
A Unified Vision for Transforming Mental Health and Substance Use Care in Georgia

GEORGIA MENTAL HEALTH
POLICY PARTNERSHIP

JULY 25, 2022

Georgia Mental Health Policy Partnership: United for Behavioral Health

The Georgia Mental Health Policy Partnership (GMHPP) consists of organizations from across the state, including the largest group of peer-led organizations in Georgia. GMHPP represents millions of Georgians, both those with lived experience of mental illness and substance misuse, as well as families, friends, and allies. It is united in support of equal access to behavioral health care, eliminating the stigma of mental illness and substance use, and creating caring, compassionate, and connected communities that support all Georgians..

The term “behavioral health” is used in this document. It is a broader term than “mental health,” and encompasses persons with addiction, ADHD or learning disabilities, anxiety, depression, eating disorders, grief, mood disorders, relationship problems, stress, thought disorders, and other psychological concerns.

A Golden Opportunity

Georgia is engaged in a multiyear process of transforming the state’s behavioral health care system. It is a process that builds on the passage of multiple bills addressing behavioral health issues during the 2022 Session of the Georgia General Assembly, including the unanimous passage of the Georgia Mental Health Parity Act (HB 1013) by both House and Senate. GHMPP is committed to collectively working with stakeholders over the coming years to create a behavioral health care system worthy of all Georgians..

Contents



- Preface
- Goal
- Foundational Elements
- Early Identification and Prevention
- Workforce
- Parity
- Integrated Care
- Community-Based Care
- Peer Support
- Emergency Crisis and Response
- Behavioral Health Care Equity
- Standards

Preface

Behavioral health affects every aspect of our lives: how we feel about ourselves and the world; solve problems, cope with stress, and overcome challenges; build relationships and connect with others; and perform in school, at work, and throughout life.

At any one time, a diverse set of individual, family, community and structural factors may combine to protect or undermine our behavioral health and shift our position on the behavioral health continuum.

Although most people are remarkably resilient, people who are exposed to unfavorable circumstances – including poverty, violence, and inequality – are at higher risk of experiencing behavioral health conditions.

Behavioral health risks can manifest themselves at all stages of life, but those that occur during developmentally sensitive periods, especially early childhood, are particularly detrimental.

Behavioral health protective factors similarly occur throughout our lives and serve to strengthen resilience. They include our individual social and emotional skills and attributes as well as positive social interactions, quality education, decent work, safe neighborhoods and community cohesion.

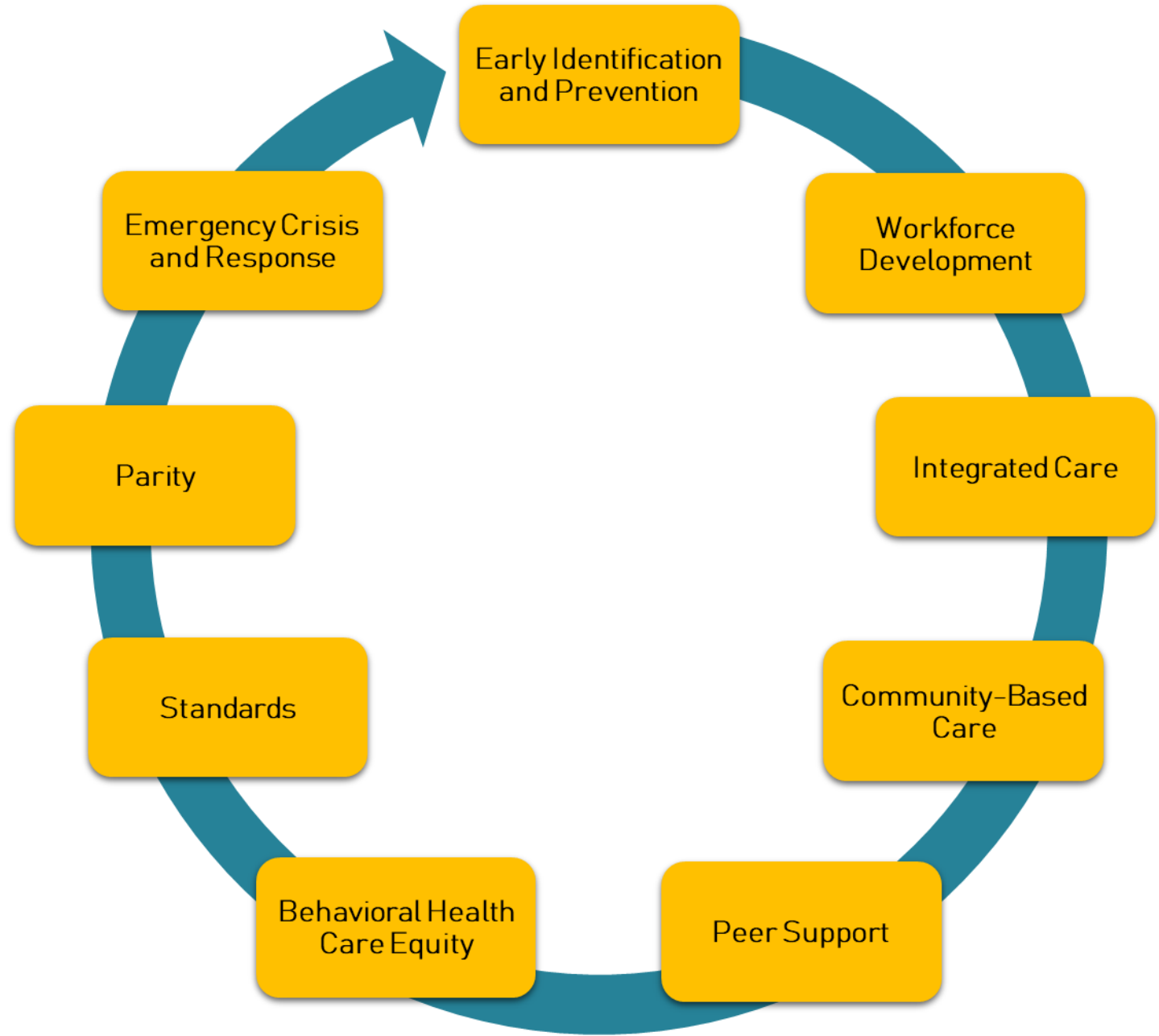
GOAL: Improve the lives of people with mental health and substance use conditions through a transformed system of care

HOW?

- Fundamentally **shift perceptions** around behavioral health and well-being through education and stigma reduction
- **Improve access** to behavioral care by increasing the number of in-network behavioral health care providers, enhancing use of telehealth, and strong parity accountability
- **Integrate care** and ensure people can receive the services and support they need, when and where they need them
- **Address population health** through prevention, promotion, and recovery efforts that incorporate social determinants of health including housing, transportation, and employment
- **Advance health equity** to address geographic, socioeconomic, and racial inequities in care and disparities in behavioral health outcomes so that all Georgians have equal access to care
- **Drive accountability** to quality standards in order to improve health outcomes and quality of life for people with behavioral health conditions

Unified Vision

Foundational Elements



Early Identification and Prevention

Early identification and prevention efforts can alleviate suffering for young people and their families. Early intervention is proven to be clinically effective and to reduce aggregate health care costs.

Insufficient sleep among children and adolescents is associated with an increased risk for obesity, diabetes, injuries, poor mental health, attention and behavior problems, and poor academic performance. .



Wheaton AG, Jones SE, Cooper AC, Croft JB. Short Sleep Duration Among Middle School and High School Students — United States, 2015. MMWR Morb Mortal Wkly Rep 2018;67:85-90

Sleep loss is fixable by actions that include: (A) setting later middle school and high school start times, (B) maintaining a consistent sleep schedule during the school week and weekends, and (C) limiting permitted use of electronic devices in terms of time (e.g., only before a specific time, and place (e.g., not in their child's bedroom)

➤ Require K-12 schools to establish school-based plans and toolkits that (A) help eligible students and family members enroll in health insurance, (B) provide behavioral health screenings, (C) establish suicide risk referral protocols, (D) expand behavioral health literacy, (E) expand reimbursable health services in schools, (F) expand services for at-risk students, and (G) promote healthy school practices through nutrition, physical activity, and health education,.

➤ Rigorously evaluate APEX and expand the program to other schools if the evaluation is positive

➤ Increase First Episode Psychosis treatment initiatives (3 in 100 persons affected)

➤ Expand statewide trauma-informed training for staff in all settings where children receive services

For U.S. high school students as of the first half of 2021

44 percent report persistent feelings of sadness and hopelessness

37 percent report experiencing poor mental health

9 percent report having attempted suicide

Source: CDC

For Georgia high school students in 2021

45 percent report experiencing intense anxiety, worries or fears that get in the way of their daily activities

40 percent report feeling depressed, sad, or withdrawn one or more times over the past 30 days

11 percent report harming themselves on purpose one or more times in the past year

Source: Georgia Student Health Survey (DoE)

Mental health problems in youth are **often associated with other behavioral health risks** such as drug use, experiencing violence, and higher risk sexual behaviors. And these problems can have lasting negative effects well into adulthood.

Why Early Intervention?

Percentage of Individuals with Onset of Behavioral Health Conditions On or Before Ages 14, 18, and 25, and Peak Age at Onset

Symptom Onset	<= 14	<= 18	<= 25	Peak Age at Onset
Anxiety/fear-related disorders	38.1%	51.8%	73.3%	5.5 years
Feeding/eating disorders	15.8%	48.1%	82.4%	15.5 years
Mood disorders	2.5%	11.5%	34.5%	20.5 years
Neurodevelopmental disorders	61.5%	83.2%	95.8%	5.5 years
Obsessive-compulsive/related disorders	24.6%	45.1%	64.0%	14.5 years
Personality disorders/related traits	1.9%	9.6%	47.7%	20.5 years
Schizophrenia disorders/primary psychotic states	3%	12.3%	47.8%	20.5 years
Stress disorders	16.9%	27.6%	43.1%	15.5 years
Substance use disorders/addictive behaviors	2.9%	15.2%	48.8%	19.5 years
Behavioral disorders (aggregated)	34.6%	48.4%	62.5%	14.5 years

On average, more than 10 years elapse between the first symptom and a diagnosis of a mental disorder.

Workforce

In discussing any behavioral health care workforce shortage in Georgia, one must distinguish between: (A) the overall number of behavioral health care professionals in the state, and (B) the overall number of behavioral health care professionals that are part of insurer networks. The latter number is significantly less than the former, meaning that in large part the “workforce shortage is an artificial construct of the insurers”

One must also distinguish between the amount of time existing in-network professionals spend on providing care to Georgians and the amount of time they spend on “insurer bureaucracy.” The more time spent on bureaucracy, the less time spent on care.

Finally, one must distinguish between real and artificial barriers to behavioral health care practice (e.g., “guild rules”)

- Hold public and private insurers accountable for having adequate networks of behavioral health by requiring market-based reimbursement rates(see next slide).
- Allow health care providers to offer a range of care fully consistent with their education and training.(see yellow box below)
- Improve provider efficiency by use of single audit (see box below)
- Increase access to culturally and linguistically appropriate care

Less time spent on administrative and bureaucratic activities by behavioral health professionals is more time spent on care for Georgians in need. For example, behavioral health care professionals are subject to audits by each payer (insurer) from whom they receive reimbursement. Most professionals are in-network at multiple payers. The time spent responding to multiple audits is time that could be spent on providing care. A single audit used by all payers results in more care and reduces payers' costs.

Provider Network Adequacy

The Georgia Mental Health Parity Act (HB 1013) went into effect on July 1, 2022, and the biggest change that can be demanded of Georgia's insurers as a result of the act is the expansion of their provider networks to include many more behavioral health providers.

While little can be done in the short-term to address the difference between **Overall Demand** and **Overall Supply**, much can be done by insurers to quickly fill the **Provider Gap**.

Many behavioral health care providers do not take insurance due to factors that include below market reimbursement rates, bureaucracy, and interference in the doctor/patient relationship..



A study by the actuarial firm Milliman found that behavioral health professionals in Georgia were paid **37% less** than general health professionals providing comparable care (as determined by Medicare codes). In a state where there is a high demand for, and low supply of, mental health professionals, it is no surprise that Georgia mental health professionals are uninterested in working for substantially below market compensation.

Insurers can directly address the **Provider Gap** and **Payment Gap** on their own, and they must in order to comply with the Mental Health Parity Act. As it currently stands, far too many Georgians with insurance are forced to go out of network for behavioral health care, **that is if they can afford to do so**. Georgians lacking resources to pay out-of-pocket must forgo needed health care, with possible **life-threatening consequences**

10x

Children are **10 times more likely** to receive outpatient mental health care **out of network** compared to primary care visits

Parity (a Georgian-centered approach to care and coverage)

Insured Georgians have significantly greater difficulty accessing behavioral health care than accessing other types of medical care. Insurance companies impose limitations, both quantitative and non-quantitative, on accessing mental health benefits that delay or deny access to mental health care in violation of their legal and contractual parity obligations. A significant element in insurers' parity violations rests with their inadequate networks of behavioral health care providers.

Listed below are actions to be taken, in addition to full and timely implementation of the parity obligations under HB 1013 by the Department of Community Health (DCH) and Office of Insurance and Safety Fire Commissioner (DOI).,

- Fund and implement a statewide marketing campaign to educate Georgians on their parity rights..
- Implement additional network adequacy measures for insurers/CMOs, including (1) minimum provider to enrollee ratios, (2) minimum percentages of contracted providers accepting new patients, and (3) provider choice (at least 2 providers),
- Establish and implement (1) monitoring plans for determining insurer/CMO network adequacy and (2) network adequacy enforcement plans (i.e., no new enrollees in regions where network is inadequate)
- Include comparison of insurer-created provider directories with constructed directories based on actual claims in data calls and comparative analyses provided by insurers to DOI and DCH pursuant to HB 1013 (see next slide).
- Establish an independent process that provides both online search and scheduling of appointment sand real time compliance information regarding insurer/CMO compliance with network adequacy requirements

Inaccurate Directories and Phantom Providers

A study found that in California, the percentages of accurate directory listings were 68.48% for endocrinology, 72.36% for gastroenterology, 72.46% for cardiology, and 74.54% for primary care.

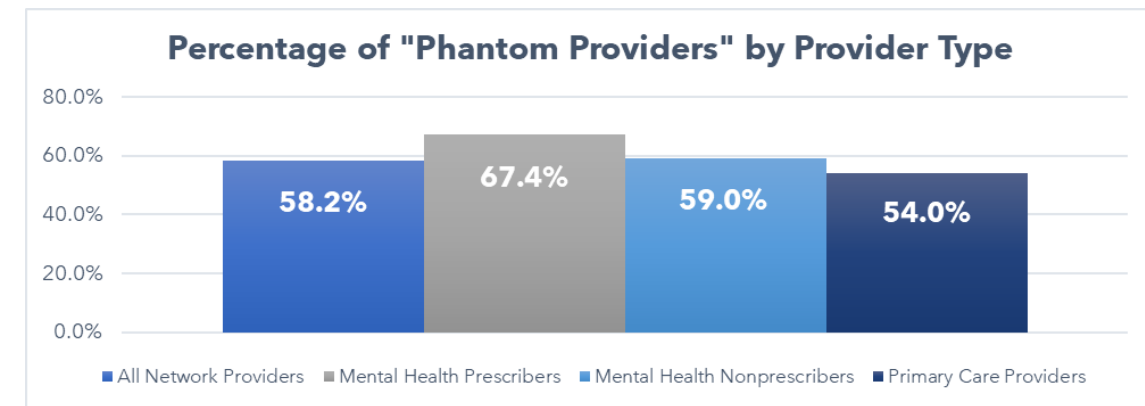
Directory inaccuracies are more than a mere inconvenience for consumers, with the potential to cause significant consequences for consumers' well-being and finances.

They may force consumers to either delay needed health care or forgo it entirely if they are unable to overcome the often cumulative limitations imposed by incorrect phone numbers and addresses as well as the listing of providers who are not actually in network, not currently seeing patients, or not accepting new patients.

Consumers may also face instances of "coerced billing," when they knowingly receive out-of-network care because, despite their best efforts, they cannot find appointments at an in-network provider or because they reside in an artificial provider desert created by the carrier's insufficient network

Source: Burman A, Haeder SF. Potemkin protections: assessing provider directory accuracy and timely access for four specialties in California. *J Health Polit Policy Law.* 2022;47(3): 319–49

A July 2022 research article found significant discrepancies between behavioral health providers listed in 2018 Oregon Medicaid directories and those whom enrollees were able to access. Between one-half to two-thirds of the providers listed in the directories were not actively providing care for Medicaid enrollees..



J. Zhu, C. Charlesworth, D. Polsky, and K. McConnell, *Phantom Networks: Discrepancies Between Reported And Realized Mental Health Care Access In Oregon Medicaid*, *Health Aff (Millwood)*. 2022 Jul;41(7):1013–1022.

The discrepancies demonstrate the failure by Medicaid managed care organizations to comply with their legal obligations to establish and maintain adequate networks of behavioral health providers

Integrated Care

Individuals with chronic behavioral health conditions die on average more than 20 years earlier than the general population. This is due to the frequent co-occurrence of physical and mental health challenges.

Persons providing Integrated behavioral health care and supports work together as a team to address a person's concerns. Care is delivered by these integrated teams in a primary care setting unless there is a need for specialty services. The advantage is better coordination and communication, while working toward one set of overall health goals.

In rural areas, Federally Qualified Health Centers (FQHCs) provide a comprehensive set of health services including primary care, behavioral health, chronic disease management, preventive care, and other specialty services. FQHCs are outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid

- Develop and implement integrated treatments for co-occurring addiction and mental illness ([see next slide](#))
- Encourage student-led Co-Occurring Disorder Awareness (CODA) clubs ([see next slide](#))
- Support implementation of integrated care grant program under HB 132 to address and improve integrated care and services where there are work force shortages
- Increase the number and capacity of FHQCs in Georgia
- Incentivize co-location of behavioral health clinicians in primary care centers and vice versa.
- Encourage the use of behavioral health screening tools in primary care centers and vice versa

Co-Occurring Disorder Awareness

Addiction and Mental Illness

Substance use is especially dangerous for people with mental health conditions. They are much more likely to become addicted and face a higher risk of overdose and other bad outcomes when they do.

The problem is that too many systems treat people who suffer from both mental health and substance use disorders (referred to as co-occurring disorders) as the exception, when in fact they are the rule.

They make up more than half of all people who seek treatment for one condition or the other. And it's crucial for them to be managed together, especially in teenagers whose brains are still developing, because they tend to amplify one another.

Individuals with co-occurring mental illnesses and substance use disorders experience greater functional impairment, with greater negative outcomes, than people diagnosed with a single disorder. Moreover, youth and young adults specifically diagnosed with these co-occurring disorders are at increased risk of suicidal ideation and attempts, failure to graduate high school on time, and early pregnancy compared to others without a disorder or those with one disorder.

ENCOMPASS is an outpatient treatment for youth and young adults with mental illness and addiction.. The treatment involves weekly talk therapy supplemented by psychiatric and anti-addiction medications when appropriate. Clinicians regularly assess mental health and substance use so that they can adjust treatment plans as needed.

The goal of ENCOMPASS is to start treating addiction and mental illness like the chronic conditions they are..

Student-led CODA Clubs (co-occurring disorder awareness) clubs have formed in high schools and are dedicated to improving the lives of peers diagnosed with mental illness and addiction.



Community-Based Care

A robust system of community-based care is at the heart of behavioral health transformation in Georgia. Community-based care is a person-centered, recovery-based approach that ensures all people have access to both a range of interconnected services that deliver behavioral health care, as well as necessary social services.

Community-based care is more accessible and acceptable than institutional care. It respects individual agency and autonomy, delivers better recovery outcomes for people with behavioral health conditions, supports community reintegration, and improves quality of life.

The locus of care for behavioral health conditions must shift from hospitals, jails, and prisons towards community-based behavioral health services. At the same time, care for common conditions such as depression and anxiety must be scaled up. Both strategies are critical to improve the coverage and quality of behavioral health care in Georgia's communities.

- Expand the use of Recovery Community Organizations ([see next slide](#))
- Encouraging compliance by Georgia with the Supreme Court's Olmstead decision and related settlement agreement requiring the state to (A) place qualified persons with disabilities in the least-restrictive settings (e.g., in community), (B) establish a waiting list of community-based services that ensures people can receive services and be moved off the list at a reasonable pace, and (C) address issues including affordable and accessible housing, transportation and work force development for persons with disabilities.

Expand the Use of Recovery Community Organizations

A Recovery Community Organization (RCO) is an independent, non-profit organization led and governed by representatives of local communities of recovery. Georgia has only 40 RCOs – in 159 counties.

RCOs support and provide SBIRT (screening, brief intervention and referral to treatment) services, a comprehensive, integrated, public health approach for early identification and intervention with patients whose patterns of alcohol and/or drug use put their health at risk. RCOs do not provide clinical services

RCOs organize local advocacy activities, carry out recovery-focused community education and outreach programs, and provide peer-based recovery support services..

RCOs routinely engage people in recovery, their families, and other stakeholders in a participatory process of program decision-making and conducting activities.

RCOs help create caring, compassionate, and connected communities that are critical to recovery and sustained behavioral health.

RCOs

- Are led and governed by local people in recovery
- Respect and support all pathways of recovery
- Develop and support local resources and leaders
- Have their own governing boards and mission statements focusing on peer-led recovery
- Maintain an open feedback loop to support working together
- Develop local awareness of the recovery movement and local behavioral health services.



Peer Support

In behavioral health, a peer is usually used to refer to someone who shares the experience of living with a psychiatric disorder and/or addiction.

Peers are living proof that recovery is possible; and they have a vital role in supporting other people with behavioral health conditions in their recovery. Peer support is a critical element of community-based care – a person-centered, recovery-based approach that ensures all people have access to both a range of interconnected services that deliver behavioral health care, as well as necessary social services.

Social and informal supports delivered by peers complement formal services and are vital to ensure enabling environments for people with behavioral health conditions.

Peer-led networks and organizations have a key role in enabling people with lived experience to engage with their care. Such networks can be a vital source of mutual support for behavioral health service users. They supply encouragement, resources and formal infrastructure for the systemic advocacy and self-advocacy that is needed to facilitate change.

- Grow peer workforce programs – e.g., CPS and CARES – and expand payer reimbursement for certified peer support services.
- Expand number of behavioral health community service centers, as well as increasing respite care and peer support service locations

Emergency and Crisis Response

All Georgians in crisis should receive a humane response that treats them with dignity and respects their right to self-determination..

Carceral responses, like involuntary committal and jail awaiting evaluation and rights restoration, must be choices of last resort.

Community-based care funding must be increased, and emergency response must provide the person in crisis with as much agency and freedom as possible.



- Implement fully the 988 number and crisis response system, including culturally and linguistically responsive and accessible services for Georgia's increasingly diverse population, together with implementation of co-responder models
- Support and facilitate Stepping Up initiatives in Georgia's counties (see next slide)
- Establish Medicaid state plan option to cover short-term acute care across a continuum of settings, while also improving step-down and step-up transitions and access to outpatient treatment
- Encourage people with known behavioral health challenges to prepare advance directives or what types of treatment they want and don't want in a time of crisis. Prepare them when not in crisis and share with appropriate family and friends. .

Stepping Up in Georgia

Approximately **2 million** times each year, people who have mental illnesses are admitted to jails across the nation. Almost **three-quarters** of these adults also have substance use disorders. Once incarcerated, individuals with mental illnesses tend to **stay longer** in jail and, upon release, are at a **higher risk** of returning to incarceration than people without these illnesses.

The [Stepping Up Initiative](#) seeks to bolster cross-systems collaboration and build out community-based services and supports to reduce incarceration and reincarceration, respond effectively to people in crisis, and ultimately prevent contact with the justice system in the first place.

Equipped with accurate and accessible data on the prevalence of mental illness and substance use disorders in their local jails, counties can effectively match people to appropriate services and supports that help address their needs and reduce their likelihood of reoffending.

- Educate county governments and supporting organizations about the Stepping Up Initiative and Innovator Counties in Georgia
- Partner with Stepping Up Initiative to develop and implement statewide support for counties, including working with one or more University System of Georgia member institutions
- Ensure emergency and crisis response systems are culturally and linguistically responsive and accessible to Georgia's increasingly diverse population.

13 counties in Georgia implement elements of the Stepping Up Initiative: Carroll, Chatham, Clarke, DeKalb, Dougherty, Douglas, Floyd, Forsyth, Fulton, Newton, Richmond, Rockdale, and Union.

The Stepping Up initiative is a partnership of The Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation.

Behavioral Health Care Equity

Advancing behavioral health care equity involves ensuring that all Georgians have a fair and just opportunity to lead healthy and fulfilling lives.

Under Georgia's constitution "[p]rotection to person . . . is the paramount duty of government and shall be impartial and complete, No person shall be denied the equal protection of the laws,".

Yet many Georgians struggle to obtain adequate health care. Racial and ethnic minorities, low-income groups, persons in correctional facilities, and members of the LGBTQ+ community are disproportionately exposed to a combination of health risks, such as poverty, violence, unsafe living conditions, and environmental health hazards, that increase the need for health care interventions....

- Expand access to behavioral health care for low-income Georgians by reducing the number of Georgians without health insurance
- Seek 1115 waiver to allow a portion of Medicaid funding to be used to address social determinants of health
- Expand access to behavioral health care for justice-involved populations, including addressing the significant jail wait times for persons awaiting competency evaluations (**see next slide**)
- Expand offerings of culturally and linguistically appropriate services (CLAS) and cultural awareness and diversity training – 1 in 10 Georgians are foreign-born.
- Expand access to behavioral health care in rural and other underserved communities through mobile health clinics or telehealth initiatives..
- Expand the talent pipeline to build a more diverse professional workforce

Competency Evaluation and Restoration Services

More than 870 persons in Georgia are awaiting evaluations to determine their competency to stand trial on criminal charges. More than 350 persons in Georgia are awaiting mental health competency restoration services so that they may then stand trial.

The period between arrest and competency evaluation is measured is several months, and the time between evaluation and competency restoration services is around **ten months**

While awaiting either evaluation or restoration services, persons are incarcerated in local or county jails, and the length of their incarceration – before any trial is held – may exceed the maximum length of their sentence had they been convicted.

On May 8, 2022, a lawsuit was filed against Indiana asserting that it has grossly insufficient capacity to provide competency restoration services. Defendants are held in jail for months and the resulting improper confinement violates due process, the Americans with Disabilities Act, and the Rehabilitation Act.

In April 2015, a U.S. District Court found that a Washington State agency was taking too long to provide competency evaluation and restoration services and ordered that they take place within **14** and **7** days, respectively.

The Court later found the agency in contempt for failing to meet those timelines and imposed fines which ultimately totaled over **\$80 million**.

Washington entered into a settlement agreement to resolve the lawsuit by creating a plan delivering an array of services for class members and potential class members (e.g., **those persons arrested who need competency evaluations and, potentially, restorative services**)..

The agreement includes expanding residential mental health with crisis services; additional training for jail staff and law enforcement; hiring additional forensic navigators and more mental health professionals to educate courts about the availability of supports that could meet the needs of individuals who have to wait in jail for evaluation and restoration services.

Standards

Organizations, systems, and persons must be held accountable to quality standards in order to improve health outcomes and quality of life for people with behavioral health conditions,

Quality standards need to address elements as varied as the safety, effectiveness, and timeliness of treatment, case review practices (case review with a supervisor and case review by an appointed quality review committee), and the continuing education of health care professionals,

Quality measures address many parts of healthcare, including health outcomes, clinical processes, patient safety, efficient use of healthcare resources, care, coordination, patient engagement in their own care, patient perceptions of their care, and population and public health achievements.

- DHS to Implement core set measurements including, the CAHPS survey, and the MLTSS measure set for Georgia's Medicaid and PeachCare programs.
- **DHS to actively engage on an annual basis to determine whether Georgia CMOs are implementing appeal and grievance systems as required by 42 CFR § 438.66(a)**
- Implement national culturally and linguistically appropriate services standards and evaluate access to such services.
- Develop public-facing scorecards allowing Georgians to compare the quality and evidence base of health plans and MH/SUD facilities
- Implement program fidelity reviews to ensure compliance with legislative purpose:
- Operationalize the Georgia Student Health Survey (DoE) data, for use by stakeholders, decisionmakers, and Georgia citizens..
- Expand statewide trauma-informed knowledge base and services

Improve Oversight of Medicaid and PeachCare Programs

On July 6, 2022, CMS unveiled a suite of new resources to improve oversight of Medicaid and Children's Health Insurance Program (CHIP) managed care programs.. Released in a [Center for Medicaid and CHIP Services Informational Bulletin](#) (CIB), the new resources include tools, templates, and updates on tactics to improve states reporting on their managed care programs.

The CIB provides an update to the new web-based portal for state reporting on managed care programs to CMS. It also offers additional reporting templates and a new technical assistance toolkit, to help states improve their overall monitoring and oversight of managed care. The templates provide a standard format for states to report managed care medical loss ratios (MLRs) and network adequacy to CMS.

To promote transparency in Medicaid and PeachCare, the CIB reminds states of the requirement to post their Network Adequacy and Access Assurances reports on a state website for each program they operate.

The CIB includes a reminder that existing CMS regulations require states to publish their network adequacy standards on their state operated website. Additionally, states are required to post the documentation on which it based its assurance of compliance of availability and accessibility of services to CMS.

The July 6, 2022 CIB builds on a June 2021 informational bulletin, which provided a reporting template for the Annual Managed Care Program Report, announced the development of the web-based reporting portal, and released two technical assistance toolkits related to quality and behavioral health network adequacy for state use.