

Understanding the Implications of Georgia's New Mental Health Parity Act for the State's Child Abuse and Neglect Prevention Plan

The **Mental Health Parity Act** (MHPA) was signed into law by Governor Kemp on April 4th, 2022. The legislation, sponsored by House Speaker David Ralston and co-authored by Rep. Todd Jones and Rep. Mary Margaret Oliver, was crafted with input from the Behavioral Health Reform and Innovation Commission, advocates, and members of the community. The changes brought about by the Mental Health Parity Act have important implications for **Georgia's Child Abuse and Neglect Prevention Plan** (CANPP). Below is an overview of how the MHPA will affect CANPP objectives, as well as information about coordinating bodies established by the bill. The CANPP objectives are in **bold**, followed by the MHPA provisions with line numbers.

Key Acronyms:

BHCC: Behavioral Health Coordinating Council

BHRIC: Behavioral Health Reform and Innovation Commission

CANPP: Child Abuse and Neglect Prevention Plan

CMO: Care Management Organization

CSB: Community Service Board

DBHDD: Georgia Department of Behavioral Health and Developmental Disabilities

DCH: Georgia Department of Community Health

DECAL: Georgia Department of Early Care and Learning

DFCS: Georgia Division of Family and Children's Services

DHS: Georgia Department of Human Services

DJJ: Georgia Department of Juvenile Justice

DOE: Georgia Department of Education

DOC: Georgia Department of Corrections

DPH: Georgia Department of Public Health

MHPA: Mental Health Parity Act

OHSC: Office of Health Strategy and Coordination

TCSG: Technical College System of Georgia

USG: University System of Georgia



MHPA & CANPP

CANPP Objective: Increase Family Resiliency

- **Promote and expand comprehensive and specialized supports for families of children with disabilities**
 - Instructs DBHDD to establish programs designed to serve infants, children, and youth with disabilities, cooperating with DOE, USG, TCSG, DJJ, DECAL, DPH, and the CSBs (1641-1647).
- **Promote, link, and support information and referral systems**
 - Establishes the Multi-Agency Treatment for Children (MATCH) team within DBHDD with representatives from DFCS, DJJ, DECAL, DPH, DOE, Office of the Child Advocate, and DOC to facilitate collaboration across state agencies and accept referrals from local interagency children's committees for children with complex needs not met in their local community (1663-1679).
 - Creates a statewide system for sharing data related to the care and protection of children across all child-serving state agencies (1709-1723).

CANPP Objective: Increase Family Mental Health

- **Expand substance abuse-prevention programs aimed at school-aged children and youth and implement and expand the use of evidence-based practices and approaches to reduce opioid addiction in youth and young adults**
 - Instructs that funds collected from the "County Drug Abuse Treatment and Education Fund" shall be used for drug abuse treatment and education programs related to controlled substances, alcohol, and marijuana for adults and children (1238-1239).
- **Increase access to low-/no-cost community-based behavioral health services for low-income families**
 - Compels the CMOs to comply with a minimum 85 percent medical loss ratio or such higher minimum percentage as may be set out in a contract between DCH and a CMO (329-393).
 - Allows CSBs to enroll and contract with DBHDD, DPH, or DCH to provide mental health, developmental disability, and addictive diseases services for children and adults (1684-1701).

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- **Promote evidence-based behavioral health training, assessment, and treatment models for all ages**
 - Establishes service cancelable loans for nurses or medical doctorates specializing in psychiatry or primary care medicine practicing in a geographical area in the State of Georgia that has been approved by the authority. For service repayment, the loan shall be repaid at a rate of one year of service for each academic year (668-702).
 - Establishes service cancelable loans for mental health or substance use professionals with ties to and agreeing to serve underserved geographic areas or communities disproportionately affected by social determinants of health (749-770).
 - Creates and maintains the Behavioral Health Workforce Database to collect and analyze a minimum data set survey, which will include demographic information, practice status and setting, education, training, and specialties, hours worked per week, percentage of practice engaged in direct patient care and other activities, years until retirement, specialization in treating children and adolescents and percentage of practice dedicated to treating children and adolescents, capacity to accept new patients, and types of insurance accepted, including Medicaid and Medicare (788-848).
 - Instructs DBHDD to establish and support programs for the training of professional and technical personnel as well as regional advisory councils and CSBs (1561-1562).
- **Promote policies and approaches to ensure medical co-payments and the authorization of services by insurance companies are not barriers to mental health treatment**
 - Instructs every health insurer and state health care entity that provides coverage for mental health or substance use disorders as part of a health care plan to provide coverage for the treatment of mental health or substance use disorders with parity to physical health services in accordance with the federal Mental Health Parity and Addiction Act of 2008....and to provide such coverage for children, adolescents, and adults (108-113; 298-309).
 - Instructs health insurers and state health care entities that they shall not implement any prohibition on same-day reimbursement for a patient who sees a mental health provider and a primary care provider on the same day (151-152; 338-339).

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- Instructs the Insurance Commissioner and Commissioner of Community Health to implement and maintain a streamlined process for accepting, evaluating, and responding to complaints from consumers and health care providers regarding suspected mental health parity violations (153-155; 341-342).
 - Provides that any medical assistance applicant whose application is delayed or denied and any medical assistance recipient who is denied a medical or remedial care service shall be entitled to a hearing (625-632).
- **Shape social-norms about mental health and how to recognize and seek help for mental illness and substance**
 - Instructs DBHDD to plan for and implement the coordination of mental health, developmental disability, and addictive disease services with physical health services and ensure providers of mental health, developmental disability, or addictive disease services coordinate with providers of primary and specialty health care so treatment of conditions of the brain and body can be integrated to promote recovery, health, and well-being (1540-1549).
 - **Expand specialty/accountability courts (e.g., drug, mental health, family treatment) with an emphasis toward ensuring access to behavioral health treatment for families**
 - Outlines Assistant Outpatient Treatment (involuntary outpatient care for adults), which will provide evidence-based treatment, rehabilitation, and case management services to patients receiving involuntary outpatient care and establish routine communications between the probate court and providers of treatment and case management so that courts receive all necessary clinical information and providers can leverage all available resources in motivating a patient to engage with treatment (856-894).
 - Establishes a grant program to fund CSBs in providing assistant outpatient treatment (907-1042).
 - Instructs the Criminal Justice Coordinating Council to establish a grant program for the provision of funds to accountability courts that serve the mental health and co-occurring substance use disorder population to facilitate the implementation of trauma-informed treatment (1224-1226).

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Coordinating bodies:

- **The Office of Health Strategy and Coordination (OHSC)** within the Governor's Office will oversee the coordination of mental health policy and behavioral health services across state agencies by bringing together experts, state elected and appointed leaders, and state agency leaders to achieve the goals of lowering costs and improving access to quality care (1251-1354).
- **The Behavioral Health Coordinating Council (BHCC)**, chaired by the Commissioner of DBHDD, will be responsible for developing solutions to the systemic barriers to delivery of behavioral health services (1446-1524). Of note, the Council will include the Commissioners of DHS, DCH, DPH, DOE, and DECAL, an expert on early childhood mental health, a pediatrician, a representative from the Child Advocate for the Protection of Children, and a parent of a child receiving public behavioral health services.
- **The Behavioral Health Reform and Innovation Commission (BHRIC)**, extended until 2025, will study reimbursement rates for mental health services under Medicaid, PeachCare for Kids, and the State Health Benefit Plan with other states, reimbursement for hospitals caring for uninsured patients with mental health and substance use disorders in the emergency department, an accurate accounting of mental health fund distribution across state agencies, medical necessity denials for adolescent mental health services, and implementation of coordinated care for children entering foster care (1755-1828).
 - The BHRIC will collaborate with experts including pediatricians, family medicine physicians, and early childhood and pediatric mental health professionals to develop and implement a mechanism for CMOs to better serve child-welfare and juvenile-justice-involved children and adolescents, develop a mechanism to provide adoptive caregivers with support necessary to meet the mental and behavioral health needs of children and adolescents for the first 12 months after finalization of adoption, identify pathways to care, including physical, behavioral, and dental health care, for children and adolescents, and ensure appropriate healthcare supports for pediatric patients with mental health or substance use disorders who have high utilization of emergency department, crisis services, or psychiatric residential treatment facilities (1755-1828).

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