



Georgia Behavioral Health Reform and Innovation Commission

First Year Report

Governor Kemp's Appointees

Rep. Kevin Tanner, Chairman
Dr. Sarah Y. Vinson
Dr. DeJuan White
Dr. Michael R. Yochelson
Jason Downey
Dr. Joseph Bona (*deceased*)
Dr. Karen Bailey
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Sen. Renee Unterman
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Wayne Senfeld
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Rep. Mary Margaret Oliver
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Gwen Skinner
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Chief Justice Melton's Appointees

Justice Michael Boggs
Judge Brian J. Amero
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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. This commission has 24 appointed members and expires on June 30, 2023.

The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas:

1. Hospital and Short-Term Care Facilities chaired by Dr. Brenda Fitzgerald (**page 3**);
2. Workforce and System Development chaired by Gwen Skinner (**page 9**);
3. Involuntary Commitment chaired by Judge Brian Amero (**page 16**);
4. Mental Health Courts and Corrections chaired by Justice Michael Boggs (**page 19**); and
5. Children and Adolescent Behavioral Health chaired by Dr. Sarah Vinson (**page 22**).

During its inaugural year, the commission held two public meetings in Atlanta at the Georgia Regional Hospital on December 16, 2019 and the Paul D. Coverdell Legislative Building on November 19, 2020. Each subcommittee held meetings separately and heard hours of expert testimony from the major interest groups and professionals in these fields.

Meetings and documents from each meeting are archived on the Georgia House of Representatives [website](#). Each subcommittee independently drafted a first-year report. The remainder of this document represents a collection of those reports and the commission's findings and recommendations.

Hospital and Short-Term Care Facilities

Dr. Brenda Fitzgerald - Chair

Dr. Joseph Bona (*deceased*)

Dr. Michael Yochelson

Jason Downey

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Introduction

The Behavioral Health Reform and Innovation Commission's Hospital and Short-Term Care Subcommittee believes that the following recommendations will help Georgia build capacity, flourish, and improve access to behavioral health services. The subcommittee identified several "quick wins" that will begin to improve access for Georgians. This report is comprised of five areas of work: Trauma Informed Care; State Parity; State Telehealth Expansion; the Hospital/Crisis Care Continuum; and Workforce Capacity Building.

Findings and Recommendations

1. Build Trauma-Informed Knowledge Base Statewide

In July, the Kaiser Family Foundation released a [tracking poll](#) showing that for the first time a majority of American adults, 53 percent, believe that the pandemic is taking a toll on their mental health. A recent [report](#) from Well Being Trust and The Robert Graham Center for Policy Studies in Family Medicine and Primary Care suggests that the COVID-19 pandemic could claim up to 75,000 associated deaths from alcohol and drug misuse and suicide. We must protect children who may be at heightened risk of maltreatment because of mental distress, social isolation, financial stress, or physical harm brought on by the pandemic. Widespread, robust prevention and education can and will save lives and dollars.

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

Recommendations

- a. Explore how to best implement a virtual statewide trauma-informed training similar to the Georgia Department of Administrative Services (DOAS) Human Trafficking Training Program for all state employees; and
- b. Continue to focus on behavioral health prevention, such as the Department of Behavioral Health and Developmental Disabilities' (DBHDD) "Free Your Feels" campaign, specifically through building resilience by normalizing conversations around feelings, teaching children coping skills, and identifying behavioral and mental health concerns early. These efforts will play a key role in breaking down the stigma of mental and behavioral health and help parents and children, as well as child-serving adults like educators, realize behavioral and mental health are just as important as physical health.

2. Address State Parity

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

The Georgia Parity Collaborative endorses the following list of recommendations. This group consists of over 20 leading non-profit organizations that address mental health and substance use treatment needs in Georgia. The collaborative convenes to examine the issue of parity in insurance coverage for behavioral health across private and public insurers. They have identified what comparable states have done to advance parity through legislative and administrative policy reform and continually gather data and stories about the challenges many Georgia families face when they attempt to get coverage for behavioral health care.

Recommendations

- a. Create a working group with the state's Department of Insurance (DOI), Department of Community Health (DCH), and Department of Behavioral Health and Developmental Disabilities (DBHDD). The purpose of the working group is to research other states and consider legislation needed to adopt parity in Georgia. It is recommended that the governor establish this group and consider a date for the submission of a report summarizing the working group's findings to the commission;
- b. Ensure that DCH includes clear parity provisions in its renewed Medicaid managed care contracts and requires CMOs to submit complete parity compliance analyses and data to demonstrate compliance, as well as sets targets for improvement and enforces parity provisions;
- c. Ensure that DOI performs regular market conduct exams for parity compliance, including a focus on non-quantitative treatment limitations (NQTLs) such as prior authorization, reimbursement rates, and denials based on medical necessity, and takes action to address violations;
- d. Require a published annual status report of the conduct exams that reviewed parity in the previous year, along with results and corrective actions taken;
- e. Require DCH and DOI to report annually on the methodology used to ensure compliance with federal and state parity law to the commission and the Georgia General Assembly;
- f. Make it easier for consumers to report suspected parity violations; for example, have dedicated web pages with a clear explanation of parity and instructions for how to file a complaint linked from the DOI, DCH, and the DBHDD websites. Upon the determination of a reporting process and reviewing authority, the commission recommends that the agency with

authority to set rates creates this web page, and makes data available from it to the commission upon request; and

- g. Explore how to establish a process for publicly reporting how consumer complaints were addressed.

3. Build and support telehealth and technology capacity statewide

DOAS is currently identifying telehealth providers that can effectively serve Georgians virtually while managing a fully licensed, remote health care provider network and a web-based platform compliant with the 'Health Insurance Portability and Accountability Act of 1996' (HIPAA). DOAS has determined, through analysis encompassing Fiscal Years 2017 to 2020, that state agencies and state higher education entities spend just over an average of \$257 million annually on medical health services. By deploying telehealth services through statewide contracts, and promoting the opportunity, the state will save money and create access to those Georgian's who need it most.

Recommendations

- a. Promote the utilization of the Department of Administrative Services contract to all eligible agencies upon completion of the current request for proposal (RFP);
- b. Ensure statewide telehealth parity for schools; and
- c. Explore how to effectively open lines of communication for continued knowledge sharing and telehealth best practices over the next 12 months and beyond as the state regains composure from COVID-19.

4. [Project ECHO](#) (Extension for Community Health Care Outcomes)

Project ECHO is a revolutionary guided practice model that reduces health disparities in underserved and remote areas of the state, nation, and world. Through innovative tele-mentoring, the ECHO model uses a hub-and-spoke knowledge-sharing approach where expert teams lead virtual clinics, amplifying the capacity for providers to deliver best-in-practice care to the underserved in their own communities. A total of five ECHO "hubs" or groups implementing the model exist or have existed in Georgia: Centers for Disease Control and Prevention, Georgia Department of Public Health, Georgia Chapter of the American Academy of Pediatrics, American Cancer Society, and Children's Healthcare of Atlanta (CHOA). The Georgia Rural Health Innovation Center is opening the next hub in the winter of 2020.

Recommendations

- a. Develop a communication channel that will promote all existing ECHOs to health care providers and subject matter experts that may benefit from participation; and
- b. Create a working group in partnership with the Georgia Rural Health Innovation Center that will identify needed ECHO topics and begin to create innovative ECHOs to bridge behavioral health gaps in Georgia.

5. Streamline the Hospital/Crisis Care Continuum

Once a child or young adult moves into a behavioral health crisis mode, they are a risk to themselves or others and there is a need for immediate intervention. This may result in a trip to the emergency room (ER) at the local hospital. In many cases, ERs are not equipped to provide the necessary care to a child in crisis, and in many cases the transition to a short- or long-term behavioral health facility can be filled with barriers that extend the amount of time a child awaits

appropriate treatment. The following recommendations are designed to remove some of these barriers:

- a. CHOA reports that about 12.5 percent of the patients transferred from the ER to a crisis stabilization unit (CSU) or an acute psychiatric inpatient unit returns to CHOA within 30 days. Due to multiple electronic medical record systems among these facilities, effectively tracking patients who are high utilizers of crisis beds is a challenge that leads to fragmented care and poor outcomes.

Recommendation:

1. Develop a partnership with leaders from CHOA, DCH, DBHDD, Georgia Collaborative Administrative Services Organization, private insurers, CMOs, acute psychiatric hospitals and CSUs to discuss how to best support the needs of children who are high utilizers of crisis care.
- b. One of the most common reasons CHOA patients with behavioral mental health support needs are denied placement in an acute psychiatric inpatient unit or CSU is due to the aggression level of the child. Specifically, CSUs are impacted by limited bed capacity; milieu/acuity; payor sources that primarily serve the uninsured, such as Supplemental Security Income (SSI) Medicaid; and also provide admission for CMO covered lives during occasions when all in-state private facilities have denied admission.

Recommendation:

1. Consider implementing a reimbursement leveling system that would allow for additional staffing at CSUs and acute psychiatric inpatient units to accommodate patients who are in psychiatric crisis and aggressive.
- c. In CHOA's experience, there are extended lengths of stay in emergency departments for patients awaiting acceptance to a CSU at night because the Georgia Crisis and Access Line (GCAL) currently does not use pediatric-specific vital sign and lab value ranges and there is not a physician available after hours to review patients.

Recommendation:

1. The commission recommends that DBHDD continue to work with the subcommittee to further review whether there is a need to support the CSUs to have an on-call physician after hours to review pending patients so that acceptance is not delayed during the night. A potential option is to provide additional resources to DBHDD to make technology upgrades to the GCAL system to include pediatric-specific vital sign and lab value ranges; this improvement would significantly decrease the after-hours medical clearance challenges at the CSU level.
- d. Several CSUs require that legal guardians sign admission consent forms as part of the acceptance requirements and before a patient can be transferred to the CSU. Consent forms can be over 20 pages long, are different for each facility, and are time consuming to complete. Additionally, many CSUs do not have consent forms in Spanish.

Recommendations:

1. The commission recommends that DBHDD work with CSUs to further review the need for a universal consent form, in English and Spanish, which can be

- used by all CSUs, as well as consider developing an electronic process for sending/receiving consent forms via the electronic GCAL bed board or another electronic platform; and
2. The members recommend that DBHDD informs the subcommittee if potential technology upgrades are necessary for universal electronic consents.
- e. There are multiple reimbursement challenges that exist particularly for the care of children with autism or a developmental delay who are in psychiatric crisis.

Recommendation:

1. Further explore the reimbursement landscape for options.
- f. The availability of services for children with autism who present in psychiatric crisis is a challenge. Specifically, navigating the crisis continuum of services, including acute psychiatric care, crisis support homes, and the psychiatric residential treatment facilities becomes difficult due to the limitations related to matching the service to the child's needs, age, and acuity.

Recommendation:

1. The commission is aware that DBHDD and DCH are currently in dialogue regarding possible solutions given the current benefit package and recommends they explore a full range of options to address complex needs and further review the need for increased bed capacity across the crisis care system.

6. Improve the Behavioral Health Workforce Shortage

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

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

Recommendation:

1. Require minimum data set surveys (MDSS) for licensed behavioral health providers to help understand the behavioral health workforce and plan for solutions. Data sets could include who is actively taking patients, or practicing, and where; types of insurance accepted; certifications specialties; telehealth offered; and retirement plans. Several other states, including Virginia, North Carolina, Texas, and Indiana already do this. Voices for Georgia's Children has also recommended this and has [detailed information](#) about where to house the information and the costs associated with implementing an MDSS for licensed behavioral health providers.
- b. Licensed Marriage Family Therapists (LMFTs) and Licensed Professional Counselors (LPCs) are not able to be independent providers in Georgia. Alabama, North Carolina, and Texas allow them to be, so many new professionals leave the state to practice elsewhere. In

addition, the cost of supervision is often extremely high for new graduates. For example, over 80 percent of LMFTs polled in Georgia pay over \$50 an hour for supervision, and almost 20 percent of them pay over \$100 an hour.

Recommendations:

1. Explore how to allow LMFTs and LPCs to become independent providers in Georgia and have the capability to bill Medicaid; and
2. Identify new and innovative ways to create cost effective supervisory opportunities for new graduates.

Workforce and System Development

Gwen Skinner – Chair
Representative Mary Margaret
Oliver (82nd District)
Senator Renee Unterman (45th
District)

Cindy Levi
Dr. Sallie Coke
Dr. Nicoleta Serban

The System

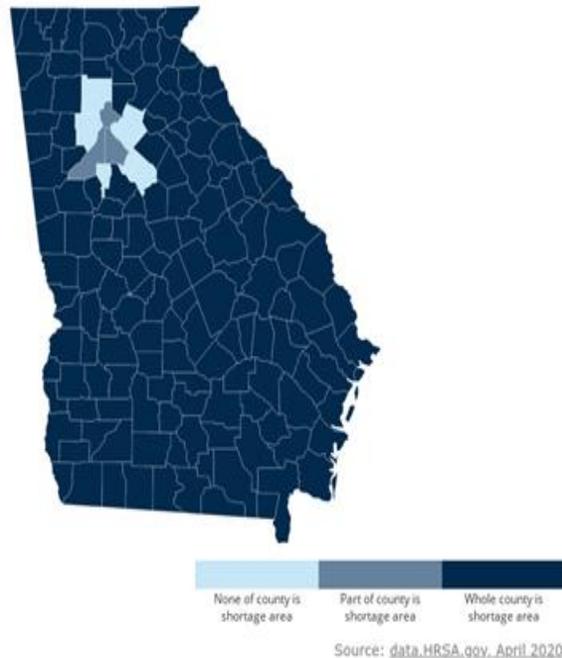
Georgia’s public system for behavioral health is a complex amalgam of state and county agencies, contracted care management and administrative service organizations, public and private providers, professional associations, accrediting bodies, licensing boards, and consumer and advocacy organizations. It serves children and adults from early childhood to end-of-life who are living with mental health conditions and/or substance use behaviors. It serves children who: live in poverty and in low-income families; are in the custody of the state; are involved in the juvenile justice system; and attend schools. The network serves adults with: low-incomes; no health insurance; interactions with the criminal justice system; disabilities and unable to work; or aging adults. It serves people of all races, ethnicities, gender identities, and religious affiliations across Georgia’s large cities, mountains, coast, and farmlands.

The Behavioral Health Workforce

The goal of workforce development is to improve the behavioral health of individuals and communities by ensuring there is a workforce of appropriate size, composition, and competency to address the needs of Georgia’s residents across their lifespan.

Similar to many states, there is a critical shortage of behavioral health professionals in Georgia; 150 out of 159 counties are considered mental health care professional shortage areas. Seventy-seven counties have no psychiatrists working full-time; 76 counties do not have a licensed psychologist, 52 counties do not have a licensed social worker, and 60 counties are without pediatricians. Only 53 percent of Georgia’s psychiatrists accept Medicaid clients.¹

Health Professional Shortage Areas: Mental Health, by County, 2019 - Georgia



¹ Presentation to Subcommittee on Workforce and System Development by Voices for Georgia’s Children. June 8, 2020

In 2016, the Health Resources and Services Administration (HRSA) described the workforce challenges in its first report on behavioral health practitioners, and detailed the projected supply and demand of practitioners through 2025 at the national level. The report indicated significant shortages of psychiatrists, psychologists, social workers, school counselors, and marriage and family therapists.²

Behavioral Health Workforce



The mental health and addiction workforce has long been plagued by shortages, frequent turnover, a lack of diversity, low compensation and limited competence in evidence-based treatment, resulting in concerns about its effectiveness.³ Workforce development requires a long-term, comprehensive plan and sustained action, which does not fit within the time-limited, issue-focused agendas of ever-changing government administrations.

At the national and state levels there is no systematically-collected uniform data on the behavioral health workforce. Information must be gleaned by piecing together disparate information from professional associations, licensing and certification boards, and scattered state and federal sources.

A brief review of the existing literature on behavioral health workforce development resulted in the following key findings:

- The most comprehensive effort to address behavioral health workforce issues was conducted by the Annapolis Coalition on the Behavioral Health Workforce to develop a national action plan. The result was the creation of a useful framework to guide workforce development planning efforts. The “Annapolis Framework” focuses on:
 - **Broadening the concept of “workforce” by:**
 - Developing the capacity of health care providers other than behavioral health specialists to address behavioral health conditions;
 - Integrating care models that shift the locus of responsibility to primary care providers; and
 - Creating a peer workforce.
 - **Strengthening the workforce with:**
 - Early exposure to career opportunities;

² Health Resources and Services Administration/National Center for Health Workforce Analysis. National projections of supply and demand for selected behavioral health practitioners: 2013-2025. Rockville, MD: HRSA.

³ Hogue, M., et al. Mental Health and Addiction Workforce Development: Federal Leadership is Needed to Address the Growing Crisis. Health Affairs 32:11. November 2013.

- Mentoring;
- Loan repayment programs;
- Wages commensurate with education, experience, and responsibility;
- Expedited curriculum reform in higher education and by accrediting bodies;
- Lessened educational “silos”;
- Greater use of technology; and
- Training in addiction treatment included across all disciplines.
- **Creating structures to support the workforce with:**
 - Appropriate salaries/payment for services;
 - An economic return on graduate education costs that is comparable with training/costs for other careers; and
 - Infrastructure that provides technical assistance on the implementation of best practices in workforce development.
- Salaries in behavioral health professions are well below those for comparable positions in other health care sectors and in business; because salaries and reimbursements are so much lower, medical schools and Ph.D. students are avoiding behavioral health professions;⁴
- Psychiatric mental health nurses are underutilized in behavioral health care delivery;⁵
- New Mexico enacted the ‘Health Care Work Force Data Collection, Analysis and Policy Act’ in 2011 in order to survey state licensed health professionals to understand reasons for shortages and to address those shortages through policy. The act established mandatory practices for collecting a core essential data set across all health-related licensure boards at the time of licensure renewal via an online survey; completion of the survey is required for license renewal. A robust list of data elements is collected;⁶
- Eliminate overly restrictive scope-of-practice regulations and unlock the full potential of the country’s health workforce;⁷
- In late 2019, Milliman released a report card regarding the status of mental health parity across the states. Findings indicate that disparities exist in provider reimbursement levels when comparing behavioral health care to medical health care. In Georgia, the payment rate for primary care is 38 percent higher than the rate for behavioral health care;⁸ and
- In February 2020, the Massachusetts Senate passed a bill to help support the mechanisms underlying parity. Such mechanisms include expanding the mental health practitioner workforce and seeking a rate floor to ensure mental health clinicians and primary care providers are paid the same for similar services.

To garner Georgia-specific information, key state stakeholders were given the opportunity to present and share their knowledge. Key findings from their testimonies are:

- The Georgia Board of Health Care Workforce tracks demographic and practice information on physicians and physician assistants. Nursing data was added in August 2020. Data completion is not mandatory; therefore some of the information is incomplete. Loan repayment programs are

⁴ The State of the Behavioral Health Workforce: A Literature Review. American Hospital Association. 2015

⁵ Angela J Beck et al. The Future of the Behavioral Health Workforce: Optimism and Opportunity. American Journal of Preventive Medicine 2018

⁶ Adborah B. Altschul et al. State Legislative Approach to Enumerating Behavioral Health Workforce Shortages: Lesson Learned in New Mexico. American Journal of Preventive Medicine. 2018

⁷ Bianca K. Frogner, et al. Modernizing Scope-of- Practice Regulations – Time to Prioritize Patients. New England Journal of Medicine. February 13, 2020.

⁸ Milliman Research Report. Widening Disparities in Network Use and Provider Reimbursement. November 2019.

available for physicians, physician assistants, advance practice registered nurses, and dentists who agree to work in targeted underserved Georgia counties with populations of 50,000 or less. There is no current mechanism to track the behavioral health workforce;

- State agencies, CMOs, and other stakeholders provide multiple training opportunities for the workforce, but they are not managed across sectors and may be duplicative or conflictive; and
- Georgia is a national leader in the certification of peer specialists, individuals with life experiences who are trained to empower others, and it is the first state to include the service as Medicaid billable. There are certifications specific to mental health, addictive disease, youth, parent, and ancillary credentials for whole health and forensics.

Proposed Recommendations

SYSTEM DEVELOPMENT		
Strategic Area	Area of Interest	Recommendations
System Improvement	Reform & Innovation	Conduct a comprehensive review of prior commissions, via the subcommittees, and House/Senate and joint study committee reports specific to behavioral health to determine which recommendations were implemented. Of those not acted upon, determine their relevancy for reform and innovation in the current system, prioritize, and establish strategies for implementation.
Parity	Compliance	Establish processes and collaborative structures across agencies and their contractors to ensure parity in contracting, monitoring, etc.
WORKFORCE DEVELOPMENT		
Strategic Area	Area of Interest	Recommendations
Broadening the Concept of Workforce	Peer Workforce	Analyze the utilization of peer support and develop a plan for the targeted expansion of Certified Peer Specialists, adult and youth/parent and forensic specialists, to include salary and funding strategies.
	Modernizing Scope-of-Practice Regulations	<p>Allow psychiatric mental health nurse practitioners to practice to the full extent of their training; and grant full prescriptive authority.</p> <p>Allow psychiatric nurse practitioners in psychiatric residential treatment facilities to lead treatment team meetings without the presence of a psychiatrist or physician.</p> <p>Propose legislation to allow licensed marriage and family therapists to conduct 1013s.</p>

Strengthening the Workforce	Training	Continue to work with the subcommittee to determine the need and appropriateness of preferred training topics/curriculum, etc. and the development of tracking and training calendars across agencies.
Creating Structures to Support the Workforce	Pay/Salaries	Study salary disparities between medical and behavioral health practitioners and staff; make recommendations for parity. Promote and create a loan forgiveness program for behavioral health professionals.
	Data for Workforce Planning	Determine the optimum methodology for collecting and reporting relevant data across the several state boards and agencies that oversee the behavioral health professional workforce, such as the Secretary of State, Board of Nursing, and Board of Health Care Workforce and establish processes for implementation.
	Technology	Continue the flexibilities in telehealth service delivery allowed during the COVID-19 response and make them permanent. The commission recognizes certain federal requirements related to telehealth platforms were relaxed in response to the pandemic and recommends further exploration pending additional guidance from federal entities as the pandemic continues.
	Billing	Study the impact to workforce expansion and management of the provider network if private practitioners are allowed to bill Medicaid Fee-for-Service (Aged, Blind, and Disabled population) for services rendered.

Recommendations with Required Actions for Initial Year

Recommendation	Justification	Legislative Requirement	Funding Requirement
Conduct a comprehensive Review of prior commission and House/Senate and joint study committee reports, via the subcommittees, specific to behavioral health to determine which recommendations were implemented. Of those not acted upon, determine their relevancy for reform and	Massive time, money, and effort were invested in all previous behavioral health commissions and study committees. It is important to build upon previous work.	No	No

innovation in the current system, prioritize and establish strategies for implementation.			
Promote and create a loan forgiveness program for behavioral health professionals.	Strategy for increasing the number of professionals and recruiting them to work in rural or underserved areas.	Yes	Yes
Allow psychiatric mental health nurse practitioners to practice to the full extent of training; and grant full prescriptive authority.	This is one of the most efficient and effective methods to cover the gap of psychiatrists across the state.	Yes, and possible amendment to the State Medicaid Plan.	May increase Medicaid costs as more individuals are able to access service.
Determine the optimum methodology for collecting and timely reporting of relevant data across the several state boards and agencies that oversee the behavioral health professional workforce, such as Secretary of State, Board of Nursing, and Board of Health Care Workforce and establish processes for implementation.	The state cannot conduct effective behavioral health workforce development without accurate and sufficient data.	Possibly – data collection must be mandatory to be effective.	Yes – funded position(s) to input, track, and analyze data.
Propose legislation to allow licensed marriage and family therapists to conduct 1013s.	Provides additional access for individuals in crisis.	Yes	No
Continue the flexibilities in telehealth service delivery allowed during the COVID-19 response and make them permanent.	Provides easy access to services across the entire state.	Amendment to State Medicaid Plan	May increase Medicaid costs as more individuals are able to access service.
Allow psychiatric nurse practitioners in psychiatric residential treatment facilities to lead treatment team	Nurse practitioners would continue to work under the supervision of a psychiatrist/physician but would not require both be present in the	Amendment to State	Cost-savings

meetings without the presence of a psychiatrist or physician.	room for treatment team meetings. This would expand the clinical/medical capacity within the psychiatric residential treatment facilities.	Medicaid Plan	
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Involuntary Commitment

Judge Brian Amero - Chair

Justice Michael Boggs

Judge Sarah Harris

Dr. Karen Bailey

Nora Haynes

Dr. DeJuan White

Representative Don Hogan

Judge Bedelia Hargrove

Judge Stephen Kelley

Assisted Outpatient Commitment Grant Program:

- **Fund and establish within DBHDD a multi-year grant program to foster the creation of new county-level “assisted outpatient treatment” (AOT) programs across Georgia.**

According to the Treatment Advocacy Center (TAC), the current Georgia law on involuntary outpatient commitment does not require substantial revision. Aside from one modest change to the eligibility criteria removing the requirement of “imminence” of risk, the commission does not identify any other barriers in the existing law to the ideal practice of outpatient commitment in Georgia.

This is not to say that the ideal practice of outpatient commitment is happening for people with severe mental illness who struggle to maintain engagement with treatment. At the subcommittee’s February 8, 2020, hearing in Atlanta, members heard several presenters testify that outpatient commitment orders are routinely issued in their counties, but are usually not impactful in helping those placed under them to engage with treatment. Based on other states that have dramatically better results with such court orders, the commission believes the missing piece in Georgia is the widespread failure to practice outpatient commitment within the framework of an “assisted outpatient treatment” (AOT) program.

A full explanation of the AOT model can be accessed in the [AOT Implementation White Paper](#), but for present purposes, an AOT program is a fully-coordinated collaboration between a local treatment system and civil court to ensure that outpatient orders are taken seriously by patients and their caregivers as mutual commitments between them. As in most states, there is nothing in the Georgia outpatient commitment law to compel counties to practice programmatic AOT; however, the law does afford a clear opportunity to do this in any jurisdiction where there is ample interest and willingness to invest resources wisely. This investment is shown in multiple studies to ultimately yield significant treatment cost savings through reduced hospital recidivism.

The commission believes the most impactful thing Georgia could do to encourage this critical shift in approach to outpatient civil commitment would be to establish a multi-year grant program, administered by DBHDD, to foster the launch of new AOT programs at the county level. This program could be modeled on a highly successful federal AOT grant program established by Congress in 2016 and administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). Interested counties would apply to DBHDD for funding, and grants would be awarded to the counties that most convincingly demonstrate their readiness to establish truly collaborative programs to identify individuals “caught in the revolving door” who meet legal criteria for AOT to ensure their access to high-quality, community-based services, and leverage the power of a court order (“the black robe effect”) to motivate participants to stay engaged in their treatment.

Based on the results from the initial class of SAMHSA grantees, we are confident that grantee counties in a Georgia program would both attract the notice of neighboring counties through significantly better

outcomes with a highly challenging population and ultimately find ways to sustain their programs well beyond their grant periods. Although there are some disparities in the baseline per capita behavioral health funding of various states, the commission envisions this as the catalyst for Georgia becoming the next state, joining New York, New Jersey, Ohio and others, to make AOT a routine tool of most local mental health systems.

Recommendations for Legislative Reform:

- **Remove requirements that a tragic outcome be “imminent” before an individual in crisis can qualify for civil commitment for mental illness.**

Under Georgia’s current mental health civil commitment criteria, an individual cannot be required to receive inpatient (hospital) care unless it is found that a substantial risk of harm or a life-threatening crisis is “imminent.” Similarly, a court may not order outpatient care without finding the individual to be “imminently” at risk of meeting inpatient criteria. This unreasonably high bar forces families and caregivers to postpone intervention until it appears that tragedy is on the verge of striking, even when it is obvious to all that the individual is in crisis and heading swiftly and inevitably to that point. Forcing people to get worse before they can get help defies copious research demonstrating that the longer severe mental illness remains untreated, the lower the person’s prospects for recovery are. Of course it is rarely possible to intervene at the very moment that disaster is “imminent.” More typically, the waiting allows disaster to occur, causing needless human suffering and victimization, and often damning the individual to face serious criminal charges. There is no legal or constitutional imperative to link civil commitment to the “imminence” of a feared result. Many other states have discarded this misguided requirement. Georgia should join them.⁹

- **Allow psychiatric deterioration as a basis for inpatient commitment.**

To offer its residents a truly compassionate inpatient commitment law, Georgia must expand its conception of what it means to be a danger to oneself. Under the current law, the potential harms recognized as important enough to warrant intervention are, by definition, those that involve serious physical injury or death. Unfortunately this disqualifies many individuals in mental health crisis who may not be facing obvious external dangers, but who are powerless due to loss of insight (ability to recognize their own illness and need for treatment) to volunteer for care and protect their minds from harm that could be irreparable in the absence of timely medical aid. In recognition of this, at least 20 states have incorporated the risk of psychiatric deterioration as a distinct and independent basis for civil commitment. The subcommittee considers language of this kind an essential component of a gold-standard civil commitment law. The language proposed in the legislative amendment included below incorporates the phrase “significant psychiatric deterioration,” in keeping with the civil commitment criteria in Colorado, Minnesota, and New Jersey.

- **The commission recommends that the subcommittee provide a recommendation and continue to collaborate with, DBHDD, law enforcement agencies, and advocacy groups to explore the**

⁹ In the interest of consistency, the commission recommends pairing the removal of the “imminence” requirement from the mental health civil commitment criteria with the same amendment to the criteria for substance abuse civil commitment under Chapter 7 of the Mental Health Law.

possibility of peace officers transporting persons in a mental health crisis to a psychiatric evaluation without evidence of a penal offense.

Like all states, Georgia authorizes a law enforcement officer encountering an individual in apparent mental health crisis, under certain circumstances, to take the individual into custody for the purpose of transporting them to an appropriate site for psychiatric evaluation; however, Georgia is the only state that requires the commission of a penal offense as a precondition for the officer's intervention.

- **Proposed legislative amendments incorporating the recommendations below:**

§ 37-3-1. Definitions

As used in this chapter, the term:

(9.1) "Inpatient" means a person who is mentally ill and:

(A)

(i) Who presents a substantial risk of ~~[imminent]~~ harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons; or

(ii) Who is so unable to care for that person's own ~~[physical]~~ health and safety as to create ~~[an imminently]~~ **a reasonable expectation that a life-endangering crisis or significant psychiatric deterioration will occur in the near future;** and

(B) Who is in need of involuntary inpatient treatment.

(12.1) "Outpatient" means a person who is mentally ill and:

(A) Who is not an inpatient but who, based on the person's treatment history or current mental status, will require outpatient treatment in order to avoid predictably ~~[and imminently]~~ becoming an inpatient;

(B) Who because of the person's current mental status, mental history, or nature of the person's mental illness is unable voluntarily to seek or comply with outpatient treatment; and

(C) Who is in need of involuntary treatment.

§ 37-7-1. Definitions

As used in this chapter, the term:

(14.1) "Inpatient" means a person who is an alcoholic, a drug dependent individual, or a drug abuser and:

(A)

(i) Who presents a substantial risk of ~~[imminent]~~ harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons; or

(ii) Who is incapacitated by alcoholic beverages, drugs, or any other substances listed in paragraph (8) of this Code section on a recurring basis; and

(B) Who is in need of involuntary inpatient treatment.

(15.1) "Outpatient" means a person who is an alcoholic, drug dependent individual, or drug abuser and:

(A) Who is not an inpatient but who, based on the person's treatment history or recurrent lack of self-control regarding the use of alcoholic beverages, drugs, or any other substances listed in paragraph (8) of this Code section, will require outpatient treatment in order to avoid predictably ~~[and imminently]~~ becoming an inpatient;

(B) Who because of the person's current mental state and recurrent lack of self-control regarding the use of alcoholic beverages, drugs, or any other substances listed in paragraph (8) of this Code section or nature of the person's alcoholic behavior or drug dependency or drug abuse is unable voluntarily to seek or comply with outpatient treatment; and

(C) Who is in need of involuntary treatment.

Mental Health Courts and Corrections

Justice Michael Boggs- Chair

Judge Brian Amero
Sheriff Andy Hester
Chief Louis Dekmar

Judge Brenda Weaver
Judge Kathleen Gosselin
Stan Cooper

Recommendations from the Council of State Governments Justice Center – Department of Community Supervision (DCS) Data Project (scope expansion):

1. The commission acknowledges DBHDD’s role as the State Behavioral Health Authority and recommends that DBHDD work with law enforcement agencies to continue to explore and potentially set a course for Georgia to develop, and Criminal Justice/Behavioral Health (CJ/BH) agencies to adopt and utilize, a shared definition of “Serious Mental Illness” (SMI) to ensure eligibility for services is consistent, has a common metric for measuring prevalence rates, and tracks changes over time:
 - a. This may involve charging an entity with assessing and aligning existing definitions;
 - b. It may require the use of a shared definition; and
 - c. It should include guidance and support for adoption.
2. Set a goal for increased screening upon admission to jail for mental illnesses, substance use disorders, and homelessness;
 - a. Issue best practices and support implementation to accelerate adoption.
3. Charge an agency with issuing state guidance, tools, and templates to facilitate sharing information across BH/CJ systems; and
4. Review policies and suggest changes to support crisis response instead of traditional/sole law enforcement response; this would require more quick analysis, but examples are citation in lieu of bookings, authorizing transport to non-emergency settings, and/or a co-responder model.

Recommendations from the Georgia Council of Accountability Court Judges (CACJ) – Mental Health Court:

1. Provide state funding for gender-specific trauma treatment modalities and 22 curriculum court trainings for judges and mental health court professionals (Moral Reconciliation Therapy (MRT) Trauma and Trauma Recovery and Empowerment Model (TREM));
2. Provide funding for a Treatment Fidelity Monitor position. Currently, only two persons perform this work for 169 courts within the Accountability Court Council to monitor the treatment provided in all courts to ensure treatment fidelity to best practices, provide coaching and feedback;
3. Establish grant funding from the Criminal Justice Coordinating Council for courts to facilitate the implementation of gender-specific trauma treatment in accountability courts serving the mental health and/or co-occurring population;
4. Fund a dedicated CACJ position to provide technical assistance to 169 courts to interpret the per/court data analysis reports to support policy and procedure changes, such as an enhanced referral process to better identify the mental health population, to better serve program participants; and
5. Amend O.C.G.A. § 15-21-101 to include a new subparagraph (5) that permits the expenditure of fees collected pursuant to O.C.G.A. § 15-21-100 for the Drug Abuse Treatment and Education

Fund to be expended “[i]f a mental health court has been established in the county under Code Section 15-1-16 that also serves participants with co-occurring substance use disorders, for the purposes of the mental health court division.”

Recommendations to assist the Georgia Sheriff’s Association:

1. Provide supplemental state funding to counties to permit the expansion of the currently existing or new local contracts with medical care providers to pay for mental health and substance use disorder treatment. The funding contract will have specific language prohibiting counties from supplanting their current contractual obligations upon receipt of this mental-health related appropriation;
2. Provide state funding to pay for increased crisis intervention training for local law enforcement personnel;
3. Provide state funding to pay for inmate mental health transfers as provided for and mandated within Code Sections § 37-3-41(a)(b), and § 37-3-101(a), which specifically relate to 1013/2013 transports to include pay for: overtime compensation to off-set the costs for additional deputies called-in to make the transports; shift coverage; and vehicle maintenance;
4. Consider supplemental state funding to pay for increased psychotropic medication costs to Sheriff’s Departments; and
5. Continue to work with the subcommittee to consider implementing a pilot co-responder model where trained mental health professionals are teamed with (or otherwise available to assist) law enforcement officers (e.g. EMT’s) in mental health related 911 emergency calls.

Recommendations related to assisting the Georgia Department of Corrections (GDC):

1. Evaluate the viability of a long-term acute care psychiatric facility for Level VI inmates requiring one to one oversight/intensive treatment, which is currently a level of care beyond what GDC can provide;
2. Evaluate the viability of expanding integrated treatment within GDC facilities for those offenders with mental health dual diagnoses;
3. Provide supplemental state funding to increase the availability of forensic peer mentors for those offenders who are preparing for release from prison within the current program offered through the Mental Health Consumers Network, Department of Behavioral Health and Developmental Disabilities, and Georgia Department of Corrections; and
4. Partner with the Behavioral Health Coordinating Council to evaluate the expansion of mental health wrap-around services and connectivity to local mental health resources for clients in our current state re-entry plan.

Recommendations to assist the Georgia Department of Community Supervision (DCS):

1. Provide supplemental state funding for forensic peer mentors;
2. Partner with the Behavioral Health Coordinating Council to evaluate the ability to share mental health data across agencies, such as between local community service boards (CSBs) and the DCS database to assist the departments in identifying, tracking, and treating those on community supervision who are also receiving community-based mental health services;
3. Evaluate the efficiencies that can be gained by reducing specialized mental health caseloads consistent with best care practices; and

4. Evaluate the need for continuity of care and a seamless collaboration with local CSB and behavioral health providers for treatment and housing, to include impediments and solutions to shorten the wait-time for individuals referred for services.

Recommendations to assist the Georgia Department of Juvenile Justice (DJJ):

1. Provide funding for evidence-based best practices training;
2. Consider modalities to improve access to population health insurance funding to address funding stream gaps; and
3. Increase the availability of residential programming bed capacity to meet the diversified needs of Georgia's children, reduce wait lists for medium-need/risk youth, and address denials from current providers for high-risk, special needs, and/or gang affiliated youth.

Child and Adolescent Behavioral Health

Dr. Sarah Vinson - Chair

Miriam Shook

Senator Donzella James

Wayne Senfeld

Dr. Garry McGibbony

Dr. Eric Lewkowicz

Introduction

Georgia's children and adolescents are experiencing many mental health crises as reflected in other commission subcommittees' reports. This leads to utilization of high-cost emergency department and crisis stabilization unit services. A population-based, developmental approach in addressing this problem requires an examination of *why* so many children face mental health crises and *where* the state can strategically target resources for youth mental health needs. Developing minds of youth require stability, nutrition, and safety to grow optimally. The social determinants of health are particularly relevant for children and adolescents.

Social Determinants of Children's Mental Health and Child Poverty in Georgia

The child and adolescent population is uniquely impacted by the social determinants of mental health that is reliant on the family of origin, adoptive parents, or agents of the child welfare system. Youth do not have control over significant resources and are unable to independently enter leases for housing, go grocery shopping, or even consent for treatment. Additionally, youth are physically, cognitively and emotionally immature, rendering them susceptible to abuse and exploitation, limiting their means to support themselves financially, and undercutting their ability to skillfully navigate social situations and societal structures. Finally, youth are often subject to compulsory education, meaning that most children spend the majority of their waking hours during the week in a school setting.¹⁰

Social determinants can adversely impact mental health synergistically, resulting in significant distress, impairment, and developmental limitations. Youth impacted negatively by social determinants of health are at higher risk for the development of mental health problems, such as depression, anxiety, attention deficit hyperactivity disorder, and post-traumatic stress disorder. This can lead to a higher risk for symptom exacerbation and more severe symptoms from developmental disorders, such as autism spectrum disorder and intellectual disabilities. Though these youth need more help, families contending with these social determinants are less likely to seek or remain engaged in care. This lack of treatment engagement is, in part, due to structural issues with insurance coverage gaps, Medicaid reimbursement rates, and transportation that can limit health care access.

Poverty reliably undermines the social determinants of health, which threatens a child's wellbeing; this is a strategic priority for the American Academy of Pediatrics.¹¹ In Georgia, one out of three rural children live in poverty, and one out of five urban children live in poverty. In the United States complement to the End of Childhood Report, Georgia ranks 45th out of 50 states for child malnutrition; 40th out of 50 for high school dropout; and 46th out of 50 states in which children are more likely to experience safe, secure, and healthy childhoods.¹² The social determinants experienced by Georgia's youth increases the risk of both developing mental illness and of having a worse symptom course. A preventative, population-based

¹⁰ Murray, P., Vinson, S., Social Determinant of Children's Mental Health in Cultural Psychiatry in Children, Adolescents and Families. Washington D.C. American Psychiatric Publishing

¹¹ <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/poverty/Pages/About-Us.aspx>

¹² <https://www.savethechildren.org/content/dam/usa/reports/emergency-response/end-of-childhood-report-us.PDF>

approach to children’s mental health in Georgia would require a commitment to providing every child with these elements: solid home and community foundation; housing stability; food security; a reliable, consistent adult caregiver; and safe communities and schools.

Vast Unmet Children’s Mental Health Services Need

A critical need is that 16 to 20 percent of youth contending with emotional, behavioral, and/or developmental disorders need an adequate, accessible mental health system that is able to address symptoms across the continuum of severity. According to the American Academy of Child & Adolescent Psychiatry, most children suffer an average delay of eight to ten years between the onset of symptoms and intervention. This is a lengthy period of time, but a potentially devastating delay for youth and their life trajectories. Additionally, Georgia is identified as a state with a severe shortage of child psychiatrists, with only eight psychiatrists per 100,000 youth, which is far from the needed 47 per 100,000 needed for an adequate supply.¹³ As is identified in the workforce subcommittee’s section of this document, a systematic evaluation of the mental health clinician workforce is needed for other mental health professionals. Parents of children with mental health needs, pediatric primary care providers, and mental health professionals in Georgia have first-hand experience with this severe shortage of child psychiatrists. This is merely one element of a grossly undermanned children’s mental health professional workforce in fields such as counseling, behavioral specialists, psychology, and nursing.

Initial Recommendations

Addressing the deeply-entrenched, multifaceted drivers of youth mental health service needs in Georgia requires substantial time and investment in the state’s social and safety net services; however, Georgia has attainable, implementable opportunities for strategic utilization of resources that allows for substantive improvements in the care provided to our youth. The child and adolescent subcommittee echoes the support contained in other subcommittee recommendations for peer support specialists, with the additional specification of youth peers and parent peers. The commission agrees with the requirement of minimum data set surveys (MDSS) for licensed behavioral health providers. Given the wide gap between children’s mental health needs and providers/systems’ ability to meet them, an approach that optimizes the current system in place to serve youth throughout the state was employed in the determination of the subcommittee’s initial recommendations. As 124 of Georgia’s 159 counties are rural, geographical reach is also a key consideration.

Improve Medicaid Function and Adequacy

Medicaid is a major payor for children’s mental health services. Medicaid covers three out of eight children in Georgia. In FY 2016, 1.3 million children in the state relied on Medicaid and the Children’s Health Insurance Program (CHIP). Additionally, 76 percent of children living in or near poverty are served by public coverage and 70 percent of all Medicaid/CHIP enrollees are children.

I. Recommendation for year one:

- a. Explore a unified Medicaid formulary to decrease wasteful spending and administrative hurdles. Given the number of Georgia’s youth covered by Medicaid, administrative requirements for Medicaid have a disproportionately large impact on children’s care. The Georgia Chapter of the American Academy of Pediatrics has requested a common formulary for a number of conditions, including mental health conditions like attention deficit hyperactivity disorder.
 - i. Potential Benefits

¹³ https://www.aacap.org/AACAP/Resources_for_Primary_Care/Workforce_Issues.aspx

1. Several states have implemented this and benefited from the cost savings: Texas, Louisiana, Montana, New York, Ohio, Tennessee, Missouri, and California. As an example, New York saved an estimated \$87.2 million in one fiscal year;
 2. Decrease unnecessary administrative burdens associated with the mental health care of Georgia’s children;
 3. Fiscal savings for the state because of bigger volume discounts from pharma;
 4. Increase transparency regarding prescription drug costs; and
 5. Prevent burnout of the mental health workforce.
- ii. First step is to convene DCH, managed Medicaid providers, and children’s primary care and mental health care clinicians to explore the implementation of a unified formulary. This process may be aided by consultation from other companies that have assisted other states, such as [Change Healthcare](#) and [G.L.O and Associates](#).

II. Recommendation for years two to three:

- a. Evaluate best practices for community mental health service reimbursement, including payment structures and rates that cover the cost of service provision for outpatient care, high-fidelity wrap-around services, and therapeutic foster care homes, within the bounds of federal regulatory guidance.

Increase the Children’s M.H. Clinician Workforce

The mental health clinician workforce shortage impacts care across populations in Georgia and is even more pronounced in youth. Interventions such as telepsychiatry have limited utility without providers to actually provide care.

I. Recommendation for year one:

- a. Require minimum data set surveys for licensed mental health providers to characterize the current workforce and improve the pipeline. As noted in this document, the subcommittee is in agreement with a requirement for minimum data set surveys (MDSS) for licensed behavioral health providers and recommends that providers are asked three additional questions:
 - i. Do they have specialized training in treating children and adolescents?
 - ii. What proportion of their practice is children and adolescents?
 - iii. Are they currently accepting new patients?

II. Recommendation for years two to three:

- a. Implement training program support and loan repayment programs to feed the pipeline of clinicians and improve graduate retention. In order to have the best return on investment in meeting the needs of Georgia’s children who are disproportionately impacted by poverty, it is imperative to prioritize the support of academic institutions and training programs with a track record of providing care to underserved youth and the support of trainees and clinicians with ties to underserved geographic or racial/ethnic communities that are disproportionately impacted by the social determinants of health.

Optimize Use of Current Personnel and/or Infrastructure

It can take years to build out the state’s mental health system and bolster the mental health clinician workforce, but Georgia’s children simply cannot wait that long. Fortunately, there are untapped resources within communities that provide services.

I. **Recommendation for year one:**

- a. Increase funding for Apex programs and school-based health centers and increase the budget to 150% of the pre-cut funding level to provide greatly needed services to children quickly. In 2020, the budgets for these programs were reduced, which impacted children throughout the state, including vastly underserved rural areas. This occurred at a time when the social determinants of health and societal stressors impacting children, and in turn, mental health problems, were increasing. These programs provide critical, community-based, upstream, potentially preventative services in communities with children who are disproportionately adversely impacted by the social determinants of health.

I. **Recommendation for year one:**

- a. The commission recommends that DBHDD and DCH work together to explore the option of having state plans, including state Medicaid, cover integrated care billing codes. This includes forecasting the cost of implementation and potential return on investment for the models. Implementation strategies would then be considered by the governor's office and legislature for state adoption. This action could financially support the provision of mental health services by primary care providers sustainably. Integrated care improves the scope and quality of mental health services that can be provided by children's primary care providers and maximizes the use of mental health specialists' expertise that are able to serve a much larger population using this approach compared to seeing each patient and treating them on an on-going basis individually. Though billing codes are available to support this model of care, the state currently does not reimburse for them. It has been implemented at various times with grant support, but in order for it to be sustainable, longstanding, and widespread, providers need a reliable method for reimbursement. Additionally, the use of these codes would bolster the effectiveness and sustainability of behavioral health ECHO programs. The table at the end of this document includes a description of these codes.

II. **Recommendation for years two to three:**

- a. Evaluate the cost of a child and adolescent access phone consultation program to provide on-going support for primary care providers in the provision of children's mental health services. Implementation strategies can then be considered by the governor's office and legislature for state adoption.

Table 1. Integrated Care Billing Codes

Psychiatric Collaborative Care Management Services

These codes are for use in the context of collaborative care teams that include the treating physician, a behavioral care manager (staff with a masters-/doctoral level education or specialized training in behavioral health) and a psychiatric consultant.

- a) 99492 – Initial Psychiatric Collaborative Care Management
- b) 99493 – Subsequent Psychiatric Collaborative Care Management
- c) 99494 – Initial or subsequent psychiatric collaborative care management

General Behavioral Health Integration Care Management

These services are performed by clinical staff for a patient with a behavioral health condition that requires care management services (can be face-to-face or non-face-to-face) of 20 minutes or more in a calendar month. This cannot be used in the same month as the Psychiatric Collaborative Care Management Services Codes.

- a) 99484 – Care Management Services for Behavioral Health Conditions

Inter-professional Telephone/Internet Consultations

This code is an assessment and management service in which a patient’s treating physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise. This can include review of records, the medical consultative verbal/internet discussion, and written report to the patient’s treating/requesting physician or other qualified health professional:

- a) 99446 – 99449 – Depending on time spent

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