The Behavioral Health Reform and Innovation Commission: Hospital and Short-Term Care Subcommittee Recommendations

November 2020

Introduction: It can be challenging for Georgians to get quality behavioral health care for themselves and/or their children. Georgia currently ranks 50th in the nation[1] according to the Access Ranking reported by Mental Health America. The Access Ranking indicates how much access to mental health care exists within a state. The access measures include access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability. A high Access Ranking indicates that a state provides relatively more access to insurance and mental health treatment.

The Behavioral Health Reform and Innovation Commission Hospital Short- and Long-Term Care Subcommittee believes that the following recommendations will help Georgia build capacity, flourish, and improve access. The Subcommittee has identified several low- to no-cost "quick wins" that will begin to improve access for Georgians. This report is comprised of five areas of work: Trauma-Informed Care, State Parity, State Telehealth Expansion, the Hospital/Crisis Care Continuum, and Workforce Capacity Building.

1. **Build Trauma-Informed Knowledge Base Statewide**
   In July, the Kaiser Family Foundation released a tracking poll[2] showing that for the first time, a majority of American adults – 53- percent – believe that the pandemic is taking a toll on their mental health. A recent joint report[3] from Well Being Trust and Robert Graham Center for Policy Studies in Family Medicine and Primary Care suggests that the COVID pandemic could claim up to 75,000 additional deaths from suicide, and alcohol and drug misuse. We must protect children who may be at heightened risk of maltreatment because of mental distress, social isolation, financial stress, or physical harm brought on by the pandemic. Widespread, robust prevention and education can and will save lives and dollars.

   Physical disease prevention programs have historically received enthusiastic support from the payer and provider communities, but too often behavioral health prevention attracts scarce attention and few resources. However, high-quality prevention and early-intervention programs for mental and substance use disorders, such as school-based mental well-being efforts, can yield returns on investment as high as $65 per $1 invested[4]. The demonstrated cost effectiveness of these programs suggests that philanthropy, payers, providers, employers, and governmental entities can all positively and economically influence behavioral health outcomes through prevention and early intervention.

   Recommendations
   a. Explore how to best implement a virtual Statewide Trauma-Informed training similar to the Georgia Department of Administrative Services (DOAS) Human Trafficking training for all state employees.
   b. Continue to focus on behavioral health prevention, specifically through building resilience by normalizing conversations around feelings, teaching children coping skills and identifying behavioral and mental health concerns early. These efforts will play a key role in breaking down the stigma of mental and behavioral health and help parents and children, as well as child-serving adults, like educators, realize behavioral and mental health are just as important as physical health.

2. **Adopt state parity**

Parity in insurance coverage for behavioral health treatment, including substance use disorders, is central to all the issues being considered by the Behavioral Health Reform and Innovation Commission. Prioritizing the enforcement of parity is a low-cost and effective way to allow insured individuals to access care without paying out of pocket to achieve better behavioral health outcomes, to decrease rates of hospitalization and incarceration, and to reduce the need for crisis services. The state's Department of Community Health is responsible for ensuring compliance with federal and state parity laws for Medicaid care management organizations (CMOs), and the state's Department of Insurance is responsible for enforcement of parity laws for private insurance plans (including individual, marketplace, small business, and large employer plans that are not self-funded). These departments have the authority to: gather comprehensive, accurate data from insurance companies responsible for implementing parity; make data on parity compliance transparent and available to the public, elected officials, and the Behavioral Health Reform and Innovation Commission; improve parity compliance through a strong monitoring and accountability framework. The following policy recommendations can be achieved through administrative action, rule, or legislation in the short-term to help achieve the goals of enforcing parity in Georgia.

The following recommendations have been endorsed by the Georgia Parity Collaborative. This group consists of more than 20 of the leading nonprofit organizations that address mental health and substance use treatment needs in Georgia. They convene to examine the issue of parity in insurance coverage for behavioral health across both private and public insurers. They have identified what comparable states have done to advance parity through legislative and administrative policy reform, and continually gather data and stories about the challenges many Georgia families face when they attempt to get coverage for behavioral health care.

Recommendations

a. Create cross-departmental collaboration, such as forming a permanent working group with the state's Department of Insurance, Department of Community Health and Department of Behavioral Health and Developmental Disabilities.
b. Ensure that the Georgia Department of Community Health includes clear parity provisions in its renewed Medicaid managed care contracts, that it requires CMOs to submit complete parity compliance analyses and data to demonstrate compliance, and that it sets targets for improvement and enforces parity provisions.
c. Ensure that the Georgia Department of Insurance conducts regular market conduct exams for parity compliance, including a focus on non-quantitative treatment limitations (NQTLs) such as prior authorization, reimbursement rates, and denials based on medical necessity, and that it takes action to address violations. Require the publishing of an annual status report of the conduct exams that reviewed parity in the previous year, along with results and corrective actions taken.
d. Require these departments to report annually on the methodology used to ensure compliance with federal and state parity law to the Behavioral Health Reform and Innovation Commission and the Georgia General Assembly.
e. Make it easier for consumers to report suspected parity violations, for example by having dedicated web pages with a clear explanation of parity and instructions for how to file a complaint linked from the Department of Insurance, Department of Community Health and the Department of Behavioral Health and Development Disabilities websites.

f. Further explore how to establish a process for publicly reporting how consumer complaints were addressed.

3. Build and support telehealth and technology capacity statewide

The State (Department of Administrative Services) is currently identifying telehealth providers that can effectively serve Georgians virtually while managing a fully licensed, remote health care provider network and a HIPAA compliant web-based platform. DOAS has determined, through spend analysis encompassing fiscal years 2017 – 2020, that state agencies and higher education spend (on average) just over $257 million annually on medical health services. Deploying telehealth services through statewide contracts, and promoting the opportunity, the state can and will save money and create access to those Georgian's that need it most.

Recommendations

a. Upon completion of the current RFP, the Commission recommends promoting the utilization of statewide contracts for telehealth to all eligible agencies.
b. Ensure that Behavioral Health services are available to all eligible agencies through RFP mentioned above.
c. Ensure statewide telehealth parity for schools.
d. Further explore how to effectively open lines of communication for continued knowledge sharing and telehealth best practices over the next 12 months as the state regains composure from COVID 19 and beyond.

Project ECHO[5] (Extension for Community Healthcare Outcomes) *is a revolutionary guided-practice model that reduces health disparities in under-served and remote areas of the state, nation, and world. Through innovative telementoring, the ECHO model uses a hub-and-spoke knowledge-sharing approach where expert teams lead virtual clinics, amplifying the capacity for providers to deliver best-in-practice care to the underserved in their own communities.* Currently, Georgia has five ECHO "Hubs" or groups implementing the model: CDC, Georgia DPH, Georgia Chapter of the American Academy of Pediatrics, American Cancer Society and Children's Healthcare of Atlanta. The Georgia Rural Health Innovation Center is opening the next hub in Georgia in winter 2020.

Recommendations

e. Develop a communication channel that will promote all current ECHO's to healthcare providers and subject matter experts that may benefit from participation.
f. Create a work group in partnership with the Georgia Rural Health Innovation Center that will identify needed ECHO topics and begin to create innovative ECHO's to bridge behavioral health gaps in Georgia.

4. Streamline the Hospital/Crisis Care continuum

Once a child or young adult moves into behavioral health crisis mode, they are no longer safe to themselves or others, and there is a need for immediate intervention. This usually results in a trip to the emergency room at the local hospital. In many cases, emergency rooms are not equipped to provide the necessary care to a child in crisis, and in many cases the transition to a short- or long-term behavioral health facility can be filled with barriers that extend the amount of time a child sits in the emergency department awaiting appropriate treatment. The following low- or no-cost recommendations will help remove some of these barriers.

Children's Healthcare of Atlanta Reports that about 12.5 percent of the patients transferred from the emergency department to a Crisis Stabilization Unit (CSU) or an acute psychiatric inpatient unit return to Children's within 30 days. Due to multiple electronic medical records assigned to patients among these facilities, effectively tracking patients who are high utilizers of crisis beds is a challenge. This leads to fragmented care and poor outcomes.

Recommendation

a. Develop a partnership with leaders from Children's, the Department of Community Health, Georgia's Department of Behavioral and Developmental Disabilities, Georgia Collaborative ASO, private insurers, CMOs, acute psychiatric hospitals and CSUs to discuss children who are high utilizers of crisis care and how we can best support the needs of the child.

One of the most common reasons Children's Healthcare of Atlanta patients with BMH support needs are denied placement to an acute psychiatric inpatient unit or CSU is due to the aggression level of the child. Specifically, the CSUs are impacted by limited bed capacity, payor source (primarily serve uninsured, SSI Medicaid; also provide admission for CMO covered lives during occasions where all in-state private facilities deny), milieu/acuity.

Recommendation

b. Consider implementing a reimbursement leveling system that would allow for additional staffing at CSUs and acute psychiatric inpatient units to accommodate patients who are in psychiatric crisis and aggressive.

There are extended lengths of stay in emergency departments for patients awaiting acceptance to a CSU at night because GCAL currently does not use pediatric specific vital sign and lab value ranges and there is not a physician available after-hours to review patients requiring review.

Recommendation

c. Provide funding that would support the CSUs to have an on-call physician after-hours to review pending patients so that acceptance is not delayed during the night. Potential additional option is to provide additional resources to DBHDD to make IT upgrades to their GCAL system to include pediatric specific vital sign and lab value ranges. This IT improvement would significantly decrease the need for afterhours medical clearance challenges at the CSU level.

Several CSUs require that legal guardians sign admission consent forms as part of acceptance requirements before a patient can be transferred to the CSU. Consent forms are 20+ pages long, are different for each facility, and are extremely time-consuming to complete. Additionally, many CSUs who have consent forms do not have them translated in Spanish.

Recommendations

d. Create a universal consent form, in English and Spanish that can be used by all CSUs. Develop an electronic process for sending/receiving consent forms via the electronic GCAL bed board or another electronic platform.
e. Provide resources to DBHDD to support IT upgrades that would support universal electronic consents.

There are multiple reimbursement challenges that exist particularly in care of children with Autism or developmental delay who are in psychiatric crisis.

Recommendation

f. Further explore the reimbursement landscape.

The availability of services for children with autism who present in psychiatric crisis is a challenge. Specifically, navigating the crisis continuum services including acute psychiatric care, crisis support homes, and the Psychiatric Residential Treatment Facilities becomes difficult due to the limitations related to matching the service to the child's needs, age and acuity.

Recommendation

g. Increase bed capacity across the crisis care continuum to ensure that there is improved access resulting in the child needs appropriately matched.

5. Improve the Behavioral Health Workforce Shortage

There is a huge behavioral health workforce shortage in Georgia[6]. Georgia, especially rural communities, often has trouble retaining licensed professionals and the cost of licensure can be very expensive for new graduates. The following low- or no-cost workforce recommendations will improve behavioral health access for all Georgians.

There is no current monitoring of behavioral health workforce in Georgia. This leads to outdated online resources for locating community behavioral health providers (i.e. psychologists, social workers, counselors and marriage and family therapists).

Recommendation

a. Require a minimum data set surveys (MDSS) for licensed behavioral health providers to help understand the behavioral health workforce and plan for solutions. Data set could include who is actively practicing and where, types of insurance accepted, certifications specialties, telehealth offered, and retirement plans. Several other states, including VA, NC, TX, and IN already do this.

Note: Voices for Georgia's Children has also recommends this and has detailed information[7] about where to house this information and costs associated with implementing an MDSS for licensed behavioral health providers.

Licensed Marriage Family Therapists and Licensed Professional Counselors are not able to be independent providers in Georgia. Alabama, North Carolina, and Texas allow them to be, so many new professionals leave the state to practice elsewhere. In addition, the cost of supervision is often extremely high for new graduates. Over 80% of LMFT's polled in Georgia pay over $50 an hour for supervision, and almost 20% pay over $100 an hour.

Recommendations

a. Explore how to allow LMFTs and LPCs to become independent providers in Georgia.
b. Identify new and innovative ways to create cost effective supervisory opportunities for new graduates.

Appendix A
Model Georgia Parity Bill- Private Insurance

Senate Bill XXX

By: Senator _____

A BILL TO BE ENACTED

AN ACT

To amend Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance generally, so as to provide that insurers authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to report compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008; to provide updated definitions; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

Section 1

Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance coverage for mental illness, is amended as follows:

"33-24-28. 1

(a) As used in this Code section, the term:

(1) "Accident and sickness insurance benefit plan, policy, or contract" means:

(A) An individual accident and sickness insurance policy or contract, as defined in Chapter 29 of this title; or

(B) Any similar individual accident and sickness benefit plan, policy, or contract.

(2) "Mental disorder" shall have the same meaning as defined by the most recent version of The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association) or The International Classification of Diseases (World Health Organization) ~~as of January 1, 1981~~, or as the Commissioner may further define such term by rule and regulation.

(b) Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed on or after July 1, 1984, coverage for the treatment of mental disorders, which coverage shall be at least as extensive and provide at least the same degree of coverage as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract. Every insurer that issues accident and sickness insurance

benefits plans, policies, or contracts that provide coverage for the treatment of mental disorders shall provide such coverage in accordance with the Mental Health Parity and Addiction Equity Act of 2008 found at 42 U. S. C. 300gg-26 and its implementing and related regulations found at 45 CFR 146. 136, 45 CFR 147. 160, and 45 CFR 156. 115(a)(3) ~~In no event shall such an insurer be required to cover inpatient treatment for more than a maximum of 30 days per policy year or outpatient treatment for more than a maximum of 48 visits per policy year under individual policies~~.

(c) The optional endorsement required to be made available under subsection (b) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to the treatment of mental disorders unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(d) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(e) Nothing in this Code section shall be construed to prohibit the inclusion of coverage for the treatment of mental disorders that differs from the coverage provided in the same insurance plan, policy, or contract for physical illnesses if the policyholder does not purchase the optional coverage made available pursuant to this Code section.

(f) All insurers that issue individual accident and sickness insurance benefits plans, policies, or contracts that provide coverage for the treatment of mental disorders shall submit an annual report to the Commissioner on or before January 1, 2022 that contains the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(2) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental disorder benefits but do not apply to medical and surgical benefits within any classification of benefits.

(3) The results of an analysis that demonstrates that for the medical necessity criteria described in item (1) and for each NQTL identified in item (2), as written and in operation, the processes, strategies,

evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to mental disorder benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

(A) Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each NQTL

(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to mental disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to medical and surgical benefits

(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental disorder benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits

(E) Disclose the specific findings and conclusions reached by the insurer that the results of the analyses above indicate that the insurer is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations and related regulations, which includes 45 CFR 146. 136, 45 CFR 147. 160, and 45 CFR 156. 115(a)(3).

Section 2

Chapter 24 of Title 33 of the Official Code of Georgia Annotated, relating to insurance coverage for mental illness, is amended as follows:

“33-24-29. 1

(a) As used in this Code section, the term:

(1) "Accident and sickness insurance benefit plan, policy, or contract" means:

(A) A group or blanket accident and sickness insurance policy or contract, as defined in Chapter 30 of this title;

(B) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(C) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(D) Any similar group accident and sickness benefit plan, policy, or contract.

(2) "Mental disorder" shall have the same meaning as defined by the most recent version of The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association) or The International Classification of Diseases (World Health Organization) ~~as of January 1, 1981~~, or as the Commissioner may further define such term by rule and regulation.

(b) This Code section shall apply only to accident and sickness insurance benefit plans, policies, or contracts, certificates evidencing coverage under a policy of insurance, or any other evidence of insurance issued by an insurer, delivered, or issued for delivery in this state, except for policies issued to an employer in another state which provide coverage for employees in this state who are employed by such employer policyholder, providing major medical benefits covering all groups ~~except small groups as defined in subsection (a) of Code Section 33-30-12~~.

(c) Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed on or after July 1, 1998, coverage for the treatment of mental disorders, which coverage shall be at least as extensive and provide at least the same degree of coverage and the same annual and lifetime dollar limits as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract. Every insurer that issues accident and sickness insurance benefits plans, policies, or contracts that provide coverage for the treatment of mental disorders shall provide such coverage in accordance with the Mental Health Parity and Addiction Equity Act of 2008 found at 42 U. S. C. 300gg-26 and its implementing and related regulations found at 45 CFR 146. 136, 45 CFR 147. 160, and 45 CFR 156. 115(a)(3).

(d)

(1) The optional endorsement required to be made available under subsection (c) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, including without limitation limits on the number of inpatient treatment days and outpatient treatment visits, which apply to the treatment of mental disorders unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract, except as otherwise provided in paragraph (2) of this subsection.

(2) The optional endorsement required to be made available under subsection (c) of this Code section may contain deductibles or coinsurance provisions which apply to the treatment of mental disorders~~, and such deductibles or coinsurance provisions need not apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract; provided,~~

~~however, that if a separate deductible applies to the treatment of mental disorders, it shall not exceed the deductible for medical or surgical coverages. A separate out-of-pocket limit may be applied to the treatment of mental disorders, which limit, in the case of an indemnity type plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages and which, in the case of a health maintenance organization plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages or the amount of $2,000. 00 in 1998 and as annually adjusted thereafter according to the Consumer Price Index for health care, whichever is greater~~.

(e)

(1) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(2) Nothing in this Code section shall be construed to prohibit any person issuing an accident and sickness insurance benefit plan, policy, or contract from providing the coverage required to be made available under subsection (c) of this Code section through an indemnity plan with or without designating preferred providers of services or from arranging for or providing services instead of indemnifying against the cost of such services, without regard to whether such method of providing coverage for treatment of mental disorders applies generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(f) The requirements of this Code section with respect to a group or blanket accident and sickness insurance benefit plan, policy, or contract shall be satisfied if the coverage specified in subsections (c) and (d) of this Code section is made available to the master policyholder of such plan, policy, or contract. Nothing in this Code section shall be construed to require the group insurer, nonprofit corporation, health care plan, health maintenance organization, or master policyholder to provide or make available such coverage to any insured under such group or blanket plan, policy, or contract.

(g) All insurers that issue group accident and sickness insurance benefits plans, policies, or contracts that provide coverage for the treatment of mental disorders shall submit an annual report to the Commissioner on or before January 1, 2022 that contains the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(2) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental disorder benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTLs that apply to mental disorder benefits but do not apply to medical and surgical benefits within any classification of benefits.

(3) The results of an analysis that demonstrates that for the medical necessity criteria described in item (1) and for each NQTL identified in item (2), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to mental disorder benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

(A) Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each NQTL

(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to mental disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to medical and surgical benefits

(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental disorder benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits

(E) Disclose the specific findings and conclusions reached by the insurer that the results of the analyses above indicate that the insurer is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations and related regulations, which includes 45 CFR 146. 136, 45 CFR 147. 160, and 45 CFR 156. 115(a)(3).

Section 3

All laws and parts of laws in conflict with this Act are repealed.

Appendix B

Model Georgia Parity Bill- Medicaid

Senate Bill XXX
By: Senators _____

A BILL TO BE ENACTED

AN ACT

To amend Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally, so as to provide that Care Management Organizations that contract with the Department of Community Health shall be required to report compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

Section 1

Article 7 of Chapter 4 of Title 49 of the Official Code of Georgia Annotated, relating to medical assistance generally, is amended by adding a new Code section to read as follows:

"49-4-159.

(a) All Care Management Organizations (CMOs) shall submit an annual report to the Department of Community Health on or before January 1, 2022 that contains the following information:

(1) A description of the process used to develop or select the medical necessity criteria for mental health and substance used disorder (MH/SUD) benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(2) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both MH/SUD benefits and medical and surgical benefits within each classification of benefits.

(3) The results of an analysis that demonstrates that for the medical necessity criteria described in item (1) and for each NQTL identified in item (2), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to MH/SUD benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

(A) Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each NQTL

(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to medical and surgical benefits

(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for MH/SUD benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits

(E) Disclose the specific findings and conclusions reached by the CMO that the results of the analyses above indicate that the CMO is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations and related regulations, which includes 42 CFR 438. 910, 42 CFR 440. 395, and 42 CFR 457. 496.

(b) The Department of Community Health shall provide to the General Assembly the reports submitted by the CMOs no later than January 1, 2023.

Section 2

All laws and parts of laws in conflict with this Act are repealed.

Appendix C

Comparison of Mental Health & Addiction Parity Bills in Four States and Proposed Regulation in TX

There are several common provisions in Arizona SB 1523, Indiana HB 1092, Oklahoma SB 1718, West Virginia SB 291, and Texas Proposed Regulations Subchapter P, Part I, Chapter 21. There are also a few unique provisions and key distinctions which will be addressed below.

All of the above bills and the proposed regulation attempt to generally align their respective state laws with the federal Mental Health Parity and Addiction Equity Act of 2008.

Background:

First, it should be noted that not all of the examined states are at the same stage with regard to the enforcement of their mental health and addiction parity laws. Legislatures in Arizona, Indiana, Oklahoma, and West Virginia all passed new legislation earlier this year but their respective state insurance departments have not yet offered proposed regulations for public comment. The Texas Department of Insurance did not pass new parity laws this year but has posted draft regulations for public comment. Those regulations are based in part on Texas statutes that became law in 2017. (See the attached Texas Code Title 8, Subtitle E, Chapter 1355, Subchapter F for reference.) The proposed Texas regulations are intended to be consistent with the Texas Code and closely track federal law.

Insurer reporting to state Departments of Insurance

The bills (or proposed regulation) in each state require relevant insurers to review their processes each year with regard to parity between their mental health and addiction benefits and their medical and surgical benefits. Oklahoma, West Virginia, and Texas require or would require relevant insurers to submit an annual report to that state's department of insurance (or equivalent state agency) demonstrating that medical necessity criteria and non-quantitative treatment limitations for mental health and addiction benefits are comparable to medical and surgical benefits. Indiana merely requires that each insurer submit a report to the Insurance Commissioner no later than one year after accompanying rules are promulgated, and any year thereafter during such time as the insurer makes significant changes to its relevant processes. Arizona requires insurers to file a detailed report every three years and a less detailed summary report during the interim years, along with an attestation that the insurer is in compliance with the law.

State Departments of Insurance reporting to State Legislatures:

The Indiana and West Virginia bills each require their state department's of insurance to submit at least one initial report to their respective state legislature concerning, at minimum, the department's implementation of rules and procedures to ensure insurer compliance with the state's mental health and addiction parity laws. The Arizona bill does not require that a

report be made to its legislature. Oklahoma previously required a department submission to its legislature regarding the costs to insurers incurred from compliance with the law but the 2020 statutory changes do not explicitly require any future department submission to its legislature.

State Departments of Insurance making insurer compliance data publically available

The approaches vary somewhat among the states examined regarding the way and extent that insurer compliance data is made publically available. Oklahoma provides that the Insurance Commissioner shall make available to the public the reports submitted by the insurers (with redactions for proprietary information). West Virginia's and Indiana's bills do not explicitly address the processes whereby insurer compliance data would become available to the public. Accordingly, assuming that West Virginia's and Indiana's Open Records (or analogous) Laws are similar to Georgia's, the presumption in the law is that information held by an agency must be disclosed unless otherwise specifically exempted from disclosure by statute. For example, confidential personal information (like a person's medical records) or trade secret protected information would likely be exempted from disclosure but requested information would otherwise have to be released.

Arizona requires its department to develop a web-page with consumer friendly information regarding the scope and applicability of the federal Mental Health Parity and Addiction Equity Act to insurers in its state. The web-page must also include information regarding how consumers can file a complaint against offending insurers. Additionally, the web-page must include an aggregated summary of the department's analysis of the reports that it received from insurers but the web-page shall not disclose any proprietary information. Arizona is unique among the five states examined in that it explicitly prohibits the insurance department from posting any analysis or other information on its web-page that would allow a person to identify any specific insurer.

Additional Unique Features:

Arizona's bill is also unique in that it establishes an advisory committee to assist the Department of Insurance.

supported institution of this state or a community center for mental health or mental retardation services shall consider any insurance policy or policies that provide coverage to the patient for mental illness or mental retardation.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

SUBCHAPTER F. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS

Sec. 1355.251. DEFINITIONS. In this subchapter:

(1) "Mental health benefit" means a benefit relating to an item or service for a mental health condition, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

(2) "Nonquantitative treatment limitation" means a limit on the scope or duration of treatment that is not expressed numerically. The term includes:

(A) a medical management standard limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether a treatment is experimental or investigational;

(B) formulary design for prescription drugs;

(C) network tier design;

(D) a standard for provider participation in a network, including reimbursement rates;

(E) a method used by a health benefit plan to determine usual, customary, and reasonable charges;

(F) a step therapy protocol;

(G) an exclusion based on failure to complete a course of treatment; and

(H) a restriction based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of a benefit.

(3) "Quantitative treatment limitation" means a treatment limitation that determines whether, or to what extent, benefits are provided based on an accumulated amount such as an annual or lifetime limit on days of coverage or number of visits. The term includes a deductible, a copayment, coinsurance, or another out-of-pocket expense or annual or lifetime limit, or another financial requirement.

(4) "Substance use disorder benefit" means a benefit relating to an item or service for a substance use disorder, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law.

Added by Acts 2017, 85th Leg., R.S Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.252. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that provides benefits or coverage for medical or surgical expenses incurred as a result of a health condition, accident, or sickness and for treatment expenses incurred as a result of a mental health condition or substance use disorder, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, an individual or group evidence of coverage, or a similar coverage document, that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a health maintenance organization operating under Chapter 843;

(6) a reciprocal exchange operating under Chapter 942;

(7) a Lloyd's plan operating under Chapter 941;

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(9) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846.

(b) Notwithstanding Section 1501.251 or any other law, this subchapter applies to coverage under a small employer health benefit plan subject to Chapter 1501.

(c) This subchapter applies to a standard health benefit plan issued under Chapter 1507.

Added by Acts 2017, 85th Leg., R.S Ch. 769 (H.B. 10), Sec. 2, eff September 1, 2017.

Sec. 1355.253. EXCEPTIONS. (a) This subchapter does not apply to:

(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for dental or vision care;

(E) only for hospital expenses;

(F) only for indemnity for hospital confinement; or

(G) only for accidents;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss(g)(1));

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1355.252.

(b) To the extent that this section would otherwise require this state to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit under this subchapter that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

Added by Acts 2017, 85th Leg., R S Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.254. COVERAGE FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE USE DISORDERS. (a) A health benefit plan must provide benefits and coverage for mental health conditions and substance use disorders under the same terms and conditions applicable to the plan's medical and surgical benefits and coverage.

(b) Coverage under Subsection (a) may not impose quantitative or

nonquantitative treatment limitations on benefits for a mental health condition or substance use disorder that are generally more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

Added by Acts 2017, 85th Leg., R S Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.255. COMPLIANCE. The commissioner shall enforce compliance with Section 1355.254 by evaluating the benefits and coverage offered by a health benefit plan for quantitative and nonquantitative treatment limitations in the following categories:

(1) in-network and out-of-network inpatient care;

(2) in-network and out-of-network outpatient care;

(3) emergency care; and

(4) prescription drugs.

Added by Acts 2017, 85th Leg., R S Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.256. DEFINITIONS UNDER PLAN. (a) A health benefit plan must define a condition to be a mental health condition or not a mental health condition in a manner consistent with generally recognized independent standards of medical practice.

(b) A health benefit plan must define a condition to be a substance use disorder or not a substance use disorder in a manner consistent with generally recognized independent standards of medical practice.

Added by Acts 2017, 85th Leg., R.S Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Sec. 1355.257. COORDINATION WITH OTHER LAW; INTENT OF LEGISLATURE. This subchapter supplements Subchapters A and B of this chapter and Chapter 1368 and the department rules adopted under those statutes. It is the intent of the legislature that Subchapter A or B of this chapter or Chapter 1368 or a department rule adopted under those statutes controls in any circumstance in which that other law requires:

(1) a benefit that is not required by this subchapter; or

(2) a more extensive benefit than is required by this subchapter.

Added by Acts 2017, 85th Leg., R.S Ch. 769 (H.B. 10), Sec. 2, eff September 1, 2017.

Sec. 1355.258. RULES. The commissioner shall adopt rules necessary to implement this subchapter.

Added by Acts 2017, 85th Leg R.S., Ch. 769 (H.B. 10), Sec. 2, eff. September 1, 2017.

Appendix D

Testimonials and Subject Matter Expert Advisement provided to the BHRIC Hospital and Short-Term Care Sub Committee

Emily Acker, President and CEO, Hillside
-Parity in Georgia, Hospital/Crisis Care Continuum

Debbie Atkins, Director of Crisis Coordination, Georgia Department of Behavioral Health and Developmental Disabilities
-Hospital/Crisis Care Continuum

Kristen Cranmer, MSN, RN, CPNP, PCNS-BC, NEA-BC, Children's Director Case Management
-Hospital/Crisis Care Continuum

Michele Davis-Martin, MSW/LCSW, Children's Director Family Support Services
-Hospital/Crisis Care Continuum

Erika Fener-Sitkoff, PhD, Executive Director, Voices for Georgia Children
- Behavioral Health Workforce in Georgia

Blake Fulenwider, Department of Community Health
-Parity in Georgia, Hospital/Crisis Care Continuum

Erin Harlow-Parker, APRN, PMHCNS-BC, Children's Behavioral Health Program Manager and Consult Psychiatry CNS
-Hospital/Crisis Care Continuum

Betsy Howerton, Deputy Legislative Counsel, Office of Legislative Counsel
-Parity Legislative Analysis

Amy Greenblatt, MPH, BSN, RN-PhD Candidate, Emory School of Nursing
-Parity in Georgia, Hospital/Crisis Care Continuum

David Lloyd, Senior Policy Advisor, The Kennedy Forum
-National perspective on parity

Catherine Ivy, LCSW, Deputy Executive Director, Georgia Department of Community Health
-Telehealth expansion during the pandemic

Ted Lutterman, National Association of State Mental Health Program Directors Research Institute
-Parity in Georgia, Hospital/Crisis Care Continuum

Monica Johnson, Director of Division of Behavioral Health, Georgia Department of Behavioral Health and Developmental Disabilities
-Hospital/Crisis Care Continuum

Lynn Perez, Children's VP, Brain Health Center & Marcus Autism Center
-Hospital/Crisis Care Continuum

Helen Robinson, Associate Director, Public Policy, Mental Health Program, The Carter Center, and the Georgia Parity Collaborative
-Parity in Georgia

Dan Salinas, MD, Children's Chief Medical Officer
-Hospital/Crisis Care Continuum

Mary-Linden Salter, LCSW, Executive Director, Tennessee Association of Alcohol, Drug & other Addiction Services
-Tennessee case study on parity

Laura Sellers, RHIA, VP Quality Improvement, Hillside
-Parity in Georgia, Hospital/Crisis Care Continuum

Adam Silberman, MD, Medical Director, Hillside
-Parity in Georgia, Hospital/Crisis Care Continuum

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