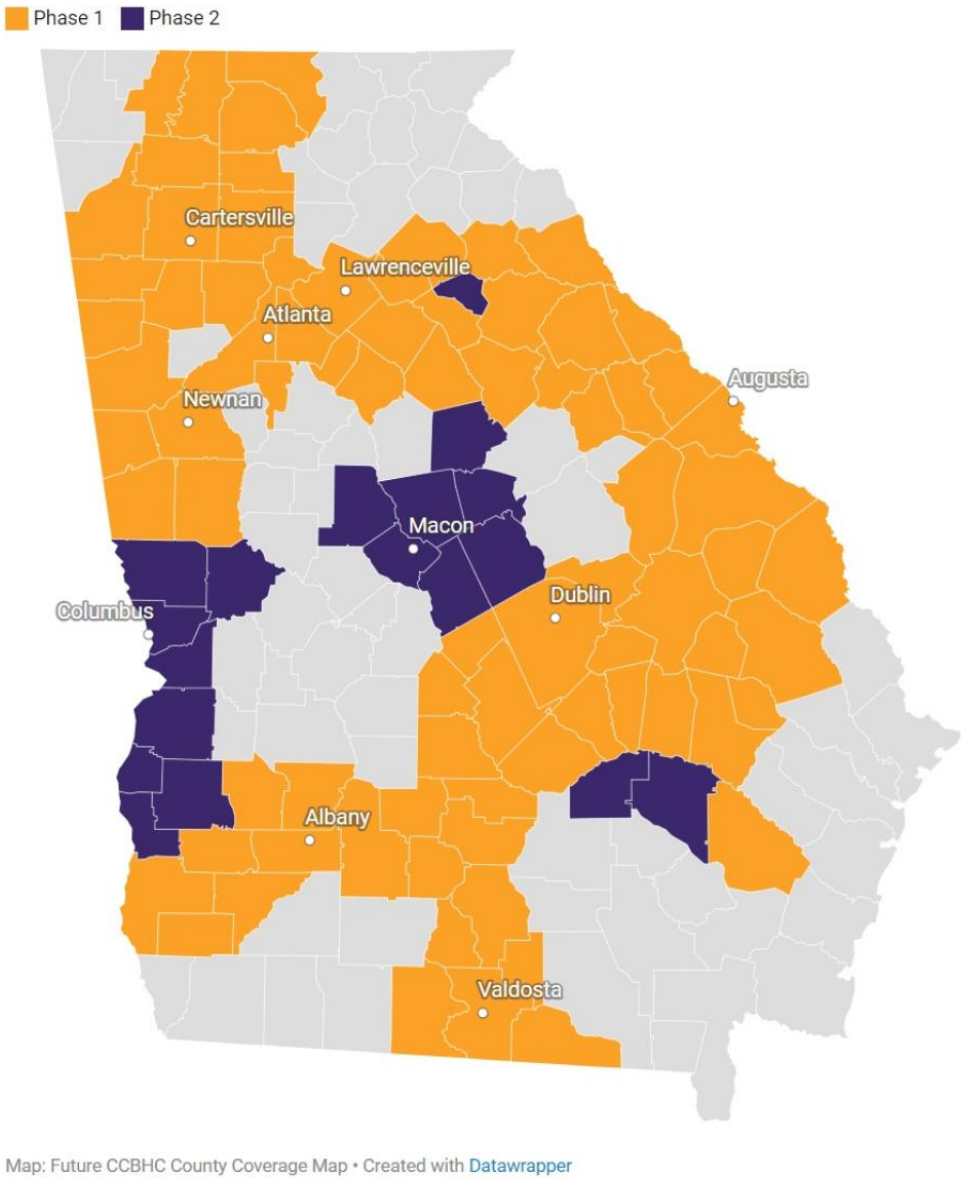
Increasing Access to Mental Health Systems at the Community Level

- The following three recommendations relate to increasing access to school-based services and Certified Community Behavioral Health Clinics (CCBHCs) in Georgia. These recommendations come from the testimony of experts in provision of community-based services including partners from Georgia HOPE and View Point Health.

Increasing Access to Mental Health Systems at the Community Level

- Increase outreach and education around the benefits of tele-mental health for school-based services; specifically, to school boards.
- 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.
- CCBHCs can utilize the Prospective Payment System which is a payment methodology designed to provide sustainable funding for CCBHCs.

- Counties highlighted in orange are in the **beginning** phase of the CCBHC process
- Counties highlighted in purple are in the **implementing** phase of the CCBHC process



Mental Health Systems

- The committee identified 7 recommendations to improve overall systems for mental health in Georgia. These recommendations relate to funding, workforce, ecosystem, and public information and come from the testimony of the Co-Founder of the Georgia Mental Health Policy Partnership, Roland Behm.

Mental Health Systems

- Invest in and collaborate with digital platforms that are offering Single Session Interventions to integrate local Georgia resources into the platforms.
- 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, 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.
- Evaluate implementing Managed Care Organization (MCO) tax funding.
- Implement "in lieu of service" (ILOS) Medicaid funding to support families receiving services.
- Consider dyadic services to support children 0-5 and their caregivers.
- 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.
- Invest in and create an online appointment scheduling and compliance tool that embeds an automated online claims denials appeal process.

Infant and Maternal Mental Health

- After hearing testimony from experts from Georgia Family Connection Partnership and 2Gen Family Integrated Care, the committee identified 8 recommendations to continue to improve infant and maternal mental health specifically related to babies and families who experience time in the NICU.

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.
- Include education during the prenatal period for families expecting a baby to the implications of premature birth and family leave..
- 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.
- Include coverage through the 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.
- Increase resources through private-public partnerships to support parental presence in the NICU.
- Expand implementation of NICU peer-to-peer support for all families with a priority focus on families experiencing substance use disorder.
- Expand implementation of family integrated relationship-based care with families of infants admitted to the NICU by investing in the 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.
- Require CMOs to reimburse obstetric and pediatric providers for maternal mental health screenings and referrals from the prenatal to postpartum period.

Psychological Services for Medicaid Children and Families

- The Georgia Psychological Association provided the committee with a recommendation to address Medicaid billing for psychologists, psychology interns and post-docs to increase access to psychological services for families enrolled in Medicaid.

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.

Youth Mental Health Systems Change

- The Georgia Mental Health Funders Collaborative shared five recommendations with the committee. Their recommendations were developed from informant interviews, focus groups, feedback and interaction; advocates, providers, public systems, and philanthropy were engaged. Their recommendations aim to increase the understanding of the youth mental health crisis and GA and the actions that can be taken to address it.

Youth Mental Health Systems Change

- Make it easier to qualify for care by reimagining access criteria and linking eligibility to the true drivers of the youth mental health crisis.
- Meet children and families where they are by providing mental health services at pediatric appointments, churches, and schools and treat parents with their children.
- Develop, retain, and expand the workforce by increasing access by supporting existing MH staff, streamlining processes for paneling and credentialing, and expanding provider classes.
- 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.
- Pursue the federal matching dollars to maximize matching funds and formally require CMO accountability.

School-Based Behavioral Health

- The School Based Behavioral Health Collaborative, which involves the Carter Center, Georgia Appleseed, Resilient GA, and Voices for Georgia's Children identified several recommendations for the committee to consider to expand and improve school-based behavioral health programs in GA.

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.
- Expand the school healthcare workforce to meet the needs of GA's children – increase the number of school nurses.
- Ensure GA Medicaid and CMOs cover services provided in schools (both in person and through telehealth).
- Enforce parity by ensuring all provider types can be reimbursed at the appropriate rate and in a timely fashion.
- Support mental health awareness by continuing to train teachers and other educators.
- Increase awareness and funding of proven tools, such as PBIS, Positive School Climate and the Georgia Student Health Survey that are important for prevention and intervention and program evaluations.

Addressing Gaps in Therapeutic Care for Children and Adolescents

- After hearing testimony from Dr. Jordan Murphy, the CEO of the Center for Inter-relational Science and Pediatrics, the committee identified three recommendations to improve therapeutic care for youth across all levels of care.

Addressing Gaps in Therapeutic Care for Children and Adolescents

- Expand prevention and early intervention approaches that are proven to be effective.
- Provide additional training, technical assistance, and support for community health workers, peer support specialists, paraprofessionals, and health care providers.
- Address practice and reimbursement barriers for mental health services delivered by primary care providers.
- Include social determinants of health and mental health when developing delivery systems.

Top Ten Priority Recommendations

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.

Top Ten Priority Recommendations

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.

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.

Top Ten Priority Recommendations

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.

Georgia Behavioral Health Reform and Innovation Commission

Involuntary Commitment

Subchair Judge Sarah Harris,
Probate Court Judge, Macon/Bibb

Committee Work

- Through two meetings held by the subcommittee between August and October, the following items were discussed:
  - Shortage of psychiatrists and psychologists to perform AOT evaluations
    - Possibility of nurse practitioners being added to the list of approved clinicians
    - Possibility of developing a credentialing program for certified AOT examiners
  - Continuing to evaluate AOT as a diversion option for individuals with high mental health needs
  - Enhancing options for non-law enforcement transportation of individuals experiencing psychiatric crisis
  - The processes guiding the development and issuance of orders to apprehend in probate courts

Recommendations

- 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.
  - 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 one 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.

Georgia Behavioral Health Reform and Innovation Commission

Workforce and System Development Subcommittee

Subchair Rep. Mary Margaret Oliver, District 82

Workforce Issue in Georgia

- Georgia faces severe workforce shortage issues with 989 geographic areas considered mental health professional shortage areas as of October 2024. These shortages are largely exacerbated by barriers to obtaining licenses; especially for providers who are internationally trained, low reimbursement rates, and inadequate recognition of behavioral healthcare interns and post-docs.

- Fostering a strong behavioral health workforce is critical to the continued effort of implementing parity in Georgia by increasing access to care

Subcommittee Work

The Workforce and Systems Development subcommittee held two public meetings between July 30th and October 21st, 2024. The following themes were discussed:

- Behavioral health licensure and reimbursement issues specifically related to internationally licensed providers
- Workforce data collection
- Loan forgiveness for behavioral health professionals
- Growing a skilled and robust behavioral healthcare workforce

Recommendations

Licensure

- Coordinate recommendations from other study committees on licensure, such as the Blue-Ribbon Commission
- Continue efforts to improve out-of-state licensure reciprocity and use of existing interstate compacts
- Enhance opportunities for internationally trained behavioral health professionals
- Modernize the licensing process

Recommendations

Grow a Skilled and Robust Behavioral Healthcare Workforce

- Look at flexible scheduling and benefits for staffing
- Amend Georgia's Medicaid State Plan to maximize eligible services and utilize providers in training
- Invest in the peer support workforce
- Continue efforts around loan repayment assistance programs for mental health and substance use professionals
- Invest in innovative workforce solutions such as the use of digital Single Session Interventions to help youth connect with the local services they may need

Recommendations

Evaluate Programs, Practices, and Polices

- Evaluate modifications of barriers to practice for APRNs and PAs in Georgia
- Evaluate legislative actions taken

Georgia Behavioral Health Reform and Innovation Commission

Forensic Competency Advisory Committee

Subchair Judge Kathlene Gosselin,
Superior Court Judge, Hall County

Committee work

- Through five meetings held by the subcommittee between May and October, the following items were discussed:
  - The need for alternatives to traditional hospital-based competency evaluation and restoration
    - Jail based alternatives
    - Community based alternatives
  - The need for diversion alternatives to processing through the legal system for individuals with high mental health needs who are charged with misdemeanors
    - Avoiding unintended consequences of such alternatives
  - Adjustments to the law to establish parameters for nonviolent misdemeanor restoration
    - Adjustments to restoration processes
    - Additional judicial processes to assure that competency is the appropriate process

Recommendations

- Recommend that a judge will hold an initial hearing regarding defense requests for the competency process, including procedures to provide guidance to the court and alternatives suggestions for the defense.
- Recommend adjustments to restoration processes:
  - 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).
  - 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.
  - 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.
- Recommend that next year's work focus on the needs of individuals with cognitive and developmental disorders in relation to the competency process