NAMI Georgia
National Alliance on Mental Illness

Rural Development Council

Supporting Documents

NAMI Georgia

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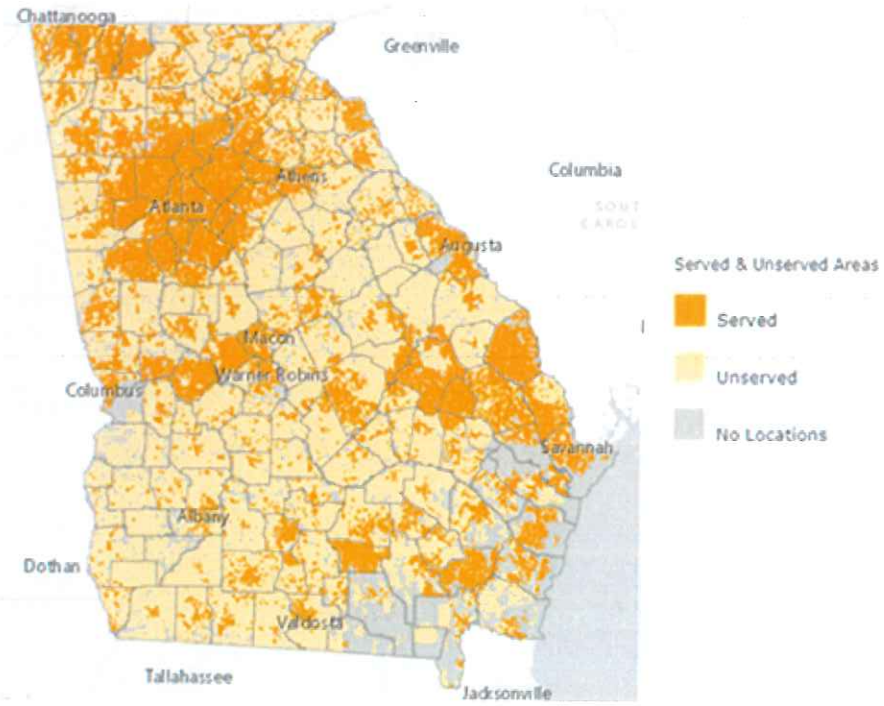
Broadband Recommendations

A suggestion for the BHRIC Hospital and Short-Term Care Subcommittee to build on its previous work relating to telehealth and access to behavioral health care.

As shown by the map below, created by the Georgia Broadband Deployment Initiative, the lack of broadband Internet connectivity in many of Georgia's rural communities segregates those communities from access to opportunity and upward mobility, including access to health care.



Funding made available by the recently-passed federal infrastructure bill and also by several of the federal pandemic recovery acts makes statewide broadband Internet access a very real possibility.

The infrastructure bill allocates about $65 billion to improve broadband internet access in rural areas and make broadband more affordable for lower-income households across the U.S. The bulk of the money, $42.5 billion, will go directly to states and territories to fund internet improvements. The intent is to focus on unserved and underserved areas of the country, those that lack any internet access or where consumers can receive only low-bandwidth speeds.

As noted previously by the Hospital and Short-Term Care Subcommittee, telehealth — the use of telecommunications technologies to deliver healthcare, public health services, and health education from a distance — is reshaping the delivery of clinical care and health-related services.

Most of Georgia's rural communities suffer from healthcare access issues, stemming in large part from acute shortages of healthcare providers and geographic barriers to care. The delivery of healthcare services remotely through telehealth approaches improves health care access for those communities.

Statewide broadband Internet access is crucial to Georgia's ability to address the chronic shortage in the number of health professionals, especially those providing behavioral health services. Telehealth reduces health disparities by bringing behavioral healthcare to communities where care was previously unavailable, facilitating monitoring and follow-up care for chronic health conditions, and connecting providers to Georgians in more remote areas.

Importance of our Medicaid and PeachCare programs
December 2021

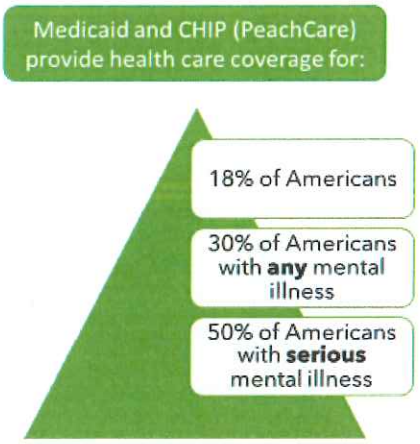
The info below sets out the importance of our Medicaid and PeachCare programs for Georgians with behavioral health challenges, especially our children.

As set out in more detail below, while Medicaid and CHIP (PeachCare) cover about **18%** of the population, that population includes **30%** of persons with ANY mental illness and **50%** of persons with SERIOUS mental illness.

Georgia's PeachCare and Medicaid programs cover **3 in 8** children and about **half** of all lifetime cases of mental illness begin by **age 14.** Among Medicaid and CHIP (PeachCare) beneficiaries, only **54.1 percent** of youth with a major depressive episode received any form of mental health treatment in the past year.

The importance of Medicaid and PeachCare to Georgians with behavioral health challenges, especially our youth

- Georgia's Medicaid and PeachCare programs provide health care for more than **2.1 million** of Georgia's most medically-vulnerable citizens, including, **3 in 8 children**, 5 in 7 nursing home residents, and 1 in 3 individuals with disabilities.
  - **About half** of all lifetime cases of mental illness **begin by age 14** and three-fourths by age 24.
- Among Medicaid and CHIP beneficiaries, only **54.1 percent** of youth with a major depressive episode received **any form** of mental health treatment in the past year.
- Preliminary data show a **44 percent drop** in outpatient mental health visits among children covered by Medicaid and CHIP during the pandemic, even after accounting for an uptick in telehealth visits.
- Adolescents with significant mental health conditions are **less likely to finish high school** and attain higher education They are also at **increased risk** for institutional placements, cooccurring substance use disorder, and suicidal behaviors.



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Network Adequacy and Mental Health Care in Georgia

Presentation to the House Special Committee on Access to Quality Health Care

November 16, 2021

Roland Behm

Presenting on behalf of NAMI Georgia

Network Adequacy

What it is and why we should care

Network adequacy refers to whether a health plan

- contracts with a sufficient number and type of qualified health care providers
- to ensure members have access to covered benefits
- within a reasonable travel distance and appointment wait time.

When plans do not have sufficient numbers or types of providers, patients are forced to wait or travel long distances for care, pay higher costs to receive care from an out-of-network provider, or forgo needed medical care all together.

Network adequacy and parity compliance

- Network adequacy is a foundational element of behavioral health care parity.
- The processes, factors and standards used to build the plan's network of mental health and substance use disorder treatment providers must be comparable to, and applied no more stringently than, those used to create the plan's network of medical/surgical providers.
- Assessing network adequacy is critical for evaluating parity compliance.

Network inadequacy

When plans do not have sufficient numbers or types of providers, patients are forced to pay more money to receive care from an out-of-network provider or forgo needed medical care all together.

Consumers with private health plans access mental health and substance use disorder services from out-of-network providers at a significantly higher rate than for non-MH/SUD services.

A fundamental driver of network inadequacy is that, in general, health insurance issuers and claims administrators significantly underpay in-network behavioral health providers, particularly in comparison to in-network medical and surgical providers.

Milliman Report Findings (2019)

Inadequate Number of In-Network MH/SUD Providers

Behavioral health **access disparities escalated from 2013 to 2017 in all three categories** of care examined: office visits, inpatient facilities, and outpatient facilities.

Notwithstanding the national opioid and suicide crises, mental health and substance use treatment together accounted for **less than 3.5%** of total heath care spend, with **substance use treatment ranging from 0.7 to 1%** of that total over the five-year period measured.

Children were 10 times more likely to receive outpatient mental health care out of network compared to primary care visits, twice the disparity faced by adults.

Georgia-Specific Findings

Georgians are **4.4 times more likely** to have to go out of network for inpatient access to behavioral health

Georgians are **4.2 times more likely** to have to go out of network for office visit access to behavioral health

Georgians are **9.7 times more likely** to have to go out of network for outpatient facility access to behavioral health

You Get What You Pay For

Access barriers to in-network providers are particularly acute for mental health (MH) and substance use disorder (SUD) providers and facilities.

- Approximately half of all psychiatrists do not accept insurance, and network participation has been declining for psychiatrists at a greater rate than other medical specialties.
- Studies show a consistent pattern among private health plans, both nationally and in most states, of higher utilization of out-of-network services and higher out-of-pocket costs for MH and SUD services as compared to other medical providers.

The Milliman study found that in-network mental health professionals in Georgia received 38% less than other health professionals for similar billing codes. In a state where there is a high demand for, and low supply of, mental health professionals, it is no surprise that Georgia mental health professionals are uninterested in working for substantially below market compensation.

Georgia's shortage of psychiatric beds

There is a widely-acknowledged lack of psychiatric beds* for Georgians in need of intensive behavioral health care.

A distinction must be drawn, however, between:

1. The number of in-state psychiatric beds available to Georgians, and
2. The number of psychiatric beds available in Georgia.

Many of the psychiatric beds in Georgia are being used by non-Georgians whose insurance, including their state's Medicaid programs, pay more than do Georgia's insurers and Medicaid managed care providers.

Payments being made by out-of-state insurers and Medicaid providers are clearly communicating that Georgia insurers and Medicaid providers are offering below-market rates.

* The lack of psychiatric beds has nothing to do with the beds themselves; rather, it is a shorthand reference to the shortage of in—state behavioral health professional to staff those beds.

Network adequacy and medical workplace violence

An inadequate network of behavioral health care professionals leads to increased risks of violence.

The lack of an adequate network results in persons being unable to access non-critical behavioral health care. In 2018, 50 percent of Medicaid beneficiaries with serious mental illness reported that they needed but did not receive treatment. Untreated behavioral health symptoms lead to crisis and the need for crisis care at the emergency department (ED).

There are limited mental health resources at EDs for persons with psychiatric medical emergencies, causing persons in crisis to wait hours or days to get seen by a medical professional. Prolonged waiting times in EDs increase the risk for violence.

Further, a critical shortage of psychiatric beds forces mentally ill patients with severe symptoms to be held in emergency rooms and hospitals while they wait for a bed, sometimes for weeks. The practice, known as psychiatric boarding, prevents patients from getting the care they need.

Timely access to necessary and appropriate care will reduce the risk of violence, especially in the ED, where up to 50% of all attacks on healthcare workers occur.

Georgia's Medicaid and PeachCare programs

Georgia's Medicaid and PeachCare programs provide health care for more than 2.1 million of Georgia's most medically-vulnerable citizens, including, 3 in 8 children, 5 in 7 nursing home residents, and 1 in 3 individuals with disabilities.

Medicaid covers 17.8% of the U.S. adult population, but that population accounts for 30.2% of all persons with any mental illness, 22% of adults with mild to moderate mental illness, and 49.5% of adults with serious mental illness.

50% of Medicaid beneficiaries with serious mental illness reported that they needed but did not receive treatment.

Status of Medicaid Parity Compliance

In April 2016, CMS published a final rule on Medicaid/CHIP (PeachCare) parity, setting out detailed elements, timelines and requirements, including specific contract amendments and public information requirements

DCH and Georgia's Medicaid and PeachCare CMOs do not comply with legally-mandated parity obligations.

Money For Nothing: Medicaid and Medical Loss Ratios

A medical loss ratio (MLR) is a measure of the percentage of premium dollars that a health plan spends on medical claims and quality improvements, versus profits and administrative costs. CMS regulations require that Medicaid capitation rates be set using an 85% MLR.

Most states have adopted MLRs of 85% or more (some as high as 90%). Georgia has not. Many states also recoup the difference between their MLR rates and actual MLRs (when less than state MLR). Georgia does not.

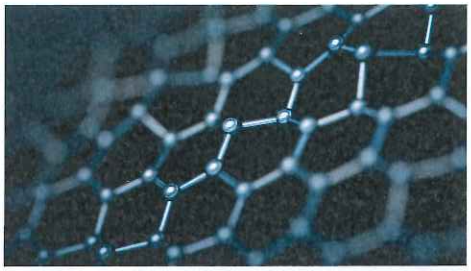
Instead of ensuring adequate health care networks for Georgia's children, Georgians with disabilities, and Georgians in nursing facilities, hundreds of millions of dollars go instead to the Georgia CMOs' bottom lines.

State	MLR	Variance Percentage[1]	Variance Amount[2]
Florida	89.1%	6.1%	$671 million
Georgia	83.0%[3]	--	--
Kentucky[4]	89.7%	6.7%	$737 million
Louisiana[4]	87.0%	4.7%	$517 million
Mississippi[4]	91.5%	8.5%	$935 million
South Carolina	89.6%	6.6%	$726 million
Tennessee	84.6%	1.6%	$176 million
Texas	90.2%	7.2%	$792 million

Notes:
1 Difference between state MLR and Georgia MLR
2 Georgia Medicaid expenditures ($11 billion/year) multiplied by Variance Percentage
3 States with MLRs equal to or less than Georgia: Michigan (79.7%) and Nevada (83.0%)
4 State requires remittances from Medicaid plans not meeting MLRs

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)

Potential actions to address inadequate behavioral health care networks in Georgia



Adopt

Adopt a minimum MLR for Medicaid CMOs of at least 85% and require repayment by CMOs to DCH of all amounts under the minimum MLR.

Establish

Establish parity compliance units at both DCH and DOI. The former to enforce Medicaid parity requirements, the latter to enforce parity requirements for non-Medicaid providers

Ensure

Ensure insurance providers offer market-based reimbursement rates to attract and retain behavioral health care workers and that their provider directories are accurate.

Direct

Direct DCH and OIC to conduct periodic examinations and audits of insurance providers for parity compliance, including network adequacy reviews.

That which gets measured gets done.

A **medical loss ratio (MLR)** is a measure of the percentage of premium dollars that a health plan spends on medical claims and quality improvements, versus profits and administrative costs. Many states have adopted MLRs of **85% or more** (some as high as 90%). Georgia currently has not. Many states also **recoup the difference between their minimum MLR rates and actual MLRs** (when less than state minimum MLR). Georgia currently does not.

Set out below are three tables:

1. The first shows the actual 2019 MLRs for all "SEC States" that use managed care organizations to provide Medicaid and CHIP (PeachCare) services.

2. The second shows the difference between Georgia's actual MLR for 2019 and each of the other SEC States' actual MLR for that year (**Variance Percentage**)

3. The third shows the additional amount that would have been spent in 2019 on health care for Georgia Medicaid and PeachCare recipients if Georgia' actual MLR equaled each of the other SEC States' actual MLR (**Variance Amount**)

State	MLR
Missouri	95.0%
Mississippi	91.5%
Texas	90.2%
Kentucky	89.7%
South Carolina	89.6%
Florida	89.1%
Louisiana	87.0%
Tennessee	84.6%
Georgia	83.0%

State	Variance Percentage
Missouri	12.0%
Mississippi	7.5%
Texas	7.2%
Kentucky	6.7%
South Carolina	6.6%
Florida	6.1%
Louisiana	4.0%
Tennessee	1.6%

State	Variance Amount
Missouri	$1.32 billion
Mississippi	$825 million
Texas	$792 million
Kentucky	$737 million
South Carolina	$726 million
Florida	$671 million
Louisiana	$440 million
Tennessee	$176 million

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)

Georgia ranks last in actual MLRs among the SEC States. If Georgia's actual MLR equaled the MLRs of the other SEC States, anywhere **between $176 million and $1.32 billion more** would have been spent on health care for Medicaid and PeachCare recipients.

Repayment due to failure to achieve the minimum MLR is a **second-best result**, though better than the money remaining with the CMOs. If money is repaid, about 72% of the amount must go back to the CMS as repayment of the federal share. The **best result** is for the CMOs to meet or exceed the minimum MLR as this result provides more health care Georgia's most vulnerable citizens, including 3 out of every 8 children.

Georgia's CMOs may point to their relatively "minimal profitability." This is misleading since many of the CMOs provide services like claims processing, education and outreach programs, and information systems, through affiliates and none of those services are provided at cost. For example, Centene, the St. Louis-headquartered publicly traded parent company of Peach State, **set aside $1.1 billion** to settle claims that a subsidiary misrepresented costs to obtain Medicaid overpayments from states including Georgia. In announcing the settlement, Mississippi Attorney General Lynn Fitch said it "*makes clear that the days of hiding behind a convoluted flow of money and numbers are over.*"

Reporters have expressed interest in the issue of MLRs and MLRs can easily become a political issue. Questions can be raised as to why the state is concerned more about the economic health of the CMOs than the physical and mental health of its citizens or why "big fraud" (no minimum MLR and no repayment) is tolerated while "little fraud" (e.g., doctor overbilling) is not.

Georgia Medicaid and PeachCare Parity Reporting

A suggestion that parity compliance reporting for Medicaid and PeachCare CMOs be included as part of the CMO compliance reporting being sought by the House Budget & Fiscal Affairs Oversight Committee.

The Committee held a hearing.on November 17, 2021, at which Jesse Weatherington and Blake Fulenwider delivered a presentation on possible elements of the proposed reporting. They appeared to recognize an irritation among committee members regarding the lack of transparency and insight into the CMOs and the functioning of the Georgia Medicaid and PeachCare programs.

Since the CMOs and DCH are obligated under federal regulation to report on party-related matters, consideration may be given to including those reporting obligations in the reporting being considered by the committee, thereby eliminating potential duplication.

Medicaid is the single largest payer of behavioral health care in Georgia -- currently, 2.4 million Medicaid recipients in the state -- and approximately 50% of persons with serious mental illness are covered by Medicaid in the U.S.

In order to ensure an effective parity compliance system for Georgia residents, there is a need for a dedicated complaint portal for residents aggrieved by alleged parity violations to file a complaint with the Office of Insurance Commissioner (OIC). Currently, there is little to no insight into the number of Georgians challenging coverage denials for mental health and substance use disorders.

Attached is a draft bill based on a bill passed by the Texas state legislature last year directing the OIC to establish an online parity complaint portal, to prepare and disseminate educational materials on parity rights for insured Georgians with mental health conditions and substance use disorders, and to inform the public about the portal and its functions.

The Texas legislation had an attached fiscal note. The funds needed to stand up the portal might come from some of the federal COVID relief funding, inasmuch as the expenditures can be made over the next 2-3 years.

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Mental Health Workforce
December 2021

This 11Alive story talks about the fight for insurance coverage for applied behavioral analysis (ABA) for Georgia's children with autism, told by reference to the young child (Ava) for whom the legislation is named. The entire article is worth a read and I wanted to highlight a couple of areas that are relevant to the work being done on the draft bill.

If we fund it they (workforce) will come
When Ava's Law passed seven years ago, Georgia set a high Medicaid reimbursement rate compared to other states. As a consequence, many more providers came into the Medicaid/PeachCare network.

It's proof that if you set appropriate reimbursement rates, providers able to deliver the services will come into the Medicaid networks.

Like psychiatric beds, out-of-staters are taking advantage of Georgia's ABA
Gwen Skinner of Devereux, a psychiatric residential treatment facility in metro Atlanta, and Chair of Georgia's Workforce and System Development Committee on the BHRIC. notes that while Georgia pays about $2850 for a youth to receive a week of treatment at Devereux. Florida pays $4200.for the same week of treatment).

"We're losing capacity in Georgia. The providers are beginning to take more and more out-of-state youth in order to remain financially viable. So that means Georgia youth when they have those needs, there's nowhere to go," Skinner said.

Increasing reimbursement rates to "market level" (as evidenced by Florida's rate) might be a good use of some of the Medicaid funds to get Georgia CMOs to achieve a minimum MLR.

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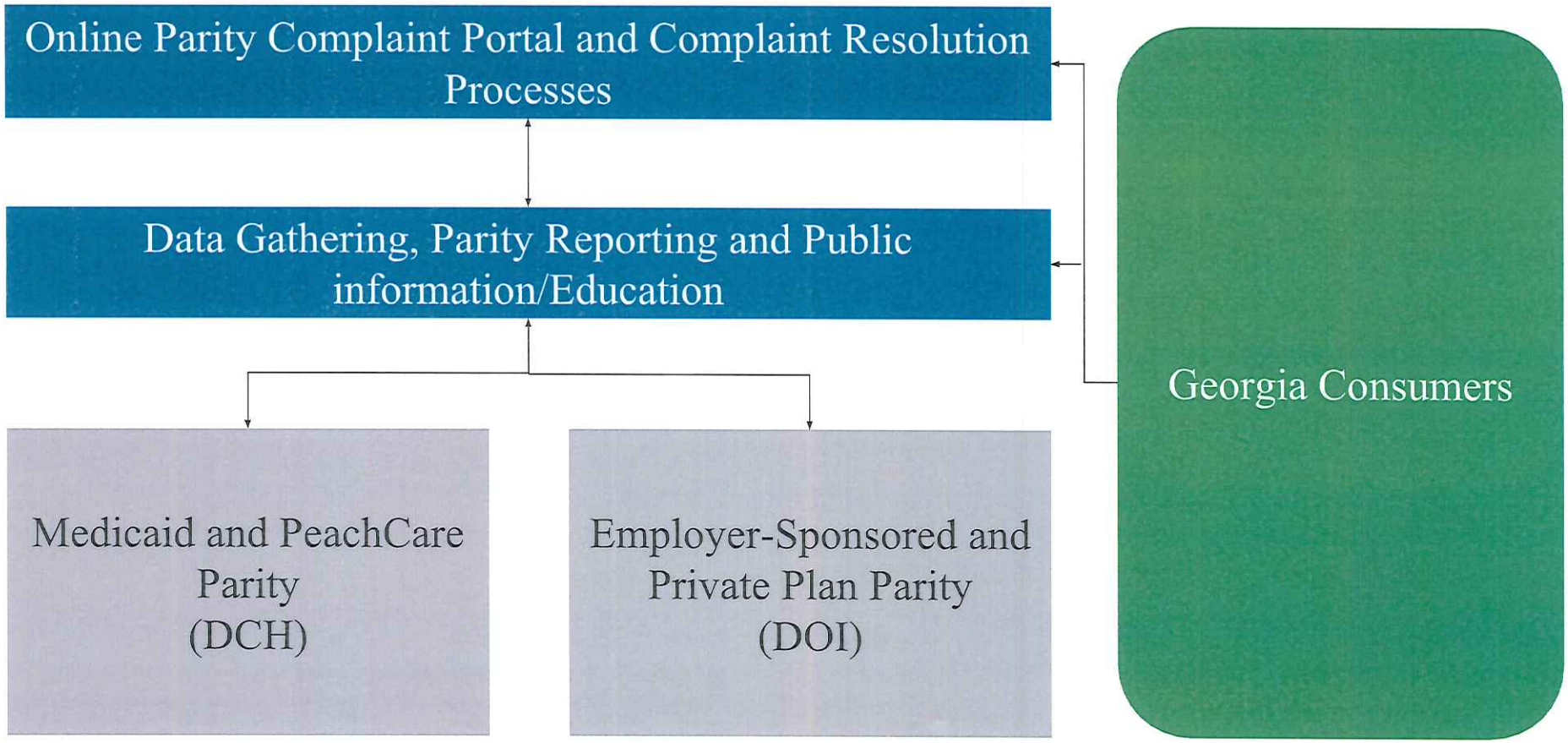
GEORGIA PARITY COMPLIANCE OFFICE



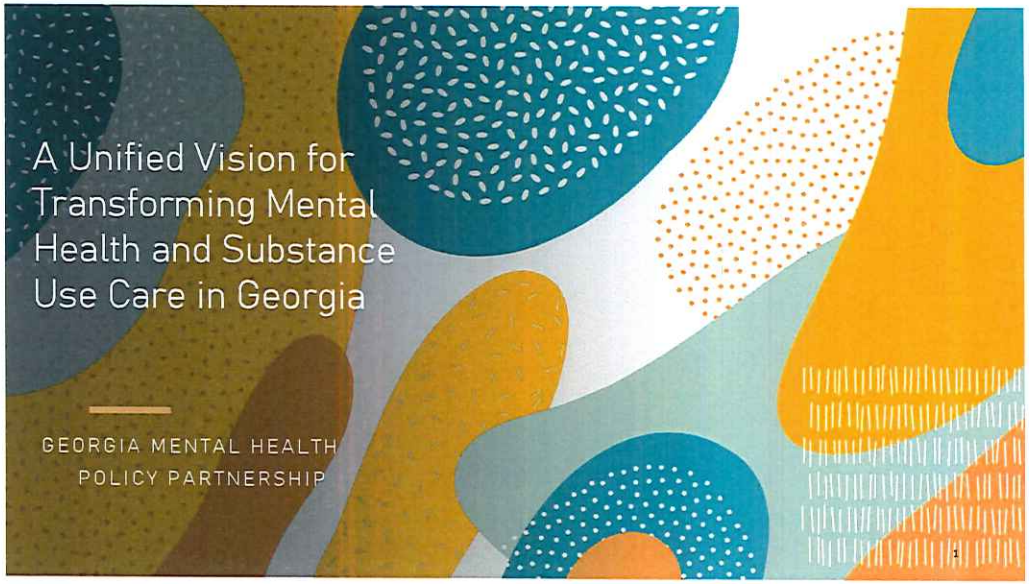
GEORGIA

PARITY COMPLIANCE OFFICE

(Concept)

- Assumes responsibility for parity transparency and accountability for all relevant insurance plans, including Medicaid/PeachCare (DCH) and employer and private insurance plans (DOI), eliminating duplication
- Establishes and maintains an online parity complaint portal that is an integrated system allowing for the enrollee of insurance plans to submit complaints of suspected parity violations:
  - Allows enrollees to submit a complaint via multiple methods (e.g., online submission, text, call, writing)
  - Provides updates on the status of an enrollee's complaint
  - Ensures timely, effective, and equitable resolution of submitted complaints
  - Distributes educational materials on Georgians' parity rights
- Educates Georgians about their parity rights and the complaint portal and its function though ongoing statewide marketing campaign
- Oversees and audits parity-related actions taken by DCH and DOI
- Reports periodically to the Executive and Legislative branches and provides public reporting of performance and quality metrics

There are substantial commonalities between government-funded plans and employer/individual funded plans. This Parity Office Compliance concept allow for the establishment and use of a single online complaint portal for all plans. Further, the office's purpose is focused on parity transparency and accountability, and it will not run the risk of becoming an agency afterthought.



WHAT

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

HOW

- Fundamentally shift perceptions around behavioral health and well-being
- Embrace the concept of population health, which includes prevention, promotion, and recovery
- Address vital conditions such as housing, transportation, and employment
- Transform the systems that impact whole-person health
- Integrate care and ensure people receive the services and support they need, when and where they need them
- Institute policies, programs, and standards that value the critical importance of behavioral health
- Intentionally address racism and discrimination that have created inequities in care and unacceptable disparities in outcomes

Seven foundational elements

Early identification and prevention

Georgia must increase efforts that emphasize the early identification and prevention of behavioral healthcare challenges, including addressing social determinants of health like trauma and adversity..

Left unaddressed, the negative effects of failing to address early traumatic events manifest themselves over a person's lifespan in terms of physical and mental illnesses and substance abuse disorders.

Early intervention is proven to be effective and to reduce costs.

- Expand APEX and other school-focused behavioral health services
- Increase access to behavioral telehealth in schools
- Expand gatekeeper training for school personnel – e.g., mental health/suicide prevention/substance misuse
- Increase first Episode Psychosis treatment initiatives (3 in 100 persons affected)
- Expand SBIRT (screening brief intervention referral treatment) efforts
- Implement evidence-based mental health/substance abuse screenings
- Establish and encourage community-based MH/SUD information and education

Workforce

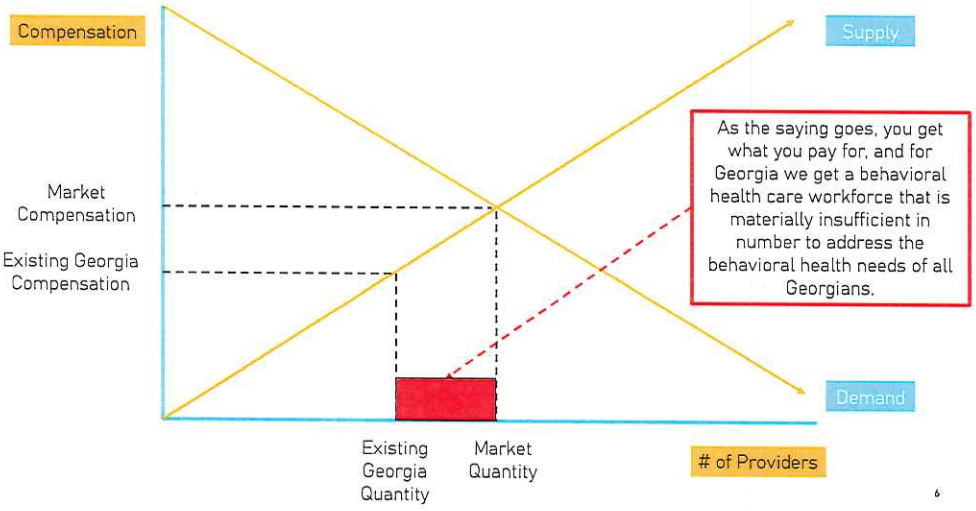
In a state that embraces free market capitalism, it is no surprise that Georgia ranks 51st out of the 50 states and D.C. in terms of its citizens access to mental health care.

The actuarial firm Milliman found significantly compromised reimbursement rate systems for Georgia mental health professionals, including a finding that mental health care professionals in Georgia are being paid 38% less by insurers than health professionals providing comparable services.

Milliman also found that Georgians are: (A) 4X more likely to have to go out of network for inpatient behavioral care, and (B) 9.7X more likely to have to go out of network for outpatient behavioral care than they are for general health care. When in-network access is not available, patients are forced to pay more out-of-pocket for the services– in addition to their premiums that purport to cover such services -- or forego needed treatment with potentially life-threatening consequences.

The result? A significant lack of mental health providers in Georgia as shown in the red box on the follow page's chart.

- Ensure that state-administered programs like Medicaid and PeachCare offer market-based reimbursement rates to attract and retain behavioral health care workers.
- Enforce parity obligations of both private insurers and Georgia's Medicaid and PeachCare programs. Current reimbursement rates by private insurers are more than 25% below market rates
- Grow peer workforce programs – e.g., CPS and CARES
- Allow providers to offer a range of care fully consistent with their education and training
- Increase access to culturally and linguistically appropriate care



Parity

Imagine if one's access to necessary and appropriate health care is dependent on one's illness? What if one could access medical care for cancer, but not for diabetes or sickle cell anemia?

One doesn't have to imagine such a scenario in Georgia.. Discrimination in access to behavioral health coverage is a disturbing and illegal reality for many Georgians.

Insured Georgians have significantly more difficulty accessing behavioral health treatment -- treatment for mental illnesses and substance use disorders -- than accessing other medical care. Insurance companies impose limitations, both quantitative and non-quantitative, on accessing behavioral health benefits that are not imposed for other medical benefits.

- The Department of Community Health (DCH) and Office of Insurance and Safety Fire Commissioner (OIC) should conduct periodic examinations and audits of Medicaid and CHIP providers and commercial health insurance plans for parity compliance, including:
  - Market conduct examinations
  - Network adequacy reviews
- Funding should be provided to DCH and DOI to fund and train staff who will conduct those examinations.
- DCH must comply with the 2016 CMS Final Rule on Parity, including the insertion of contractual provisions in contracts with Medicaid and PeachCare CMOs obligating the CMOs to fulfill legislative and regulatory parity requirements
- Implement a marketing campaign to educate Georgians on their parity rights and to develop, market, and maintain a parity complaint tracking and resolution process.

Emergency and crisis response

Behavioral health treatment and suicide prevention are critical health care issues. Yet, when someone experiences a behavioral health crisis, they are often more likely to interact with a law enforcement officer than a medical professional.

The absence of a truly comprehensive community mental health system means that law enforcement are often the first responders to mental health crises. When law enforcement responds, people in crisis too often end up in jails..

We need readily accessible crisis care as an essential component of our behavioral health service system, with three core elements:

There are three core elements: :

1. regional or statewide 24/7 crisis call centers,
2. mobile crisis teams, and
3. crisis receiving and stabilization programs.

- Implement fully the 988 number and crisis response system, including funding through mobile phone fee provided by the legislation signed by President Trump
- Establish additional behavioral health community service centers (BHCSCs)
- Implement co-responder models of law enforcement and MH/SUD clinicians or peers
- Accelerate CIT training for law enforcement
- Increase number and utilization of mobile assessment team services
- Establish Medicaid state plan option to cover short-term acute care in specialized inpatient and residential settings, while also improving step-down and step-up transitions and access to outpatient treatment

Integrated care

Individuals with chronic behavioral health conditions die on average more than 20 years earlier than the general population and it is routinely due to their physical health ailments being unaddressed.

In integrated behavioral health care, medical and behavioral health clinicians work together as a team to address a patient's concerns. Care is delivered by these integrated teams in the primary care setting unless patients request or require specialty services. The advantage is better coordination and communication, while working toward one set of overall health goals.

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

- Increase the number and capacity of FHQCs in Georgia and build on existing collaborative partnerships between FHQCs and Community Service Boards (CSBs)
- Incentivize co-location of mental health clinicians in primary care centers and vice versa.
- Encourage the use of behavioral health screening tools in primary care centers and vice versa

Reduce stigma and increase help-seeking behavior: It is easier to access behavioral health care treatment in a familiar health care setting, rather than going to a behavioral health setting.

Healthcare equity

"Protection to person . . . is the paramount duty of government and shall be impartial and complete," so reads Article I, Section I of Georgia's constitution.

Many people in Georgia are starving, in a figurative sense, for adequate health care. Some groups are disproportionately exposed to a combination of health risks, such as poverty, violence, unsafe living conditions, and environmental health hazards that can increase the need for health care interventions.

Racial and ethnic minorities, low-income groups, and members of the LGBTQ+ community face health risks at a higher rate than the general population..

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

- Reducing the number of Georgians without health insurance
- Expanding access to health care through the introduction of mobile health clinics or telehealth initiatives such as remote healthcare services or education
- Addressing social determinants of health (housing, employment, transportation, food shortage)
- Expanding offerings of culturally and linguistically appropriate services (CLAS) and cultural awareness and diversity training
- Expanding pipeline for professional workforce development – representation matters
- Encouraging challenged populations to participate in system design

Standards

To improve health outcomes and quality of life for people with mental health and substance use conditions, it is necessary to establish and hold systems accountable to standards of quality care and to adopt payment models that support the cost of providing effective, integrated care.

Accountability (quality measurement) requires standards for measuring the performance of healthcare providers in caring for patients and populations. Quality measures identify important aspects of care like safety, effectiveness, timeliness, and fairness.

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.

- Engage in information gathering – e.g., surveys, polls, listening sessions – to define the baseline on MH/SUD in Georgia.
- Develop public-facing scorecards allowing Georgians to compare the quality and evidence base of health plans and MH/SUD facilities
- Implement program fidelity reviews to ensure compliance with legislative purpose. That which gets measured, gets done.
- Universal and repeated MH/SUD screening of relevant demographics – e.g., public school students and incarcerated Georgians.
- Operationalize the data from the Georgia Student Health Survey
- Build statewide trauma-informed knowledge base