Georgia House Bill 1013 Legislative Report

Georgia Department of Community Health: Results of Study Responsive to O.C.G.A. Sec. 31-2-17

1-18-2023

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1. Introduction

House Bill 1013 (HB1013), "The Mental Health Parity Act" was signed into law by Georgia Governor Brian Kemp on April 4, 2022. With an effective date of July 1, 2022, the law enacts several policy changes intended to expand access to behavioral health services throughout the state. One requirement of the law is that the Department of Community Health (DCH) conduct a study which assesses several topics related to behavioral health care in Georgia. Specifically, the law states that:

"The department [DCH] shall undertake a study of the following:

(1) Comparison of reimbursement rates for mental health services under Medicaid, PeachCare for Kids, and the state health benefit plan with other states;
(2) Reimbursement for health care providers providing mental health care services under Medicaid, PeachCare for Kids, and the state health benefit plan and comparison with other states;
(3) Reimbursement for hospitals caring for uninsured patients with mental health and substance abuse disorders in the emergency department for extended periods of time while the patient is waiting on placement and transfer to a behavioral health facility for evaluation and treatment;
(4) An accurate accounting of mental health fund distribution across state agencies, including, but not limited to, the department, the Department of Behavioral Health and Developmental Disabilities, the Department of Human Services, and the Department of Juvenile Justice;
(5) Medical necessity denials for adolescent mental and behavioral health services; and
(6) Implementation of coordinated health care for any child who enters foster care such that Medicaid claims data shall be shared immediately with the Division of Family and Children Services of the Department of Human Services." [1]

DCH has engaged Deloitte Consulting LLP (Deloitte) for assistance with producing this report, which contains the elements requested above. Throughout this report, the requested studies are provided in the same order they were listed in HB1013.

2. Comparison of Georgia's Behavioral Health Reimbursement Rates to Other States

2.1. Background and Legislative Request

Georgia House Bill 1013 directs the Department of Community Health to undertake a study of "reimbursement rates for mental health services under Medicaid, PeachCare for Kids, and the State Health Benefit Plan with other states." The comparison of *reimbursement rates* discussed in this section differs from the comparison of *reimbursement for health care providers* which is discussed in the next section. The ***reimbursement rate*** comparison discussed in this section refers to comparisons of the amount charged for services, while ***reimbursement*** *for healthcare providers* discussed in the next section refers to the total amount of money a provider receives for the services that they deliver. This section will include comparisons of Georgia's Medicaid and State Health Benefit Plan (SHBP) rates for behavioral health services to each other and to rates for the same services in six comparator states.

To produce a focused analysis, the behavioral health services included for comparison to other states were Georgia's Community Behavioral Health Rehabilitation Services (CBHRS). CBHRS are reimbursed in Georgia through both fee for service and capitated rates. Medicaid Fee for Service (FFS) is provided through the Department of Community Health (DCH) in partnership with the Department of Behavioral Health and Developmental Disabilities (DBHDD). CBHRS for Medicaid and PeachCare for Kids are also administered by DCH through Care Management Organizations (CMOs). PeachCare for Kids is a health care insurance program for children below the age of 18 living in Georgia, which provides access to a CMO to coordinate the enrollee's care.

While Medicaid capitated rates can differ from FFS rates, they are often set based on FFS rates, so this analysis makes the simplifying assumption that Medicaid FFS and capitated rates are equivalent (and thus are also equivalent to rates for PeachCare for Kids). Thus, rate comparisons in this section compare Medicaid FFS rates for CBHRS to Medicaid FFS rates in other states.

The Georgia SHBP provides health care to Georgia's teachers, state employees, public school employees, retirees, and their respective dependents through a self-funded plan. Depending on the individual's status as an active, pre-65 retiree, or retiree, members of the SHBP have a choice of up to six different plan options across three vendors. [2] Data for similar plans in other states was not available, so Georgia's SHBP rates were compared to Georgia's Medicaid FFS Rates in this analysis. It should be noted, however, that one limitation of this approach is that the behavioral health service offerings within SHBP do not match one-to-one with the CBHRS available within Medicaid.

The remainder of this section includes a description of the methodologies used to compare Medicaid FFS rates to similar Medicaid services in other states, methodologies used to compare Georgia SHBP rates to Georgia's Medicaid FFS rates, a summary of key findings, and a discussion of the findings and study limitations.

2.2. Methodology

In order to compare Georgia's reimbursement rates to other states, several methodological and data analysis steps were taken, including:

- Selection of comparator states used to compare Medicaid FFS rates with rates in Georgia. Ideal comparator states were similar to Georgia in terms of Medicaid network, population,

economics, and access to behavioral health services. The selected states are Maryland, Ohio, North Carolina, Kentucky, Illinois and Pennsylvania.
- Identification of data sources in Georgia and other states which provide detail regarding behavioral health services provided, their FFS rates, and their rate methodology. Data for the SHBP was also requested from the Department of Community Health.
- Data analysis steps taken to compare Georgia's CBHRS rates across states, with separate approaches and assumptions used for comparison of Medicaid rates and rates for the SHBP.

Each of these steps are described in detail below.

2.2.1 Selection of Comparator States

The first step in comparing Georgia's CBHRS rates to other states was to identify comparator states. Four main criteria were used in determining state selection, including population, economics, access to care, and Medicaid network considerations. Descriptions of these criteria are as follows:

- **Population:** Considered population size, density, and urban/rural composition. The ideal comparator states would have a similar population composition.
- **Economics:** Considered states with comparable economies to Georgia in terms of cost of living and uninsured rates.
- **Access to Behavioral Health Services:** Considered states' 2022 National Alliance on Mental Illness (NAMI) overall ranking, which factors prevalence of behavioral health conditions and access to care. [3] The ideal comparator states had a similar ranking to Georgia.
- **Medicaid Network:** Considered Medicaid managed care usage in comparator states. The ideal comparator states had similar usage levels to Georgia.

Six states were chosen as comparators based on similarity to Georgia across the criteria outlined, or for offering specific services that could give insight into Georgia's programs. The states chosen are Maryland, Ohio, North Carolina, Kentucky, Illinois and Pennsylvania. Some states, such as Maryland, were chosen because the state has the same demonstration services (Intensive Customized Care Coordination or IC3). Though the population and cost of living in Maryland are very different compared to Georgia, the network and accessibility to care is similar.

2.2.2 Data Sources

Publicly available data sources were used to identify the CBHRS FFS rates in Georgia and comparator states. Georgia's Fiscal Year 2023 Community Behavioral Health Provider Manual was used to identify Georgia's FFS rates for CBHRS. [4] The document also provides information on procedure codes, modifiers, service, billing and staffing requirements, as well as detailed definitions for each service. For the comparator states, FFS rate schedules and provider manuals were obtained in order to identify rates and their respective methodologies. Given that states update their rates and rate methodologies at different intervals, data sources across states were not standardized to a single year. However, when reviewing the fee schedules and rate manuals, the most recent versions were used. A summary of sources used is provided in the appendix to this section.

Though fee schedule data was unavailable for the SHBP, the Decision Support Services (DSS) team within DCH provided a data extract, which included SHBP expenditures and units by behavioral health service.

This data was used as a proxy for fee schedule data, as expenditures divided by units provided can serve as a proxy for the rate for a given service.

2.2.3 Analysis Approach

2.2.3.1. Comparison of Georgia's FFS Rates to Other States

In order to compare Georgia's rates for CBHRS to Medicaid FFS rates for similar services in other states, several analysis steps were taken, including:

1. Comparison of services and service descriptions between Georgia and the comparator states to ensure that the rates obtained from other states reflect the same, or a similar service, to the rate in Georgia.
2. Evaluation of reimbursement rate, along with the rate's associated unit value (e.g., 15 minutes, 30 minutes, "per encounter"), practitioner levels allowed (five levels representing levels of education, credentialing, or skillset of the practitioner; definitions for each practitioner level can be found in the appendix to this section) and location of service (e.g., in clinic, out of clinic). Reimbursement rates for each service presented in this section are provided with the corresponding unit value. It is important to note that differences in unit values across states may limit the degree to which comparison across states can be made.
3. Compared FFS reimbursement rates for Georgia's CBHRS and Medicaid FFS rates for similar services in other states. This process included identifying services for which Georgia's practitioner levels allowed to bill for the service aligned with practitioner levels, allowed in one or more comparator state. For aligning states, the relevant rate was identified and compared to Georgia's rate.

To provide more insightful rate comparisons, a deep dive was performed on Georgia's CBHRS with the highest FFS spend to analyze the percentage differences in rates between Georgia and comparator states. This analysis was performed by closely analyzing the Georgia practitioner levels and finding comparable practitioner levels in other states. Rates were then compared at specific practitioner levels and for in-office and out-of-office rates.

Throughout the analysis several assumptions were applied, given the differences in the way each state structures the rates for the services considered. First, several of the fee schedules, service definitions, and provider manuals utilized were obtained from public sources. The sources used were assumed to be the most complete and recent data publicly available. In addition, some inferences needed to be made where provider manuals and fee schedules provided limited documentation on the services being provided. For example, it was assumed that services in comparator states offered with the same name as those offered in Georgia are directly comparable to those offered in Georgia.

2.2.3.2. Comparison of Georgia's FFS Rates to SHBP Rates

The process to compare the Georgia CBHRS FFS rates to the SHBP rates was different than the approach taken to compare Georgia's Medicaid FFS rates to other states. This different approach was necessary given that SHBP rates were estimated from an analysis of claims data, as opposed to a summary of fee schedules. The following steps were taken in order to produce comparisons of SHBP rates to FFS Rates:

1. Request SHBP data from the DSS team within DCH. Requested data fields included procedure code (with modifiers), allowed amount, dollars paid and paid units of service between January 2019 and June 2022.
2. Calculate a proxy reimbursement rate for each SHBP procedure code in order to compare the SHBP rate to the FFS rates. The SHBP rate was developed by dividing the total SHBP allowed amount by the total units.
    - Rates were calculated at the procedure code level and reflect an average rate across all practitioner levels and facility types.
3. Calculate average unit cost for Medicaid FFS services in order to produce a like-for-like comparison to SHBP rates. While the actual Medicaid FFS rates are available via the fee schedule, FFS unit costs were used for comparison to the SHBP because the calculated FFS unit costs roll up rate differences by practitioner type and place of service, which is also true of the SHBP proxy rates.
    - Unit costs were calculated at the procedure code level, similar to the calculation for SHBP unit costs. This calculation results in an average unit cost estimate for which dollars and units are rolled up across all practitioner levels and locations of service.

There are some data limitations that impact the degree to which SHBP proxy rates can be compared to FFS rates. Within the FFS data, modifiers distinguish between group and individual services, the practitioner providing the service, the location of service, and at times, the modifier also distinguishes between services themselves. In the SHBP data, services are differentiated by using different procedure codes than the FFS data. Therefore, it is difficult to calculate the rates at the granular level that aligns with the level of specificity available for the FFS rates. Thus, there were some instances where one procedure code in the SHBP data aligned to more than one service as defined in the Medicaid FFS data. Services for which this was the case were excluded from the analysis.

Additionally, comparisons were made at the procedure code level without taking into account modifiers for practitioner level or facility type. To compare the average FFS unit costs to SHBP unit costs, adjustments were made to the FFS data. Specifically, average unit costs for the FFS data were calculated at the procedure code level (i.e., rolling up modifier detail) for federal fiscal year (FFY) 2021. Comparisons at this level should be interpreted with caution as different mixes of practitioner levels and facility types may drive the difference between unit costs. For example, if the SHBP provides a service using practitioner levels of a higher education level than practitioners providing services for Medicaid FFS, one would expect the SHBP reimbursement rates to be higher to account for a higher educated practitioner.

Finally, for the services with the highest dollar spending in Medicaid FFS, there was, for the most part, very little dollar spending within SHBP. For example, case management is a higher utilization service in Medicaid FFS but has low SHBP utilization (eight percent of overall Medicaid FFS Utilization but zero percent of SHBP utilization). This difference in high utilization services between the two programs is likely due to differences in their respective beneficiary populations. In the case management example, the SHBP population (who are generally employed or the family of those who are employed) may be less likely to need the support that case management services provide, compared to individuals enrolled in Medicaid. Given the differences in high-spend services between SHBP and Medicaid FFS, a subset of

services – the high-spend SHBP services – were included in this analysis, and it is important to consider the results with this caveat in mind.

2.3. Key Findings

Notable findings resulting from the comparison of Georgia's Medicaid FFS rates to rates in other states fall into two broad categories: 1) a comparison of Georgia rates by practitioner level for top spend FFS services to rates for similar services and practitioner levels in other states, and 2) instances where Georgia uses a different rate methodology compared to other states. The discussion of differences in rate methodology between Georgia and other states is important to consider, along with comparisons of the magnitude of the rate differences, since the methodological differences discussed represent a significant constraint when comparing rate magnitudes. Given these constraints, the rate comparisons within this section are limited to a select number of rates for specific practitioner levels for which a like-for-like comparison can be made between Georgia's rates and rates in other states.
A more general summary comparison of CBHRS reimbursement rates for 30 CBHRS services in Georgia and comparator states can be found in the Appendix to this section.

2.3.1 Comparison of Medicaid FFS Reimbursement Rate Magnitudes Between Georgia and Comparator States

State-to-state differences in rate methodologies, units of service, the types of practitioners providing services and even the type of benefits included in the services make rate comparisons across states challenging. To make like-for-like rate comparisons, a narrow comparison of rates was performed for the CBHRS with the highest FFS spend in Georgia. These high-spend services include:

- Peer supports,
- Assertive Community Treatment (ACT),
- Psychosocial rehabilitation, and
- Individual counseling.

These services combine to make up 51% of FFS spend for CBHRS. For each service, the rates from other states for practitioner levels that most closely match Georgia's practitioner levels were used for the rate comparisons. For example, to compare Georgia's rate for individual counseling delivered with practitioner level five, which includes non-licensed, non-degreed, and trained paraprofessionals, Pennsylvania's rate for practitioners who are unlicensed was used for comparison. Each of the services are discussed below.

2.3.1.1. Peer Supports

Peer support services made up 13% of the overall Medicaid CBHRS FFS spend in 2021. The peer support services in Georgia are provided at both the group and individual levels. In addition, peer support services span different focus areas, including parent peer support, youth peer support, mental health peer support, addictive disorders peer support, and peer support whole health. Many other states do not pay for peer support services, and for those that do, even fewer separate the services by type of peer support. For the purposes of comparison, and because Georgia has the same rate for all individual peer support services and all group peer support services, comparisons to other states are done at those levels.

Georgia practitioner level five rates for peer support were compared across states. For individual peer support, Kentucky, North Carolina, and Pennsylvania offered rates for comparable practitioner levels.

Individual peer support rates in Georgia were higher than other states for both in-clinic and out-of-clinic delivery settings. For group peer support, comparator states included Kentucky, North Carolina and Ohio. Consistent with individual peer support, Georgia also pays more for group services. Summaries of the rates are shown in Figure 1 and Figure 2 below.

Figure 1. Peer Support – Individual: Comparison to Georgia's Level 5 Rates

Peer Support – Individual (Georgia Level 5 Comparison)									
State	Facility Type	GA	KY	KY % Diff	NC	NC % Diff	PA	PA % Diff	Average % Diff
Rate (15 min)	In Clinic	$15.13	NA	NA	$12.51	21%	$10.00	51%	36%
	Out of Clinic	$24.36	$8.61	183%	NA	NA	NA	NA	183%

*Georgia level 5 includes non-licensed, non-degreed, and trained paraprofessionals
*Kentucky reimburses for one level that includes non-bachelor's degrees, Peer Support Specialists, Community Support Associates and Registered Behavior Technicians

*North Carolina reimburses for one level that includes paraprofessionals

Figure 2. Peer Support – Group: Comparison to Georgia's Level 5 Rates

Peer Support – Group (Georgia Level 5 Comparison)									
State	Facility Type	GA	KY	KY % Diff	NC	NC % Diff	OH	OH % Diff	Average % Diff
Rate (1 hour)	In Clinic	$13.20	NA	NA	$12.08	9%	$7.76	70%	40%
	Out of Clinic	$16.12	$14.24	13%	$12.08	33%	$7.76	108%	51%

*Georgia level 5 includes certified peer supports without bachelor's degrees
*Kentucky reimburses for one level that includes non-bachelor's degrees, Peer Support Specialists, Community Support Associates and Registered Behavior Technicians

*Ohio and North Carolina reimburse for one level that includes paraprofessionals

2.3.1.2. Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) encompassed 11% of total Medicaid CBHRS FFS spend in 2021. ACT is a bundled service that includes practitioners from levels one through five. In Georgia, ACT is reimbursed with one set 15 minute rate that does not vary by facility type or practitioner type. Illinois rates were used for comparison to Georgia's ACT rate as Illinois also bundles the rate across practitioner level and uses 15 minute units. Georgia's rates are lower than those in Illinois for both in-clinic and out of clinic service delivery (Figure 3).

Figure 3. ACT Reimbursement Rate Comparison

Assertive Community Treatment - Individual				
State	**Facility Type**	**GA**	**IL**	**IL % Diff**
Rate (15 minutes)	In Clinic	$32.46	$41.98	-23%
	Out of Clinic	$32.46	$46.78	-31%

*GA ACT must include practitioner levels 1 through 5 ranging from a physician/psychiatrist to a paraprofessional.
*IL ACT team must consist of six FTE staff including a licensed clinician and a full-time RN, must be supported by psychiatrist and a program/administrative assistant. At least one member has training in substance abuse treatment, one in rehabilitative counseling and one person qualified as a Certified Recovery Support Specialist

2.3.1.3. Individual Counseling

Individual counseling services in Georgia made up 13% of the overall Medicaid CBHRS FFS spend in 2021 and are offered for practitioner levels two through five in Georgia. When compared to other states, Georgia's levels three and four were comparable in terms of units and types of practitioners. Georgia's rates for level three practitioners were close to rates for similar practitioner levels in Illinois, and higher than the rate in Pennsylvania. Georgia's level four rates were slightly lower than comparable in-clinic rates in Ohio and Illinois, and slightly higher than out of clinic rates in Kentucky and Pennsylvania. Additional details can be found in Figure 4 and Figure 5 below.

Figure 4. Individual Counseling: Comparison to Georgia's Level 3 Rates

Individual Counseling - Equivalent to Georgia Level 3							
State	**Facility Type**	**GA**	**IL**	**IL % Diff**	**PA**	**PA % Diff**	**Average % Diff**
Rate (30 minutes)	In Clinic	$50.02	$51.68	-3%	NA	NA	-3%
	Out of Clinic	$61.13	$58.00	5%	$39.12	56%	31%

*Georgia level 3 practitioners includes Registered Nurse, Licensed Dietician, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Certified/Registered Addictions Counselor -II
*Illinois practitioners include Qualified Mental Health Professionals (Physician, clinical psychologist, Licensed Clinical Professional Counselor, Licensed Marriage and Family Therapist, Clinical Social Worker, Registered Nurse) [5]
*Pennsylvania practitioners include Licensed Practitioners (note that licensed practitioners could span across level 2 and level 3 in comparison to Georgia)

Figure 5. Individual Counseling: Comparison to Georgia's Level 4 Rates

Individual Counseling - Equivalent to Georgia Level 4											
State	Facility Type	GA	KY	KY % Diff	OH	OH % Diff	PA	PA % Diff	IL	IL % Diff	Average % Diff
Rate (30 minutes)	In Clinic	$33.83	NA	NA	38.62	-12%	NA	NA	36.64	-8%	-10%
	Out of Clinic	$40.59	$35.56	14%	NA	NA	$29.74	36%	42.52	-5%	15%

*Georgia level 4 practitioners includes Licensed Practical Nurse (LPN), Licensed Associate Professional Counselor (LAPC), Licensed Master's Social Worker (LMSW), Licensed Associate Professional Counselor (LAPC), Licensed Master Social Worker, Certified Addictions Counselor, Certified Peer Specialist, Trained Paraprofessional or Certified Psychiatric Rehabilitation Professional with bachelor's degree

*Kentucky professionals include Licensed Psychological Associate, Certified Psychological Support , Clinical Social Worker Associate, Licensed Professional Counselor Associate, Marriage and Family Therapist Associate, Licensed Professional Art Therapy Associate, Licensed Assistant Behavioral Analyst, Licensed Clinical Alcohol and Drug Counselor Associate

*Ohio Professionals include BH Professionals Under Supervision (Social Worker-Trainee, Psychology Assistant/Intern/Trainee, Marriage and Family Therapist-Trainee, Chemical Dependency Counselor-Assistant, Counselor-Trainee)

*Pennsylvania includes unlicensed practitioners

*Illinois professionals include Mental Health Professionals (Practical Nurse, Recovery Support Specialist, Occupational Therapy Assistant, Individual who has High School Degree/GED and 5 years of experience in Mental Health) [5]

2.3.1.4. Psychosocial Rehabilitation

Psychosocial rehabilitation services (PSR) made up 14% of Medicaid CBHRS FFS spend in 2021. PSR is provided at both the individual and group levels in Georgia and is provided at practitioner levels four and five. For individual PSR services, Georgia's level four rate was higher than the comparable rate in Illinois (the only comparator), but Georgia's level five rate was lower than the comparator rates (Figure 6, Figure 7). For group PSR services, Georgia's rates were lower than those in Illinois for both level four and level five practitioners (Figure 8, Figure 9).

Figure 6. Psychosocial Rehabilitation – Individual: Comparison to Georgia's Level 4 Rates

Psychosocial Rehabilitation - Individual (Level 4)				
State	Facility Type	GA	IL	IL % Diff
Rate (15 minutes)	In Clinic	$20.30	$18.32	11%
	Out of Clinic	$24.36	NA	NA

*Georgia level 4 practitioners includes Licensed Practical Nurse (LPN), Licensed Associate Professional Counselor (LAPC), Licensed Master's Social Worker (LMSW), Licensed Associate Professional Counselor (LAPC), Licensed Master Social Worker, Certified Addictions Counselor, Certified Peer Specialist, Trained Paraprofessional or Certified Psychiatric Rehabilitation Professional with bachelor's degree

*Illinois practitioners include mental health professionals

Figure 7. Psychosocial Rehabilitation – Individual: Comparison to Georgia's Level 5 Rates

Psychosocial Rehabilitation - Individual (Level 5)							
State	Facility Type	GA	IL	IL % Diff	OH	OH % Diff	Average % Diff
Rate (15 minutes)	In Clinic	$15.13	$15.05	1%	$15.84	-4%	-2%
	Out of Clinic	$18.15	NA	NA	$20.32	-11%	-11%

*Georgia level 5 practitioners includes non-licensed, non-degreed, and trained paraprofessionals
*Illinois practitioners include Rehabilitative Services Associate
*Ohio practitioners include high school Qualified Mental Health Specialist and Associate Qualified Mental Health Specialist, Social Worker-Trainee, Social Worker-Associate, Marriage and Family Therapist-Trainee, Counselor-Trainee

Figure 8. Psychosocial Rehabilitation – Group: Comparison to Georgia's Level 4 Rates

Psychosocial Rehabilitation - Group (Level 4)				
State	Facility Type	GA	IL	IL % Diff
Rate (1 hour)	In Clinic	$17.72	$18.32	-3%
	Out of Clinic	$21.64	NA	NA

*Georgia level 4 practitioners includes Licensed Practical Nurse (LPN), Licensed Associate Professional Counselor (LAPC), Licensed Master's Social Worker (LMSW), Licensed Associate Professional Counselor (LAPC), Licensed Master Social Worker, Certified Addictions Counselor, Certified Peer Specialist, Trained Paraprofessional or Certified Psychiatric Rehabilitation Professional with bachelor's degree

*Illinois practitioners include mental health professionals

Figure 9. Psychosocial Rehabilitation – Group: Comparison to Georgia's Level 5 Rates

Psychosocial Rehabilitation - Group (Level 5)				
State	Facility Type	GA	IL	IL % Diff
Rate (1 hour)	In Clinic	$13.20	$15.08	-12%
	Out of Clinic	$16.12	NA	NA

*Georgia level 5 practitioners includes non-licensed, non-degreed, and trained paraprofessionals

*Illinois practitioners include RSA

2.3.2 Comparison of Medicaid FFS Reimbursement Rate Methodologies Between Georgia and Comparator States

The study and comparison of Georgia's CBHRS and their corresponding rates to rates in other states yielded some notable state-to-state differences between rate methodologies. Key findings include:

1. Differences in methodologies used to develop rates.
2. Differences in reimbursement units used.
3. Differences in service delivery: ACT example.

1. **Differences in methodologies used to develop rates**. The methodologies in other states differed based on service and included bundled rates, flat rates, and tiered rates.[1] Maryland, for example, has FFS rates that do not vary by the location of services provided, and many of the services are paid based on complexity rather than tiered by practitioner level (levels range from minimally-to-highly complex, where complexity level depends on clinical considerations related to each patient's case). On the other hand, Georgia's rates are often based on the location of service (telehealth, in-office and out-of-office) and based on the level of the practitioner delivering the service. Another notable methodological difference between the way Georgia and other states reimburse is to pay based on group services. Pennsylvania is the only state amongst Georgia and the comparator states to vary reimbursement based on group size, with larger groups having a lower rate per person.

2. **Differences in reimbursement units used**. The rate comparison also uncovered differences across states related to the units used to reimburse services, which in some instances varied widely across states for a given service. For example, individual counseling in Georgia is reimbursed at one rate for each encounter, whereas other states reimburse at 15 minute or one hour units. Similarly, the Substance Abuse Intensive Outpatient Program (SAIOP) service in Georgia is reimbursed for one hour units, whereas other states reimbursed this service on a per diem basis.

3. **Differences in Service Delivery: ACT example**. One finding related to how services are rendered was for ACT. Maryland has a unique model that allows for practitioners to provide both the evidence-based practice (EBP) version of ACT, and a version of the service similar to ACT but that is non-EBP, known as the mobile crisis team. In Maryland, the evidenced-based model pays a bundled monthly rate, whereas the non-EBP has rates differing based on the service provided. Within Georgia, ACT is bundled and is paid for using a flat rate for all practitioners and does not have an equivalent non-high-fidelity service.

While these observations represent notable findings, they also represent significant constraints when attempting to compare rates in Georgia to rates in other states. For these reasons, the rate comparisons included in the section above were selected for very specific service and practitioner level combinations for which like-for-like comparisons could be made between Georgia and other states.

2.3.3 Comparison of Georgia's SHBP Rates to Georgia's Medicaid FFS Rates

Georgia Medicaid FFS and SHBP unit costs for CBHRS were compared in an effort to capture differences in reimbursement rates between the two programs. The unit costs were analyzed at the procedure code level and by overall weighted average unit cost. The overall weighted average unit cost was calculated across services for both SHBP and Medicaid FFS in order to calculate a single overall estimate for the degree to which SHBP rates exceeded the Medicaid FFS rates.

The average weighted unit cost across all CBHRS services offered in the SHBP was higher than the FFS average weighted cost by approximately 25%. Though as a whole, SHBP average unit costs tended to be

[1] Bundled rates are when a provider receives a fixed predetermined rate for a pre-determined amount of time that includes the delivery of multiple services. Flat rates are when a provider receives a fixed, predetermined rate for a single service for a designated unit of time. Tiered rates are when a provider receives payment for one service in which the rate varies by an identified characteristic of the individual, the provider, or some combination of both.

higher than Medicaid FFS, the magnitude and direction of the differences between SHBP and FFS unit costs varied from service to service.

As prefaced in the methodology section, the high-utilization services in the SHBP plans differ from the high-utilization services in Medicaid FFS, and one key reason for this is differences in the populations who enroll in the SHBP (commercial plans) and those enrolling in Medicaid plans. These types of population differences are important to consider when making comparisons between the Medicaid and SHBP programs. Given the differences in service-specific utilization between the SHBP and Medicaid FFS, the top three SHBP services (by dollars spent) were selected for the comparison of SHBP and Medicaid FFS rates. The services include:

- Individual Counseling (Procedure codes 90834 and 90837)
- Psychiatric Treatment - Established Patients (Procedure codes 99213 and 99214)
- Diagnostic Assessment (Procedure code 90791)

The procedure codes listed above account for 78% of SHBP spending on CBHRS services included for January 2019 through June 2022, whereas these procedure codes account for 17% of total Medicaid FFS spend in FFY2021. A breakdown of the total spending across the three high-spend SHBP services for January 2019 through June 2022 is shown in Figure 10.

Figure 10. Proportion of SHBP and Medicaid Spend for Three High Spend SHBP Services

Service	Procedure Code	Proportion of SHBP Spend (January 2019-June 2022)	Proportion of Medicaid FFS 2021 Spend
Individual Counseling	90837	35%	11%
Psychiatric Treatment	99214	19%	3%
Psychiatric Treatment	99213	14%	2%
Individual Counseling	90834	6%	1%
Diagnostic Assessment	90791	4%	0%

Figure 11 shows the percentage difference between the Medicaid fee for service average unit costs for FFY 2021 and the average unit costs for the SHBP data from January 2019 through June 2022. SHBP unit costs for Individual counseling procedure codes 90834 and 90837 were similar to Medicaid FFS unit costs, with SHBP being slightly higher (7%) for code 90834 and slightly lower (-6%) for code 90837. SHBP unit costs were higher than Medicaid FFS for psychiatric treatment (46% for code 99214 and 37% for code 99213) and diagnostic assessment (51%). As mentioned earlier, the unit costs calculated do not consider the practitioner providing the service or location of the services rendered, so differences in the way these services are delivered between Medicaid FFS and the SHBP may limit the degree to which inferences can be made from these comparisons. However, these comparisons give a general understanding of how average unit costs between the SHBP and Medicaid FFS compare.

Figure 11. Comparison of SHBP and Medicaid FFS Unit Costs for Select CBHRS Services

Service	Procedure Code	FFS Average Unit Cost FFY 2021	SHBP Average Unit Cost (Jan 2019-June 2022)	Percentage Difference
Individual Counseling	90834	$69.66	$74.30	7%
Psychiatric Treatment	99214	$88.19	$128.49	46%
Psychiatric Treatment	99213	$63.48	$86.69	37%
Individual Counseling	90837	$101.53	$95.12	-6%
Diagnostic Assessment	90791	$74.68	$112.47	51%

2.4. Discussion

2.4.1 Comparison of Georgia's Medicaid Reimbursement Rates to Other States

Within this section, Georgia's Medicaid FFS reimbursement rates for CBHRS were compared to FFS reimbursement rates for similar services in other states. Across the specific CBHRS FFS services for which Georgia offered comparable practitioner types, units of service and location of service to other states, Georgia's rates were lower, on average than eight of the rates, and higher, on average, than seven of the rates. Thus, in aggregate, across the included rates, Georgia's rates were generally in alignment with other states. It should be noted, however, that this aggregated observation does not account for some of Georgia's services having significantly higher or lower rates compared to other states. For example, Georgia's practitioner level five peer support out-of-clinic rate was 183% above the comparator average, while Georgia's rate for ACT services delivered out-of-clinic was 31% below the comparator average. In addition, it is important to note that the findings discussed are specific only to the rate comparisons included in this study and cannot be generalized to all of Georgia's rates. Additionally, more general comparisons of Georgia's rates for CBHRS services to rates in other states can be found in this section's Appendix.

While the rates were standardized and compared across states to the extent possible, several assumptions were made which limit the degree to which inferences can be drawn from these comparisons. These limitations, described in more detail in the methodology and key findings sections above, include differences in the way states define and deliver services, differences in provider types allowed to deliver services and differences in unit values used for billing. In addition, there are other, state-specific factors which may influence why rates differ and can add additional complexity when comparing rates. For example, providers in one state may face a higher administrative burden with respect to audits or other interactions with state agencies, which may increase non-billable time. While these state-to-state differences may limit the comparability of Georgia's rates to those in other states, they also represent findings in and of themselves, and were discussed in the key results.

Within Georgia, PeachCare for Kids is reimbursed using Medicaid CMO reimbursement rates. While Medicaid CMO reimbursement rates are derived from FFS reimbursement rates, actual CMO rates can be above or below FFS rates. This study assumes that CMO rates are approximately equal to FFS rates, and thus actual differences in the rates may not be captured. While data availability and limitations necessitated that some assumptions were made in order to compare Georgia's reimbursement rates to

those in other states, the rate analysis discussed in this section provides insights into how other states' reimbursement rates and methodologies compare to Georgia's.

2.4.2 Comparison of Georgia's FFS and SHBP Rates

Georgia's SHBP average unit costs were also compared with Georgia's Medicaid FFS average unit costs within this section. Overall, across the CBHRS services included in the analysis, SHBP unit costs were approximately 25% higher than Medicaid FFS unit costs. Relative Medicaid FFS and SHBP unit costs did vary at the service and procedure code level, however, where in some instances unit costs were comparable between the two programs (or Medicaid FFS amounts exceeded the SHBP amounts), and in other instances, SHBP unit costs exceeded those for Medicaid. Like the comparison of FFS rates to rates in other states, there were a number of assumptions made within the SHBP data analysis in order to produce comparisons to Medicaid FFS rates. Two key limitations of the SHBP data analysis included limited overlap of services within the SHBP with the CBHRS services and the use of average unit cost estimates in place of actual fee schedule rates. In addition, the proxy rates did not account for the practitioner level or place of service, so the proxy rates may not reflect typical service delivery. Finally, there are often significant differences in the populations that enroll in Medicaid and populations enrolled in the SHBP (for example, SHBP populations may be more likely to be employed). Because of these limitations, benchmarking SHBP proxy rates with the Georgia FFS rates must be done with the understanding of important program differences.

2.5. Appendix

2.5.1 Data Sources for Reimbursement Rate Information for Comparator States

Figure 12 documents the sources used to identify Georgia and comparator state rates, service descriptions, and methodologies.

Figure 12. Data Sources for Behavioral Health Reimbursement Rate Information for Comparator States

State Name	Source Type	Data Source
Kentucky	Fee Schedule	https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx
	Service Definitions	https://dbhdid.ky.gov/dbh/documents/siac/ServiceArrayDefinitions.pdf?t=1036040320 2022
North Carolina	Fee Schedule	https://medicaid.ncdhhs.gov/providers/fee-schedules-archive
	Service Definitions	https://www.ncdhhs.gov/providers/provider-info/mental-health-development-disabilities-and-substance-abuse-services/service-definitions
	Provider Manual	https://www.ncdhhs.gov/media/17561/download?attachment
Maryland	Fee Schedule	https://maryland.optum.com/content/dam/ops-maryland/documents/provider/information/pbhs/fy2023-fee-schedules/Indv%20Prac%20&%20OMHC%20FY%202023%20PBHS%20Fee%20Schedule.pdf
	Level of Care Appendix	https://maryland.optum.com/content/dam/ops-maryland/documents/provider/providermanual/Maryland%20PBHS%20LOC%20Appendix_BH2555_FINAL_REVISED%2012.17.20.pdf
	Provider Manual	https://maryland.optum.com/content/dam/ops-maryland/documents/provider/information/pbhs/fy2023-fee-schedules/SUD%20FY%202023%20PBHS%20Fee%20Schedule.pdf
Ohio	Provider Manual	https://bh.medicaid.ohio.gov/Portals/0/OTP%20Manual%20Version%201_4%2012-21-21.pdf
	Fee Schedule	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fbh.medicaid.ohio.gov%2FPortals%2F0%2FBHCodingWorkbook%2520updated%25203_1_22.xlsx&wdOrigin=BROWSELINK
Illinois	Fee Schedule	https://www2.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/CMHP.aspx
	Provider Manual	https://www2.illinois.gov/hfs/SiteCollectionDocuments/10.11.16%20SDRG%20Handbook%20-%209-30-16.pdf
Pennsylvania	Fee Schedule	https://www.paproviders.org/wp-content/uploads/2022/08/Early-Intervention-Fee-Schedule-Rates_FY2223-_Updated-August-2022.pdf
	Fee Schedule	https://www.dhs.pa.gov/HealthChoices/HC-Providers/Documents/IBHS%20Bulletin%20OMHSAS-20-01%20%E2%80%94%20Procedure%20Codes%20for%20IBHS%20Providers.pdf
	Fee Schedule	https://www.dhs.pa.gov/providers/Providers/Documents/ODP/Public%20Notices%20Related%20to%20Rates/Community-Based%20Fee%20Schedule%20rates-chart-UPDATED.pdf
Georgia	Provider Manual	http://dbhdd.org/files/Provider-Manual-BH.pdf

2.5.2 Overview of Georgia Practitioner Levels

Many of Georgia's Medicaid FFS rates for CBHRS differ based on the practitioner level of the practitioner delivering the service. Figure 13 contains a summary description of the credentials required for each of Georgia's practitioner levels. [6]

Figure 13. Definitions for Georgia's Practitioner Levels 1-5

Georgia's Practitioner Levels		
Level	**Description**	**Practitioners**
1	Highest trained licensed practitioners	Physician, Psychiatrist
2	Licensed practitioners of health care and behavioral health (highly trained and specialized, or specially skilled, salary scale)	Psychologists, Physician's Assistants, Nurse Practitioners, Clinical Nurse Specialists/PMHs, Pharmacists
3	Licensed/certified practitioners of health care and behavioral health (highly trained and skilled salary scale)	Includes practitioners such as Registered Nurse, Licensed Dietician, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Certified/Registered Addictions Counselor II
4	Associate licensed and other certified practitioner (significantly trained and skilled salary scale)	Licensed Practical Nurse (LPN), Licensed Associate Professional Counselor (LAPC), Licensed Master's Social Worker (LMSW), Licensed Associate Marriage and Family Therapist (LAMFT), Certified/Registered Addictions Counselor, Certified Peer Specialist, Trained Paraprofessional or Certified Psychiatric Rehabilitation Professional (CPRP) with bachelor's degree or higher in the social sciences/helping professions
5	Non-licensed, non-degreed and trained paraprofessionals (moderately trained and skilled salary scale)	Certified/Registered Addiction Counselor (CAC-I or Registered Alcohol and Drug Technician), Certified Peer Specialist, Certified Psychiatric Rehabilitation Professional, and Qualified Medication Aide

2.5.3 Overall Comparison of Georgia's CBHRS FFS Reimbursement Rates to Rates in Other States

Within this section, Georgia's reimbursement rates for CBHRS were compared to reimbursement rates for similar services in other states. Figure 14 illustrates some of the challenges encountered when comparing reimbursement rates across states. Across several of the services, a range of rates is presented for each state. These ranges reflect that rates for the service differ based on practitioner level or place of service. For example, the lower end of the range may reflect a service delivered in-clinic for a practitioner level with less training; while the higher end of the range may reflect a service delivered out-of-clinic for a practitioner level reflecting the highest-level of training. In addition, units of time used across states for billing can be highly variable, and while one state may use a 15 minute billing unit, another state may use a per diem rate for billing the same service. Thus, while this figure contains a summary comparison of Georgia's rates to other states, it is difficult to ascertain from this type of comparison whether Georgia's rates are truly higher or lower.

Figure 14. Comparison of Georgia's Reimbursement Rates to Reimbursement Rates in Other States

Service	GA FFS Spend (%)	Georgia FFS Rate	Maryland Rate	Ohio Rate	North Carolina Rate	Kentucky Rate	Illinois Rate	Pennsylvania Rate
Individual Counseling	13%	$25.21- $226.26 (30 minutes to 1 hour)	$27.12 (15 Mins)	$19.31- $23.10 (15 min.)	$46.01 (1 Hour)	$17.78- $25.40 (15 min.)	$18.32-$29.00 (15 min.)	$14.87-$19.56 (15 min.)
Assertive Community Treatment	11%	$3.30 – $32.46 Group/Individual (15 min.)	$1,161.15 - $1,637.51 (Month)	$159.24 - $615.64 (Per Diem)	$295.32 (Event)	$750 - $1000 (Month)	$9.99 - $54.78 Group/ Individual (15 min.)	N/A
Psychosocial Rehabilitation-Program	11%	$13.20 - $21.64 (1 Hour)	$590.62 (Monthly)	N/A	N/A	N/A	$3.77 - $6.62 (15 min.)	N/A
Peer Support-Group	9%	$13.20-$21.64 (1 Hour)	N/A	$1.94 (15 min.)	$3.02 (15 min.)	3.56 (15 min.)	N/A	N/A
Case Management	8%	$15.13-$24.36 (15 min.)	$150.23 (Daily)	N/A	$17.52 (15 min.)	$60.28-$73.20 (Per Event)	$30.05- $36.26 (15 min.)	$24.19 (15 min.)
Psychiatric Treatment	6%	$64.95- $345.80 (15-74 Mins)	$179.40 (Per Diem)	N/A	$66.78- $104.54 (1 Hour)	$225.00 (Per Diem)	N/A	$12.73-$15.76 (15 Mins)
Addictive Disease Support Services	5%	$15.13- $24.36 (15 min.)	$69.43 (1 Week)	$26.45 (15 min.)	$27.51- $38.61 (15 min.)	$8.61- $18.30 (15 min.)	$15.05-$23.32 (15 min.)	N/A
Family Outpatient Services	4%	$15.13- $46.76 (15 Mins)	N/A	$34.05- $38.98 (15 min.)	$46.01 (1 Hour)	$13.80- $19.72 (15 min.)	$18.32-$23.00 (15 min.)	$26.01 (15 min.)
Peer Support-Individual	4%	$15.13- $24.36 (15 min.)	N/A	N/A	$12.51 (15 min.)	$8.61 (15 min.)	N/A	$10.00 (15 min.)

Service	GA FFS Spend (%)	Georgia FFS Rate	Maryland Rate	Ohio Rate	North Carolina Rate	Kentucky Rate	Illinois Rate	Pennsylvania Rate
Behavioral Health Assessment	4%	$15.13 - $46.76 (15 Mins)	$145.90 (Per Event)	$56.11 (1 hour)	$75.81 - $83.32 (30 min.)	$60.28 - $86.12 (Per Event)	$15.57 (Per Event)	$22.18 - $23.60 (15 min.)
Nursing Assessment and Health Services	4%	$20.30- $62.35 (15 Mins)	N/A	N/A	$87.09 (15 Mins)	N/A	N/A	$22.91-$30.58 (Not Specified)
Intensive Family Intervention	3%	$16.50 - $41.26 (15 min.)	N/A	$19.54 (15 Mins)	$239.66 (Per Diem)	N/A	N/A	N/A
Community Support	3%	$15.13-$24.36 (15 min.)	N/A	$27.51-$38.60 (15 Mins)	N/A	$8.61-$18.30 (15 min.)	$3.77-$38.00 (15 min.)	$4.09-$32.85 (15 min.)
Psychosocial Rehabilitation-Individual	2%	$15.13- $24.36 (15 min.)	N/A	$15.84 - $26.42 (15 min.)	$2.87 (Not Specified)	$4.30 - $15.85 (Not Specified)	$15.05 - $19.84 (15 min.)	N/A
Service Plan Development (Individual Recovery Plan	2%	$15.13- $46.76 (15 min.)	N/A	N/A	$81.25 (1 Week)	$60.28- $73.20 (Per Event)	$18.31-$31.00 (Unspecified)	$41.87-$19.56 (Unspecified)
Group Outpatient Services	2%	$3.30- $10.39 (15 Mins)	$52.90 (60-90 Mins)	$8.37- $11.02 (15 min.)	$46.07 (1 Hour)	$6.99-$9.98 (15 min.)	$4.58-$7.67 (15 min.)	$5.13-$16.63 (15 min.)
Medication Administration	2%	$12.97-$42.51 (Per Encounter)	$25.44-$195.63 (Per Encounter)	$21.39 (Per Visit)	N/A	Bundled Under Medication Assisted Treatment Services	Med. Admin: $11.24-$15.71 (Per Visit) Other Medication Services: $6.11-$30.80 (15 min.)	N/A

Service	GA FFS Spend (%)	Georgia FFS Rate	Maryland Rate	Ohio Rate	North Carolina Rate	Kentucky Rate	Illinois Rate	Pennsylvania Rate
Diagnostic Assessment	1%	$90.03-$222.26 (1 Encounter)	$146.65-$235.59 (1 Event)	$94.45-$130.72 (Per Encounter)	$231.30 (Per Event)	$90.67-$129.53 (Not Specified)	$19.84-$30.01 (15 min.)	$26.25 (30 min.)
Intensive Case Management	1%	$15.13- $24.36 (15 min.)	$40.13 (15 min.)	$19.54 (15 min.)	$81.25 (1 Week)	$331-$541 (Month)	$33.31-$38.00 (15 min.)	N/A
Crisis Intervention	1%	$15.13-$74.09 (15 min.)	N/A	$20.59-$26.42 (15 min.)	$117.42-$125.20 (1 Hour)	$10.77-$21.53 (15 min.)	$32.98-$45.27 (15 min.)	N/A
Intensive Customized Care Coordination	1%	$915.96* (Month) *From FFS Claims	$267.78 (Weekly)	N/A	N/A	N/A	N/A	N/A
Crisis Stabilization Unit Services	1%	$209.22 (1 Day)	$331.16 (Not Specified)	$432.63 - $476.64 (Per Diem)	$90.00 (15 Mins)	$43.11 - $86.21 (1 Hour)	$53.32 (1 Hour)	N/A
Community Support Team	0%	15.13 - $36.68 (15 min.)	$114.63 (Not Specified)	$34.05 - $34.98 (15 min.)	$26.45 (15 min.)	N/A	$34.84 - $38.00 (15 min.)	N/A
Psychological Testing	0%	$48.71 - $187.04 (30 min. or 1 hour)	$156.55 (1 Hour)	$ 59.26 (1 Hour)	$69.95 (1 Hour)	$61.43 - $87.75 (1 Hour)	$17.14 (Per Event)	$24.73 (15 min.)
Substance Abuse Intensive Outpatient Program (SAIOP)	0%	$13.20-$33.00 (1 Hour)	$169.51 (Per Diem)	$103.04-$224.82 (Per Diem)	$133.72 (Per Diem)	$125 (Per Diem)	N/A	N/A

Service	GA FFS Spend (%)	Georgia FFS Rate	Maryland Rate	Ohio Rate	North Carolina Rate	Kentucky Rate	Illinois Rate	Pennsylvania Rate
Ambulatory Substance Abuse Detoxification	0%	$20.30-$38.97 (15 min.)	$94.93 (Per Diem)	$90.16-$338.35 (Per Diem)	$21.25 (15 min.)	N/A	N/A	$6.00 (Not Specified)
Task Oriented Rehabilitation Services	0%	$18.15-$24.36 (15 min.)	N/A	N/A	N/A	N/A	N/A	N/A
Behavioral Health Clinical Consultation	0%	$25.98-$38.81 (15 min.)	N/A	N/A	$14.48 (Not Specified)	N/A	N/A	N/A
Medication Assisted Treatment	N/A	N/A	$77.20-182.02 (Per Visit)	$16.38 (Event)	$16.60 (Event)	$105 (1 Week)	$113.06 (1 Week)	$7.50 (Event)

*The total fee for service percentage spend was calculated by dividing total spending by service by the total spend across all services for fiscal year 2021. Spend data by service was provided by DSS.

3. Reimbursement for Health Care Providers Providing Mental Health Care Services under Medicaid, PeachCare for Kids, and the State Health Benefit Plan and Comparison with Other States

3.1. Background and Legislative Request

Georgia House Bill 1013 directs the Department of Community Health to undertake a study of "reimbursement for health care providers providing mental health care services under Medicaid, PeachCare for Kids, and the state health benefit plan and comparison with other states." The comparison of *reimbursement* with other states discussed in this section differs from the comparison of *reimbursement rates* discussed in the previous section. The *reimbursement* comparison in this section refers to the amount of money a health care provider receives for services they have provided, while the *reimbursement rate* comparison refers to the amount charged for those services.

To completely assess provider reimbursement, an ideal data source would be a survey of health care providers that requests the amount they are reimbursed from each payer (e.g., commercial insurance, Medicare, Medicaid, PeachCare for Kids, State Health Benefit Plan [SHBP]). From this data, the Medicaid, SHBP, and PeachCare for Kids (a health care program for uninsured children in Georgia) reimbursement amounts could then be isolated and summarized. In the absence of this type of data, this section uses the salaries for occupations providing behavioral health services as a proxy for provider reimbursement. Salaries for health care practitioners represent a significant portion of the cost for health care providers to deliver these services and are thus an important driver of reimbursement rates and the amount providers are ultimately paid for their services.

In this section, wage data for behavioral health occupations is summarized and compared across states. It may be helpful to review these results with the additional context provided by the comparison of Medicaid reimbursement rates across states discussed in the previous section of this report. It is important to note, however, that the way Georgia delivers specific services may differ compared to how other states deliver the services. For example, a service typically only delivered by a psychiatrist in one state may most often be delivered by an advanced practice provider in another state. Given the potential state-to-state differences in service delivery, a comparison of behavioral health salaries across states provides a separate view into how reimbursement levels may compare. One key limitation of the wage analysis, however, is that the wage data is not specific to those delivering services for Medicaid, PeachCare for Kids, or the SHBP. The remainder of this section describes the methodology used for this analysis, a summary of key findings, and a discussion of the results and limitations.

3.2. Methodology

The methodology for comparing Georgia's salaries for behavioral health practitioners to salaries for practitioners in other states consists of 1) selection of states that are comparable to Georgia, and 2) summarization of wage data from the U.S. Bureau of Labor Statistics (BLS) for practitioner types commonly delivering behavioral health services. Cost of living data for each state was also summarized to provide additional context to wage differences. For completeness, cost of living-adjusted and unadjusted salaries have been compared for Georgia and comparator states in this section.

3.2.1 Selection of Comparator States

Comparator states were selected for this analysis using the same methodology described for the comparison of reimbursement rates in the previous section of this report. The selection process consisted of four main considerations: population, economics, access to care, and Medicaid network similarity. Descriptions of the categories and criteria examined are as follows:

- **Population:** Considered population size, density, and urban/rural composition. The ideal comparators have a similar population composition.
- **Economics:** Considered states with comparable economies to Georgia in terms of cost of living and uninsured rates.
- **Access to Care:** Considered states' National Alliance on Mental Illness (NAMI) 2022 "overall ranking," which factors prevalence of behavioral health conditions and access to care. [3] The ideal comparator states had a ranking similar to Georgia.
- **Medicaid Network:** Considered managed care usage in comparator states. The ideal comparator states had similar usage levels as Georgia.

Six states – Maryland, Ohio, North Carolina, Kentucky, Illinois and Pennsylvania – were chosen as comparators based on these criteria. While cost of living information is an important contributing factor to a state's wages, this metric was selected as only one of several used for evaluating the suitability of comparator states. The ideal comparator states for a reimbursement comparison should be similar to Georgia with respect to behavioral health patients served, access to care, and Medicaid network.

3.2.2 Data Sources and Analysis Approach

As a basis for this analysis, BLS wage data for behavioral health occupations in Georgia were compared with the BLS wage information for the same practitioner types in comparator states. [7] The selected practitioner types include professions specializing in behavioral health (e.g., psychiatrists), but also include some professions that, while not specializing in behavioral health, provide behavioral health services (e.g., general internal medicine physicians). The wage data used for this analysis represent a monthly state and occupation-specific average wage across the 12-month period ending in May 2021. Cost of living data from the Missouri Economic Research and Information Center was also provided for each state to provide additional context when comparing salaries across states. [8]

Comparison of salaries in Georgia to salaries in other states consisted of the following data analysis steps:

1. Collect BLS wage data for practitioners who provide behavioral health services in Georgia.
2. Summarize data by average wages for each occupation.
3. Compare Georgia wage data to wage data from comparator states, as well as the national average wage for each occupation.
4. Calculate a straight average wage across the six comparator states for comparison to Georgia.
5. Standardize wages using the cost of living index for each state.

While the occupations selected for inclusion were occupations that commonly provide behavioral health services, due to data constraints, it was not possible to identify with certainty that salaries included are specific to individuals that provide behavioral health services. For example, the physician assistant salaries included for each state represent overall physician assistant salaries (and are not specific to

physician assistants specializing in behavioral health). Similarly, salaries provided are not specific to practitioners who provide services through Medicaid, PeachCare for Kids, or similar programs in other states, so the extent to which salaries differ for providers delivering those services is not captured.

3.3. Key Findings

Figure 15 below shows the average annual wage in Georgia (without adjustment for cost of living), with a comparison to the national average and the six comparator state average, for the selected occupations. Across the 14 included behavioral health occupations, 12 had lower annual wages in Georgia compared to the national average. Compared to the average wage across the six comparator states, wages for 10 of Georgia's occupations were lower.

For some occupations, wages in Georgia are lower than the national average by a significant margin: psychiatrists, clinical & counseling psychologists, and social & human service assistants had wages lower than the national average by 32%, 26% and 22%, respectively. Social workers and counselors were the only two occupations studied where Georgia's wages were higher than the national average (by 19% and 16%, respectively).

Figure 15. 2021 Annual Mean Wages for Occupations Providing Behavioral Health Services

	Annual Mean Wages (Not Adjusted for Cost of Living)				
		National Average		Comparator States	
Occupation Title	Georgia	National	% GA Difference from National Average*	Average of 6 States	% GA Difference from Comparator Average*
Psychiatrists	$170,220	$249,760	-32%	$254,323	-33%
Family Medicine Physicians	$220,070	$235,930	-7%	$233,123	-6%
General Internal Medicine Physicians	$223,830	$242,190	-8%	$278,402	-20%
Clinical and Counseling Psychologists	$73,350	$99,640	-26%	$94,632	-22%
Physician Assistants	$108,290	$119,460	-9%	$108,222	0%
Nurse Practitioners	$109,560	$118,040	-7%	$114,122	-4%
Marriage and Family Therapists	$48,280	$59,660	-19%	$53,395	-10%
Registered Nurses	$75,380	$82,750	-9%	$74,503	1%
Social Workers, All Other	$75,270	$63,010	19%	$62,815	20%
Counselors, All Other	$57,720	$49,730	16%	$53,067	9%
Mental Health and Substance Abuse Social Workers	$46,720	$57,800	-19%	$49,452	-6%
Licensed Practical and Licensed Vocational Nurses	$47,370	$51,850	-9%	$50,988	-7%
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	$45,740	$53,490	-14%	$51,322	-11%
Social and Human Service Assistants	$31,660	$40,460	-22%	$38,157	-17%

*Percentages are rounded to the nearest whole percent.

It is important to note cost of living when making these types of salary comparisons. Georgia's cost of living index ranking of 87.8 (as of the second quarter of 2022) is the lowest of the included states. The

cost of living rankings for five of the six comparators were below the national average, but higher than Georgia's (ranging from 91.4-97.5), while the cost of living index in Maryland was above the national average at 125.1. A summary of Georgia's and the six comparator states' 2021 wages for the included occupations, alongside the states' cost of living index value, is shown in Figure 17, within this section's appendix.

Figure 16 contains a summary comparison of Georgia's 2021 behavioral health wages adjusted for cost of living, compared to the average cost of living-adjusted wages across the six comparator states. Compared to Georgia's unadjusted wages, Georgia's adjusted wages are more consistent with national and comparator state adjusted wages. Adjusted wages for six of the 14 occupations were lower in Georgia compared to the national average. Psychiatrist, clinical & counseling psychologist, and social & human service assistant adjusted wages were lower than the national average by 22%, 16% and 11%, respectively. Wages for social workers and counselors, on the other hand, were significantly higher than the national average by 36% and 32%, respectively.

Compared to the average wages across the six comparator states, Georgia's adjusted wages were lower for only four professions: psychiatrists (by 24%), clinical and counseling psychologists (by 12%), general internal medicine physicians (by 8%), and social and human service assistants (by 5%). Detailed comparisons of Georgia's cost of living-adjusted wages to adjusted wages in other states are presented in Figure 18, within this section's appendix.

Figure 16. 2021 Annual Mean Wages Adjusted for Cost of Living for Occupations Providing Behavioral Health Services

	Annual Mean Wages (Adjusted for Cost of Living)				
		National		Comparator States	
Occupation Title	Georgia	National	% GA Difference from National Average*	Average of 6 States	% GA Difference from Comparator Average*
Psychiatrists	$193,872	$249,760	-22%	$254,323	-24%
Family Medicine Physicians	$250,649	$235,930	6%	$233,123	8%
General Internal Medicine Physicians	$254,932	$242,190	5%	$278,402	-8%
Clinical and Counseling Psychologists	$83,542	$99,640	-16%	$94,632	-12%
Physician Assistants	$123,337	$119,460	3%	$108,222	14%
Nurse Practitioners	$124,784	$118,040	6%	$114,122	9%
Marriage and Family Therapists	$54,989	$59,660	-8%	$53,395	3%
Registered Nurses	$85,854	$82,750	4%	$74,503	15%
Social Workers, All Other	$85,729	$63,010	36%	$62,815	36%
Counselors, All Other	$65,740	$49,730	32%	$53,067	24%
Mental Health and Substance Abuse Social Workers	$53,212	$57,800	-8%	$49,452	8%
Licensed Practical and Licensed Vocational Nurses	$53,952	$51,850	4%	$50,988	6%
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	$52,096	$53,490	-3%	$51,322	2%
Social and Human Service Assistants	$36,059	$40,460	-11%	$38,157	-5%

*Percentages are rounded to the nearest whole percent.

3.4. Discussion

This analysis found that, after standardizing for cost of living, Georgia's reimbursement rates for psychiatrists remained significantly lower than both the national average and the six-state average wages, while Georgia's wages for most other professions were higher. It is possible this finding is reflective of low reimbursement rates for psychiatrists; for example, if reimbursement for services delivered by psychiatrists is low, this may result in lower psychiatrist wages. Furthermore, this challenge may lead to providers having difficulties hiring for open positions. If this results in other occupations providing services that may otherwise be delivered by a psychiatrist, demand for those occupations, and thus their salaries, may increase. While there are several potential explanations for Georgia's current wage levels compared to other states, reimbursement rates and service delivery are two important considerations.

Review of Georgia's reimbursement compared to other states included a review and comparison of the salaries of practitioners who provide behavioral health services in Georgia. There are some limitations to using provider wages as a proxy for provider reimbursement. Salaries were collected from BLS by overall occupation. Due to data limitations, the salaries were not restricted based on whether practitioners provide care through Medicaid or behavioral health services. If practitioners providing care to Medicaid

or behavioral health patients disproportionately have lower salaries than other practitioners, this differential is not captured in this analysis. Similar data limitations prevented an analysis of salaries specific to those delivering services for the State Health Benefit Plan. While these limitations may prevent concrete conclusions being drawn from this analysis, the salary comparison does provide some context surrounding Georgia's reimbursement levels.

3.5. Appendix

Detailed BLS salary information for occupations that provide behavioral health services in Georgia and comparator states are shown in Figure 17, and the same salaries adjusted for cost of living are shown in Figure 18.

Figure 17. 2021 Annual Mean Wages for Occupations Providing Behavioral Health Services

	Annual Mean Wages (Not Adjusted for Cost of Living)								
Occupation Title	**GA**	**National**	**Average of 6 States**	**IL**	**KY**	**MD**	**NC**	**OH**	**PA**
Cost of Living Index August 2022 [8]	87.8	100	N/A	91.4	95.2	125.1	95	92	97.5
Psychiatrists	$170,220	$249,760	$254,323	$282,240	$260,870	$262,380	$224,080	$248,470	$247,900
Family Medicine Physicians	$220,070	$235,930	$233,123	$255,310	$248,220	$230,530	$240,330	$206,220	$218,130
General Internal Medicine Physicians	$223,830	$242,190	$278,402	$288,860	$289,850	$278,350	$303,230	$220,000	$290,120
Clinical and Counseling Psychologists	$73,350	$99,640	$94,632	$101,090	$96,290	$93,330	$94,480	$105,460	$77,140
Physician Assistants	$108,290	$119,460	$108,222	$117,480	$96,010	$99,530	$116,110	$110,670	$109,530
Nurse Practitioners	$109,560	$118,040	$114,122	$120,470	$106,080	$115,700	$112,730	$112,490	$117,260
Marriage and Family Therapists	$48,280	$59,660	$53,395	$53,560	$57,210	$56,840	$46,900	$54,600	$51,260
Registered Nurses	$75,380	$82,750	$74,503	$78,260	$67,260	$82,660	$71,200	$71,640	$76,000
Social Workers, All Other	$75,270	$63,010	$62,815	$66,490	$56,810	$68,040	$62,450	$56,380	$66,720
Counselors, All Other	$57,720	$49,730	$53,067	$52,170	$52,760	$44,570	$64,830	$47,440	$56,630
Mental Health and Substance Abuse Social Workers	$46,720	$57,800	$49,452	$52,560	$44,560	$53,890	$54,860	$47,190	$43,650
Licensed Practical and Licensed Vocational Nurses	$47,370	$51,850	$50,988	$54,080	$47,140	$56,380	$49,210	$48,030	$51,090
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	$45,740	$53,490	$51,322	$52,480	$45,310	$56,700	$52,850	$51,110	$49,480
Social and Human Service Assistants	$31,660	$40,460	$38,157	$41,630	$34,720	$38,950	$37,020	$37,690	$38,930

Figure 18. 2021 Annual Mean Wages Adjusted for Cost of Living for Occupations Providing Behavioral Health Services

	Annual Mean Wages (Adjusted for Cost of Living)								
Occupation Title	**GA**	**National**	**Average of 6 States**	**IL**	**KY**	**MD**	**NC**	**OH**	**PA**
Cost of Living Index August 2022 [8]	87.8	100	N/A	91.4	95.2	125.1	95	92	97.5
Psychiatrists	$193,872	$249,760	$258,794	$308,796	$274,023	$209,736	$235,874	$270,076	$254,256
Family Medicine Physicians	$250,649	$235,930	$237,533	$279,333	$260,735	$184,277	$252,979	$224,152	$223,723
General Internal Medicine Physicians	$254,932	$242,190	$283,147	$316,039	$304,464	$222,502	$319,189	$239,130	$297,559
Clinical and Counseling Psychologists	$83,542	$99,640	$96,592	$110,602	$101,145	$74,604	$99,453	$114,630	$79,118
Physician Assistants	$123,337	$119,460	$110,633	$128,534	$100,851	$79,560	$122,221	$120,293	$112,338
Nurse Practitioners	$124,784	$118,040	$116,154	$131,805	$111,429	$92,486	$118,663	$122,272	$120,267
Marriage and Family Therapists	$54,989	$59,660	$54,237	$58,600	$60,095	$45,436	$49,368	$59,348	$52,574
Registered Nurses	$85,854	$82,750	$75,519	$85,624	$70,651	$66,075	$74,947	$77,870	$77,949
Social Workers, All Other	$85,729	$63,010	$63,710	$72,746	$59,674	$54,388	$65,737	$61,283	$68,431
Counselors, All Other	$65,740	$49,730	$54,336	$57,079	$55,420	$35,627	$68,242	$51,565	$58,082
Mental Health and Substance Abuse Social Workers	$53,212	$57,800	$50,200	$57,505	$46,807	$43,078	$57,747	$51,293	$44,769
Licensed Practical and Licensed Vocational Nurses	$53,952	$51,850	$51,693	$59,168	$49,517	$45,068	$51,800	$52,207	$52,400
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	$52,096	$53,490	$52,045	$57,418	$47,595	$45,324	$55,632	$55,554	$50,749
Social and Human Service Assistants	$36,059	$40,460	$38,836	$45,547	$36,471	$31,135	$38,968	$40,967	$39,928

4. Reimbursement for Hospitals Caring for Uninsured Patients with Behavioral Health Disorders in the Emergency Department for Extended Periods of Time

4.1. Background and Legislative Request

Georgia House Bill 1013 directs the Department of Community Health to undertake a study of "reimbursement for hospitals caring for uninsured patients with mental health and substance abuse disorders in the emergency department for extended periods of time while the patient is waiting on placement and transfer to a behavioral health facility for evaluation and treatment."

Boarding patients in the emergency department (ED) is not a new phenomenon but is an issue that is particularly acute for behavioral health patients given they, on average, are more likely to experience health care access barriers. Patients with mental illness, for example, are uninsured at higher rates on average than those without mental illness. [9] Similarly, research has shown that people with mental illness are more likely to forgo necessary medical care. [10] These barriers to accessing preventative care can ultimately lead to patients in crisis situations seeking care in the emergency department, a situation which may have been avoided with regular routine care.

Recent news reports indicate that emergency department boarding of behavioral health patients has become a more frequent practice in Georgia. This issue is exacerbated by workforce shortages in behavioral health facilities – psychiatric hospitals in particular – which ultimately result in reduced bed capacity at these facilities. [11] As a result, behavioral health patients seeking care in the emergency department are less likely to have a timely transfer to a psychiatric facility when necessary. The COVID-19 pandemic has contributed to this issue given its effects on the workforce shortage. Throughout the pandemic, nurses have had increasing opportunities to seek higher-paying jobs as travel nurses, which is more appealing to some than lower-paying jobs in state-run facilities. [11]

Uninsured patients remaining in the emergency department for extended stays often result in hospitals delivering care for which they are not compensated. This section also considers the research approach, key findings, and a discussion related to reimbursement options for hospitals caring for patients who are in such a situation – specifically, those with behavioral health diagnoses who stay in the emergency department for extended periods of time while waiting to be transferred to an alternative behavioral health facility.

4.2. Approach

Information and findings within this section are primarily derived from publicly available sources of information, including peer reviewed research articles, policy briefs, and state-specific methodologies. While the research question pertains to *reimbursement* options for hospitals treating uninsured behavioral health patients, options that may reduce the overall cost burden on these hospitals more generally (for example, options which could increase overall population insurance coverage, therefore reducing the number of *uninsured* patients seeking care in emergency departments) were also reviewed.

Based on the above criteria, reimbursement and policy options were identified and categorized according to the mechanism by which they address the reimbursement/financial concerns for hospitals. The categories and identified reimbursement and policy options include:

1. Direct or indirect reimbursement to hospitals for care provided to uninsured patients (or uninsured behavioral health patients specifically)
    a. Disproportionate Share Hospital (DSH) funding
    b. State or local program
    c. Increase in hospital fee to fund increase in add-on payments to outpatient payment rates
2. Increasing the percentage of the overall population with health insurance coverage
    a. 1915(i) State Plan Option
    b. 1115 Waiver

Options identified are then considered across several metrics, including advantages, disadvantages, ease of implementation, focus of funding, costs and other financial implications (for example, whether the option brings new money to Georgia), and overall implications for hospitals.

4.3. Key Findings

4.3.1 Direct or Indirect Reimbursement to Hospitals

4.3.1.1. DSH Funding

Disproportionate share hospital funding programs, by design, are intended to provide funding to hospitals that treat large numbers of Medicaid and indigent patients. Thus, Georgia's DSH program can, and currently does, provide some reimbursement to hospitals caring for uninsured behavioral health patients in the emergency department for extended periods of time. These payments are not allocated to hospitals based on the number of uninsured *behavioral health* patients, so these funds are distributed using a formula generalized to uncompensated care overall and are not targeted to behavioral health patients specifically.

The total amount allocated for DSH payments in Georgia each fiscal year is based on the State's federal allotment and the required state matching contribution. With the current DSH distribution methodology, this sum is then split into two pools: one for small, rural hospitals and one for all other eligible hospitals. In SFY 2022, the total allotment for the small, rural hospital pool was $76,361,083 and the allotment for the *non*-small rural pool was $416,080,803. [12] Georgia hospitals qualify for a portion of the funds within their respective pool based on program eligibility requirements, calculation of DSH limits (which is the Medicaid loss incurred for services provided to Medicaid and uninsured patients), and other adjustments, which include adjustments related to intergovernmental transfers, and upper payment limit rates. [13]

Georgia does have the option to change the methodology for distributing DSH funding. Any proposed changes to the DSH payment methodology would need to be described in a state plan amendment and would be subject to the Centers for Medicare and Medicaid Services (CMS) review and approval, which does add potential administrative complexity. If desired, though, the State may propose a separate pool of funds be created for hospitals caring for uninsured behavioral health patients in the emergency department, but funding for this pool would need to come from reductions in either the small-rural pool or the non-small rural pool, or both. Such a proposal would create "winners and losers" in that money diverted to hospitals caring for these patients would likely come from reductions in DSH allotments to other hospitals. It is also important to note that this solution would have no effect on hospitals that have

already maximized their hospital-specific DSH allotment under the current methodology, since these hospitals, at best, would end up with the same DSH payment under the new formula.

Generally, fluctuations in the amount hospitals are paid from the DSH programs are dependent on the annual federal allotment and state matching contribution, and hospital-specific characteristics for that year, such as the hospital's loss incurred for treating Medicaid and uninsured patients. In 2022, however, the Georgia Advancing Innovation to Deliver Equity (GA-AIDE) program – a value-based, hospital directed payment program – was approved, which makes directed payments to Grady Memorial Hospital (Georgia's largest provider of Medicaid services) and Augusta University Medical Center (Georgia's state-owned academic medical center). Implementation of this program is expected to free up over $100 million in DSH funds, which can be used to increase DSH payments to other hospitals (though the State is now responsible for producing the state share for these funds). [14] The Department of Community Health notes that it plans to submit a state plan amendment which would redirect the newly available DSH funds to the DSH funding pool for small, rural hospitals. [14] To the extent that small, rural hospitals experience significant delays when attempting to transfer uninsured behavioral health patients from their ED to another facility, these additional DSH funds may help reimburse some of the care delivered to these patients.

One important concern related to hospitals relying on DSH payments to fund care delivered to uninsured patients is that the Affordable Care Act called for DSH allotment reductions that would be gradually phased in over time. The Consolidated Appropriations Act of 2021 delayed the phase-in of these reductions until 2024, and while there is a possibility that these reductions may be further delayed, the proposal creates uncertainty about the DSH program's future. [15] As currently proposed, annual DSH allotments would be reduced by $8 billion per year from FY2024 to FY2027, which would result in FY2027 allotments that are 57.8% of FY2024 allotments. [15]

In summary, DSH funding is a natural option for hospitals providing care to uninsured behavioral health patients, given that its purpose is to provide some reimbursement to hospitals caring for indigent patients (even though it is not a solution targeted towards behavioral health patients). In addition, it comes with the added benefit that it brings federal dollars into Georgia. Given that program eligibility and the amount of funds available for distribution is determined, at least in part, by the federal government, it may be difficult to increase the amount of money that can be distributed to hospitals. In addition, it may be difficult to rely on DSH payments as a long-term strategy, given federal proposals to reduce DSH funding in the near future.

4.3.1.2. State or Local Program

An additional option for direct reimbursement to hospitals includes the possibility of state or local governments allocating funds for the specific purpose of reimbursing hospitals that care for uninsured behavioral health patients in the emergency department for extended time periods. The advantage to this approach is that the legislature has the flexibility to target the funding to hospitals caring for these specific patients, without the fund allocation being generalized to care provided to any uninsured or Medicaid patients, as DSH funds are currently. In addition, this option is not subject to many of the federal requirements and approval processes that would be needed to implement 1115 Waivers, 1915(i) State Plan Options, or some changes to the DSH program. As such, this option is likely one of the easiest to implement.

There are, however, some notable disadvantages to this option. First, these funds would come out of the state or local budget and will need to be weighed against other legislative priorities. In addition, given that this program would not be tied to Medicaid or another federal program, the funds would not be matched with federal dollars. Furthermore, while a state or local program is likely one of the easiest options to implement in that it would be subject to fewer federal requirements and take less time, there are limited examples of similar programs being implemented in other states, so the administrative complexity of structuring and implementing such a program would need to be detailed by policymakers. It should also be noted that some counties already make payments to hospitals – for example, Fulton and Dekalb counties pay Grady Health System to support care provided to indigent patients. [16] This highlights that, at least in some cases, state or local governments are willing to provide financial support to hospitals, though on the other hand, to the extent these types of payments are already happening, this may limit the willingness of policymakers to provide additional funds for this purpose.

4.3.1.3. Increase Hospital Fee to fund Increase in Outpatient add-on Payment

Recent research has found that health care-related fees have been an increasing funding source for states – by 2018, 17% of state Medicaid funds came from these types of fees. [17] Today, Georgia levies a 1.45% fee on hospital net patient revenue (and 1.40% of net patient revenue for trauma centers),[2] which is below the 6% practical limit on such fees. [17] [18] Georgia has the option to increase this fee rate, which would result in increases in both the state share and federal matching dollars, and these funds can be used to fund increases to the add-on payment to outpatient Medicaid rates or more targeted reimbursement increases. The provider fee currently in place funds the 11.88% add on-payment for hospital outpatient and inpatient services.

The increase in federal matching funds coming to Georgia is a key advantage to this approach. While the option would help hospital reimbursement overall, an overall increase in the add-on payment is neither targeted towards behavioral health patients, nor targeted specifically towards uninsured patients. The increase in add-on payment may, however, be targeted towards certain services (e.g., behavioral health services) if desired; however, this approach may result in a disproportionate impact on some hospitals relative to others and would likely need to gain general support among stakeholders. An additional concern with increasing emergency department reimbursement is that it could also create the incentive of additional emergency department utilization rather than less intensive care. Thus, while the solution is not necessarily specific to the patient population in this study, it may indirectly help hospitals treating disproportionate numbers of behavioral health and uninsured patients in the emergency department.

There are several requirements for these fees, however, including that they be *broad based*, *uniform*, and *not hold taxpayers harmless.* They also cannot be targeted towards certain facilities, types of facilities, or specific types of services or items to which the fee applies. In addition, the hospitals on which the fees are applied cannot be guaranteed that they will be repaid at least the amount they paid in their fee, and Medicaid payments to providers on which the fees were assessed may not depend on the amount the hospital originally paid in fees. [17] These requirements create uncertainty for providers

[2] The 6% practical limit on provider fees is driven by the federal requirement that the state does not hold taxpayers harmless, i.e., the state may not guarantee taxpayers that they will be repaid, in part or in full, the amount they were taxed by the program. Similarly, the state may not make return payments to providers such that the payments depend on the amount of fee originally collected. A fee over 6% (the safe harbor threshold) of patient revenue would implicitly hold taxpayers harmless, while a fee below 6% does not imply a violation of the hold-harmless requirement based on the amount of the fee alone.

– particularly hospitals caring for fewer Medicaid patients, on average, than other hospitals. For these hospitals, one concern is that the amount of the fee increase may be larger than the amount of additional revenues that come from the increased Medicaid payments. Other hospitals, however, may see revenue increases that do offset the amount of the original fee, which suggests that under this option, some hospitals will benefit financially, and others may end up worse off financially. It should be noted, however, that since there is already a provider fee in place, some hospitals already benefit financially from the current system, while others do not. Thus, increasing the provider fee to fund increases in the outpatient add-on payment or making targeted reimbursement changes may change the hospitals which benefit financially and the hospitals that are worse off financially.

Given that the funds raised through a provider fee will not necessarily be distributed proportionately based on the amount of the hospitals' original fees, they may be unpopular and extra scrutiny may be given to how the funds are spent. Further, policymakers must weigh the use of additional funds raised by way of the provider fee increase (to fund increases to the Medicaid outpatient add-on payment) against other uses of these funds and assess possible resistance from providers and other stakeholders.

4.3.2 Increasing Insurance Coverage

4.3.2.1. 1915(i) State Plan Option

A 1915(i) State Plan Option can be used to provide Medicaid coverage for home and community-based services (HCBS) through a state plan amendment (SPA). This process allows for the HCBS benefit to be targeted to one or more specific populations established for a new Medicaid eligibility group, and the specific HCBS benefit can be defined to meet the needs of the targeted population. This option is subject to a number of federal guidelines, however, which detail requirements including (a) a process must be established that ensures assessments and evaluations are independent and unbiased; (b) the benefit is available to all individuals within the state; (c) adequate provider standards are established to meet the needs of the population; (d) the HCBS benefit services are provided "in accordance with a person-centered benefit plan"; and (e) a quality assurance, monitoring, and improvement strategy is established for the benefit. [19] Once the state Medicaid agency drafts a 1915(i) SPA it is submitted to CMS for review. Approval would establish a 1915(i) HCBS benefit, and 1915(i) benefits, when targeted to a specific population, are subject to an approval period of five years, at which point they become subject to renewal by CMS for an additional five-year period. Georgia may implement this option to increase coverage for a targeted group of patients in the state such as non-elderly adults with mental health or substance use disorders – a population for which several states have targeted their 1915(i) SPAs. [20] More specifically, if a 1915(i) state plan option was approved for individuals meeting the clinical criteria for serious mental illness or certain substance use disorders, these qualifying individuals could become eligible for the full Medicaid benefit package. If they later end up in an emergency department for a behavioral health reason, they will be insured for the visit, which will help reduce the financial strain on the hospital.

This option can indirectly help to alleviate part of the cost burden on hospitals providing care for uninsured patients in the ED for extended periods by increasing the proportion of the population that is insured. In addition, more insurance coverage for behavioral health patients may also result in patients being more likely to receive routine care, reducing their likelihood of showing up in the ED in a crisis situation. While not directly reimbursing hospitals for care provided to uninsured patients, this solution is more likely to, at least in part, address the root cause issue that results in some financial strain on

hospitals. In addition, this option allows the State to take advantage of federal matching funds, which will bring additional money to Georgia.

While this option has several advantages, there are also several challenges and disadvantages that must be considered. One concern about 1915(i) state plan options cited by state officials in a 2016 report produced by the U.S. Department of Health and Human Services, is the inability for states to cap enrollment in the program, which increases cost exposure to the State if enrollment is higher than originally forecasted. [20] This risk can be mitigated to some extent if the State modifies the program eligibility criteria to make it more restrictive (which would only apply to *future* enrollees); however, such a modification would reduce the effectiveness of this approach as a way to reduce hospitals' cost burden related to caring for uninsured patients. [20] An additional concern related to implementation of 1915(i) state plan options is that the federal requirements related to quality measurement can be burdensome to implement. Likewise, the development of the SPA, along with the processes related to CMS application, review, and approval, are resource intensive and time consuming. [20]

4.3.2.2. 1115 Waiver

One option Georgia may consider implementing to reduce the financial burden on hospitals caring for uninsured patients is to use a Section 1115 Waiver to expand insurance coverage for Georgia's population. Section 1115 Demonstrations allow states to propose, subject to CMS approval, experimental or pilot projects which further the objectives of the Medicaid program. Advantages to this option may include expanded coverage for additional services or new populations, as well as the State being able to take advantage of increased federal matching funds. Some disadvantages to 1115 Waivers in this context include the time and complexity required to draft the proposal, the ensuing approval process with CMS, and the administrative complexities and federal requirements (e.g., related to monitoring and evaluation) associated with the waiver.

Georgia's Pathways to Coverage Waiver is intended to increase Medicaid coverage for childless adults up to 100% of the federal poverty level and parents between 35-100% of the federal poverty level, who are not otherwise eligible for Medicaid. [21] Coverage eligibility under the waiver would be contingent on enrollees spending at least 80 hours per month on qualifying activities, including employment, education, "specified job readiness activities," or community service (this requirement has been collectively termed "qualifying activities"). [22] This waiver was initially approved in 2020, though in December 2021 CMS withdrew its approval, citing that the demonstration's qualifying activities being used as a condition of Medicaid eligibility "compromise[] the demonstration's effectiveness in promoting coverage for its intended beneficiaries". [22] Georgia appealed this decision in federal court, won its case, and is proceeding with implementation activities of the waiver. The Pathways to Coverage Waiver may help reduce financial strain placed on hospitals caring for uninsured patients in the emergency department for extended periods of time, to the extent that these patients may now be eligible for Medicaid coverage. On the other hand, uninsured behavioral health patients who show up in the emergency department may be less likely to qualify for coverage under the waiver (i.e., ineligibility due to the qualifying activities, federal poverty level, or other reason), so the degree to which the waiver helps hospitals in this situation may be limited.

4.4. Discussion

Throughout this section, various options for reimbursement to hospitals caring for uninsured behavioral health patients in the emergency department for extended periods of time were considered. These

options are varied across multiple factors, including mechanisms by which they address hospitals' financial concerns (e.g., directly reimbursing hospitals for uncompensated care versus increasing health insurance coverage for Georgia's population). In addition, options which are currently in-use and available today (e.g., DSH) were discussed, and options not currently in place that would need to be designed were also discussed. Each option has its own advantages, disadvantages, and other considerations which may affect its suitability as a solution in this context.

If Georgia wishes to expand reimbursement options for uninsured patients, one key consideration is ease of implementation. Often, factors which make some options more difficult to implement include the time complexity required to design a new program and compliance with federal or other statutory requirements. By these metrics, state and local programs and hospital fees are likely easier to implement than the other options proposed, and while it is difficult to increase the amount of DSH funding available, it is less difficult to re-allocate the existing pool of funds. Another key consideration is whether the option brings new funds to Georgia. Many of the proposed options may result in federal matching dollars coming to the State upon implementation, while state or local programs – though easier to implement – would likely not result in federal matching dollars sent to the State. These considerations, along with additional considerations for each proposed reimbursement/coverage option are summarized in Figure 19.

Figure 19. Summary of Options for Reimbursement to Hospitals Caring for Uninsured Patients

	DSH Program	State/Local Program	Hospital Fee to Raise Outpatient Add-On Payments	1915(i) State Plan Option for Behavioral Health	1115 Waiver
Targeted to Behavioral Health Patients	Not currently, but could be	Yes	Can be, but a behavioral health-specific increase to add-on payments may be more difficult for stakeholders to support compared to an overall increase in the outpatient add-on payment.	Yes	Can be, but non-targeted waiver may also help by increasing the population's insurance coverage overall
Technical Ease of Implementation (Excluding Political Considerations)	Difficult to free up new funds that can be distributed Moderate difficulty to re-distribute existing pool of funds based on new allocation and formula.	Easier	Easier	More Difficult	More Difficult
Brings New Funds to GA	Yes – but program is already in place, so the amount by which federal match can increase is limited.	No	Yes	Yes	Yes
Advantages	Direct reimbursement to hospitals Program is set up for this purpose (compensating for care delivered to uninsured patients)	Direct reimbursement to hospitals Not a federal program so subject to fewer federal requirements	Can result in net gain financially for hospitals treating more Medicaid patients	Increased health insurance coverage overall	Increased health insurance coverage overall

	DSH Program	State/Local Program	Hospital Fee to Raise Outpatient Add-On Payments	1915(i) State Plan Option for Behavioral Health	1115 Waiver
Disadvantages	DSH is an existing program and the degree to which the State can increase the amount of funds to be distributed is limited. DSH re-allocation may create "winners and losers" – some hospitals may benefit at other hospitals' expense DSH re-allocation would not benefit hospitals which are already at the hospital specific DSH limit under the current methodology	No federal matching funds would be available Administrative complexity required to set up the program given limited programs in other states to use as a model.	May create new "winners and losers" – some hospitals may be reimbursed a lower amount than the original fee An increase in the overall outpatient add-on payment does not directly address "reimbursement for uninsured patients in the emergency department" but does so indirectly, with potentially limited efficiency. An add-on payment targeted to behavioral health services addresses this more directly.	Subject to federal requirements that may create an administrative burden for the State. Amount of time needed to draft SPA and undergo federal approval process may be limiting Enrollment cannot be capped (and thus costs may exceed projected costs)	Subject to federal requirements that may create an administrative burden for the State. Significant time and complexity associated with drafting a new waiver Subject to federal review and approvals process, that may be time consuming

5. Accounting of Mental Health Fund Distribution Across State Agencies

5.1. Background and Legislative Request

Georgia House Bill 1013 directs the Department of Community Health to undertake a study regarding "an accurate accounting of mental health fund distribution across state agencies, including, but not limited to, the department [DCH], the Department of Behavioral Health and Developmental Disabilities [DBHDD], the Department of Human Services [DHS], and the Department of Juvenile Justice [DJJ]." To meet this request, behavioral health spending data was requested and summarized for these departments and the Division of Family and Children Services (DFCS) within DHS. While each department's mission differs, they all provide behavioral health services that uniquely help care for Georgia's population with behavioral health needs. An overview of each agency's mission and behavioral health service offerings follows.

DBHDD serves individuals in Georgia (primarily uninsured or on Medicaid) with behavioral health challenges and/or intellectual and developmental disabilities through its network of providers of community-based services and state behavioral health hospitals. DCH provides access to healthcare for Georgians in Medicaid (which includes PeachCare for Kids) who are underserved and vulnerable. DCH also provides access to behavioral health services through the State Medicaid program. [23] DJJ offers probation supervision and secure detention services for justice-involved youth, as well as behavioral health services which include general counseling and case management, sexually harmful behaviors treatment, and substance abuse treatment services. [24] Finally, Georgia's DFCS provides financial and support services to families and children in fulfillment of their mission to prioritize the safety of Georgia's children. Behavioral health services provided by DFCS include comprehensive child and family assessments and wraparound services to support children and families in crisis or other unsafe situations. [25]

The remainder of this section contains a summary of the approach, key findings, and a discussion related to summarization and comparison of DBHDD, DCH, DJJ, and DFCS departmental spending on behavioral health services.

5.2. Approach

To account for behavioral health spending across DBHDD, DCH, DJJ and DFCS, financial data was requested from each department and summarized, including a comparison of State Fiscal Year (SFY) 2019-2022 total behavioral health spending by funding source, and a more detailed service-level breakdown of SFY 2022 spending for each department. These years were selected to have a pre-pandemic baseline and a current sample, providing insight into any changes which might be associated with pandemic service delivery disruptions.

5.2.1 Data Request

To generate the summaries of DBHDD, DCH, DJJ, and DFCS behavioral health spending, a data request was sent to each of the four agencies. Given the differences in departmental missions and levels of involvement with behavioral health services, definitions were specified and standardized to the extent possible. The following data was requested:

Total dollars spent totaled across the following fields:

- Department: DBHDD/DCH/DJJ/DFCS

- Funding source: State/Federal/Other (e.g., grants, any other specific funding sources if applicable)
- Behavioral Health Service (to include administrative services that support behavioral health services)
- Population Served: Adult/Child
- Date Range: SFY2019, SFY2020, SFY2021, SFY2022

Within the data request, the following definitions were provided:

- Behavioral Health: includes both mental health and substance use disorders as specified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). It does not include neurodevelopmental disorders (intellectual disability, autism spectrum disorder, attention deficit hyperactivity disorder, specific learning disorders, communication and motor disorders) as specified in the DSM-V.
- Child: Under the age of 21
- Adult: Age 21 and older

5.2.2 Data Refinements and Limitations

While the data request sent to each department was standardized and provided specific definitions of the fields requested, fulfillment differed across departments due to variances in processes for accounting for behavioral health services. DBHDD and DFCS account for spending across each of the behavioral health services provided by their respective departments. DCH tracks Medicaid behavioral health spending via fee for service (FFS) and care management organization (CMO) claims or encounters for categories of service which include behavioral health services. DJJ does not maintain a separate accounting for behavioral health services. Therefore, the department provided budgeted behavioral health-related salary and other ancillary costs (including, for example, computer costs and contract costs).

Since the data received from each department varied, it required refinement in order to conduct a meaningful analysis. Meetings were held with representatives of each department to answer questions related to the requested data, enhancing the representativeness and completeness of each data set. Therefore, one overarching assumption is that the data received represents a complete and accurate summary of behavioral health spending for each department. Additional department-specific data nuances and refinements are summarized below.

5.2.2.1. DBHDD

The Department of Behavioral Health and Developmental Disabilities provided information on budgeted SFY2019-SFY2022 spending on behavioral health services in a manner that was consistent with the data request. DBHDD service-level spending was rolled into the following categories for summarization purposes: adult mental health, child mental health, adult addictive disorders, child addictive disorders, and DBHDD hospital system spending.

5.2.2.2. DCH

The Department of Community Health provided FFS claims and CMO encounter data to represent the department's spending on behavioral health services. Data provided was restricted to categories of service which represent behavioral health services (this restriction may result in funds related to

behavioral health prescription medication being excluded from the analysis). The categories of service, along with data restrictions and analysis steps taken to summarize DCH spending, include:

- Physician Services (Category of Service [COS] 430): data was restricted to dollars spent for adult psychiatry and child & adolescent psychiatry.
- Community Mental Health Services (COS 440): DCH state-funded spending for FFS community mental health services includes only preadmission screening and resident review (PASRR) spending, while all federal-funded community mental health services spending is paid through DCH. Community mental health spending provided in this analysis thus reflects these amounts.
- Children's Education - School (COS 960): DCH covers only the federal match portion of spending in this service, while the state portion is paid for by the Department of Education. DCH provided total children's education – school spending data, so spending within this category was adjusted accordingly to produce the DCH-only spending.
- Psychological and Therapy Services (COS 570) and Children's Intervention Services (COS 840) spending data was not adjusted, reflecting that DCH pays for all the spending for these categories.
- Federal Matching Assistance percentages (FMAP) for SFY2019-SFY2022 for each included category of service was obtained from the DCH Finance Department, and these percentages were applied to overall spending by category of service in order to calculate the amount of spending funded by federal and state sources. The FMAP percentages for federal fiscal years were applied to the SFY data with a weighted average based on the number of months of overlap (for example, for SFY22 FMAP percentage was calculated by taking ¼ of Federal Fiscal Year (FFY) 2021 FMAP percentage and ¾ FFY22 FMAP percentage). The SFY19 FMAP was set equal to FFY19 since the FFY18 FMAP was not provided.

5.2.2.3. DJJ

The Department of Juvenile Justice provided spending amounts for Regional Youth Detention Centers (RYDCs), Youth Development Campuses (YDCs) and federal education funds. DJJ spending listed in this report primarily represents the costs to employ staff who provide behavioral health services (but also includes computer charges and other operating costs). The department does not track budget and spending on specific behavioral health services since the department does not bill an external payer for the services provided. Representatives from DJJ advised that dollars spent on RYDCs and YDCs come from state sources, except for costs related to residential substance abuse treatment.

5.2.2.4. DFCS

The Division of Family and Children Services provided department budget information on SFY2019-SFY2022 spending on behavioral health services in a manner consistent with the data request. Upon receipt of this data, some services were identified that were not behavioral health services, so these were excluded from the final data summaries. The remaining services were identified as being either "behavioral health services" or "partial behavioral health services" and services falling into either of these categories were included in the analysis. For the purposes of this summary, partial behavioral health services include services whose goal includes addressing behavioral health diagnoses or services for which a behavioral health practitioner or other practitioner may be reimbursed. DFCS indicated that all the funding associated with the services included in the data summary came from a federal source.

5.3. Key Findings

5.3.1 Overall Funding by Department

Across DBHDD, DCH, DJJ, and DFCS, SFY2022 behavioral health spending totaled $1.42 billion, as shown in Figure 20. DBHDD's spending accounted for the majority (69%) of this amount, while DCH's spending accounted for approximately 26%. The remaining 5% of spending is split between DFCS and DJJ.

Figure 20. DBHDD, DCH, DJJ and DFCS SFY2022 Behavioral Health Spending

SFY2022 (*spending reported as thousands of dollars*)	
Department	Total Spending
DBHDD	$987,432
DCH	$370,567
DJJ	$16,884
DFCS	$47,710
Total	**$1,422,593**

Figure 21 contains a more detailed summary of behavioral health spending across the four departments and includes spending by funding source (state-funded, federal-funded, and other). Total DBHDD, DCH, DJJ, and DFCS behavioral health spending over this time period increased by 21% (the $1.18 billion spent in SFY2019 increased to $1.42 billion in SFY2022). Total average annual spending across the four years was $1.27 billion. In each fiscal year, the majority (60%-66%) of behavioral health spending across these four departments was funded from State sources.

Figure 21. DBHDD, DCH, DJJ and DFCS Behavioral Health Spending by Funding Source (SFY2019-SFY2022)

SFY2019 (*spending reported as thousands of dollars*)				
Department	Funding Source: State	Funding Source: Federal	Funding Source: Other	**Total**
DBHDD	$705,999	$126,428	$7,902	**$840,329**
DCH	$57,614	$229,457	$0	**$287,071**
DJJ	$17,947	$338	$0	**$18,285**
DFCS	$0	$32,617	$0	**$32,617**
Total	**$781,560**	**$388,840**	**$7,902**	**$1,178,302**
SFY2020 (*spending reported as thousands of dollars*)				
Department	Funding Source: State	Funding Source: Federal	Funding Source: Other	**Total**
DBHDD	$726,404	$125,941	$5,850	**$858,195**
DCH	$74,407	$260,793	$0	**$335,200**
DJJ	$18,841	$18	$0	**$18,859**
DFCS	$0	$36,189	$0	**$36,189**
Total	**$819,652**	**$422,941**	**$5,850**	**$1,248,443**
SFY2021 (*spending reported as thousands of dollars*)				
Department	Funding Source: State	Funding Source: Federal	Funding Source: Other	**Total**
DBHDD	$707,820	$123,178	$4,129	**$835,127**
DCH	$69,339	$274,525	$0	**$343,864**
DJJ	$17,929	$193	$0	**$18,122**
DFCS	$0	$37,525	$0	**$37,525**
Total	**$795,088**	**$435,421**	**$4,129**	**$1,234,638**
SFY2022 (*spending reported as thousands of dollars*)				
Department	Funding Source: State	Funding Source: Federal	Funding Source: Other	**Total**
DBHDD	$767,037	$214,044	$6,351	**$987,432**
DCH	$72,275	$298,292	$0	**$370,567**
DJJ	$16,646	$238	$0	**$16,884**
DFCS	$0	$47,710	$0	**$47,710**
Total	**$855,958**	**$560,284**	**$6,351**	**$1,422,593**

**DCH provided amount spent in FFS Claims and CMO Encounters instead of department budget*

5.3.2 DBHDD Spending

The Department of Behavioral Health and Developmental Disabilities spent $987 million on behavioral health services during SFY2022. Adult mental health services accounted for $498 million (50%) of this amount, while spending on adult addictive disorders accounted for $158 million (16%). These two categories combined represent 66% of the department's behavioral health spending. Child addictive disorders and child mental health combine to represent 9% of DBHDD behavioral health spend, and

DBHDD hospital system spending represents the remaining 25% of the department's spending on behavioral health services. Figure 22 contains a summarization of DBHDD behavioral health spending by service type and funding source.

Figure 22. DBHDD Behavioral Health Spending by Funding Source, SFY2022

SFY2022 (*spending reported as thousands of dollars*)				
Category	Funding Source: State	Funding Source: Federal	Funding Source: Other	**Total**
Adult Mental Health	$423,316	$74,194	$518	**$498,028**
DBHDD Hospital System	$239,644	$2,281	$4,804	**$246,729**
Adult Addictive Disorders	$51,406	$105,997	$943	**$158,346**
Child Mental Health	$49,831	$21,201	$86	**$71,118**
Child Addictive Disorders	$2,840	$10,371	$0	**$13,211**
DBHDD Total	**$767,037**	**$214,044**	**$6,351**	**$987,432**

5.3.3 DCH Spending

The Department of Community Health provided behavioral health spending (via FFS claims and CMO encounter data) for physician services, community mental health services, psychological and therapy services, children's intervention services, and children's intervention school services. Across these services and categories, spending for child CMO encounters and adult FFS claims for community mental health services represented a significant portion of the department's behavioral health spending, and combine to represent 43% of DCH's SFY2022 spending. Similarly, a large portion of DCH behavioral health spending goes towards children's intervention services, with $76.8 million spent on CMO encounters and $52.3 million spent on FFS Claims, which combined represent 35% of DCH behavioral health spending. Approximately 80% of the included DCH spending on behavioral health services comes from federal sources, while the remaining spending is funded from state sources. Summarized DCH spending across categories of service are shown in Figure 23.

Figure 23. DCH Behavioral Health Spending by Funding Source, SFY2022

SFY2022 (*spending reported as thousands of dollars*)			
Category	Funding Source: State	Funding Source: Federal	Total
FFS Claims			
FFS Claims Total	**$16,751**	**$147,443**	**$164,194**
Child Physician Services (COS 430)	$485	$1,318	$1,803
Child Community Mental Health Services (COS 440)	$31	$14,389	$14,420
Child Psychological and Therapy Services (COS 570)	$556	$1,512	$2,068
Children's Intervention Services (COS 840)	$14,079	$38,249	$52,328
Children's Intervention School (COS 960)	$0	$13,733	$13,733
Adult Physician Services (COS 430)	$1,476	$4,011	$5,487
Adult Community Mental Health Services (COS 440)	$124	$74,231	$74,355
Adult Psychological and Therapy Services (COS 570)	$0	$0	$0
CMO Encounters			
CMO Encounters Total	**$55,524**	**$150,849**	**$206,373**
Child Physician Services (COS 430)	$3,193	$8,674	$11,867
Child Community Mental Health Services (COS 440)	$22,484	$61,083	$83,567
Child Psychological and Therapy Services (COS 570)	$3,428	$9,314	$12,742
Children's Intervention Services (COS 840)	$20,680	$56,184	$76,864
Children's Intervention School (COS 960)	$0	$0	$0
Adult Physician Services (COS 430)	$1,108	$3,012	$4,120
Adult Community Mental Health Services (COS 440)	$4,343	$11,800	$16,143
Adult Psychological and Therapy Services (COS 570)	$288	$782	$1,070
DCH Total	**$72,275**	**$298,292**	**$370,567**

5.3.4 DJJ Spending

The Department of Juvenile Justice provided dollar spending amounts for RYDCs, YDCs and federal education funds. Total SFY2022 DJJ spending across the RYDC, YDCs, and education categories was $16.9 million. Approximately 54% ($9.2 million) of this amount was spent on RYDCs, which provide "[m]edical, education, behavioral health, nutrition, and general programming." [26] YDCs, which provide "youth services that include education, health and mental health services, food services, resident counseling, substance abuse units, vocational programming, and family visitation, among other services," account for $7.7 million (approximately 45%) of the department's spending across the categories. [26] Education funds represent less than 1% of overall DJJ behavioral health spending. Overall, reported DJJ behavioral health spending is funded primarily from state funding sources (99%), with only 1% of the spending funded from federal sources. Figure 24 contains a breakdown of DJJ behavioral health spending by funding source.

Figure 24. DJJ Behavioral Health Spending by Funding Source, SFY2022

SFY2022 (*spending reported as thousands of dollars*)			
Category	Funding Source: State	Funding Source: Federal	Total
Regional Youth Detention Center	$9,185	$0	**$9,185**
Youth Development Campus	$7,461	$193	**$7,654**
Federal Education Funds	$0	$45	**$45**
DJJ Total	**$16,646**	**$238**	**$16,884**

5.3.5 DFCS Spending

In SFY2022, the Georgia Division of Family and Children Services spending on behavioral health services totaled $47.7 million, which includes $31.2 million (65%) for behavioral health-specific services, and $16.5 million for *partial*-behavioral health services. Within behavioral health-specific services, emergency hoteling/supervision behavioral aide services represent the service with the highest dollar spend ($22.5 million; 47% of DFCS behavioral health spending). All DFCS behavioral health and partial-behavioral health service spending comes from a federal funding source. An overall summary of reported DFCS behavioral health spending by funding source is provided in Figure 25.

Figure 25. DFCS Behavioral Health Spending by Funding Source, SFY2022

SFY2022 (*spending reported as thousands of dollars*)	
Category	Funding Source: Federal
Behavioral Health Services	**$31,245**
Emergency Hoteling/Supervision Behavioral Aide Services	$22,547
Behavioral Aide	$5,874
In-Home Intensive Clinical/Therapeutic Services (High Risk)	$735
In Home Intensive Clinical/Therapeutic Services (Moderate Risk)	$2,089
Partial Behavioral Health Services	**$16,465**
Initial Child/Family Assessment	$2,025
Court Appearance and/or Testimony (High Level)	$31
Court Appearance and/or Testimony (Low Level)	$31
Court Appearance and/or Testimony (Moderate Level)	$24
WRAP Mileage	$9,695
WRAP Missed Scheduled Appointments	$146
Crisis Intervention (High Risk)	$4
Crisis Intervention (Lower Risk)	$2
Crisis Intervention (Moderate Risk)	$5
In Home Targeted Case Management (High Risk)	$379
In Home Targeted Case Management (Lower Risk)	$1,726
In Home Targeted Case Management (Moderate Risk)	$2,397
DFCS Total	**$47,710**

5.4. Discussion

Due to variations in data reporting processes across departments, there may be inconsistencies in the data elements which may limit the ability to make comparisons across departments. In addition, it is important to note that while this analysis summarized behavioral health spending for some of Georgia's agencies that provide behavioral health services, there are other agencies which provide behavioral health services to Georgia's population which were not included in this analysis, and thus this is not an exhaustive summary of departmental behavioral health spending statewide.

6. Summarization of Medical Necessity Denials for Adolescent Behavioral Health Services

6.1. Background and Legislative Request

House Bill 1013 directs the Department of Community Health to undertake a study of "medical necessity denials for adolescent mental and behavioral health services." Prior authorization is required for behavioral health services covered by Medicaid (including PeachCare for Kids) and state funds. Prior authorization, also called authorization or pre-certification, is an approval for services from a health plan based on policy terms and medical necessity. [27] Not all prior authorizations guarantee payment from the health plan. [28] For the purposes of this study, denials are considered the rejection (or disapproval) of a prior authorization request.

Authorizations may be denied for an array of reasons such as administrative errors (e.g., missing information, incorrectly completed request), service requests that are not covered under the plan, or not meeting medical necessity. Medical necessity denials encompass those situations when the diagnosis does not qualify for the service requested. For example, if an individual is diagnosed with an intellectual and developmental disability but not a behavioral health condition, and an authorization for a behavioral health service is requested, this request may be denied on medical necessity grounds. Similarly, a request for a service that is not indicated based upon diagnosis may also be denied for not meeting medical necessity.

Care Management Organizations (CMO) can deny part of a prior authorization request. For instance, they may approve 10 units of service rather than the 20 units requested, while services paid through the fee-for-service (FFS) model are either approved or denied entirely. There are three CMOs in Georgia that authorize Medicaid behavioral health services: Amerigroup Community Care, a subsidiary of Amerigroup Corporation; CareSource, part of a national Medicaid managed care plan; and Peach State Health Plan, a subsidiary of Centene Corporation. The FFS behavioral health authorizations are initiated and reviewed by Beacon Health Options on behalf of the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). [29]

6.2. Methodology

The intent of this study is to understand the frequency in which behavioral health service authorizations for adolescents are denied for not meeting medical necessity. Specifically, this study assesses the percentage of approvals and denials by reason and service, for FFS and CMO prior authorization requests. Behavioral health services are those tailored to address mental health and substance use disorders, exclusive of neurodevelopmental disorders. Neurodevelopmental disorders include autism spectrum disorders, intellectual disabilities, attention deficit disorder, motor disorder, communication disorder and specific learning disorder. [30] For this study, behavioral health services include the following categories of services (COS) that are provided to adolescents:

- COS 440: Community Behavioral Health and Rehabilitation Services (CBHRS)
- COS 570: Psychological and Therapy Services

Additionally, for the purposes of this report, adolescence is defined as between the ages of 12 and 20 inclusive. This age range aligns with the World Health Organization's definition of adolescence between the ages of 10 and 19. [31] It also aligns with the service definition for DBHDD's Intensive Residential

Treatment program of between 13 and 17, as well as conforms to the previous study of spending across departments, which defined an adult as age 21 and older. [32] This definition also conforms to the CMO definitions, which define an adult as age 21 and older. [33]

6.2.1 Data Request

To summarize FFS and CMO authorization denial rates based on medical necessity for adolescent behavioral health services, a data request was produced and submitted to the CMOs and DBHDD. The number of approved and denied authorizations, and their associated units of service, summarized across month of service, procedure code and modifier, provider NPI, patient age and reason for denial, were requested. Data was requested for calendar year 2019, to include pre-pandemic numbers, and State Fiscal Years 2021 and 2022. The data is reported by the month the authorization was incurred and assigned based on mappings to aggregate waiver groups determined by service codes. The data elements requested are noted below:

- Month of Service
- Patient's Age
- Category of Service (COS) Code
- Place of Service Code
- Procedure Code
- Procedure Modifier Code
- Denied Authorization (=Y)
- Partial Denial (Y/N)
- Authorization Count
- Units of Service Requested
- Units of Service Allowed/Approved
- Reason for Denial Code

6.2.2 Analysis

Data was reviewed to confirm that all authorizations were for the intended target population and services. Additionally, the data was cleansed to ensure that all data elements fall within the expected range, e.g., calendar year (CY), State Fiscal Year (SFY), etc. Then, the following calculations were performed:

- Calculated the percentage of approvals and denials for FFS, specifically:
    - Percentage of all denials
    - Percentage of denials by service
- Calculated the percentage of authorization denials aggregated across CMOs, specifically:
    - Percentage of all denials
    - Percentage of denials by service
    - Number of partial denials
    - Number of partial denials by service
    - Average percentage of service units denied when there is a partial approval for each service

6.3. Key Findings

6.3.1 Fee-for-Service Data

Overall, the rate of FFS medical necessity authorization denials for adolescent behavioral health services was consistent across the years and services. The denial rates across years were consistently less than 0.2%: 0.19% (CY 2019), 0.18% (SFY 2021), 0.17 % (SFY 2022), as shown in Figure 26. In 2019, the highest percentage of authorization denials were for community support team (CST) services, at approximately 18%. However, this percentage represents only two denials out of 11 requested for the calendar year, limiting the ability to make inferences. In following years, this trend does not continue. In SFY 2021, Assertive Community Treatment had the most denials with 2.33% (two out of 86 requests), and in SFY 2022, Intensive Care Management had the most denials with 2.33% (one out of 43 requests). Overall, the rate of medical necessity authorization denials remains consistent across the years and services.

Figure 26. Fee-for-Service (FFS) Authorization Denials Based on Medical Necessity CY2019, SFY2021, and SFY2022

	CY2019 FFS Authorizations			SFY2021 FFS Authorizations			SFY2022 FFS Authorizations		
Services	**# Requested**	**# Denied**	**% Denied**	**# Requested**	**# Denied**	**% Denied**	**# Requested**	**# Denied**	**% Denied**
Intensive Care Management	48	1	2.08%	42	0	0.00%	43	1	2.33%
Psychiatric Residential Treatment Facility	726	4	0.55%	536	10	1.87%	353	4	1.13%
Crisis Stabilization - Adults	97	1	1.03%	50	1	2.00%	92	1	1.09%
Intensive Family Intervention	712	7	0.98%	616	0	0.00%	519	5	0.96%
Non-Intensive Outpatient Services	7,771	2	0.03%	6,292	1	0.02%	6,126	3	0.05%
Adult Peer Supports	138	0	0.00%	66	0	0.00%	59	0	0.00%
Assertive Community Treatment	97	1	1.03%	86	2	2.33%	55	0	0.00%
C&A Peer Supports	145	0	0.00%	167	0	0.00%	185	0	0.00%
Case Management	5	0	0.00%	1	0	0.00%	0	0	N/A
Community Support Team	11	2	18.18%	13	0	0.00%	8	0	0.00%
Crisis Services	251	0	0.00%	280	0	0.00%	206	0	0.00%
Crisis Stabilization - C&A	312	2	0.64%	319	2	0.63%	417	0	0.00%
Intensive Customized Care Coordination	278	0	0.00%	233	0	0.00%	234	0	0.00%
Opioid Maintenance	3	0	0.00%	2	0	0.00%	3	0	0.00%
Psychosocial Rehabilitation Program	46	0	0.00%	21	0	0.00%	17	0	0.00%
Substance Abuse Intensive Outpatient Program	7	0	0.00%	4	0	0.00%	0	0	N/A
Supported Employment (TORS)	12	0	0.00%	15	0	0.00%	14	0	0.00%
Treatment Court - Addictive Disease	0	0	N/A	1	0	0.00%	0	0	N/A
Women's Treatment Program	1	0	0.00%	1	0	0.00%	1	0	0.00%
Women's Treatment Program - Outpatient	3	0	0.00%	2	0	0.00%	1	0	0.00%
All Services	**10,663**	**20**	**0.19%**	**8,747**	**16**	**0.18%**	**8,333**	**14**	**0.17%**

Note: Data sorted by highest % denied in SFY2022.

6.3.2 Care Management Organization Data

Two of the three CMOs provided data that was included in the analysis. One CMO reported that they do not require prior authorization for most behavioral health services unless a specified number of units have been utilized. For example, psychological and therapy services that are in COS 570, such as psychological testing evaluation, do not require authorization unless the participant has received more than 24 units in a calendar year. Thus, if participants are not exceeding the allotted units, authorization for these services is not requested. Since this CMO's data was not comparable to the other two CMOs, it was not included in the analysis.

6.3.2.1. Authorization Denials

Overall, CMO authorization denials from CY 2019, SFY 2021 and SFY 2022 remained steady between four and five percent (Figure 27). However, across the three years, the rate of authorization requests increased: 26,312 (CY 2019), 32,952 (SFY 2021) and 43,292 (SFY 2022) respectively. This increase reflects national trends of increased behavioral health needs. **[34] [35] [36]** In general, psychological testing was the most likely to be denied for medical necessity; 0% (CY 2019), 28% (SFY 2021) and 22% (SFY 2022). The three most requested behavioral health services for adolescents across all years were as follows:

- Community support:
    - CY 2019: 10,365 requested, 6% denied for medical necessity
    - SFY 2021: 12,133 requested, 4% denied for medical necessity
    - SFY 2022: 15,673 requested, 3% denied for medical necessity
- Individual counseling:
    - CY 2019: 4,947 requested, 0% denied for medical necessity
    - SFY 2021: 6,183 requested, 0% denied for medical necessity
    - SFY 2022: 7,274 requested, 0% denied for medical necessity
- Family outpatient- family training:
    - CY 2019: 4,902 requested, 7% denied for medical necessity
    - SFY 2021: 6,030 requested, 4% denied for medical necessity
    - SFY 2022: 8,019 requested, 3% denied for medical necessity

Figure 27. CMO Authorization Denials by Service Based on Medical Necessity CY 2019, SFY 2021, and SFY 2022

Services	CY2019 CMO Authorizations			SFY2021 CMO Authorizations			SFY2022 CMO Authorizations		
	# Requested	# Denied	% Denied	# Requested	# Denied	% Denied	# Requested	# Denied	% Denied
Psychological Testing	620	1	0%	1,787	509	28%	3,553	769	22%
Psychosocial Rehabilitation	452	46	10%	705	47	7%	883	49	6%
Family Outpatient Services - Family Counseling	2,214	208	9%	2,581	161	6%	2,971	140	5%
Intensive Family Intervention	1,651	70	4%	1,953	113	6%	2,759	87	3%
Community Support	10,365	603	6%	12,133	494	4%	15,673	499	3%
Family Outpatient Services - Family Training	4,902	324	7%	6,030	265	4%	8,019	246	3%
Intensive Customized Care Coordination	448	20	4%	753	23	3%	673	6	1%
Individual Counseling	4,947	0	0%	6,183	7	0%	7,274	2	0%
Peer Supports	122	7	6%	167	1	1%	489	0	0%
Psychiatric Treatment	365	0	0%	384	0	0%	385	0	0%
Crisis Stabilization Unit Services	24	0	0%	55	0	0%	265	0	0%
Case Management	70	0	0%	133	0	0%	205	0	0%
Diagnostic Assessment	6	0	0%	13	0	0%	39	0	0%
Assertive Community Treatment (ACT)	20	1	5%	23	0	0%	32	0	0%
Behavioral Health Assessment	83	0	0%	5	0	0%	23	0	0%
Service Plan Development	4	0	0%	4	0	0%	21	0	0%
Crisis Intervention	5	0	0%	5	0	0%	13	0	0%
Substance Abuse Intensive Outpatient Program	2	1	50%	2	1	50%	6	0	0%
Group Psychotherapy	12	0	0%	24	0	0%	5	0	0%
Medication Administration	0	0	N/A	0	0	N/A	2	0	0%
Nursing Assessment and Health Services	0	0	N/A	11	0	0%	2	0	0%
Individual Psychotherapy	0	0	N/A	0	0	N/A	0	0	N/A
Interactive Complexity	0	0	N/A	1	0	0%	0	0	N/A
All Services	**26,312**	**1,281**	**5%**	**32,952**	**1,621**	**5%**	**43,292**	**1,798**	**4%**

Note: Data sorted by highest % denied in SFY2022. Percentages are rounded to the nearest whole percentage.

6.3.2.2. Authorization Partial Denials

When compared to denials, partial denials occur with greater frequency, between one-and-a-half to two times as often, depending on the year. Partial denials represent a fraction of all authorization outcomes as roughly 6.3% of all prior authorization requests result in a partial denial. Of authorization requests which were partially denied due to medical necessity, less than half the units of service were denied (Figure 28). Specifically, in CY 2019, 46% of the units requested were denied on average, in SFY 2021 46% of the units were denied on average, and in SFY 2022 45% were denied on average. However, some adolescent behavioral health services had more than half the units requested denied for medical necessity. The services with 50% or more of the units requested denied in SFY 2022, include:

- Individual Psychotherapy
- Peer Supports
- Case Management
- Assertive Community Treatment (ACT)
- Individual Counseling
- Family Outpatient Services - Family Counseling
- Psychiatric Treatment

Figure 28. CMO Authorization Partial Denials by Service Based on Medical Necessity CY2019, SFY2021, and SFY 2022

Services	CY 2019 CMO Authorizations		SFY 2021 CMO Authorizations		SFY2022 CMO Authorizations	
	# Partial Denials	% Units Denied	# Partial Denials	% Units Denied	# Partial Denials	% Units Denied
Individual Psychotherapy	18	58%	25	76%	8	72%
Peer Supports	18	68%	18	69%	33	60%
Case Management	3	71%	11	68%	10	60%
Assertive Community Treatment (ACT)	2	56%	5	35%	5	58%
Individual Counseling	241	61%	223	63%	296	57%
Family Outpatient Services - Family Counseling	132	46%	123	55%	67	54%
Psychiatric Treatment	0	N/A	0	N/A	1	50%
Family Outpatient Services - Family Training	405	47%	382	47%	338	47%
Intensive Customized Care Coordination	10	55%	12	90%	8	43%
Psychosocial Rehabilitation	33	41%	61	41%	43	43%
Community Support	800	42%	786	42%	581	43%
Intensive Family Intervention	152	50%	156	45%	141	39%
Psychological Testing	249	30%	400	30%	663	27%
Behavioral Health Assessment	0	N/A	0	N/A	0	N/A
Crisis Intervention	0	N/A	0	N/A	0	N/A
Crisis Stabilization Unit (CSU) Services	0	N/A	0	N/A	0	N/A
Diagnostic Assessment	2	58%	0	N/A	0	N/A
Group Psychotherapy	1	4%	9	62%	0	N/A
Interactive Complexity	0	N/A	0	N/A	0	N/A
Medication Administration	0	N/A	0	N/A	0	N/A
Nursing Assessment and Health Services	0	N/A	0	N/A	0	N/A
Service Plan Development	0	N/A	0	N/A	0	N/A
Substance Abuse Intensive Outpatient Program	0	N/A	0	N/A	0	N/A
All Services	**2,066**	**46%**	**2,211**	**46%**	**2,194**	**45%**

Note: Data sorted by highest % partially denied in SFY2022. Percentages are rounded to the nearest whole percentage.

6.4. Discussion

The overall rate of denial of authorization requests due to medical necessity for adolescent behavioral health services remained steady for the years 2019, 2021 and 2022. An average of 94% of requests were approved across both FFS and CMOs. At the same time, the number of requests for authorization steadily increased, reflecting national adolescent behavioral health need trends. However, the results of this analysis should be considered through the lens of a few assumptions and limitations. The data represents the information provided by Beacon/DBHDD for FFS and the contracted CMOs for Medicaid managed care (with the exclusion of one CMO). Since this is secondary data, one overarching assumption is that it accurately represents all the medical necessity authorization denials for the behavioral health services requested. Additionally, there is no clarity as to the exact medical necessity reasons that drove most of the denials. When considering specific services, Children's Community Behavioral Health and Rehabilitation Services' (COS 440) Assertive Community Treatment is a crisis intervention service provided to adults. According to the Georgia provider manual, adult behavioral health services, youth ages 18 and above and/or individuals who are emancipated minors under Georgia Law may also qualify. [4] Assertive Community Treatment is provided to a few adolescents and is the only adult service included in this analysis. Therefore, this service has a low request for authorization rate and should be considered atypical in both FFS and CMO denials. FFS and CMO requests for authorization were denied for medical necessity reasoning at rates at or below 0.2% and 5%, respectively. Additionally, when the CMOs partially approved the number of service units requested, on average, more than 50% were approved. These partial approvals represent only 6.3% of all prior authorization requests.

7. Implementation of Coordinated Health Care for Children Entering Foster Care: A Review of Best Practices

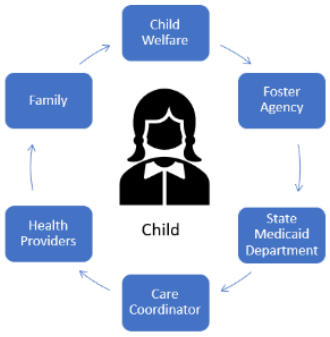
7.1. Background and Legislative Request

Georgia House Bill 1013 directs the Department of Community Health to undertake a study regarding "…implementation of coordinated health care for any child who enters foster care such that Medicaid claims data shall be shared immediately with the Division of Family and Children Services of the Department of Human Services." Within this section, best practices related to care coordination within foster care systems nationally are summarized. Best practices identified may provide insights and opportunities to enhance Georgia's current foster care system.

In Georgia, 16,043 children were served by the foster care system in Fiscal Year 2021. [37] Throughout the foster care system lifecycle, many children experience medical or behavioral health needs that stem from neglect, trauma, and abuse. These children require specialized treatment and care coordination to receive appropriate healthcare, services, and support.

The National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN), is a recognized set of standards, designed to outline the "core, system-level components of high-quality care coordination for CYSHCN." The standards were developed by the National Academy for State Health Policy, a non-partisan organization designed to develop and advance state health policy innovations and solutions. CYSHCN states that care coordination is "based on the premise of health equity, which is the concept that all children and families should have an equal opportunity to attain their full health potential, and no barriers should prevent children and their families from achieving this potential." Care coordination addresses more than healthcare needs; it aims to minimize social, behavioral, and environmental risks. [38] In foster care, these activities include screenings, assessments, referrals, monitoring, and minimizing gaps in treatment of emotional trauma, behavioral health, and other health care needs. [39] As depicted in the illustration, care coordination is designed to surround the child, youth, or young adult with support, while minimizing disruption in services that may occur across the system and among various stakeholders, whether receiving outpatient care or experiencing an extended stay in a treatment facility; living with a foster family, biological parents, or in a group home; or transitioning out of the system. To minimize disruption, key areas were researched as part of the best practices review. They include communication, data sharing, the provision of health services, and placement.

Illustration of essential stakeholders that support a child being served by the foster care system. Definitions of foster care system stakeholders are referenced in the Appendix.



Timely and efficient communication and collaboration across all stakeholders are keys to successful care coordination. When not consistent or collaborative, continuity of care, residential placement options, and overall outcomes may have negative impacts.

The State of Georgia provides Medicaid benefits for every child entering the foster care system through Georgia Families 360. This coverage includes care coordination managed through a statewide contract with a single Care Management Organization, Amerigroup Community Care (Amerigroup). Amerigroup collaborates closely with the Georgia Department of Community Health to minimize gaps in physical and

behavioral care for children served by the foster care system through coordination of care for all children in Foster Care, children receiving Adoption Assistance, and select youth within the Juvenile Justice system. Georgia Families 360 services include coordination of benefits and services, including medical services, and related transportation, and behavioral health, while through added benefits, Amerigroup supports other services like GED and housing assistance. [40] Through other added benefits, Amerigroup also works across Georgia to support the welfare of children, families (biological, foster, and adoptive), foster care agencies, and providers to promote continuous care and supports while participating in the foster care system. [41]

The remainder of this section discusses the analysis and approach taken to conduct this research, develop key findings, and draw conclusions related to best practices for care coordination in foster care. An appendix is also included, which provides additional detail on specific state and national programs from which the best practices highlighted in this research were identified.

7.2. Approach

Information was obtained through interviews with officials in Georgia and other states, care coordination entities, foster care agencies, and literature written by thought leaders on foster care.

The primary focus areas of interview questions and literature reviewed were care coordination and other best practices in foster care. Throughout this research, three key topic areas emerged: data sharing among internal and external stakeholders, the provision of health care and services, and placement options. Methods of effective and efficient communication were identified as an additional theme, which spans the three topic areas identified above.

Child welfare systems and programs reviewed included the following states: Florida, Illinois, Maryland, Missouri, North Carolina, Texas, and Washington; and the country of Denmark. Research was based on a comparison of administrative models (state versus county) and statewide vendor models (sole-source contractor versus multiple vendors), evidenced-based programs, and peer-reviewed data and metrics that highlighted best practices.

7.3. Key Findings

Issues that impact data sharing, the provision of health services, and placement within a child welfare system are summarized below. Specific state initiatives, which were designed to improve systems and/or operations, and the results achieved are found in Figure 29. While focused on key areas, each state was unique in their approach to implementing innovative programs or changes. Within these states and their programs, challenges, successes, and innovations across government departments, care coordination teams, foster care agencies, medical providers, and behavioral health practitioners were reviewed. Communication is a critical element that spans across each area researched, including data sharing, the provision of health services, and placement, and is central to research on coordinated care in foster care.

7.3.1 Data Sharing

Data sharing between organizations is crucial to eliminating silos and optimizing communication with external stakeholders. Shared and accessible computer applications between multiple agencies and organizations promote real-time access to critical information. The lack of this information exchange can negatively impact the already complex intricacies of the foster care system. As children enter the foster

care system, delays to treatment or other time-sensitive activities, such as care screenings, health assessments, and placement options, present additional risks.

Many states rely on computer applications to relay Medicaid eligibility and enrollment information internally and externally. When technology systems are not operating efficiently, or do not have the capability of sharing or receiving information, workarounds must be implemented across all stakeholders, including governmental departments, foster care agencies, vendors, and the child and family. These workarounds create delays across the care coordination process and the receipt of timely services and activities, including placement. In addition, errors can occur due to human error (i.e., entering a wrong number or misspelling a name). [42] A communication system that supports real-time data sharing is a key component of quality care coordination.

7.3.2 The Provision of Health Services

Continuous communication within the child's support team is critical for effective continuity of care efforts. Several areas relating to the provision of health services were reviewed, including network access, level of care, workforce shortages, and programs designed for children being served in foster care systems. Care delivery initiatives and best practices identified include:

- addressing the challenges of not having enough providers, workers, or families available, and
- building programs focused on specific behavioral health needs or other similar circumstances.

Many states designate a specific staff role, or care coordinator, to serve as a main contact and facilitator between the child, care management organization/vendor, state agencies, foster parents, other caregivers, and the child's medical and behavioral health providers. Continuous communication is designed to promote receipt of essential health services and other service plan activities. [43]

7.3.3 Placement

States report that workforce shortages or treatment facility capacity issues create additional challenges for appropriate placement options. In these situations, children without complex needs may be placed in settings designed to support higher levels of need or may be transferred out-of-state. [42]

Casey Family Programs, a nationally recognized leader in the foster care field which focuses on "safely reducing the need for foster care," advises that there are several key considerations when developing and implementing activities to support children being placed in the right environment. They note that:

- Setting types that are easier to access will be more relied upon.
- Investments in a resource-rich network can help to enhance outcomes – in particular, a focus on behavioral health resources can help with placement for patients with behavioral health needs, a population that often faces more placement challenges.
- Communication surrounding planned placements to all involved parties is critical. It is particularly important to emphasize the importance and feasibility of planned placements in these communications.
- Removal of logistical barriers is paramount with family-based placement.
- State border agreements are essential. Participating in the National Electronic Interstate Compact Enterprise may expedite placements with relatives in non-border states.

- Regular system monitoring and analysis of data can help monitor progress and identify areas for improvement. [44]

Another practice for consideration is an evidenced-based program, called treatment foster care or therapeutic foster care (TFC), which provides a specialized training program for foster parents to support children with significant emotional, behavioral, social, and/or medical needs. TFC is designed to provide safe and nurturing care to a child in a structured home environment. It can be a cost-effective alternative to residential treatment. [45]

Advantages of TFC

- Wraparound services, highly trained team, and 24-hour on-call case management are provided [45]
- Low child to caregiver ratio with professional foster parents
- Specialized evidence-based parent training in behavioral health

Challenges of TFC

- It typically requires more effort, training, and commitment from a foster family than traditional care
- Agencies may limit the number of children allowed in a therapeutic foster home
- There is a great need for families who are willing to become licensed and approved

Impact of TFC

- A 5-year study in Illinois of one pilot program concluded there were significant benefits to the program, with 73% of children successfully achieving their treatment goals.
- TFC is highly effective at reducing negative behavior and increasing school success.
- TFC strengthens the attachment to caregivers and improves foster parent satisfaction. [46]

7.3.4 Summary

Figure 29 provides a summary of foster care initiatives designed to impact communication across the key areas of data sharing, the provision of health services, and placement. Additional details supporting each initiative are found in the Appendix.

Figure 29. Summary of Foster Care Initiatives

Foster Care Initiative	Impact	State/Country
Data Sharing		
• **Centralize technology and data services for community-based organizations**	• Improved communication and collaboration with community partners	FL
• **Develop a secure web portal for primary care providers, other physicians, and case workers**	• Provided a full view of medical histories and medical records within a centralized system • Improved continuity of care efforts through sharing of a printed record with foster families	IL
• **Hire a Medical Director and nurse to review medical data and communicate with team** • **Communicate with providers, caregivers, and vendors regularly** • **Hold pediatrician forums**	• Increased efficiency and communication • Reduced gaps in care • Educated providers • Engaged community	MD
• **Share bidirectional information between care coordinators and the state**	• Built and maintained strong partnerships	NC
• **Restructure state divisions to include Research, Data, and Analysis Divisions**	• Increased effective communication between partners	WA
The Provision of Health Services		
• **Increase placement capacity for sibling groups and teens** • **Create a Medical Foster Care Program, to include home-based care for children who have chronic medical conditions** • **Include medical and behavioral health experts as part of care coordination team**	• Reduced placement delays • Integrated health for child and additional support for family	FL
• **Develop a Reunification Program** • **Create Reproductive Health Nurse Program for teen mothers**	• Improved care coordination and continuity • Addressed care gaps • Provided education	MD
• **Provide Treatment/ Therapeutic Foster Care**	• Provided specialized services in-home • Reduced Medicaid spending • Increased communication	NC

Foster Care Initiative	Impact	State/Country
• **Co-location of state and care coordination vendor**	• Improved transitions	
Placement		
• **Created therapeutic foster care homes, working in teams of 10 children per region**	• Trained families on how to change behaviors and build skills • Increased school performance • Reduced problem behaviors	IL
• **Implement mandatory multidisciplinary team meetings for all children requiring placement**	• Promoted an integrated approach to placement decisions	FL
• **Offer private treatment foster care programs**	• Reduced gaps in care • Addressed all service needs	MD
• **Create a nation-wide network of communities to foster knowledge, experience, and best practices**	• Supported placement of children across the nation	Denmark

7.4. Conclusion

Communication across agencies and other stakeholders in the foster care system is an ongoing challenge for many programs. Many states are improving their programs through various initiatives, which are focused on data sharing, the provision of health services, and placement. When incorporating communication as a key element, barriers can be removed, health and outcomes can be improved, and the foster care program can be strengthened. There is an opportunity for Georgia to build on current initiatives based on further review and potential incorporation of leading practices identified in this document. Consideration and incorporation of these practices or components of these initiatives could potentially enhance Georgia's foster care program.

7.5. Appendix

7.5.1 State Initiatives Detailed

7.5.1.1. The State of Florida

Data Sharing: Florida is focused on centralizing technology and data services for community-based organizations, which offers access to children's electronic Health Passport, data, and reports. This information is stored and updated in a state data system. If a child changes placements, the Health Passport moves with the child. [47]

The Provision of Health Services: The Agency for Health Care Administration (AHCA) administers Florida's Medicaid program for both physical and behavioral health care. AHCA supports a child welfare advisory committee and associated activities which include various child welfare system stakeholders, including providers.

Florida uses the wraparound model and systems of care as best practices, with the goal of blending services without complicating contracting and finance requirements, while improving the continuum of behavioral health services. Recommendations have been made to address low provider rates, provide

24-hour telephonic services to prevent urgent care and emergency room usage, and enhance training for system stakeholders, such as judges, foster parents, and case managers.

The care coordination vendor in Florida is focused on supporting integrated physical health, behavioral health, and child welfare services. The child's team consists of nurses, behavioral health clinicians, and adoption coordinators.

Placement: Florida implemented mandatory multidisciplinary team staff meetings for all children receiving out of home care that required placement services. These teams include clinical professionals, families, and community supports. [48]

7.5.1.2. The State of Illinois

Data Sharing: To improve data-sharing capabilities, Illinois developed a secure web portal for primary care providers and other physicians who treat children in the foster care system, and this system is also accessible by the child's case worker. The system houses medical records and histories. Copies of the digital file can be printed for foster families, and the State hopes to expand access to the web portal for families in the future. As claims are received by Medicaid, the system is automatically updated with current medical information as referenced in the medical claim. [49]

The Provision of Health Services: HealthWorks is a collaborative of the Illinois Department of Children and Family Services (DCFS), the Department of Healthcare and Family Services, and the Department of Human Services. It is administered by 20 lead agencies across the state and is a comprehensive system of healthcare for all children in foster care to ensure access to quality routine and specialized health care. HealthWorks provides documentation of health needs and care readily accessible to caregivers, other health care providers, and DCFS. [50]

Placement: Illinois participated in a 5-year pilot program to support TFC, and the program put in place was modeled after Oregon's "Treatment Foster Care Oregon" program. Findings from Illinois' program suggested that TFC may have significant benefits; 73% of enrolled children successfully achieved their treatment goals, which compares to a 66% average rate of completion in other pilot programs. Under this model, treatment teams focus on helping a child gain necessary skills that improve success at home, school, and within the community. The model has been effective at reducing negative behaviors, increasing success in school, improving caregiver attachment, and overall foster parent satisfaction. [51]

7.5.1.3. The State of Maryland

Data Sharing: The Making All the Children Healthy (MATCH) program supports coordination for children in the Baltimore City Department of Social Services foster care system. Through the MATCH program, a Medical Director was hired to provide oversight and review of all programs and services. Regular communication with providers, families, and the care coordination vendors is provided to review data, forms, and processes.

The Provision of Health Services: In addition to its care coordination offering, MATCH has a team of registered nurses, licensed social workers, and healthcare professionals who coordinate medical, dental, and behavioral health exams, enroll children in medical assistance, provide case management services to children with complex needs, support pregnant and parenting youth, and help transitioning youth to manage their health care. [52]

In 2022, Maryland added two new roles to support this program: a Reproductive Health Nurse, and a Reunification Liaison. These roles were designed to ensure all children receive the physical and behavioral health care needed. The Reproductive Health Nurse is a resource for all youth, providing education and support as appropriate. The Reunification Liaison's role is focused on supporting children who will be reunited with family or connect with adoptive families. The Reunification Liaison shares all medical and behavioral health plans with the family, while also providing resources and education. [52]

In 2021, Maryland was awarded a four-year federal grant to establish a national model for foster family development. Five counties were selected to pilot the Center of Excellence for the Resource Foster Parenting program. The model is designed to focus on improving selection, development, and support of foster families while supporting birth parent(s) to strengthen the parent-child relationship and support safe reunification. [53]

Placement: Maryland utilizes private TFC programs, which are operated by a licensed private child placement agency. Children eligible for this service are deemed to have serious emotional, behavioral, medical, and/or psychological conditions. Service needs are assessed, then detailed in a treatment plan and coordinated to support improvements with behavior, attitude, or general condition. A gradual discharge plan or "step-down" plan is created for all children placed in a TFC home. [54]

7.5.1.4. The State of North Carolina

Data Sharing: North Carolina engages in open dialogue between its Department of Health and Human Services (DHHS), including Medicaid, and their Department of Social Services (DSS), which includes child welfare services. The State has oversight for a Specialized Foster Care Plan (FC Plan). Bidirectional information sharing and coordination between the FC Plan care coordinators and the State is critical for success. The FC Plan includes the collaborative development of a care plan/individual support plan for each child.

The Provision of Health Services: The FC plan and State co-locate, which promotes seamless transitions and overall enhanced communications. [55]

7.5.1.5. The State of Washington

Data Sharing: The Washington State Department of Children, Youth, and Families (DCYF) and Health Care Authority (HCA), the state's Medicaid partner, have made sweeping changes in the past few years to enhance communication and create a quality-driven integrated managed care system for children in foster care. Changes include restructuring divisions within the Department of Social & Health Services to include the Research, Data, and Analysis Division, which simplified data exchange for children's services. The State uses bidirectional data sharing through their integrated client databases. HCA also has a specialized unit which processes Medicaid eligibility for their Integrated Foster Care Program. Noted keys to success include:

1. Building and maintaining strong partnerships with agencies that have shared clients
2. Ramping up capacity over time and strategically implementing data structures to support analytics
3. Establishing and leveraging subject matter expertise across systems and agencies. [56]

7.5.1.6. The Country of Denmark

Placement: Denmark's "Network Project" is an intervention that stabilized placements and strengthened support for foster families. Throughout this project, managers:

- Participated in creating a nationwide network focused on fostering the sharing of knowledge, experience, and best practices across the participating municipalities within foster care.
- Created, developed, and operated five regional networks.

Research established the background for a renewed focus that promoted foster care as a precautionary measure among the project managers and community, and to a higher degree, used network and non-network foster families as an alternative to residential institutions. The project gave local government authority managers the opportunity to develop the foster care area networks, which were designed to stabilize and support placement of children within network foster families.

Overall, the Network Project supported sharing of best practices and experiences across municipalities to develop new knowledge, methods, and tools to be implemented within the area of foster care.

7.5.2 Definitions related to the Foster Care System, as noted in Figure 29.

Term	Definition
Care Coordinator	Health professional (typically connected to a care management organization) assigned to child in foster care that coordinates activities and services relating to the child's healthcare and behavioral health needs.
Child	Child, youth, or young adult in out-of-home care.
Child Welfare Agency/Department	In the State of Georgia, the child welfare department, Division of Family & Children Services is responsible for finding foster and adoptive homes for children of abuse and neglect; ensures Medicaid enrollment for children in its care, and provides several other support services to families in need.
Family	Biological, adoptive, or foster parents or other relatives.
Foster Agency	Agency that offers 24-hour substitute care for children placed away from their parents or guardians (in foster care system).
Health Providers	Health practitioners (healthcare/behavioral health) caring for the child in foster care system.
State Medicaid Department	Agency that issues state-funded health (medical, behavioral, vision, dental) insurance coverage for children in foster care.

8. References

[1] Georgia General Assembly, "House Bill 1013 - Mental Health Parity Act," Georgia General Assembly, Atlanta, 2022.

[2] Georgia State Health Benefit Plan, "Plan Options & Programs," [Online]. Available: https://shbp.georgia.gov/plan-options-programs. [Accessed November 2022].

[3] Mental Health America, "Ranking the States 2022," Mental Health America, 2022. [Online]. Available: https://mhanational.org/issues/2022/ranking-states#overall-ranking. [Accessed August 2022].

[4] The Georgia Department of Behavioral Health and Developmental Disabilities, "Community Provider Manuals," [Online]. Available: https://dbhdd.georgia.gov/be-connected/community-provider-manuals. [Accessed December 2022].

[5] Joint Committee on Administrative Rules, "Community-based Mental Health Service Definitions and Professional Qualifications," 2022.

[6] State of Georgia, "- Community Behavioral Health Rehabilitation Services in accordance with 42 CFR," Atlanta, 2017.

[7] US Bureau of Labor Statistics, "Occupational Employment and Wage Statistics," US Bureau of Labor Statistics, [Online]. Available: https://www.bls.gov/oes/. [Accessed November 2022].

[8] Missouri Economic Research and Information Center, "Cost of Living Data Series," Missouri Economic Research and Information Center, 2022. [Online]. Available: https://meric.mo.gov/data/cost-living-data-series. [Accessed August 2022].

[9] L. Simko, "Waiting for Care: Length of Stay for ED Mental Health Patients by Disposition, Diagnosis, and Region (2009–2015)," *Cureus,* vol. 14, no. 6, 2022.

[10] K. Rowan, "Access and Cost Barriers to Mental Health Care by Insurance Status, 1999 to 2010," *Health Affairs,* vol. 32, no. 10, 2014.

[11] A. Miller, "Understaffed state psychiatric units leave patients in limbo," *The Atlanta Journal-Constitution,* 1 November 2021.

[12] Georgia Department of Community Health, "SFY 2022 DSH Payment and IGt," [Online]. Available: https://dch.georgia.gov/document/document/sfy-2022-dsh-payment-and-igt/download. [Accessed 30 October 2022].

[13] Centers for Medicare and Medicaid Services, "Disproportionate Share Hospital (DSH) Allocation Methodology Update," 5 December 2019. [Online]. Available: https://medicaid.georgia.gov/document/document/19-0005-disproportionate-share-hospital-dsh-allocation-methodology/download. [Accessed 30 October 2022].

[14] Georgia Department of Community Health, "GA AIDE Press Release | Georgia Deoartment of Community Health," 27 July 2022. [Online]. Available: https://dch.georgia.gov/announcement/2022-07-27/ga-aide-press-release. [Accessed 30 October 2022].

[15] Medicaid and CHIP Payment and Access Commission, "Chapter 5: Annual Analysis of Disproportionate Share Hospital Allotments to States," March 2021. [Online]. Available: https://macpac.gov/wp-content/uploads/2021/03/Chapter-5-Annual-Analysis-of-Disproportionate-Share-Hospital-Allotments-to-States.pdf. [Accessed 30 October 2022].

[16] B. Brasch, "Worries about Grady's viability come after word of AMC closure," *The Atlanta Journal-Constitution,* 8 September 2022.

[17] Medicaid and CHIP Payment and Access Commission (MACPAC), "Health Care-Related Taxes in Medicaid," MACPAC, Washington, DC, 2021.

[18] Georgia Secretary of State, "GA - GAC," Georgia Secretary of State, 1 July 2013. [Online]. Available: https://rules.sos.ga.gov/gac/111-3-9#. [Accessed 30 October 2022].

[19] Services, Centers for Medicare and Medicaid, "Home & Community Based Services 1915(i) | Medicaid," [Online]. Available: https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915i/index.html.

[20] U.S. Department of Health and Human Services, "The Use of 1915(i) Medicaid Plan Option for Individuals with Mental Health and Substance Use Disorders," Office of the Assistant Secretary for Planning and Evaluation, Washington, Dc, 2016.

[21] Kaiser Family Foundation, "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State," 20 September 2022. [Online]. Available: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/. [Accessed 1 November 2022].

[22] Department of Health and Human Services, Centers for Medicare & Medicaid Services, "ga-pathways-to-coverage-12-23-2021-ca.pdf," 23 December 2021. [Online]. Available: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-12-23-2021-ca.pdf. [Accessed 1 November 2022].

[23] The Georgia Department of Community Health, "About Us | Georgia Department of Community Health," [Online]. Available: https://dch.georgia.gov/about-us. [Accessed 30 October 2022].

[24] Georgia Department of Juvenile Justice, "Department of Juvenile Justice," [Online]. Available: https://djj.georgia.gov/about-us. [Accessed 30 October 2022].

[25] Georgia Department of Human Services Division of Family & Children Services, "About Us | Division of Family & Children Services," [Online]. Available: https://dfcs.georgia.gov/about-us. [Accessed 30 October 2022].

[26] The Georgia Department of Juvenile JusticeRYDCs , "RYDCs and YDCs | Department of Juvenile Justice," [Online]. Available: https://djj.georgia.gov/rydcs-ydcs. [Accessed 30 October 2022].

[27] HealthCare.gov, "Prior Authorization - Glossary," U.S. Centers for Medicare and Medicaid Services, [Online]. Available: https://www.healthcare.gov/glossary/prior-authorization/. [Accessed November 2022].

[28] The Centers for Medicare and Medicaid Services, "Prior Authorization and Pre-Claim Review Initiatives," The Centers for Medicare and Medicaid Services, 10 November 2022. [Online]. Available: https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives. [Accessed 14 November 2022].

[29] Beacon Health Options, "Georgia Collaborative ASO," Beacon Health Options, [Online]. Available: https://www.beaconhealthoptions.com/georgia/. [Accessed 17 November 2022].

[30] A. P. Association, Diagnostic and Statistical Manual of Mental Disorders (5th ed.), Online, 2013.

[31] The World Health Organization, "Adolescent Health," [Online]. Available: https://www.who.int/health-topics/adolescent-health#tab=tab_1 . [Accessed November 2022].

[32] Georgia Medicaid Management Information System, "Home," [Online]. Available: https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx . [Accessed November 2022].

[33] Georgia Medicaid, "Care Management Organizations (CMO)," [Online]. Available: https://medicaid.georgia.gov/programs/all-programs/georgia-families/care-management-organizations-cmo . [Accessed November 2022].

[34] The Centers for Disease Control and Prevention, "Adolescent Behaviors and Experiences Survey," 31 March 2022. [Online]. Available: https://www.cdc.gov/healthyyouth/data/abes.htm. [Accessed 19 December 2022].

[35] The Centers for Disease Control and Prevention, "FastStats - Adolescent Health," 19 October 2022. [Online]. Available: https://www.cdc.gov/nchs/fastats/adolescent-health.htm. [Accessed 19 December 2022].

[36] The Centers for Disease Control and Prevention, "New CDC data illuminate youth mental health threats during the COVID-19 pandemic," 31 March 2022. [Online]. Available: https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html . [Accessed 19 December 2022].

[37] Children's Bureau, Office of the Administration for Children & Families , "Trends in Foster Care and Adoption: FY 2012 – 2021," [Online]. Available: https://www.acf.hhs.gov/cb/report/trends-foster-care-adoption. [Accessed 2 November 2022].

[38] NASHP National Academy for State Health Policy, "National Care Coordination Standards for Children and Youth with Special Health Care Needs (CYSHCN)," October 2020. [Online]. Available: https://eadn-wc03-6094147.nxedge.io/cdn/wp-content/uploads/2020/10/care-coordination-report-v5.pdf. [Accessed 2 November 2022].

[39] MyFLFamilies.com, "Florida's Child and Family Services Plan 2015-2019," [Online]. Available: www.myflfamilies.com/service-programs/community-based-care/docs. [Accessed October 2022].

[40] Amerigroup Corporation, "Georgia Families 360SM | Amerigroup Georgia Medicaid," 2021. [Online]. Available: https://www.myamerigroup.com/ga/your-plan/georgia-families-360.html. [Accessed November 2022].

[41] Amerigroup RealSolutions in Healthcare, "Georgia Families 360," [Online]. Available: https://provider.amerigroup.com/georgia-provider/georgia-families-360. [Accessed October 2022].

[42] M. Butler, Interviewee, *Senior Manager, Georgia Families 360, Department of Community Health (DCH).* [Interview]. 26 September 2022.

[43] Amerigroup Georgia, "Member Handbook: Amerigroup Georgia, Georgia Families 360," [Online]. Available: https://www.myamerigroup.com/ga/gaga_fc_mhb_eng.pdf. [Accessed September 2022].

[44] Casey Family Programs, "Family Placement - Casey Family Programs," Casey Family Programs, 20 December 2018. [Online]. Available: https://www.casey.org/first-placement-family-placement/. [Accessed November 2022].

[45] Child Welfare Information Gateway, "Treatment Foster Care," [Online]. Available: https://www.childwelfare.gov/topics/outofhome/foster-care/treat-foster/. [Accessed October 2022].

[46] HealthCare Access Maryland, "MATCH Program (Foster Care) - Health Care Access Maryland," Health Care Access Maryland, [Online]. Available: https://www.healthcareaccessmaryland.org/our-programs/match-program-foster-care/. [Accessed 21 October 2022].

[47] Florida Department of Families and Children: Office of Child Welfare, "Health Care Oversight and Coordination Plan: Florida's Child and Family Services Plan 2015-2019," [Online]. Available: https://www.myflfamilies.com/service-programs/community-based-care/docs/Florida%20Health%20Care%20Oversight%20and%20Coordination%20Plan.pdf. [Accessed 2 November 2022].

[48] Florida Department of Children and Families, "Child and Family Services Plan 2020-2024," 30 June 2019. [Online]. Available: http://fosteringchamps.org/wp-content/uploads/2020/06/Florida-CFSP-2020-2024.pdf. [Accessed November 2022].

[49] Illinois Department of Children and Family Services (DCFS), "Health Oversight and Coordination Plan, Addendum C, FY22," Department of Children and Family Services, 2022.

[50] Illinois Department of Children & Family Services, "Complete_2014_Foster_Parent_Handbook," 2014. [Online]. Available: https://www2.illinois.gov/dcfs/lovinghomes/fostercare/Documents/Complete_2014_Foster_Parent_Handbook.pdf. [Accessed 21 October 2022].

[51] Lutheran Social Services of Illinois, "Therapeutic Foster Care | Lutheran Social Services of Illinois," [Online]. Available: https://www.lssi.org/services/children-youth-and-families/therapeutic-foster-care/. [Accessed November 2022].

[52] Health Care Access Maryland, "HCAM's MATCH Program Addressing the Unique Health Needs of Children in Baltimore's Foster Care System - Health Care Access Maryland," [Online]. Available: https://www.healthcareaccessmaryland.org/2022/08/10/hcams-match-program-addressing-the-unique-health-needs-of-children-in-baltimores-foster-care-system/. [Accessed November 2022].

[53] DHS News, "DHS NewsMaryland Awarded Federak Grant to Establish National Model for Foster Family Development," 6 August 2021. [Online]. Available: https://news.dhr.maryland.gov/reports/that/maryland-awarded-federal-grant-establish-national-model-foster-family-development/. [Accessed 21 October 2022].

[54] Maryland Department of Human Services, "Foster Care: Child Welfare Policies, SSA 18-15 CW Local-Department-Referrals-to-Private-Treatment-Foster-Care," 1 September 2015. [Online]. Available: https://dhs.maryland.gov/foster-care/child-welfare-policies/. [Accessed October 2022].

[55] North Carolina Deartment of Health and Human Services, "North Carolina's Specialized Foster," 11 February 2021. [Online]. Available: https://medicaid.ncdhhs.gov/media/12072/open. [Accessed October 21 2022].

[56] Centers for Medicare and Medicaid Services, "Establishing and Using Bidirectional Data," 24 May 2021. [Online]. Available: https://www.medicaid.gov/medicaid/quality-of-care/downloads/foster-care-est-usin-bider-data-shar-webinar.pdf. [Accessed 21 October 2022].