DBHDD Considerations for the
Georgia Chamber of Commerce Task Force
Closing the Coverage Gap
July 2016

BACKGROUND

DBHDD appreciates the opportunity to provide input for consideration of Task Force members. As Georgia's behavioral health authority, we embrace our obligation to provide guidance to policy planners and lawmakers with regard to individuals with mental health issues in Georgia. In response to the request of the Task Force representatives, DBHDD agreed to provide this paper as a preliminary presentation of some of our main areas of concern and interest. In this document, we also outline our efforts to enhance accountability in the public safety net. These initiatives are critical as they represent multi-million dollars of state investments that have been underway for several years.

We are particularly concerned with individuals with Serious and Persistent Mental Illness (SPMI). These individuals represent a vulnerable population that touch a number of health and social service systems. Their issues are complex and require proactive and coordinated planning. We have conducted careful research of states that have considered strategies to achieve efficiencies in the financing and delivery of care to the SPMI specialty population. While there are examples of state and local efforts that have achieved measurable advances in accountability and efficiency, there are important limits of the extent to which reform can impact complex and fragmented systems. There are also several examples of reorganization efforts that have failed to live up to the promise of cost savings and success, inflicting devastating consequences for individuals, providers and networks. This variable history compels caution and thoughtful, informed planning and execution. Deliberate sequencing of design elements, to allow for re-calibration resulting from unintended outcomes, is absolutely necessary.

While several elements of design require more thorough analysis, we raised a few issues with Task Force members and offered to provide documentation. By no means does this paper represent an exhaustive list of the issues that must be considered for the SPMI population; however, it is a preview of the concerns that result from our analysis, as well as experiences gleaned from national and state partners that have attempted to address system level adjustments.

BENEFIT PACKAGE

DBHDD is concerned that, for its beneficiaries, the standard and typical "Essential Health Benefits" mandated by exchange plans is limited when compared to Georgia's Medicaid State Plan for behavioral health, and when compared to the DBHDD offered benefits. A simple comparison of these benefits is outlined below (table A). This limitation is of particular concern when one recognizes that individuals with acute and or chronic mental illnesses may be reluctant to seek care or to remain in treatment. An individual's inability

to comply with standard expectations requires rehabilitative strategies, as well as supports and services that protect their own well-being and that of their communities.

Most Evidence Based Practices (EBPs) for serious mental illness, such as Assertive Community Treatment (ACT), are not covered benefits in Essential Health Benefit plans. In this single example of a critical EBP, state-funded ACT services (a service of which Georgia is obligated to under a 2010 settlement agreement with the U.S. Department of Justice) supported more than 1,100 adults in FY15 either as a result of the individuals being 1) completely uninsured or 2) covered by plans such as Medicare or other private insurance plans that do not cover this important benefit.

DBHDD policy acknowledges that many of our target population may have some insurance, but may not have benefit plans that adequately address their complex needs. In this scenario, DBHDD serves as a secondary "coverage" plan for the individual. For instance, DBHDD serves many individuals who have Medicare which does not provide Medicaid-covered rehabilitative services, nor does it provide other DBHDD-funded benefits (Table A).

TABLE A

	DBHDD Benefits	Medicaid Benefits	Essential Health Benefits
Acute	Inpatient Psychiatric Acute Detoxification Crisis Stabilization Forensic Hospitalization PRTF BHCCs Mobile Crisis	Inpatient Psychiatric Acute Detoxification Crisis Stabilization PRTF	Inpatient Psychiatric Acute Detoxification
Outpatient	Individual Counseling Group Counseling Family Counseling Crisis Intervention Physician Assessment/Management Nursing Assessment/Care/Med Admin Case Management Community-Based Skills Training Assessment PT/OT/Speech Group Training Family Training Service Planning	Individual Counseling Group Counseling Family Counseling Crisis Intervention Physician Assessment/Management Nursing Assessment/Care/Med Admin Case Management Community-Based Skills Training Assessment PT/OT/Speech Group Training Family Training Service Planning	Individual Counseling Group Counseling Family Counseling Physician Assessment/Management Nursing Assessment/Care/Med Admin Assessment PT/OT/Speech
Rehabilitative	Assertive Community Treatment [IFI, CST] Peer Support Intensive Residential Semi-Independent Residential Community-Based Forensics Supported Employment Psychosocial Rehabilitation Medication Assisted Treatment [Opioid Maintenance] Community-based Detoxification Financial Assistance (Bridge, Transition) Intensive Community-based Care Coordination Transportation	Assertive Community Treatment [IFI, CST] Peer Support Intensive Residential Semi-Independent Residential Psychosocial Rehabilitation Medication Assisted Treatment [Opioid Maintenance] Community-based Detoxification Intensive Community-based Care Coordination Transportation	
LTSS	DD Waiver Services C&A MH Waiver Services PASRR	DD Waiver Services C&A MH Waiver Services PASRR	
Prevention	Peer Support Whole Health Wellness Centers Clubhouse Prevention/Early Intervention Activities	Peer Support Whole Health	

HISTORICAL AND CURRENT EXPERIENCES

Competencies in serving adults with chronic health conditions, such as serious mental illness and substance use disorders, were not considerations made when selecting the current vendors who manage the Department of Community Health's CHIP, LIM, and Foster Care beneficiaries. Managing the health and services of this specialty population requires skilled clinical and cross-system knowledge. As the state's behavioral health authority, DBHDD is compelled to shape the deliverables for behavioral health care for its current beneficiaries and seeks a leadership role in directing and overseeing behavioral health for any emerging public health care products.

DBHDD frequently sees situations in which the health care of an individual diagnosed with a major behavioral health condition is managed by one of the care management organizations, and experiences significant and repeated access challenges to authorization of EBPs named in Georgia's Medicaid plans.

CARE COORDINATION/BEHAVIORAL HEALTH HOMES

DBHDD understands that "Health Home" approaches may be utilized for enhanced health management and outcomes. There are a myriad of national models for this product. DBHDD leadership has interest in using its long-standing experience with care coordination of complex individuals that coordinate across multiple funding streams and separate service systems to shape an effective model for individuals with serious mental illness, addiction issues, or both as is common.

ELIGIBILITY

Many individuals served by DBHDD would likely be eligible for the expanded benefits being discussed, but due to their cognitive and thought disorders, may be challenged to comply with basic eligibility requirements. Eligibility will not necessarily convert to enrollment for many of the current DBHDD beneficiaries. As various strategies and options are explored, mechanisms to support such individuals through the enrollment processes should be considered.

****

In addition to the areas of distinctive concern laid out in this paper, DBHDD offers the following update regarding ongoing investments to enhance the current system:

ACCOUNTABILITY ENHANCEMENT

Three years ago, the DBHDD initiated a large redesign effort for the community behavioral health network. Essential elements of this initiative include:

- Clarification of provider standards and re-organization of responsibilities through a tiered network of providers to promote statewide consistency;
- Development and implementation of key performance indicators.

- Transformation of the financing infrastructure beginning with transition from a grant-in-aid model to a fee-for-service model as of July 1, 2016.

The state's safety-net is now defined as a network of providers that offers care and recovery supports to individuals regardless of their ability to pay for services. Safety-net providers typically see a mixture of uninsured (and not eligible for insurance benefits), Medicaid-covered, and other vulnerable individuals. Safety-net providers have contracted expectations and mandates that ensure these individuals have access to the appropriate level of care, treatment and coordination of services.

The designation of safety-net providers (called Comprehensive Community Providers or CCP) is a fundamental step in the creation of a standardized public benefit across all counties, accountable and transparent to recipients of services, their families and supporters, and payers. While DBHDD continues to work with a broad array of other public and private providers to promote choice and specialization, the CCP designation promotes the focus of limited resources to a select group of publicly-funded providers as a system safety net. The CCPs have the unique capacity and infrastructure to provide a seamless continuum of care for the target population identified by DBHDD, as well as having community stature, visibility, accountability, and the credibility to be seen as the local and reliable safety-net for the delivery of supports and services.

Measuring Outcomes

Standards with key performance indicators related to access to care have been implemented and are now measured annually. A few of the standards related to addressing critical access needs include timeliness to services, crisis response, engagement, crisis management, financial stability, quality, and competency to treat.

Partnership with an Administrative Services Organization (ASO)

DBHDD maintains a Crisis and Access Line, Mobile Crisis capacity, and Crisis Stabilization Units available for all Georgians. These functions are facilitated by the ASO and are not insurance-specific.

The ASO, known as The Georgia Collaborative, is a partnership between DBHDD and Beacon Health Options, and serves as a vital partner to DBHDD in managing some traditional insurance functions, such as prior authorization. This partnership allows the state to use private industry practice in its management of public sector business. The ASO also assists DBHDD in managing reviews of provider performance, compliance, and quality to promote improvement in service delivery throughout the state.

CONCLUSION

DBHDD's unique knowledge and history of the individuals and safety-net providers currently serving Georgians with SPMI, coupled with an unwavering commitment to this complex and vulnerable population should inform Georgia's efforts moving forward. Our current relationships with elected officials, community leaders, sister agencies, providers,

and consumer and advocacy groups will be invaluable to the multi-faceted planning conversations that may lie ahead.

DBHDD understands the need for cost management and improved efficiency. Above all, we believe that a corresponding commitment to access and quality goals is essential. Georgia's recent negotiation with the United States Department of Justice resulted in an Extension of Settlement Agreement signed on May 18, 2016, by Governor Nathan Deal, the Department of Community Health, and DBHDD. This document underscores the reality of the ongoing federal scrutiny that will accompany our efforts to address the most-in-need individuals in the state.

We look forward to the opportunity to work closely with various stakeholders to inform any planning efforts in efforts to assure minimal disruption of services and supports as transformation strategies are considered. However, we urge extreme caution so as to avoid overly simplistic solutions in attempts to address the unique health, behavioral health and support needs of the SPMI population.