GEORGIA HOUSE OF REPRESENTATIVES

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March 30, 2022

HB 1013 Mental Health Parity Act; enact

AUTHOR: Rep. David Ralston (7th)

CO-SPONSORS:

Rep. Todd Jones of the 25th	Rep. Sharon Cooper of the 43rd
Rep. Mary Margaret Oliver of the 82nd	Rep. James Beverly of the 143rd
Rep. Don Hogan of the 179th	Sen. Brian Strickland of the 17th

INTRODUCED: January 26, 2022

STATUS: House Agreed Senate Amend or Sub

COMMITTEE: Health & Human Services

BILL SUMMARY:

Part I: 'Georgia Mental Health Parity Act'

House Bill 1013 requires that health care insurance plans that provide coverage for mental health treatment or substance use disorders do so in accordance with the federal 'Mental Health Parity and Addiction Equity Act of 2008.' Health insurers must also provide an annual comparative analysis report to the insurance commissioner, which will be available on the Office of the Commissioner of Insurance and Safety Fire's (OCI) website. Failure to submit timely reports can result in fines ranging from $2,000 to $5,000. The commissioner is to ensure compliance with mental health parity requirements among health insurers and establish a process for addressing complaints about mental health parity violations. Insurers that do not comply with mental health parity may face punitive action including monetary penalties, compliance plans, or reprocessing of claims. A mental health parity officer is appointed by the commissioner.

The bill revises the definition of "department" to reference OCI rather than the Department of Community Health (DCH) in the existing Act. Further, this bill creates a new definition for "generally accepted standards of mental health or substance use disorder care" and defines it as independent standards of care and clinical practice recognized by certain specialty health care providers, including psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Additionally, the definition specifies valid, evidence-based sources of accepted standards of mental health or substance use disorder care. The definition of "medical necessity," "medically-necessary care," or "medically necessary and appropriate" is also revised to include behavioral health services that screen, prevent, diagnose, manage, or treat

an illness.

HB 1013 requires that state health insurers providing coverage for mental health and substance use disorders do so to the same degree as the treatment for a physical illness, and coverage extends to a spouse and dependent(s) covered under a plan. Health insurers must provide annual comparative analysis reports to the DCH commissioner, which will be available on the department's website. The DCH commissioner is to perform parity-compliance reviews of state health insurers on an annual basis as well as establish a process for addressing complaints about mental health parity violations.

The DCH and OCI commissioners are required to make reasonable efforts to provide culturally and linguistically sensitive materials to consumers through the complaint process. Health insurers are not allowed to prohibit same-day reimbursement for someone who sees separate mental health and primary care providers in the same day.

Care management organizations (CMOs) are required to maintain a minimum 85 percent medical loss ratio (MLR) or a higher minimum established in a contract between DCH and a CMO. If the minimum ratio is not met, the CMO must provide a remittance of the amount determined by DCH. The department will post on its website the aggregate MLR for all CMOs, the MLR for each CMO, and required remittances.

Part II: Workforce and System Development
The bill authorizes service cancelable educational loans for Georgia residents enrolled in educational training for primary care medicine, psychiatry, mental health, substance use, clinical nurse specialist in mental health, or other licensed clinicians or specialists. Loans are conditional on the student agreeing to practice as a professional within an approved geographical area of the state.

The Georgia Board of Health Care Workforce is required to create a Behavioral Health Care Workforce Data Base to collect and analyze surveys for behavioral health care professional applicants and licensees. Licensing boards will require these surveys to be completed by professionals upon licensure, and the surveys must include the professional's demographics, practice status, education and training, specialties, average hours worked per week, percent of practice engaged in direct care, retirement plan if retiring in the next five years, child and adolescent specialized training, information on accepting new patients, and types of accepted insurance, including Medicaid and Medicare.

Part III: Assisted Outpatient Treatment
HB 1013 creates a three-year assisted outpatient treatment grant program to establish the efficacy of the assisted outpatient treatment model in Georgia.

The bill defines "assisted outpatient treatment" as involuntary outpatient care provided by a community service board or a private provider in collaboration with other community partners in order to: identify current residents who qualify as outpatients; establish procedures that lead to a petition being filed in the appropriate probate court when an individual is believed to be an outpatient; provide evidence-based treatment and case management under an individualized plan; safeguard the due process rights of those alleged to require and those civilly committed to

involuntary outpatient care; establish communication between the court and providers; continually evaluate each care plan and respond to non-compliance; partner with law enforcement agencies to provide an alternative to the arrest, incarceration, and prosecution of individuals who may qualify as outpatients; and maintain a patient's connection to treatment services upon transition to voluntary outpatient care.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) will establish a grant program for the implementation of assisted outpatient treatment and provide three years of funding, technical support, and oversight to five grantees. The grantees must be a collaboration between community service boards or private providers, probate courts or other courts with jurisdiction, and sheriffs' offices. The bill outlines the process for the application and award of the grants.

HB 1013 requires the DBHDD to contract with a third-party organization or consultant prior to awarding the grants in order to evaluate the program and its effectiveness. The grantees must provide the required information to the third-party organization or consultant, and the department must contractually require the third-party organization or consultant to produce a report and send it to the governor and the chairpersons of the respective House and Senate Health and Human Services committees by December 31, 2025.

Current statute states that when a law enforcement officer has probable cause to believe that an individual is mentally ill and requiring involuntary treatment, the officer is able to take that person to a physician or emergency receiving facility for an examination. HB 1013 states that the officer can transport a patient to a receiving facility if they have probable cause to believe the individual is mentally ill requiring involuntary treatment and have consulted with a physician who authorizes transportation for the purpose of evaluation. The officer is required to write a detailed report about the circumstances of the person's detainment, which will become a part of the patient's clinical record. These provisions also apply to those hospitalized for and arrested for penal offenses due to substance abuse disorder.

The governing county authority where the patient is found is required to arrange initial emergency transportation, and the transportation provider is prohibited from releasing the patient to any place other than the receiving facility. At the community mental health center's request, the court is required to order the sheriff to carry out subsequent transportation appropriate to the patient's condition. The patient can also be transported by family and friends to the health center's satisfaction. No female patient is allowed to be transported without another female present unless there is an emergency situation or they are accompanied by a male family member.

Part IV: Mental Health Courts and Corrections
Subject to appropriations, the Criminal Justice Coordinating Council (CJCC) will create a grant program to fund accountability courts serving the mental health and co-occurring substance use disorder population to implement trauma-informed treatment and designate an employee to issue technical assistance to the courts. The council will also create a grant program to fund emergency transportation cost for local governments depending on funds.

HB 1013 adds to the list of authorized expenditures of the County Drug Abuse Treatment and Education Fund to include drug abuse treatment and education programs relating to controlled

substances, alcohol, and marijuana for adults and children. Additionally, the fund can be used by a mental health court division that serves those with co-occurring substance use disorders.

The bill expands the powers and duties of the Office of Health Strategy and Coordination (OHSC) to: partner with the Department of Corrections and Department of Juvenile Justice to evaluate mental health wraparound services to meet client needs in the state reentry plan; partner with the Department of Community Supervision to evaluate the ability to share mental health data between agencies in order to facilitate identifying and treating people under community supervision who receive community-based mental health services; oversee coordination of mental health policy and behavioral health services across state agencies; develop and implement a solution to ensure appropriate health care services and supports; develop solutions to systemic barriers impeding delivery of behavioral health services; focus on goals to resolve issues related to behavioral health services; monitor and evaluate implementation of goals and recommendations to improve behavioral health access; establish common outcome measures to evaluate agencies in overseeing mental health services; and create a comprehensive formulary for behavioral health prescriptions under state health plans. Lastly, OHSC is to examine ways to increase certified peer specialists in rural and other underserved or unserved communities and conduct a survey or study on the emergency transport of individuals.

The state will fund at least five new co-responder programs, each of which will have a minimum of one team. Behavioral health co-responders are included in the entities trained at the Georgia Public Safety Training Center.

The Mental Health Courts and Corrections Subcommittee of the Georgia Behavioral Health Reform and Innovation Commission is authorized to submit recommendations to DBHDD regarding the development and future expansion of the program and continue exploring community supervision strategies. The subcommittee is also tasked with continuing to explore community supervision strategies for individuals with mental illnesses.

HB 1013 adds the following persons to the Behavioral Health Coordinating Council: the commissioner of the Department of Early Care and Learning; the commissioner of the Technical College System of Georgia; a behavioral-health expert employed by the University System of Georgia and designated by the chancellor of the university system; the Office of the Child Advocate; an expert on early-childhood mental health appointed by the governor; an expert on child and adolescent health appointed by the governor; and a pediatrician appointed by the governor.

Part V: Child and Adolescent Behavioral Health
DBHDD is to provide the following annual reports to OHSC: complaints made by individuals receiving behavioral health services; status of housing placements and needs; programs designed to serve disabled infants, children, and youth; and performance and fiscal status of each community service board.

HB 1013 clarifies that community service boards provide mental health, developmental disabilities, and addictive diseases services to both adults and children.

The bill adds a deadline of October 1, 2024, for the creation of a statewide system for sharing of

data between various state agencies for the purposes of the care and protection of children.

The Multi-Agency Treatment for Children (MATCH) team is established within DBHDD and is composed of members from the following agencies: the Division of Family and Children Services (DFCS); the Department of Juvenile Justice; the Department of Early Care and Learning; the Department of Public Health; the Department of Community Health; the Department of Human Services; the Department of Education; the Office of the Child Advocate; and the Department of Corrections. The MATCH team facilitates cross-agency collaboration to explore resources and solutions for the treatment needs of children.

Part VI: Behavioral Health Reform and Innovation Commission
HB 1013 requires DCH to study and submit a report by December 31, 2022, for its insurance programs (Medicaid, PeachCare for Kids, and the State Health Benefit Plan) that compares reimbursement rates for mental health services to other states; reviews reimbursing providers of mental health care services; provides an accurate accounting of mental health fund distribution across state agencies; reviews medical necessity of denials for adolescent behavioral health services; and implements coordinated health care for foster youth with claims being immediately shared with DFCS.

The Behavioral Health Reform and Innovation Commission is authorized to collaborate with DBHDD to develop assisted outpatient treatment fidelity protocols and education for grantees; consult with DBHDD in the selection of a research consultant or entity; coordinate initiatives to assist local communities to keep those with serious mental illness out of detention facilities; convene with various health plans and providers to examine how to develop a mechanism to meet the behavioral health needs of youth and young adults in state custody; provide adoptive caregivers with necessary support; and establish an advisory committees to evaluate methods to create pathways of care and develop and recommend solutions for appropriate health care services.

The bill requires the Georgia Data Analytic Center Project's administrator to prepare an annual unified report of suspected mental health parity violations with data received from OCI and DCH.

The bill also requires DCH to provide Medicaid coverage for any prescription prescribed to an adult by a licensed practitioner medically necessary for the treatment of delusion and mood disorders, including schizophrenia and bipolar disorder, if certain criteria are met.

The abolishment date of the Behavioral Health Reform and Innovation Commission is extended from June 30, 2023 to June 30, 2025.

BILL HISTORY:

Jan. 26, 2022 at 11:54 AM	House Hopper
Jan. 27, 2022 at 11:02 AM	House First Readers
Feb. 1, 2022 at 12:01 PM	House Second Readers
Mar. 3, 2022 at 10:05 AM	House Committee Favorably Reported
Mar. 8, 2022 at 12:06 PM	House Third Readers
Mar. 8, 2022 at 12:08 PM	House Passed/Adopted (Vote: 169 / 3)
Mar. 9, 2022 at 10:07 AM	Senate Read and Referred
Mar. 29, 2022 at 12:16 PM	Senate Committee Favorably Reported
Mar. 29, 2022 at 12:17 PM	Senate Read Second Time
Mar. 30, 2022 at 10:12 AM	Senate Committee Favorably Reported
Mar. 30, 2022 at 3:31 PM	Senate Third Read
Mar. 30, 2022 at 3:46 PM	Senate Passed/Adopted (Vote: 54 / 0)
Mar. 30, 2022 at 5:07 PM	House Agreed Senate Amend or Sub (Vote: 166 / 0)

Major Changes Between House Committee and As Passed

Changes Throughout

- "Mental health or substance use disorder" redefined as a "mental illness" or "addictive disease" as in existing code 37-1-1. Reference to the World Health Organization and DSM-5 have been removed. (i.e. 53, 86-87)
- Removes all references to "infants" relating to behavioral health services for youth.
- Redefines "generally accepted standards of mental health or substance use disorder care" to include evidence based "independence" standards, "consensus guidelines," and "nationally recognized clinical practice guidelines." (54-65)

Part I: Georgia Mental Health Parity Act

- "Health care entity" replaced with "health care plan" throughout section 1-2. Definition of "health insurer" added. (69-75)
- Parity compliance in section 1-2 only required of insurers already offering coverage for mental health or substance use disorders. (108-112)
- Fines ranging from $2,000 to $5,000 added for insurers failing to submit required timely and sufficient parity comparative analysis reports. Additionally, the OCI commissioner can take actions against insurers out of compliance with the Mental Health Parity Act including monetary penalties, compliance plans, or reprocessing of claims. (173-185)
- Social determinants of health provisions relating to the medical loss ratio removed.

Part II: Workforce and System Development

- "Family medicine" and "pediatrics" replaced with "primary care medicine" for medical specialties that qualify for service cancelable loans. (670-682)

Part III: Involuntary Commitment

- Assisted outpatient treatment unit, database, reporting requirements, and advisory council were removed.
- Provisions relating to inpatient involuntary commitment reverted back to existing law, reinstating the requirement of "imminent harm."
- Mention of "mobile crisis teams" removed in relation to emergency transport.
- Adds to code section 37-3-42 relating to standards of emergency transport so that a peace officer can complete such transport is meet the following and requires the officer to complete a written report about the circumstances for detainment which will become part of the patient's clinical record. (1075-1086)
    - Probable cause that the person is mentally ill and in need of involuntary treatment
    - Consulted with a physician that authorizes them to transport the individual for evaluation based on facts about the person's condition
- Adds section 37-3-101 relating to the responsibility of the governing authorities to arrange initial transportation of a patient to an emergency receiving facility. The substitute adds the emergency receiving facilities are required to coordinate subsequent transports with a law enforcement agency or qualified private nonemergency transport provider or ambulance service. (1088-1125)

- The definition of "outpatient" is added to code section 37-7-1 relating to hospitalization and treatment individuals with substance use disorders. (1130-1139)
- Adds to code section 37-7-42 relating to emergency admission of persons arrested for penal offenses so that a peace officer can complete such transport is meet the following and requires the officer to complete a written report about the circumstances for detainment which will become part of the patient's clinical record. (1164-1175)
    - Probable cause that the person is mentally ill and in need of involuntary treatment
    - Consulted with a physician that authorizes them to transport the individual for evaluation based on facts about the person's condition

Part IV: Mental Health Courts and Corrections

- Removes requirement that the Criminal Justice Coordinating Council funds be used for emergency transportation and allows the council to establish a grant program for local governments to use for emergency transportation. (1413-1416)
- Adds new responsibilities to the Office of Health Strategy and Coordination. (Section 4-3)
- Adds code section 35-5-5 relating to the Public Safety Training Center and adds provisions relating to co-responders throughout. (Section 4-4)
- Removes extensive provisions related to the co-responder section. (1422-1424)
- Removes accountability court technical assistance center.

Part VI: Behavioral Health Reform and Innovation Commission

- Moves several councils and task forces to the commission. (1794-1822)
- Adds mood disorders to Medicaid coverage of prescription drugs (1846-1850)