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

Georgia Mental Health Policy Partnership

July 2023

Georgia Mental Health Policy Partnership Goal

Improve the lives of Georgians with behavioral health conditions through a transformed system of care

- 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 are needed
- **Address population health** through prevention, promotion, and recovery efforts that incorporate social determinants of health including food, housing, transportation, and employment
- **Advance health equity** to eliminate disparities in behavioral health outcomes so that all Georgians have equal access to care, regardless of their race, ethnicity, language, gender, sexual orientation, socioeconomic status or geographic location.
- **Drive accountability** to quality standards in order to improve health outcomes and quality of life for people with behavioral health conditions

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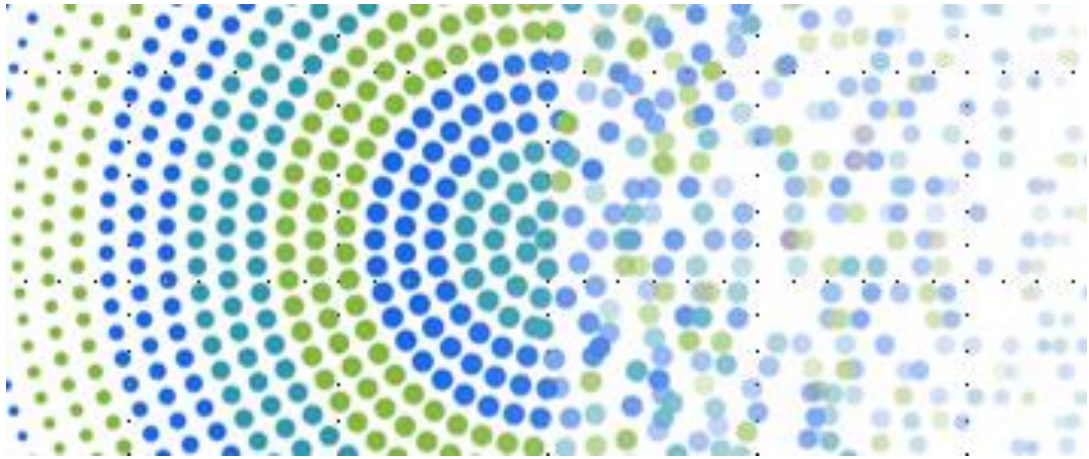
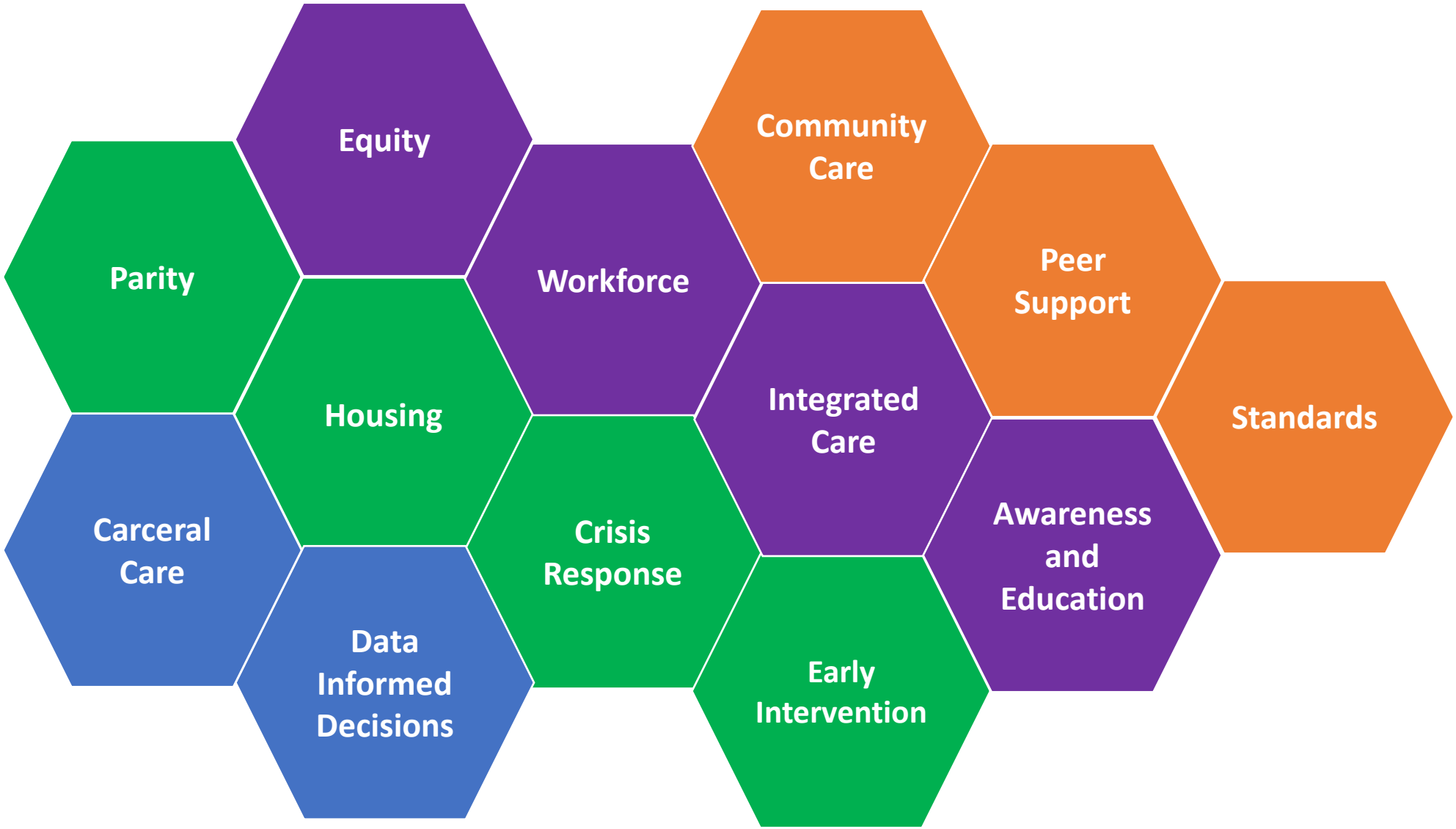


Unified Vision

Foundational Elements



More Healthcare for Georgians at No Additional Taxpayer Cost

Georgia Medicaid Medical Loss Ratio

Georgia can provide **hundreds of millions of dollars** in additional healthcare **each year** to Medicaid recipients **at no additional cost to state taxpayers**.

The Georgia Mental Health Parity Act (H 1013) established a minimum medical loss ratio (MLR) of 85% for MCOs in Georgia. This means that at least 85 cents of each dollar in Medicaid revenue received by MCOs must be spent on healthcare services for Medicaid recipients. The MLR is intended to **protect Georgia from paying for excessive administrative expenses or profits**.

As shown in the table, Georgia's MLR of 83% in 2019 was the **lowest** among states with SEC schools that used MCOs to provide Medicaid. MCO Further, as shown in the light blue box, affiliates of Georgia's Peach State Health Plan, have MLRs of **more than** 90%.

DCH will be rebidding all MCO contracts this year, and as provided by HB 1013, a provision should be inserted **establishing a minimum MLR of 90%.** Georgia MCOs receive approximately $10 billion per year in Medicaid funding in the aggregate. Increasing the MLR to 90% will result in approximately **$500 million more** to be used to address challenges, including **workforce shortages** by increasing provider reimbursement rates, thereby expanding the number of in-network behavioral healthcare providers.

Sources: Milliman Research Report, Medicaid Managed Care Financial Results For 2019 (June 2020), Center on Budget and Policy Analysis, Options to Reduce State Medicaid Costs: Managed Care Medical Loss Ratio (August 31, 2020)

State	MLR
Missouri	95.00%
Mississippi	91.50%
Texas	90.20%
Kentucky	89.70%
South Carolina	89.60%
Florida	89.10%
Louisiana	87.00%
Tennessee	84.60%
Georgia	**83.00%**

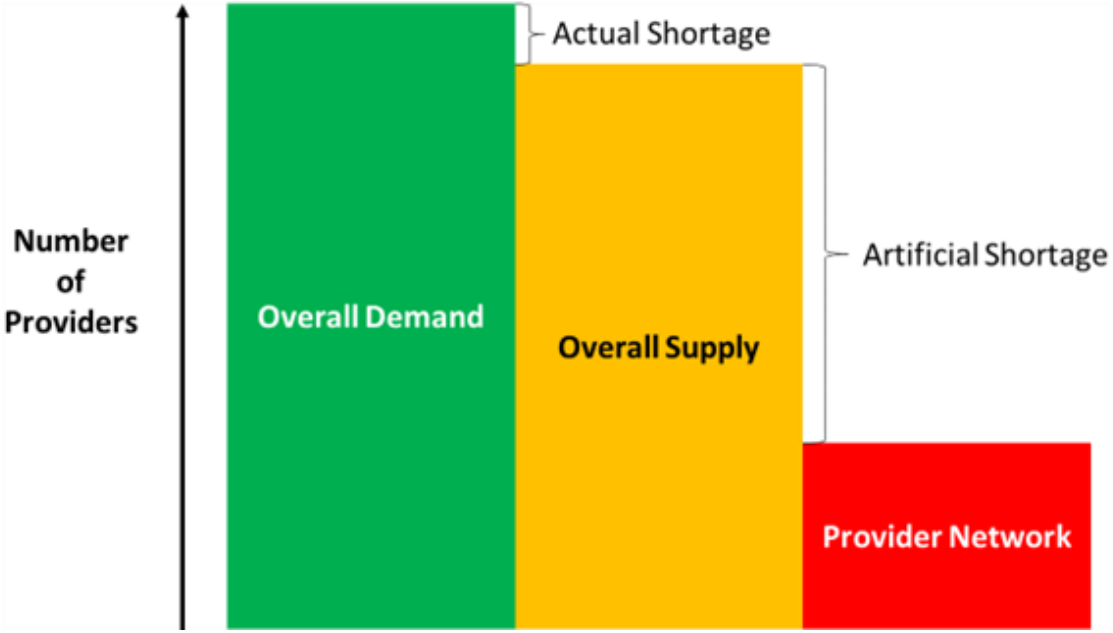
Peach State is a subsidiary of Centene Corporation, and Centene's Oregon subsidiary (Trillium Community Health Plan) had a 2019 MLR of 92.9%; its Arizona subsidiary (Arizona Complete Health) had a 2020 MLR of 92.3%; and its Iowa subsidiary (Iowa Total Care) had a 2021 MLR of 92.3%.

Workforce

An adequate number of in-network healthcare providers is the **beating heart** of parity. It is the **crucial intermediary step** between having insurance coverage and accessing medical care.

The lack of adequate numbers of healthcare providers for insurance plan members and Medicaid enrollees is due to both actual and artificial shortages:

1. The **actual shortage** is the difference between overall demand and supply of behavioral health care professionals.
2. The **artificial shortfall** is the difference between the overall number of behavioral health care professionals and the number of those professionals that are in-network with insurers or CMOs.



Health insurers point to the difference between the green and yellow columns (**actual shortage**), as compared to the more substantial difference **between** the yellow and red columns (**artificial shortage**) as the explanation for their inadequate behavioral health care provider networks.

Actual Workforce Shortages and Suggested Actions

Issue: Too few healthcare providers, whether by specialty or geography

Example: 150 of Georgia's 159 counties are considered mental health professional shortage areas. Some 77 counties have no full-time psychiatrists; 76 have no licensed psychologists; 52 have no licensed social workers; and 60 have no pediatricians. Only 53% of Georgia psychiatrists accept Medicaid clients.

Actions

- Increase the number of reimbursable behavioral health support specialists (BHSSs), including peers, addiction counselors, and community health workers
- Allow health care providers to offer a range of care fully consistent with their education and training
- Establish clear and achievable pathways for licensing of foreign-trained health professionals
- Increase provider reimbursement rates, in part by increasing minimum Medicaid MLR and implementing "network breadth" requirements (i.e., provider networks must have at least XX% of available providers by type/category of provider – **New Hampshire model**)
- Provide financial incentives for health professionals practicing in underserved areas, including expanding loan forgiveness eligibility criteria
- Eliminate administrative bottlenecks to state licensing of healthcare professionals
- Expand pipeline for education and training healthcare professionals, including at universities and technical colleges
- Expand telehealth capabilities by increasing broadband Internet access in rural and other underserved communities
- Support retention of health care professionals by establishing alternative discipline programs by both the Board of Professional Counselors, Social Workers and Marriage & Family Therapist, and the Georgia Board of Nursing

Artificial Workforce Shortages and Suggested Actions

Issue: Insurers' provider networks contain only a small subset of overall providers

Example: In 2017, McKinsey & Co found that 21% of health plans included less than one-fourth of available providers, another 20% included fewer than 40% of available providers, and 21% of plans included fewer than one-third of available hospitals.

Actions

- Increase reimbursement rates to attract more in-network providers
- Provide robust oversight and enforcement of legislative and regulatory parity requirements to, among other matters, eliminate reimbursement rate disparities between providers of MH/SUD and medical/surgical care
- Establish and enforce network adequacy requirements, including requirements that payer networks include 65% of available providers and provider directory accuracy verification using claims data
- Remove impediments to the use of telehealth services to enable broader and more efficient use of patient and provider time and make full use of the additional provider capacity provided by interstate compacts
- Reduce interference in doctor-patient relationships by limiting prior authorizations requirements and reducing claim denials
- Reduce uncompensated administrative burdens imposed by payers on providers – e.g., multiple audits
- Reimburse behavioral health support specialists, including peers, for critical nonclinical behavioral health services
- Permanently loosen restrictions on in-person requirements, such as telehealth
- Implement an online appointment scheduling tool that provides a near real-time indicator of insurer provider network adequacy
- Add provider types that can bill without requiring presence of supervising practitioner

Integrated Care

One patient. Two separate systems that attempt to collaborate with each other at best and that don't talk to each other at worst.

Mental health structural stigma is manifest in the bifurcated systems of care we have for illnesses of the brain and body. Behavioral health care is mostly separated from the primary health care system—a practice that the Institute of Medicine concluded more than **25 years ago** was leading to inferior care.

In the intervening years, evidence has continued to mount that having two, mostly independent systems of care leads to worse health outcomes and higher total spending, particularly for patients with co-occurring physical and behavioral health conditions.

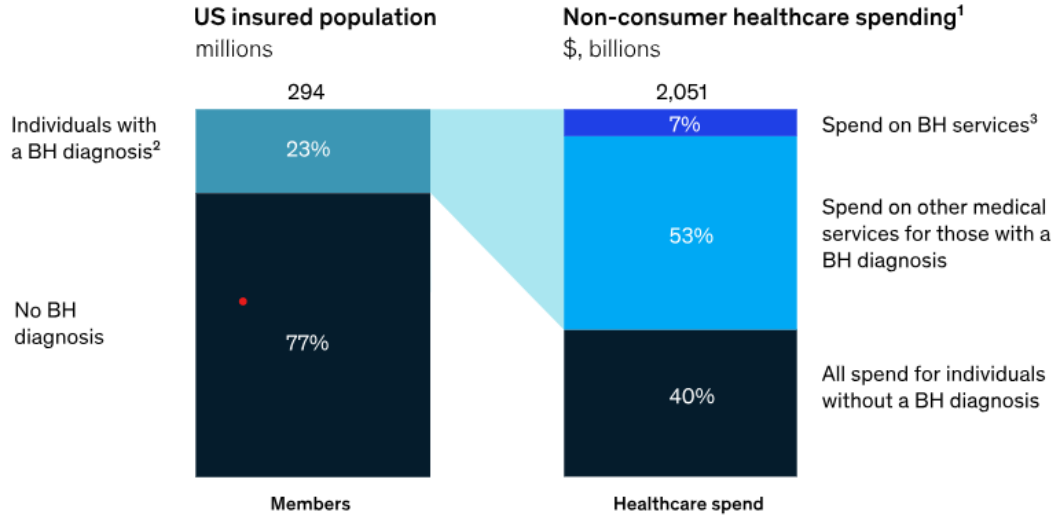
ACTIONS

- Require compliance by schools with OCGA 20-2-152.2 (trauma assessment of students in foster care) and OCGA 20-2-240 (school case manager consultation with student, designated counselor or caseworker assigned by DCH, DBHDD, DHS, or DJJ, and the parent/guardian to determine if the student requires transition or other services).
- Increase the number of federally qualified health centers (FQHCs) and Certified Community Behavioral Health Centers (CCBHCs) in Georgia and increase the capacity of all FQHCS to provide behavioral health services.
- Enable reimbursement for services provided by LPCs, MFTs and CPS specialist at FQHCs
- Expand telehealth/mental health capabilities, especially in rural and other underserved communities.

Healthcare's 80/20 (or 60/23) Rule

The graphic demonstrates the compelling need for integrated care. It comes from a McKinsey & Co. paper and shows that the **23%** of persons with behavioral health (BH) diagnoses account for **60%** of all healthcare spend. Stated differently, about 1 in 5 persons consume 3 in 5 healthcare dollars.

Out of the 60% share of spend for persons with BH diagnoses, only 7% of the spend is for BH care. The remaining 53% is for other medical services for those with BH diagnoses.



Mental illness is associated with a variety of disease risk factors, such as obesity, low physical activity, and smoking. In addition, the presence of a mental illness can profoundly affect the ability of patients and health systems to manage other chronic medical conditions. In turn, increased risk for and poor management of chronic conditions could lead to worse health outcomes and greater use of health care services, from additional emergency department visits to hospitalizations and, with worsening progression of underlying medical conditions, more expensive interventions.

For example, the cost to treat diabetes of a patient with depression is, on average, almost $20,000 higher than for a patient without depression due to factors such as medical complications, psychiatric medication side effects, reduced access to preventive care, and challenges with illness self-management.

Diabetes is just one chronic illness associated with depression. According to the CDC, **51%** of Parkinson's patients, **42%** of cancer patients, **27%** of diabetes patients, **17%** of cardiovascular patients, and **11%** of Alzheimer's patients also have depression. Further, **50-75%** of persons with eating disorders have depression.

Housing

Housing insecurity in all its forms can negatively affect human health. Whether it's difficulty paying rent, overcrowded, unhealthy, and unsafe living conditions, eviction, or homelessness, housing insecurity exposes individuals and families to increased stress and mental and physical health problems.

Contrary to popular belief, mental illness does not cause homelessness; rather, homelessness worsens mental health and exacerbates symptoms of mental illness. The mortality rate of people experiencing chronic homelessness is 4 to 9 times higher than that of people who do not experience homelessness.

Eviction has adverse effects on mental health of children and adults, including increased rates of depression and suicide. In the two years following eviction, people were more likely to visit the emergency room or require hospitalization for a mental health condition than those who had not experienced eviction.

43% of young women ages 18-25 experiencing homelessness are pregnant or parenting, with an estimated 1.1 million young children born to these young parents. Homelessness has a profound impact on child development.

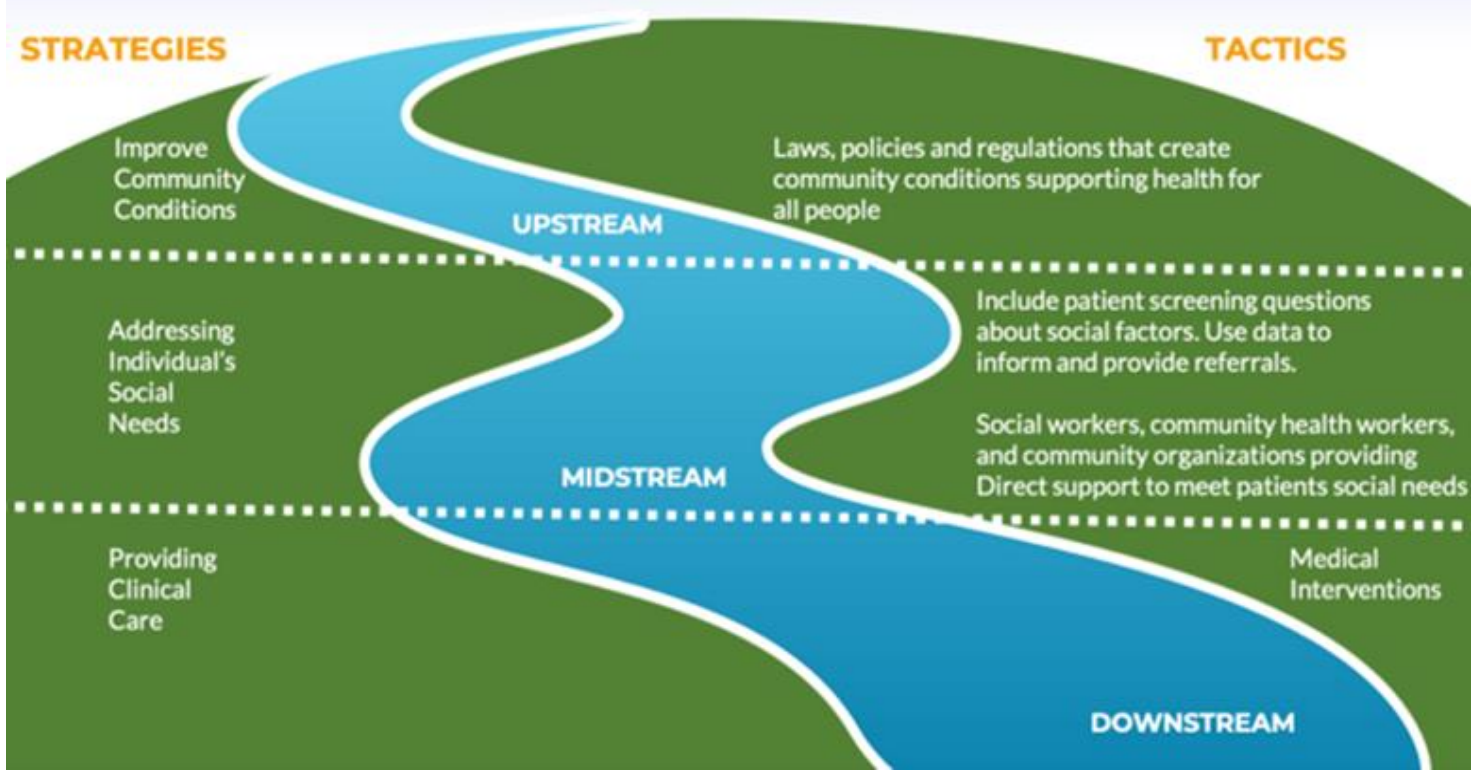
Actions

- Seek Medicaid waiver allowing Georgia to expand health-related social needs (HRSN) coverage for individuals experiencing major life transitions such as children aging out of foster care and individuals experiencing homelessness.
- Develop interventions to eliminate homelessness among mothers and infants.

Housing Supports and Medicaid

In 2022, Oregon received a Medicaid waiver allowing the state to expand health-related social needs (HRSN) coverage for individuals experiencing major life transitions such as children aging out of foster care, youth with complex behavioral health needs approaching adulthood, individuals experiencing homelessness, and justice-involved youth and adults.

Upstream Interventions from Clinical Care



HRSNs include food and housing supports (including rental assistance) for up to 6 months for the specified groups. State health officials sought federal approval to cover housing and nutritional support services to reduce health inequity and stabilize the circumstances of Medicaid enrollees who are at-risk of worsening health during major life disruptions.

Data Informed Decisions

As data about our health piles up, we *should* understand a lot more than we used to about what's wrong with our health and what to do about it. But having a lot of data is not enough. We must be aware of what we have, understand what it means, and act on that understanding.

What would it mean to be able to harness the overwhelming mass of healthcare data to measure and manage the quality of our health care?

- **Providers** could more accurately and effectively assess and improve their performance. They would catch the patients due for screenings, manage the patients whose chronic illnesses land them in the hospital periodically if they're not managed, and maybe even head off some of those chronic illnesses with strategically applied attention and education.
- **Patients** could make better choices for themselves and their families. They could find the best care by employing the same digital methods that now suggest where they should have dinner or get their oil changed.
- **Insurers and employers** could refine health benefit coverage to better serve the needs of their employees and members, pay for services proven to keep them healthier, and identify the best providers for those services. And they could do it in real time, or close to it, instead of relying on data from last year.

Enabling Georgians to Make Informed Decisions

The fundamental bargain among insurers, providers, and insurance plan members is that plan members receive necessary and appropriate healthcare from competent healthcare providers in return for premiums paid to insurers. The insurers pay providers for the healthcare services rendered from the premiums paid by plan members.

There is a marked asymmetry between the data available to insurers and the data available to plan members. That asymmetry limits plan members' ability to make informed decisions about their insurance plans, including whether the plan provides timely access to necessary and appropriate care, adequate provider networks, parity compliance, and timely payment of providers.

Plan members must have easy access to data like the following:

Appointment wait times – how many days for appointment	Denial rates, including prior authorization denial rates	Appeal rates, including internal and external, and appeal results
Active providers in-network as determined by claims filed	Percentage of overall providers in-network by type	Out-of-network rates by type of healthcare provider
Time and driving distance to nearest in-network provider	Plan medical loss ratio	Public scorecard of insurer performance vs metrics

Awareness and Education

The impact of stigma can be profound. At a time when people are at their most vulnerable and most in need of help, stigma prevents them from reaching out. This terrible paradox can deepen an illness that is often invisible to others.

The negative effects of stigma are intersecting and cumulative, such that inequities and injustices amass across time, generations, and contexts. For example, a single mother who is denied a job because she lives with a mental illness may, consequently, have difficulty finding decent (e.g., affordable, stable, secure, healthy) housing in a safe neighborhood, which can influence her and her children's' life trajectories.

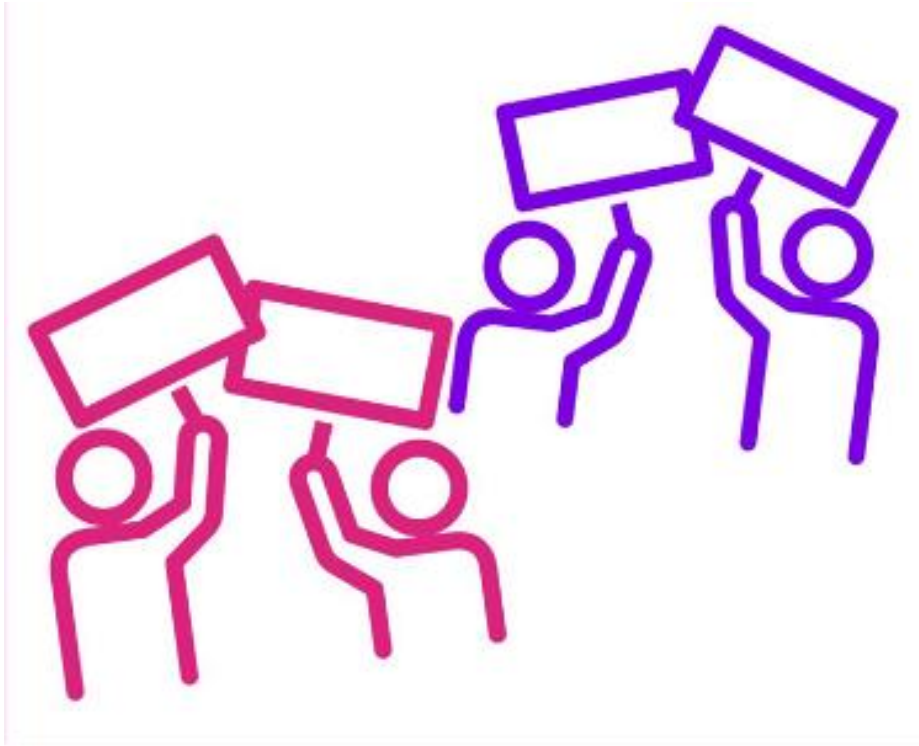
- **Self-stigma** exists at the individual level and involves the perceptions and experiences of those who possess stigmatized attributes. Individuals with mental illness, are socialized into believing that they are devalued members of society.
- **Social stigma** exists at the group level and refers to community members who judge particular traits to be contrary to community norms and behave in a harmful manner, either through action or inaction, towards individuals who possess the devalued attribute.
- In the context of mental illness, **structural stigma** refers to the rules, policies, and practices of social institutions that arbitrarily restrict the rights of, and opportunities for, people with mental illnesses. Structural stigma manifests in modern institutional systems and social contexts, including housing; healthcare; employment and income; education; criminal justice; privacy; public participation; travel and immigration; and media. Structural stigma is reinforced in law, internal regulations and procedures of private and public systems.

Stigma and Housing for Persons with Behavioral Health Challenges

Substantial numbers of people with mental illness find themselves living in unstable situations with family or friends, or in deplorable and dangerous conditions.

Housing designed for people with mental illnesses sometimes faces fierce community opposition and discriminatory zoning laws.

Consequently, housing that is affordable and/or offers support services tends to be located in communities that are geographically segregated and socially disorganized—systematically channeling people with mental illness into neighborhoods that place them at greater risk of social isolation, victimization, disease, and other stressful life situations.



Not In My Backyard (NIMBY) might look more socially acceptable on the surface, but it's still **STIGMA**

Early Intervention

Early intervention refers to recognizing the warning signs of a mental health or substance use challenge and acting before it gets worse. Studies have shown that proper care and treatment make complete recovery from a mental health or substance use challenge attainable.

Early intervention can also save a person and their loved ones from stress, prevent more serious symptoms from developing, and reduce the likelihood of problems with work, family, school and substance use.

Primary prevention focuses on the prevention of mental health disorders in the community before they occur. This level of intervention aims to decrease risk factors and increase protective factors in order to prevent a mental health disorder from occurring in the first place.

ACTIONS

- Expand use of home medical visits
- Automatically refer any denial of behavioral health coverage for those under age 22 to an independent medical review process
- 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, and (C) expand services for at-risk students.
- Increase First Episode Psychosis treatment initiatives (3 in 100 persons affected)
- Expand statewide trauma-informed and suicide prevention training for staff in all settings where children receive services

Maternal Mental Health

Maternal mental health issues are preventable conditions that can have a significant impact on a child's development and on the health of their family. 1 in 5 perinatal women will experience perinatal mood and anxiety disorders. (Chen et al. 2020).

A recent Georgia Maternal Mortality Review Committee report found that mental health disorders are a preventable leading cause of pregnancy related deaths in Georgia (Hart 2023). Suicide is a leading cause of maternal death in the first year following childbirth, accounting for approximately 20% of postpartum deaths (CDC 2022). Pregnant women are also more likely to experience suicidal ideation (Gelaye et al. 2016).

The lack of safe housing has a profound impact on child development. The lack of housing in infancy is associated with delays in language, literacy, and social-emotional development. 43% of young women ages 18-25 who are unhoused are pregnant or parenting, with an estimated 1.1 million young children born to these young parents.

Actions

- Establish a comprehensive statewide universal screening system for perinatal mood and anxiety disorders
- Develop and implement processes resulting in more home medical visits for parents and those expecting
- Require CMOs to reimburse obstetric providers for maternal mental health screenings early in pregnancy
- Expand the existing Certified Peer Specialist credential to include Perinatal Mental Health
- Require Medicaid and commercial insurers to cover doulas offering either support during pregnancy, labor, and delivery, and doulas offering postpartum home care and home health nursing care
- Encourage the Behavioral Health Reform and Innovation Commission to establish a subcommittee to make recommendations for improving maternal mental health in Georgia.
- Support pregnant, postpartum, and parenting students by providing affordable (or free) childcare options
- Implement or expand housing programs to support new mothers and their children

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 and family 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.

- Focus on maternal mental health both during and after birth
- Advocate for 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.

Medicaid "In Lieu of Services" (ILOS)

ILOS are flexible wrap-around services that Georgia can integrate into its population health strategy. These services are provided as a substitute, or to avoid, other covered higher cost/higher intensity services such as ER utilization, a hospital or skilled nursing facility admission, or a discharge delay.

ILOS can be integrated with case management for Medicaid enrollees at medium-to-high levels of risk and can fill gaps in state plan benefits to address medical or social determinants of health needs.

Examples of ILOS include:

- Home and community-based wraparound services for beneficiaries to transition or reside safely in their home or community;
- Housing transition and sustaining services
- Recuperative care
- Short-term non-medical respite

CMS encourages the use of ILOS as a means of addressing health-related social needs (HRSNs) like housing instability, food insecurity, and homelessness. HRSNs contribute to poor health and are a result of the underlying conditions in which people are born, live, grow, learn, work, age and pray.

- ILOS can be a useful tool to assist the Georgia Department of Behavioral Health and Developmental Disabilities in complying with the Georgia/DOJ settlement agreement.
- ILOS is limited to **5%** of overall Medicaid spending, in Georgia that 5% is equal to approximately $500 million.
- ILOS does **not** require a CMS Medicaid waiver, thereby providing the state with greater flexibility and control over ILOS usage.

Peer Support

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. Increased use of peer support specialists also expands cultural and linguistic diversity in healthcare service delivery.

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.

Actions

- Expand significantly the number of peer-managed and peer-led respite facilities throughout the state, especially rural areas, as a less traumatic and lower cost alternative to ED admissions for behavioral health crises
- Grow peer workforce programs - e.g., CPS and CARES - and expand and increase payer reimbursement for certified peer support services, including youth peer support
- Expand number of behavioral health community service centers, as well as increasing respite care and peer support service locations

Expanding Workforce Beyond Licensed Professionals

Georgia should foster a behavioral health workforce that extends beyond licensed professionals. Policymakers should (A) establish a greater role for **behavioral health support specialists (BHSSs)**, including peers, to deliver critical nonclinical behavioral health services, freeing up the licensed behavioral health workforce for more intensive tasks, and (B) encourage greater use of **community-initiated care (CIC),** which empowers community members to assume some behavioral health responsibilities when appropriate and trains others to respond to individuals' mental health needs

BHSSs are nonclinical behavioral health workers, like peers, who contribute to teams that administer comprehensive patient care and play important roles in delivering behavioral health services that support licensed professionals.

As providers with lived experience, peers are trusted by those with behavioral health conditions. Peers are certified and trained to provide a wide range of services (e.g., mentoring and advocating for individuals in recovery, sharing resources with others with lived experience).

CIC stresses the importance of existing relationships and wraparound services through task sharing. Task sharing enables informal behavioral health by:

- **Empowering** members of the community to assume some of these responsibilities when appropriate, and
- **Training** multidisciplinary stakeholders (e.g., educators, faith-based leaders) to respond to the behavioral health needs of community members using programs like Mental Health First Aid

These task-sharing processes would not replace the roles of providers within the health care system but, instead, **augment** them with broader community involvement.

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.

ACTIONS

- Utilize Medicaid "in lieu of services" (ILOS)
- Expand access to behavioral health care for justice-involved populations, including addressing the significant jail wait times for persons awaiting competency evaluations
- Explore use of Section 1115 Medicaid Reentry waiver allowing Medicaid to cover certain pre-release services for justice-involved individuals prior to their release date.
- 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

Rural Mental Health Care

Challenges to the provision of mental health services in rural communities include:

- **ACCESSIBILITY** - Rural residents often travel long distances to receive services, are less likely to be insured for mental health services, and providers are less likely to recognize a mental illness.
- **AVAILABILITY** – There are chronic shortages of mental health professionals and mental health providers are more likely to practice in urban centers.
- **AFFORDABILITY**– Some rural residents may not be able to afford the cost of health insurance or the cost of out-of-pocket care if they lack health insurance.
- **ACCESSIBILITY** – Rural residents may be more susceptible to the stigma of needing or receiving mental healthcare in small communities where residents know one another, and fewer choices of trained professionals can lead to a lack of faith in confidentiality.

ACTIONS

- Increase the number FQHCs and CBHCs and increase the capacity of all of them to provide behavioral health services
- Expand use of telehealth services for behavioral healthcare
- Provide clinical rotations in rural settings to expose future health care professionals to the qualities of working in rural areas
- Implement School-Based Health Center (SBHC) model when use is supported
  - SBHC model is unsustainable in many schools. Focus on healthcare "services," rather than on "centers". If service needs grow into a center, let happen organically and sustainably
- Implement School-Based Behavioral Health (SBBH) model to enhance students' academic achievement, build social skills and self-awareness, and strengthen their connections to schools and communities

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.

Actions

- 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
- 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 psychiatric advance directives on what types of treatment they want and don't want in a time of crisis

Alternatives to EDs: Hope Institute and EmPATH Units

The **Hope Institute** is an outpatient facility specializing in short-term crisis intervention and stabilization for individuals experiencing suicidal ideation. 80% or more of persons otherwise taken to EDs can be diverted to a Hope Institute.

Hope Institutes provide clients with a combination of two evidence-based, suicide-focused treatments, the Collaborative Assessment and Management of Suicidality (CAMS) and group skills in Dialectic Behavioral Therapy (DBT).

Clients can visit a Hope Institute location or opt to be treated via telehealth, sometimes multiple times per week based on need.

The Hope Institute model provides more effective, less traumatic, and less costly treatment for suicidal persons who would otherwise be treated in EDs. departments. It substitutes outpatient care for ED admission and subsequent hospitalization.

EmPATH units are physical environments designed for acute psychiatric patients to receive assessment and evaluation in a therapeutic and least restrictive setting. Complementing the emergency department, the units provide a calm and comforting environment for patients, allowing movement and, more importantly, human interaction that is vital in the first 24 hours of treatment, something often not available in EDs.

EmPATH units streamline emergency department assessment of the health needs of mental health consumers and quickly transitions them out of emergency departments into a calming space that allows for the rapid assessment, support of behavioral health needs, and linkage to other services.

75% of patints treated in an EmPATH unit stabilize and return home within 24 hours — without costly inpatient admissions or emergency department boarding.

Forensic Mental Health

People with mental illness are overrepresented in our nation's jails and prisons. About two in five people who are incarcerated have a history of mental illness (37% in state and federal prisons and 44% held in local jails). This is twice the prevalence of mental illness within the overall adult population.

About **three in five people** (63%) with a history of mental illness do not receive mental health treatment while incarcerated in state and federal prisons. In fact, **more than 50% of individuals** who were taking medication for mental health conditions at admission did not continue to receive their medication once in prison.

Better mental health, both in-prison and changes to mental health post-release, is related to a decrease in the likelihood of recidivating. Individuals with poor mental health in-prison who make significant improvements after release see the largest reduction in their odds of recidivating. Further, the combination of better mental health in-prison and increases in mental health post-release is associated with reductions in the likelihood of re-offending for both technical violations and new convictions.

Source: Wallace D, Wang X. Does in-prison physical and mental health impact recidivism? SSM Popul Health. 2020 Mar 20;11:100569. doi: 10.1016/j.ssmph.2020.100569. PMID: 32258357; PMCID: PMC7113431.)

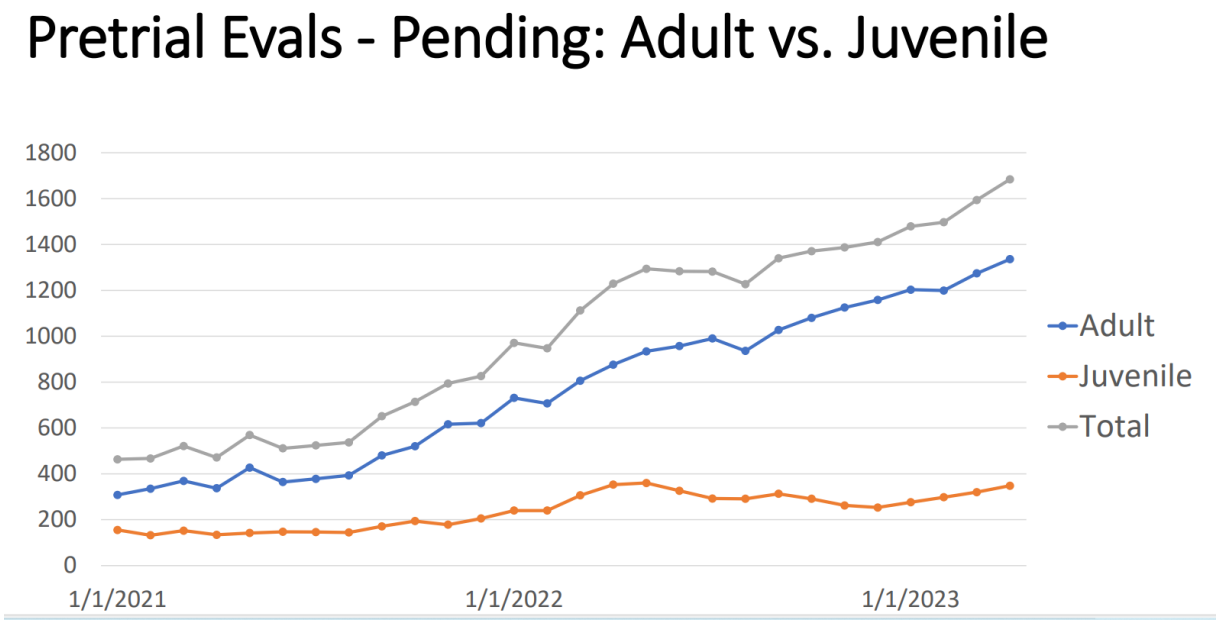
Actions:

- Support and seek expansion of behavioral health diversion programs, use of forensic peer mentors (FPMs), and jail in-reach pilot programs, including the use of a standardized and validated screening tool
- Georgia opt-in to providing Medicaid and PeachCare coverage - with federal financial participation - to juvenile youth during the initial period pending disposition of charges as set out in last year's Consolidated Appropriations Act (CAA). The option is available starting January 1, 2025.
- Georgia to provide pre-release screenings and services for certain justice involved youth, such services covered by Medicaid and PeachCare pursuant to last year's CAA.

Competency Evaluation and Restoration Services

More than 1,600 persons in Georgia are awaiting evaluations to determine their competency to stand trial on criminal charges. More than 300 persons in Georgia are awaiting mental health competency restoration services so that they may then stand trial. They are being held in jail prior to any determination of guilt or innocence. For some, they are being held in jail for longer than the maximum length of their sentence had they been convicted.

Georgia could face a lawsuit challenging the delays in competency evaluation and restoration services and alleging violations of the 6th and 14th amendments to the U.S. Constitution and the U.S./Georgia Olmstead settlement agreement.



Source: DBHDD

On July 7, 2023, a federal judge imposed a penalty of more than **$100 million** on the State of Washington for failing to provide timely competency services during the nine-month period from September 2022 through May 2023.

Action:

- Support ongoing actions by DBHDD to address this matter, including the development and implementation of pilot projects to reduce delays in evaluation and restoration services. This includes contracting for those services with third parties, using community-based mental health services, and providing services within correctional facilities.

Parity

A study by Milliman found that behavioral health professionals in Georgia were paid **37% less** than general health professionals providing comparable care and using the **same billing code** and that children are 10 times more likely to receive outpatient behavioral health care out of network compared to primary care visits.

10x

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

Source: Stoddard Davenport, Travis J. Gray, and Stephen P. Melek, Addiction and Mental Health Versus Physical Health: Widening Disparities in Network Use and Provider Reimbursement, Milliman Research Report (November 19, 2019)

ACTIONS

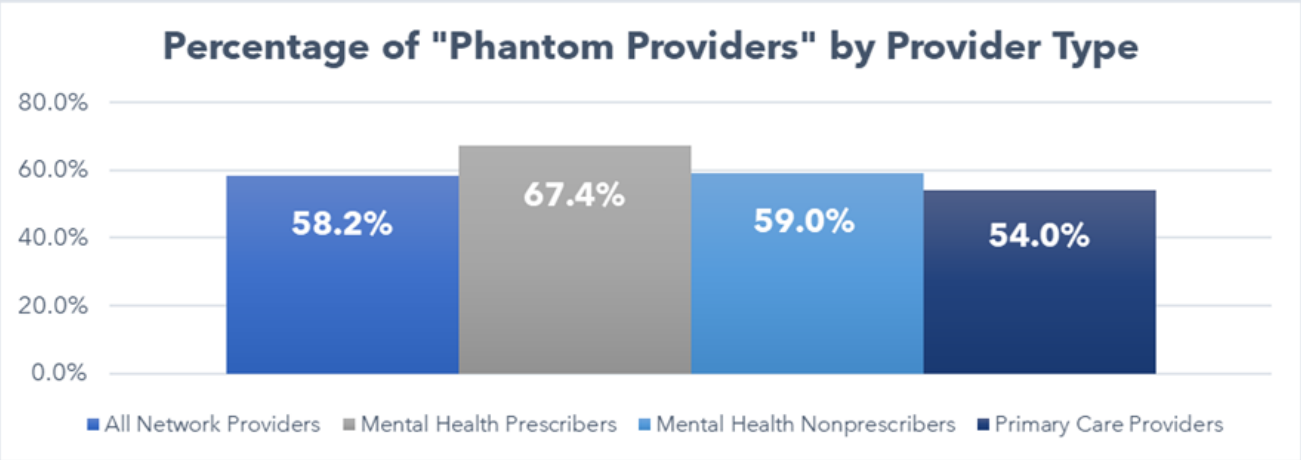
- Fund and implement a statewide marketing campaign to educate Georgians on their parity rights, including by providing culturally and linguistically responsive materials
- Implement additional measurable network adequacy measures for insurers/CMOs, including (1) minimum provider to enrollee ratios, (2) minimum percentages of contracted providers accepting new patients, and (3) ""network breadth" requirements (i.e., provider networks must have at least XX% of available providers by type/category of provider – New Hampshire model)
- 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 from data calls and comparative analyses provided by insurers to DOI and DCH pursuant to HB 1013

(In)Adequate Provider Networks

Typically, families do not self-pay for care for diabetes or asthma because they can access providers who provide quality care covered by their insurance. However, for mental health, providers of quality care covered by insurance are often so difficult to access that adequately resourced families are willing to pay for such service out of pocket, which has supported a cottage industry of outpatient mental health practitioners who do not participate in insurance networks. Lower-resourced families, particularly children insured by managed care organizations (MCOs) that execute Medicaid benefits under contract, are left to rely on what is available through their insurance. [I]n essence, a 2-tiered system for psychiatric care [has developed]. . ., in which patients who must rely on third-party payment for mental health care often compete for fragmented, delayed care from lower-reimbursed clinicians in chronically short-supply, whereas those who can self-pay are more often (but by no means always) able to receive higher-quality comprehensive care in a timely fashion.

John N. Constantino, *Bridging the Divide Between Health and Mental Health: New Opportunity for Parity in Childhood*, Journal of the American Academy of Child & Adolescent Psychiatry, 2023, ISSN 0890-8567, https://doi.org/10.1016/j.jaac.2023.03.019

A study published in July 2022 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.

Standards

Organizations, systems, and individuals should 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 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.

- Determine CMO compliance with appeal and grievance systems required by 42 CFR § 438.66(a)
- Implement national culturally and linguistically appropriate services standards and evaluate access to such services
- Shift all of Georgia's community service boards (CSBs) to Certified Community Behavioral Health Center (CCBHCs), an open access model with numerous fidelity and accountability measures (and potential SAMHSA funding)
- Expand statewide trauma-informed knowledge base and services, including compliance with state laws referenced in the first Action bullet of the Integrated Care slide

Improve Accountability of Medicaid Programs

Medicaid is the single largest payer of behavioral healthcare in the U.S.

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.

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.