House Bill 1013 (COMMITTEE SUBSTITUTE)

By: Representatives Ralston of the 7th, Jones of the 25th, Oliver of the 82nd, Hogan of the 179th, Cooper of the 43rd, and others

A BILL TO BE ENTITLED

AN ACT

To amend Titles 15, 20, 31, 33, 37, 45, and 49 of the Official Code of Georgia Annotated, relating to courts, education, health, insurance, mental health, public officers and employees, and social services, respectively, so as to implement the recommendations of the Georgia Behavioral Health Reform and Innovation Commission; to provide for compliance with federal law regarding mental health parity; to provide for definitions; to provide for annual reports; to provide for annual data calls regarding mental health care parity by private insurers; to provide for information repositories; to require uniform reports from health care entities regarding nonquantitative treatment limitations; to provide for consumer complaints; to provide for same-day reimbursements; to provide for a short title; to provide for definitions and applicability of certain terms; to revise provisions relating to independent review panels; to provide for annual parity compliance reviews regarding mental health care parity by state health plans; to provide for medical loss ratios; to revise provisions relating to coverage of treatment of mental health or substance use disorders by individual and group accidents and sickness policies or contracts; to define medical necessity for purposes of appeals by Medicaid members relating to mental health services and treatments; to provide for a state Medicaid plan amendment or waiver request if necessary; to provide that no existing contracts shall be impaired; to provide for service cancelable loans for mental health and substance use professionals; to provide for the establishment of a Behavioral Health Care

Workforce Data Base by the Georgia Board of Health Care Workforce; to provide for a grant program to establish assisted outpatient treatment programs; to provide legislative findings and determinations; to provide for definitions; to provide grant requirements; to provide for grant application and award; to establish an assisted outpatient treatment unit to provide coordination and support for grantees; to provide for an advisory council; to provide for technical support; to provide for research and reporting; to provide for rules and regulations; to authorize inpatient civil commitment for mental illness to aid a person at risk of significant psychiatric deterioration in the near future; to authorize a peace officer to take custody of a person in apparent mental health crisis and transport the person to an evaluation facility notwithstanding the absence of evidence that the person has committed a criminal offense; to provide for a grant program for accountability courts that serve the mental health and substance use disorder population; to provide for powers and duties of the Office of Health Strategy and Coordination; to provide for methods to increase access to peer specialists in rural and underserved or unserved communities; to provide for implementing certain federal requirements regarding the juvenile justice system; to provide for reporting; to provide for automatic repeal; to provide for funds from the County Drug Abuse Treatment and Education Fund for mental health divisions; to provide for initiatives and a task force to assist local communities in keeping people with serious mental illness out of county and municipal jails and detention facilities and to improve outcomes for individuals who have frequent contact with criminal justice, homeless, and behavioral health systems; to provide for implementation of a state network of local co-response teams; to provide for continued exploration of strategies for individuals with mental illnesses; to revise provisions relating to the Behavioral Health Coordinating Council; to provide for a task force to improve Medicaid function and adequacy; to provide for an annual unified report by the administrator of the Georgia Data Analytic Center relating to complaints filed for suspected violations of mental health parity laws; to extend the sunset date for the Behavioral Health Reform and

Innovation Commission; to provide for automatic repeals; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

PART I

Hospital and Short-Term Care Facilities

SECTION 1-1.

This part shall be known and may be cited as the "Georgia Mental Health Parity Act."

SECTION 1-2.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by adding a new Code section to Chapter 1, relating to general provisions of insurance, as follows:

"33-1-27.

(a) As used in this Code section, the term:

(1) 'Generally accepted standards of mental health or substance use disorder care' means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence based sources reflecting generally accepted standards of mental health or substance use disorder care include peer reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) 'Health care entity' means an insurance company, hospital or medical service plan, health care provider network, health maintenance organization, health care corporation, employer or employee organization, or managed care contractor that offers a managed care plan.

(3) 'Managed care plan' means a major medical or hospitalization plan that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(A) Arrangements with selected providers to furnish health care services;

(B) Explicit standards for the selection of participating providers; and

(C) Cost savings for persons enrolled in the plan to use the participating providers and procedures provided for by the plan.

Such term does not apply to Chapter 9 of Title 34, relating to workers' compensation.

(4) 'Medically necessary' means, with respect to the treatment of a mental health or substance use disorder, a service or product addressing the specific needs of that patient for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is:

(A) In accordance with the generally accepted standards of mental health or substance use disorder care;

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(C) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

(5) 'Mental health or substance use disorder' means a mental health condition or substance use disorder included under any of the diagnostic categories listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* or the World Health Organization's *International Classification of*

Diseases, in effect as of July 1, 2022, or as the Commissioner may further define such term by rule and regulation.

(6) 'Nonquantitative treatment limitation' or 'NQTL' means limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include, but are not limited to, the following:

(A) Medical management standards limiting or excluding benefits based on whether the treatment is medically necessary or whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) For plans with multiple network tiers, network tier design;

(D) Standards for provider admission to participate in a network, including reimbursement rates;

(E) Plan methods for determining usual, customary, and reasonable charges;

(F) Step therapy protocol;

(G) Exclusions based on failure to complete a course of treatment;

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan;

(I) In-network and out-of-network geographic limitations;

(J) Standards for providing access to out-of-network providers;

(K) Limitations on inpatient services for situations when the participant is a threat to himself or herself or others;

(L) Exclusions for court ordered and involuntary holds;

(M) Experimental treatment limitations;

(N) Service coding;

(O) Exclusions for services provided by clinical social workers;

(P) Network adequacy; and

(Q) Provider reimbursement rates, including rates of reimbursement for mental health or substance use services in primary care.

(b) Every health care entity shall provide coverage for the treatment of mental health or substance use disorders in any managed care plan it offers and shall:

(1) Provide such coverage in accordance with the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. Section 300gg-26, and its implementing and related regulations;

(2) Provide such coverage for infants, children, adolescents, and adults;

(3) In addition to the requirements of Chapter 46 of this title, apply the definitions of 'generally accepted standards of mental health or substance use disorder care,' 'medically necessary,' and 'mental health or substance use disorder' contained in subsection (a) of this Code section in making any medical necessity, prior authorization, or utilization review determinations under such coverage;

(4) Ensure that any subcontractor or affiliate responsible for management of mental health and substance use disorder care on behalf of the health care entity complies with the requirements of this Code section; and

(5) No later than January 1, 2023, and annually thereafter, submit a report to the Commissioner that contains the designated comparative analyses and other information designated by the Commissioner for that reporting year for insurers under the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. Section 300gg-26(a)(8)(A) and which delineates the comparative analysis and written processes and strategies used to apply benefits for infants, children, adolescents, and adults. No later than January 1, 2024, and annually thereafter, the Commissioner shall publish on the department's website in a prominent location the reports submitted to the Commissioner pursuant to this paragraph and a list of the designated NQTLs, comparative analyses, and other information required by the Commissioner to be reported in the upcoming reporting year.

(c) The Commissioner shall:

(1)(A) Conduct an annual data call by May 15, 2023, and every May 15 thereafter, of health care entities to ensure compliance with mental health parity requirements, including, but not limited to, compliance with the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. Section 300gg-26, and Code Sections 33-24-28.1, 33-24-29, and 33-24-29.1, as applicable. Such data calls shall include a focus on the use of nonquantitative treatment limitations. In the event that information collected from a data call indicates or suggests a potential violation of any mental health parity requirement by a health care entity, the department shall initiate a market conduct examination of such health care entity to determine whether such health care entity is in compliance with mental health parity requirements. All health care entities shall provide to the department any and all data requested by the department; and

(B) Submit an annual report to the Governor, Lieutenant Governor, and Speaker of the House of Representatives by August 15, 2023, and every August 15 thereafter, regarding the data call conducted pursuant to this paragraph, including details regarding any market conduct examinations initiated by the department pursuant to any such data call; and

(2) Include mental health parity compliance by health care entities in the examination conducted pursuant to Code Section 33-2-11 by the Commissioner annually for the years 2023 through 2025 and biennially thereafter.

(d) No health care entity shall implement any prohibition on same-day reimbursement for a patient to see more than one health care provider in a single day, including a primary care visit followed by a mental health provider visit.

(e) The Commissioner shall implement and maintain a streamlined process for accepting, evaluating, and responding to complaints from consumers and health care entities regarding suspected mental health parity violations. Such process shall be posted on the department's website in a prominent location and clearly distinguished from other types of complaints and shall include information on the rights of consumers under Article 2 of Chapter 20A

of Title 33, the 'Patient's Right to Independent Review Act,' and other applicable law. To the extent practicable, the Commissioner shall undertake reasonable efforts to make culturally and linguistically sensitive materials available for consumers accessing the complaint process established pursuant to this subsection.

(f) No later than January 1, 2023, the department shall create a repository for tracking, analyzing, and reporting information resulting from complaints received from consumers and health care entities regarding suspected mental health parity violations. Such repository shall include complaints, department reviews, mitigation efforts, and outcomes, among other criteria established by the department.

(g) Beginning January 15, 2024, and no later than January 15 annually thereafter, the Commissioner shall submit a report to the administrator of the Georgia Data Analytic Center and the General Assembly with information regarding the previous year's complaints and all elements contained in the repository.

(h) The Commissioner shall appoint a mental health parity officer within the department to ensure implementation of the requirements of this Code section.″

SECTION 1-3.

Said title is further amended in Code Section 33-20A-31, relating to definitions relative to the "Patient's Right to Independent Review Act," by revising paragraphs (1), (7), and (8) and adding new paragraphs to read as follows:

″(1) 'Department' means the Department of ~~Community Health established under Chapter 2 of Title 31~~ Insurance.″

″(2.1) 'Generally accepted standards of mental health or substance use disorder care' means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence based sources reflecting generally accepted standards of mental health

or substance use disorder care include peer reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.″

″(7) 'Medical necessity,' 'medically necessary care,' or 'medically necessary and appropriate' means:

(A) Except as otherwise provided in subparagraph (B) of this paragraph, care based upon generally accepted medical practices in light of conditions at the time of treatment which is:

~~(A)~~(i) Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee's condition;

~~(B)~~(ii) Compatible with the standards of acceptable medical practice in the United States;

~~(C)~~(iii) Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;

~~(D)~~(iv) Not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital; and

~~(E)~~(v) Not primarily custodial care, unless custodial care is a covered service or benefit under the eligible enrollee's evidence of coverage; or

(B) With respect to the treatment of a mental health or substance use disorder, a service or product addressing the specific needs of that patient for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is:

(i) In accordance with the generally accepted standards of mental health or substance use disorder care;

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(iii) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

(7.1) 'Mental health or substance use disorder' means a mental health condition or substance use disorder included under any of the diagnostic categories listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* or the World Health Organization's *International Classification of Diseases*, in effect as of July 1, 2022, or as the Commissioner may further define such term by rule and regulation.

(8) 'Treatment' means a medical, mental health, or substance use disorder service, diagnosis, procedure, therapy, drug, or device.″

SECTION 1-4.

Said title is further amended in Chapter 21A, relating to the "Medicaid Care Management Organizations Act," by adding two new Code sections to read as follows:

″33-21A-13.

(a) As used in this Code section, the term:

(1) 'Generally accepted standards of mental health or substance use disorder care' means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence based sources reflecting generally accepted standards of mental health or substance use disorder care include peer reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) 'Medically necessary' means, with respect to the treatment of a mental health or substance use disorder, a service or product addressing the specific needs of that patient for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is:

(A) In accordance with the generally accepted standards of mental health or substance use disorder care;

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(C) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

(3) 'Mental health or substance use disorder' means a mental health condition or substance use disorder included under any of the diagnostic categories listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* or the World Health Organization's *International Classification of Diseases*, in effect as of July 1, 2022, or as the Commissioner may further define such term by rule and regulation.

(4) 'Nonquantitative treatment limitation' or 'NQTL' means limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment. NQTLs include, but are not limited to, the following:

(A) Medical management standards limiting or excluding benefits based on whether the treatment is medically necessary or whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) For plans with multiple network tiers, network tier design;

(D) Standards for provider admission to participate in a network, including reimbursement rates;

(E) Plan methods for determining usual, customary, and reasonable charges;

(F) Step therapy protocol;

(G) Exclusions based on failure to complete a course of treatment;

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan;

(I) In-network and out-of-network geographic limitations;

(J) Standards for providing access to out-of-network providers;

(K) Limitations on inpatient services for situations when the participant is a threat to himself or herself or others;

(L) Exclusions for court ordered and involuntary holds;

(M) Experimental treatment limitations;

(N) Service coding;

(O) Exclusions for services provided by clinical social workers;

(P) Network adequacy; and

(Q) Provider reimbursement rates, including rates of reimbursement for mental health or substance use services in primary care.

(5) 'State health care entity' means any entity that provides or arranges health care for a state health plan on a prepaid, capitated, or fee for service basis to enrollees or recipients of Medicaid or PeachCare for Kids, including any insurer, care management organization, administrative services organization, utilization management organization, or other entity.

(6) 'State health plan' means any health care benefits provided pursuant to Subpart 2 of Part 6 of Article 17 of Chapter 2 of Title 20, Subpart 3 of Part 6 of Article 17 of Chapter 2 of Title 20, Article 1 of Chapter 18 of Title 45, Article 7 of Chapter 4 of Title 49, or Article 13 of Chapter 5 of Title 49.

(b) Every state health care entity shall provide coverage for the treatment of mental health or substance use disorders which shall be at least as extensive and provide at least the same degree of coverage as that provided by the entity for the treatment of other types of

physical illnesses. Such coverage shall also cover the spouse and the dependents of the insured if such insured's spouse and dependents are covered under such benefit plan, policy, or contract. Such coverage shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to the treatment of mental health or substance use disorders unless such provisions apply generally to other similar benefits provided or paid for under the state health plan. Every such entity shall:

(1) Provide such coverage in accordance with the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. Section 300gg-26, and its implementing and related regulations;

(2) Provide such coverage for infants, children, adolescents, and adults;

(3) Apply the definitions of 'generally accepted standards of mental health or substance use disorder care,' 'medically necessary,' and 'mental health or substance use disorder' contained in subsection (a) of this Code section in making any medical necessity, prior authorization, or utilization review determinations under such coverage;

(4) Ensure that any subcontractor or affiliate responsible for management of mental health and substance use disorder care on behalf of the state health care entity complies with the requirements of this Code section;

(5) Process hospital claims for emergency health care services for mental health or substance use disorders in accordance with this Code section regardless of whether a member is treated in an emergency department; and

(6) No later than January 1, 2023, and annually thereafter, submit a report to the commissioner of community health that contains the comparative analysis and other information required of insurers under the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. Section 300gg-26(a)(8)(A) and which delineates the comparative analysis and written processes and strategies used to apply benefits for infants, children, adolescents, and adults. No later than January 1, 2024, and annually thereafter, the

commissioner of community health shall publish on the Department of Community Health's website in a prominent location the reports submitted to the commissioner of community health pursuant to this paragraph.

(c) The commissioner of community health shall annually:

(1) Perform parity compliance reviews of all state health care entities to ensure compliance with mental health parity requirements, including, but not limited to, compliance with the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. Section 300gg-26, and Code Sections 33-24-28.1, 33-24-29, and 33-24-29.1, as applicable. Such parity compliance reviews shall include a focus on the use of nonquantitative treatment limitations; and

(2) Publish on the Department of Community Health's website in a prominent location a status report of the parity compliance reviews performed pursuant to this subsection, including the results of the reviews and any corrective actions taken.

(d) No state health care entity shall implement any prohibition on same-day reimbursement for a patient to see more than one health care provider in a single day, including a primary care visit followed by a mental health provider visit.

(e) The commissioner of community health shall establish a process for accepting, evaluating, and responding to complaints from consumers and state health care entities regarding suspected mental health parity violations. Such process shall be posted on the Department of Community Health's website in a prominent location and shall include information on the rights of consumers under Article 2 of Chapter 20A of Title 33, the 'Patient's Right to Independent Review Act,' and rights of care management organizations under Code Section 49-4-153. To the extent practicable, the commissioner of community health shall undertake reasonable efforts to make culturally and linguistically sensitive materials available for consumers accessing the complaint process established pursuant to this subsection.

(f) No later than January 1, 2023, the Department of Community Health shall create a repository for tracking, analyzing, and reporting information resulting from complaints received from consumers and state health care entities regarding suspected mental health parity violations. Such repository shall include complaints, department reviews, mitigation efforts, and outcomes, among other criteria established by the department.

(g) Beginning January 15, 2024, and no later than January 15 annually thereafter, the commissioner of community health shall submit a report to the administrator of the Georgia Data Analytic Center and the General Assembly with information regarding the previous year's complaints and all elements contained in the repository.

33-21A-14.

(a) The intent of this Code section is to implement the state option in subdivision (j) of 42 C.F.R. Section 438.8.

(b) As used in this Code section, the term 'medical loss ratio reporting year' or 'MLR reporting year' shall have the same meaning as that term is defined in 42 C.F.R. Section 438.8.

(c) Beginning July 1, 2023, care management organizations shall comply with a minimum 85 percent medical loss ratio or such higher minimum percentage as may be set out in a contract between the department and a care management organization consistent with 42 C.F.R. Section 438.8. The ratio shall be calculated and reported for each MLR reporting year by each care management organization consistent with 42 C.F.R. Section 438.8. Subject to the receipt by the Department of Community Health of a waiver pursuant to Section 1115 or Section 1915(b)(3) of the federal Social Security Act approving the inclusion of services to address social determinants of health (SDOH) in the state's Medicaid plan and the inclusion of those services in the state's managed care contracts, care management organizations providing such approved and included SDOH services may

include the costs of such SDOH services in the numerator of the medical loss ratio calculation.

(d)(1) Effective for contract rating periods beginning on and after July 1, 2023, each care management organization shall provide a remittance for an MLR reporting year if the ratio for that MLR reporting year does not meet the minimum MLR standard of 85 percent. The department shall determine the remittance amount on a plan-specific basis for each rating region of the plan and shall calculate the federal and nonfederal share amounts associated with each remittance.

(2) After the department returns the requisite federal share amounts associated with any remittance funds collected in any applicable fiscal year to the federal Centers for Medicare and Medicaid Services, the remaining amounts remitted by care management organizations pursuant to this section shall be transferred to the general fund.

(e) Except as otherwise required under this Code section, the requirements under this Code section shall not apply to a health care service plan under a subcontract with a care management organization to provide covered health care services to Medicaid and PeachCare for Kids members.

(f) The department shall post on its website the following information:

(1) The aggregate MLR of all care management organizations;

(2) The MLR of each care management organization; and

(3) Any required remittances owed by each care management organization.

(g) The department shall seek any federal approvals it deems necessary to implement this Code section.″

SECTION 1-5.

Said title is further amended by revising Code Section 33-24-28.1, relating to coverage of treatment of mental disorders, as follows:

″33-24-28.1.

(a) As used in this Code section, the term:

(1) 'Accident and sickness insurance benefit plan, policy, or contract' means:

(A) An individual accident and sickness insurance policy or contract, as defined in Chapter 29 of this title; or

(B) Any similar individual accident and sickness benefit plan, policy, or contract.

~~(2) 'Mental disorder' shall have the same meaning as defined by *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The International Classification of Diseases* (World Health Organization) as of January 1, 1981, or as the Commissioner may further define such term by rule and regulation.~~

(2) 'Mental health or substance use disorder' means a mental health condition or substance use disorder included under any of the diagnostic categories listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* or the World Health Organization's *International Classification of Diseases*, in effect as of July 1, 2022, or as the Commissioner may further define such term by rule and regulation.

(b) Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available~~, either~~ as a part of ~~or as an optional endorsement to~~ all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for the treatment of mental health or substance use disorders for infants, children, adolescents, and adults, which coverage shall be at least as extensive and provide at least the same degree of coverage as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such ~~an optional endorsement shall also provide that the~~ coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if such insured's spouse and dependents are covered under such benefit plan, policy, or contract. ~~In no event shall such an insurer be~~

~~required to cover inpatient treatment for more than a maximum of 30 days per policy year or outpatient treatment for more than a maximum of 48 visits per policy year under individual policies.~~ Every such insurer shall comply with the requirements of Code Section 33-1-27.

(c) The ~~optional endorsement~~ coverage required to be made available under subsection (b) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to the treatment of mental health or substance use disorders unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(d) Nothing in this Code section shall be construed to prohibit an insurer, health care plan, health maintenance organization, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

~~(e) Nothing in this Code section shall be construed to prohibit the inclusion of coverage for the treatment of mental disorders that differs from the coverage provided in the same insurance plan, policy, or contract for physical illnesses if the policyholder does not purchase the optional coverage made available pursuant to this Code section.~~"

SECTION 1-6.

Said title is further amended by revising Code Section 33-24-29, relating to coverage for treatment of mental disorders under accident and sickness insurance benefit plans providing major medical benefits covering small groups, as follows:

"33-24-29.

(a) As used in this Code section, the term:

(1) 'Accident and sickness insurance benefit plan, policy, or contract' means:

(A) A group or blanket accident and sickness insurance policy or contract, as defined in Chapter 30 of this title;

(B) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(C) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(D) Any similar group accident and sickness benefit plan, policy, or contract.

~~(2) 'Mental disorder' shall have the same meaning as defined by *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The International Classification of Diseases* (World Health Organization) as of January 1, 1981, or as the Commissioner may further define such term by rule and regulation.~~

(2) 'Mental health or substance use disorder' means a mental health condition or substance use disorder included under any of the diagnostic categories listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* or the World Health Organization's *International Classification of Diseases*, in effect as of July 1, 2022, or as the Commissioner may further define such term by rule and regulation.

(b) This Code section shall apply only to accident and sickness insurance benefit plans, policies, or contracts, certificates evidencing coverage under a policy of insurance, or any other evidence of insurance issued by an insurer, delivered, or issued for delivery in this state, except for policies issued to an employer in another state which provide coverage for employees in this state who are employed by such employer policyholder, providing major medical benefits covering small groups as defined in subsection (a) of Code Section 33-30-12.

(c) Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available~~, either~~ as a part of ~~or as an optional endorsement to~~ all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for the treatment of mental health or substance use disorders for infants, children, adolescents, and adults, which coverage shall be at least as extensive and provide at least the same degree of coverage and the same annual and lifetime dollar limits~~, but which may provide for different limits on the number of inpatient treatment days and outpatient treatment visits,~~ as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such ~~an optional endorsement shall also provide that the~~ coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract. Every such insurer shall comply with the requirements of Code Section 33-1-27.

(d)(1) The ~~optional endorsement~~ coverage required to be made available under subsection (c) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages which apply to the treatment of mental health or substance use disorders unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract, except ~~for any differing limits on inpatient treatment days and outpatient treatment visits as provided under subsection (c) of this Code section and~~ as otherwise provided in paragraph (2) of this subsection.

(2) The ~~optional endorsement~~ coverage required to be made available under subsection (c) of this Code section may contain deductibles or coinsurance provisions which apply to the treatment of mental health or substance use disorders~~, and such deductibles or coinsurance provisions need not apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract; provided,~~

~~however, that if a separate deductible applies to the treatment of mental disorders, it shall not exceed the deductible for medical or surgical coverages. A separate out-of-pocket limit may be applied to the treatment of mental disorders, which limit, in the case of an indemnity type plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages and which, in the case of a health maintenance organization plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages or the amount of $2,000.00 in 1998 and as annually adjusted thereafter according to the Consumer Price Index for health care, whichever is greater~~.

(e)(1) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(2) Nothing in this Code section shall be construed to prohibit any person issuing an accident and sickness insurance benefit plan, policy, or contract from providing the coverage required to be made available under subsection (c) of this Code section through an indemnity plan with or without designating preferred providers of services or from arranging for or providing services instead of indemnifying against the cost of such services, without regard to whether such method of providing coverage for treatment of mental <u>health or substance use</u> disorders applies generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(f) The requirements of this Code section with respect to a group or blanket accident and sickness insurance benefit plan, policy, or contract shall be satisfied if the coverage

specified in subsections (c) and (d) of this Code section is made available to the master policyholder of such plan, policy, or contract. Nothing in this Code section shall be construed to require the group insurer, nonprofit corporation, health care plan, health maintenance organization, or master policyholder to provide or make available such coverage to any insured under such group or blanket plan, policy, or contract.

(g) This Code section is neither enacted pursuant to nor intended to implement the provisions of any federal law."

SECTION 1-7.

Said title is further amended by revising Code Section 33-24-29.1, relating to coverage for treatment of mental disorders under accident and sickness insurance benefit plans providing major medical benefits covering all groups except small groups, as follows:

"33-24-29.1.

(a) As used in this Code section, the term:

(1) 'Accident and sickness insurance benefit plan, policy, or contract' means:

(A) A group or blanket accident and sickness insurance policy or contract, as defined in Chapter 30 of this title;

(B) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(C) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(D) Any similar group accident and sickness benefit plan, policy, or contract.

~~(2) 'Mental disorder' shall have the same meaning as defined by *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The International Classification of Diseases* (World Health Organization) as of January 1, 1981, or as the Commissioner may further define such term by rule and regulation.~~

(2) 'Mental health or substance use disorder' means a mental health condition or substance use disorder included under any of the diagnostic categories listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* or the World Health Organization's *International Classification of Diseases*, in effect as of July 1, 2022, or as the Commissioner may further define such term by rule and regulation.

(b) This Code section shall apply only to accident and sickness insurance benefit plans, policies, or contracts, certificates evidencing coverage under a policy of insurance, or any other evidence of insurance issued by an insurer, delivered, or issued for delivery in this state, except for policies issued to an employer in another state which provide coverage for employees in this state who are employed by such employer policyholder, providing major medical benefits covering all groups except small groups as defined in subsection (a) of Code Section 33-30-12.

(c) Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available~~, either~~ as a part of ~~or as an optional endorsement to~~ all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for the treatment of mental health or substance use disorders for infants, children, adolescents, and adults, which coverage shall be at least as extensive and provide at least the same degree of coverage and the same annual and lifetime dollar limits as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such ~~an optional endorsement shall also provide that the~~ coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract. Every such insurer shall comply with the requirements of Code Section 33-1-27.

(d)(1) The ~~optional endorsement~~ coverage required to be made available under subsection (c) of this Code section shall not contain any exclusions, reductions, or other

limitations as to coverages, including without limitation limits on the number of inpatient treatment days and outpatient treatment visits, which apply to the treatment of mental health or substance use disorders unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract, except as otherwise provided in paragraph (2) of this subsection.

(2) The ~~optional endorsement~~ coverage required to be made available under subsection (c) of this Code section may contain deductibles or coinsurance provisions which apply to the treatment of mental health or substance use disorders~~, and such deductibles or coinsurance provisions need not apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract; provided, however, that if a separate deductible applies to the treatment of mental disorders, it shall not exceed the deductible for medical or surgical coverages. A separate out-of-pocket limit may be applied to the treatment of mental disorders, which limit, in the case of an indemnity type plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages and which, in the case of a health maintenance organization plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages or the amount of $2,000.00 in 1998 and as annually adjusted thereafter according to the Consumer Price Index for health care, whichever is greater~~.

(e)(1) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(2) Nothing in this Code section shall be construed to prohibit any person issuing an accident and sickness insurance benefit plan, policy, or contract from providing the coverage required to be made available under subsection (c) of this Code section through an indemnity plan with or without designating preferred providers of services or from arranging for or providing services instead of indemnifying against the cost of such services, without regard to whether such method of providing coverage for treatment of mental health or substance use disorders applies generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(f) The requirements of this Code section with respect to a group or blanket accident and sickness insurance benefit plan, policy, or contract shall be satisfied if the coverage specified in subsections (c) and (d) of this Code section is made available to the master policyholder of such plan, policy, or contract. Nothing in this Code section shall be construed to require the group insurer, nonprofit corporation, health care plan, health maintenance organization, or master policyholder to provide or make available such coverage to any insured under such group or blanket plan, policy, or contract."

SECTION 1-8.

Code Section 49-4-153 of the Official Code of Georgia Annotated, relating to administrative hearings and appeals under Medicaid, judicial review, and contested cases involving imposition of remedial or punitive measure against a nursing facility, is amended by revising subsection (b) as follows:

"(b)(1) Any applicant for medical assistance whose application is denied or is not acted upon with reasonable promptness and any recipient of medical assistance aggrieved by the action or inaction of the Department of Community Health as to any medical or remedial care or service which such recipient alleges should be reimbursed under the terms of the state plan which was in effect on the date on which such care or service was

rendered or is sought to be rendered shall be entitled to a hearing upon his or her request for such in writing and in accordance with the applicable rules and regulations of the department and the Office of State Administrative Hearings. With respect to appeals regarding whether a treatment is medically necessary and appropriate, the administrative law judge shall make such determination using the definitions provided in Code Section 33-20A-31. As a result of the written request for hearing, a written recommendation shall be rendered in writing by the administrative law judge assigned to hear the matter. Should a decision be adverse to a party and should a party desire to appeal that decision, the party must file a request in writing to the commissioner or the commissioner's designated representative within 30 days of his or her receipt of the hearing decision. The commissioner, or the commissioner's designated representative, has 30 days from the receipt of the request for appeal to affirm, modify, or reverse the decision appealed from. A final decision or order adverse to a party, other than the agency, in a contested case shall be in writing or stated in the record. A final decision shall include findings of fact and conclusions of law, separately stated, and the effective date of the decision or order. Findings of fact shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings. Each agency shall maintain a properly indexed file of all decisions in contested cases, which file shall be open for public inspection except those expressly made confidential or privileged by statute. If the commissioner fails to issue a decision, the initial recommended decision shall become the final administrative decision of the commissioner.

(2)(A) A provider of medical assistance may request a hearing on a decision of the Department of Community Health with respect to a denial or nonpayment of or the determination of the amount of reimbursement paid or payable to such provider on a certain item of medical or remedial care of service rendered by such provider by filing a written request for a hearing in accordance with Code Sections 50-13-13 and 50-13-15 with the Department of Community Health. The Department of Community

Health shall, within 15 business days of receiving the request for hearing from the provider, transmit a copy of the provider's request for hearing to the Office of State Administrative Hearings. The provider's request for hearing shall identify the issues under appeal and specify the relief requested by the provider. The request for hearing shall be filed no later than 15 business days after the provider of medical assistance receives the decision of the Department of Community Health which is the basis for the appeal.

(B) The Office of State Administrative Hearings shall assign an administrative law judge to hear the dispute within 15 days after receiving the request. The hearing is required to commence no later than 90 days after the assignment of the case to an administrative law judge, and the administrative law judge shall issue a written decision on the matter no later than 30 days after the close of the record except when it is determined that the complexity of the issues and the length of the record require an extension of these periods and an order is issued by an administrative law judge so providing, but no longer than 30 days. Such time requirements can be extended by written consent of all the parties. Failure of the administrative law judge to comply with the above time deadlines shall not render the case moot.

(C) A request for hearing by a nursing home provider shall stay any recovery or recoupment action.

(D) Should the decision of the administrative law judge be adverse to a party and should a party desire to appeal that decision, the party must file a request therefor, in writing, with the commissioner within ten days of his or her receipt of the hearing decision. Such a request must enumerate all factual and legal errors alleged by the party. The commissioner, or the commissioner's designated representative, may affirm, modify, or reverse the decision appealed from.

(3) A person or institution who either has been refused enrollment as a provider in the state plan or has been terminated as a provider by the Department of Community Health

shall be entitled to a hearing; provided, however, that no entitlement to a hearing before the department shall lie for refusals or terminations based on the want of any license, permit, certificate, approval, registration, charter, or other form of permission issued by an entity other than the Department of Community Health, which form of permission is required by law either to render care or to receive medical assistance in which federal financial participation is available. The final determination (subject to judicial review, if any) of such an entity denying issuance of such a form of permission shall be binding on and unreviewable by the Department of Community Health. In cases where an entitlement to a hearing before the Department of Community Health, pursuant to this paragraph, lies, the Department of Community Health shall give written notice of either the denial of enrollment or termination from enrollment to the affected person or institution; and such notice shall include the reasons of the Department of Community Health for denial or termination. Should such a person or institution desire to contest the initial decision of the Department of Community Health, he or she must give written notice of his or her appeal to the commissioner of community health within ten days after the date on which the notice of denial or notice of termination was transmitted to him or her. A hearing shall be scheduled and commenced within 20 days after the date on which the commissioner receives the notice of appeal; and the commissioner or his or her designee or designees shall render a final administrative decision as soon as practicable thereafter.″

SECTION 1-9.

If necessary to implement any of the provisions of this part relating to the Medicaid program, the Department of Community Health shall submit a Medicaid state plan amendment or waiver request to the United States Department of Health and Human Services.

SECTION 1-10.

Nothing in this part shall be construed to impair any contracts in effect on June 30, 2022.

PART II

Workforce and System Development

SECTION 2-1.

Code Section 20-3-374 of the Official Code of Georgia Annotated, relating to service cancelable loan fund and authorized types of service cancelable educational loans financed by state funds and issued by the Georgia Student Finance Authority, is amended by revising subsection (b) as follows:

"(b) State funds appropriated for service cancelable loans shall be used by the authority to the greatest extent possible for the purposes designated in this subpart in accordance with the following:

(1) **Paramedical and other medical related professional and educational fields of study.**

(A) The authority is authorized to make service cancelable educational loans to residents of Georgia enrolled in paramedical and other medical related professional and educational fields of study, including selected degree programs in gerontology, ~~and~~ geriatrics, pediatrics, and family medicine. A student enrolled in a program leading to the degree of doctor of medicine shall not qualify for a loan under this paragraph unless the area of specialization is psychiatry or pediatrics. The authority shall, from time to time, by regulation designate the subfields of study that qualify for service cancelable loans under this paragraph. In determining the qualified subfields, the authority shall give preference to those subfields in which the State of Georgia is experiencing a shortage of trained personnel. Loans made under this paragraph need not be limited to students attending a school located within the state. However, any and all loans made

under this paragraph shall be conditioned upon the student agreeing that the loan shall be repaid by the student either:

(i) Practicing in the designated qualified field in a geographical area in the State of Georgia approved by the authority. For service repayment, the loan shall be repaid at a rate of one year of service for each academic year of study or its equivalent for which a loan is made to the student under this paragraph; or

(ii) In cash repayment with assessed interest thereon in accordance with the terms and conditions of a promissory note that shall be executed by the student.

(B) The authority is authorized to make service cancelable loans to residents of this state enrolled in a course of study leading to a degree in an educational field that will permit the student to be employed as either a licensed practical nurse or a registered nurse. Service cancelable loans can also be made available under this paragraph for students seeking an advanced degree in the field of nursing. The maximum loan amount that a full-time student may borrow under this paragraph shall not exceed $10,000.00 per academic year. Any and all loans made under this paragraph shall be conditional upon the student agreeing that the loan shall be repaid by the student either:

(i) Practicing as a licensed practical or registered nurse 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 of study or its equivalent for which a loan is made to the student under this paragraph; or

(ii) In cash repayment with assessed interest thereon in accordance with the terms and conditions of a promissory note that shall be executed by the student;

(2) **Georgia National Guard members.**

(A) The authority is authorized to make service cancelable educational loans to eligible members of the Georgia National Guard enrolled in a degree program at an eligible postsecondary institution, eligible private postsecondary institution, or eligible public postsecondary institution, as those terms are defined in Code Section 20-3-519.

Members of the Georgia National Guard who are in good standing according to applicable regulations of the National Guard shall be eligible to apply for a loan.

(B) Prior to making application for the service cancelable educational loan, an applicant shall complete a Free Application for Federal Student Aid and make application for all other available grants, scholarships, tuition assistance, and United States Department of Veterans Affairs educational benefits that have not been transferred to dependents.

(C) Such loans shall be on the terms and conditions set by the authority in consultation with the Department of Defense, provided that any such loan, when combined with any other available grants, scholarships, tuition assistance, and United States Department of Veterans Affairs educational benefits, shall not exceed an amount equal to the actual tuition charged to the recipient for the period of enrollment in an educational institution or the highest undergraduate in-state tuition charged by a postsecondary institution governed by the board of regents for the period of enrollment at the postsecondary institution, whichever is less. A loan recipient shall be eligible to receive loan assistance provided for in this paragraph for not more than 120 semester hours of study. Educational loans may be made to full-time and part-time students.

(D) Upon the recipient's attainment of a graduate degree from an institution or cessation of status as an active member of the Georgia National Guard, whichever occurs first, eligibility to apply for the loan provided by this paragraph shall be discontinued.

(E) The loan provided by this paragraph shall be suspended by the authority for a recipient's failure to maintain good military standing as an active member for the period required in subparagraph (F) of this paragraph or failure to maintain sufficient academic standing and good academic progress and program pursuit. If the recipient fails to maintain good standing as an active member of the Georgia National Guard for the required period or fails to maintain sufficient academic standing and good academic

progress and program pursuit, loans made under this paragraph shall be repayable in cash, with interest thereon.

(F) Upon satisfactory completion of a quarter, semester, year, or other period of study as determined by the authority; graduation; termination of enrollment in school; or termination of this assistance with approval of the authority, the loan shall be canceled in consideration of the student's retaining membership in good standing in the Georgia National Guard for a period of two years following the last period of study for which the loan is applicable. This two-year service requirement may be waived by the adjutant general of Georgia for good cause according to applicable regulations of the Georgia National Guard.

(G) The adjutant general of Georgia shall certify eligibility and termination of eligibility of students for educational loans and eligibility for cancellation of educational loans by members of the Georgia National Guard in accordance with regulations of the authority;

(3) **Mental health or substance use professionals.**

(A) The authority is authorized to make service cancelable educational loans to residents of the State of Georgia enrolled in educational programs, training programs, or courses of study for mental health or substance use professionals. Loans made under this paragraph need not be limited to students attending programs or schools located within the State of Georgia; provided, however, that priority shall be given to:

(i) Programs and schools with an emphasis and history of providing care to underserved youth; and

(ii) Students with ties to and agreeing to serve underserved geographic areas or communities which are disproportionately impacted by social determinants of health.

(B) Any and all loans made under this paragraph shall be conditional upon the student agreeing that the loan shall be repaid by the student either:

(i) Practicing as a mental health or substance use professional in a geographical area in the State of Georgia approved by the authority. For service repayment, the loan shall be repaid at a rate of one year of service for each academic year of study or its equivalent for which a loan is made to the student under this paragraph; or

(ii) In cash repayment with assessed interest thereon in accordance with the terms and conditions of a promissory note that shall be executed by the student.

(C) As used in this paragraph, the term 'mental health or substance use professional' means a psychiatrist, psychologist, professional counselor, social worker, marriage and family therapist, clinical nurse specialist in psychiatric/mental health, or other mental or behavioral health clinician or specialist recommended by the Department of Behavioral Health and Developmental Disabilities ~~Reserved~~; and

(4) **Critical shortage fields.** The authority is authorized to make service cancelable educational loans to residents of the State of Georgia enrolled in any field of study that the authority, from time to time, designates by regulation as a field in which a critical shortage of trained personnel exists in the State of Georgia. Loans made under this paragraph need not be limited to students attending schools located within the State of Georgia. However, any and all loans made under this paragraph shall be conditional upon the student agreeing that the loan shall be repaid by the student either:

(A) Practicing in the designated field in a geographical area in the State of Georgia approved by the authority. For service repayment, the loan shall be repaid at a rate of one year of service for each academic year of study or its equivalent for which a loan is made to the student under this paragraph; or

(B) In cash repayment with assessed interest thereon in accordance with the terms and conditions of a promissory note that shall be executed by the student.

The authority is authorized to place other conditions and limitations on loans made under this paragraph as it may deem necessary to fill the void that has created the critical shortage in the field.″

SECTION 2-2.

Chapter 10 of Title 49 of the Official Code of Georgia Annotated, relating to the Georgia Board of Health Care Workforce, is amended by adding a new Code section to read as follows:

"49-10-5.

(a) As used in this Code section, the term:

(1) 'Behavioral health care provider' means any health care provider regulated by a licensing board who primarily provides treatment or diagnosis of mental health or substance use disorders.

(2) 'Licensing board' means:

(A) Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists;

(B) Georgia Board of Nursing;

(C) Georgia Composite Medical Board;

(D) State Board of Examiners of Psychologists; and

(E) State Board of Pharmacy.

(3) 'Mental health or substance use disorder' means a mental health condition or substance use disorder included under any of the diagnostic categories listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* or the World Health Organization's *International Classification of Diseases*, in effect as of July 1, 2022, or as the board may further define such term by rule and regulation.

(b) The board shall create and maintain the Behavioral Health Care Workforce Data Base for the purposes of collecting and analyzing minimum data set surveys for behavioral health care professionals. To facilitate such data base, the board shall:

(1) Enter into agreements with entities to create, house, and provide information to the Governor, the General Assembly, state agencies, and the public regarding the state's behavioral health care work force;

(2) Seek federal or other sources of funding necessary to support the creation and maintenance of a Behavioral Health Care Workforce Data Base, including any necessary staffing;

(3) Create and maintain an online dashboard accessible on the board's website to provide access to the Behavioral Health Care Workforce Data Base; and

(4) Establish a minimum data set survey to be utilized by licensing boards to collect demographic and other data from behavioral health care providers which are licensed by such boards.

(c) Licensing boards shall be authorized to and shall require that each applicant and licensee complete the minimum data set survey established by the board pursuant to this Code section at the time of application for licensure or renewal of such applicant or licensee to his or her licensing board. Licensing boards shall provide the board with the results of such minimum data set surveys in accordance with rules and regulations established by the board regarding the manner, form, and content for the reporting of such data sets.

(d) To the extent allowed by law, the minimum data set established by the board shall include, but shall not be limited to:

(1) Demographics, including race, ethnicity, and primary and other languages spoken;

(2) Practice status, including, but not limited to:

(A) Active practices in Georgia and other locations;

(B) Practice type and age range of individuals served; and

(C) Practice settings, such as a hospital; clinic; school; in-home services, including telehealth services; or other clinical setting;

(3) Education, training, and primary and secondary specialties;

(4) Average hours worked per week and average number of weeks worked per year in the licensed profession;

(5) Percentage of practice engaged in direct patient care and in other activities, such as teaching, research, and administration in the licensed profession;

(6) Year of expected retirement, as applicable, within the next five years;

(7) Whether the applicant or licensee has specialized training in treating infants, children, and adolescents, and if so, the proportion of his or her practice that comprises the treatment of children and adolescents;

(8) Whether the applicant or licensee is or will be accepting new patients and the location or locations new patients are being or will be accepted;

(9) Types of insurance accepted and whether the provider accepts Medicaid and Medicare; and

(10) Other data determined by the board.″

PART III

Involuntary Commitment

SECTION 3-1.

Title 37 of the Official Code of Georgia Annotated, relating to mental health, is amended in Chapter 1, relating to the governing and regulation of mental health, by adding a new article to read as follows:

″ARTICLE 7

37-1-120.

The General Assembly finds and determines that:

(1) Georgia's longstanding law authorizing outpatient civil commitment for mental health or substance use disorders is intended to assist the subset of individuals with mental health or substance use disorders who struggle to maintain voluntary engagement with the treatment they require to live safely in the community. Many such individuals find themselves trapped in a cycle of repeated mental health crises, leading to hospitalizations, arrests, or both, which would not have occurred had they been receiving adequate treatment. Outpatient civil commitment is intended to help such individuals overcome the factors preventing them from maintaining voluntary treatment adherence, such as lack of insight, or inability to recognize their own need for treatment, and challenges with executive functioning;

(2) As of this enactment, Georgia's outpatient civil commitment law has not fulfilled its potential to help vulnerable individuals avoid hospitalization and the criminal justice system. Family members of individuals in desperate need of this assistance, as well as many working diligently within the mental health system to provide care, report that to the extent outpatient civil commitment orders are employed at all, the system routinely fails to provide any meaningful enforcement and lacks the necessary resources and coordination services to ensure that individuals can access treatment and the courts can track compliance and outcomes;

(3) In many other states, outpatient civil commitment has proven to be a much more effective tool in serving the needs of its target population. An impressive body of peer reviewed research from New York, North Carolina, and Ohio has associated the practice of outpatient commitment with substantial reductions in hospitalization, arrest, incarceration, and a range of harmful behaviors, as well as substantial cost savings for public mental health systems. However, this research also makes clear that it is not simply the use of outpatient court orders that drives these outcomes. Policy choices as to how outpatient commitment is implemented and resourced matter a great deal;

(4) A paper published in 2019 by the American Psychiatric Association's federally funded SMI Adviser initiative presents the essential elements of the effective practice of 'assisted outpatient treatment' (outpatient civil commitment employed in conjunction with critical resources and practices) as identified by a team of successful practitioners from across the United States. In contrasting the assisted outpatient treatment model as presented by SMI Adviser with the current practice of outpatient civil commitment in Georgia, it is evident that our state has neither provided the resources nor implemented the practices that have made assisted outpatient treatment a nationally recognized evidence based practice; and

(5) For the foregoing reasons, this article establishes a three-year assisted outpatient treatment grant program with the full expectation that the program will establish the efficacy of the assisted outpatient treatment model in Georgia and serve as a first step toward full integration of assisted outpatient treatment into the routine activities of community service boards or private providers and probate courts across the state.

37-1-121.

As used in this article, the term:

(1) 'Assisted outpatient treatment' means involuntary outpatient care, pursuant to Article 3 of Chapter 3 of this title, provided in the context of a formalized, systematic effort led by a community service board or private provider in collaboration with other community partners, endeavoring to:

(A) Identify residents of the community service board's or private provider's service area who qualify as outpatients pursuant to Code Section 37-3-1;

(B) Establish procedures such that upon the identification of an individual believed to be an outpatient, a petition seeking involuntary outpatient care for the individual is filed in the probate court of the appropriate county;

(C) Provide evidence based treatment and case management services under an individualized service plan to each patient receiving involuntary outpatient care, focused on helping the patient maintain stability and safety in the community;

(D) Safeguard, at all stages of proceedings, the due process rights of respondents alleged to require involuntary outpatient care and patients who have been civilly committed to involuntary outpatient care;

(E) Establish routine communications between the probate court and providers of treatment and case management such that for each patient receiving involuntary outpatient care, the court receives the clinical information it needs to exercise its authority appropriately and providers can leverage the court as a partner in motivating the patient to engage with treatment;

(F) Continually evaluate the appropriateness of each patient's individualized service plan throughout the period of involuntary outpatient care, and adjust the plan as warranted;

(G) Employ specific protocols to respond appropriately and lawfully in the event of a failure of or noncompliance with involuntary outpatient care;

(H) Partner with law enforcement agencies to provide an alternative to arrest, incarceration, and prosecution for individuals suspected or accused of criminal conduct who appear to qualify as outpatients pursuant to Code Section 37-3-1;

(I) Clinically evaluate each patient receiving involuntary outpatient care at the end of the commitment period to determine whether it is appropriate to seek an additional period of involuntary outpatient care or assist the patient in transitioning to voluntary care; and

(J) Ensure that upon transitioning to voluntary outpatient care at an appropriate juncture, each patient remains connected to the treatment services he or she continues to need to maintain stability and safety in the community.

(2) 'Mental health or substance use disorder' means a mental health condition or substance use disorder included under any of the diagnostic categories listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* or the World Health Organization's *International Classification of Diseases*, in effect as of July 1, 2022, or as the commissioner may further define such term by rule and regulation.

37-1-122.

The department shall establish and operate a grant program for the purpose of fostering the implementation and practice of assisted outpatient treatment in this state. The grant program shall aim to provide three years of funding, technical support, and oversight to five grantees, each comprising a collaboration between a community service board or private provider, a probate court or courts with jurisdiction in the corresponding service area, and a sheriff's office or offices with jurisdiction in the corresponding service area, which have demonstrated the ability with grant assistance to practice assisted outpatient treatment. Funding, technical support, and oversight pursuant to the grant program shall commence no later than January 1, 2023, and shall terminate, subject to the department's annual review of each grantee, on December 31, 2025.

37-1-123.

(a) No later than October 1, 2022, the department shall issue a funding opportunity announcement inviting any community service board or private provider, in partnership with a court or courts holding jurisdiction over probate matters in the corresponding service area, to submit a written application for funding pursuant to the assisted outpatient treatment grant program.

(b) The department shall develop and disclose in the funding opportunity announcement:

(1) A numerical scoring rubric to evaluate applications, which shall include a minimum score an application must receive to be potentially eligible for funding;

(2) A formula for determining the amount of funding for which a grantee shall be eligible, based on the size of the population to be served, consideration of existing resources, or both;

(3) A minimum percentage of a grant award that must be directed, and a maximum percentage of a grant award that may be directed, for purposes of enhancing the community based mental health services and supports provided to recipients of assisted outpatient treatment; and

(4) A minimum percentage of the total program budget that must be independently sourced by the applicant.

(c) The funding opportunity announcement shall require each application to include, in addition to any other information the department may choose to require:

(1) A detailed three-year program budget, including identification of the source or sources of the applicant's independent budget contribution;

(2) A plan to identify and serve a population composed of persons meeting the following criteria, including the number of patients anticipated to participate in the program over the course of each year of grant support:

(A) The person is 18 years of age or older;

(B) The person is suffering from a mental health or substance use disorder;

(C) There has been a clinical determination by a physician or psychologist that the person is unlikely to survive safely in the community without supervision;

(D) The person has a history of lack of compliance with treatment for his or her mental health or substance use disorder, in that at least one of the following is true:

(i) The person's mental health or substance use disorder has, at least twice within the previous 36 months, been a substantial factor in necessitating hospitalization or the receipt of services in a forensic or other mental health unit of a correctional facility,

not including any period during which such person was hospitalized or incarcerated immediately preceding the filing of the petition; or

(ii) The person's mental health or substance use disorder has resulted in one or more acts of serious and violent behavior toward himself or herself or others or threatens or attempts to cause serious physical injury to himself or herself or others within the preceding 48 months, not including any period in which such person was hospitalized or incarcerated immediately preceding the filing of the petition;

(E) The person has been offered an opportunity to participate in a treatment plan by the department, a state mental health facility, a community service board, or a private provider under contract with the department and such person continues to fail to engage in treatment;

(F) The person's condition is substantially deteriorating;

(G) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure such person's recovery and stability;

(H) In view of the person's treatment history and current behavior, such person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would likely result in grave disability or serious harm to himself or herself or others; and

(I) It is likely that the person may benefit from assisted outpatient treatment.

(3) For each element of assisted outpatient treatment, a statement of how the applicant proposes to incorporate such element into its own practice of assisted outpatient treatment;

(4) A commitment by the applicant that it shall honor the provisions of any legally enforceable psychiatric advance directive of any person receiving involuntary outpatient treatment;

(5) A description of the evidence based treatment services and case management model or models that the applicant proposes to utilize;

(6) A description of any dedicated staff positions the applicant proposes to establish;

(7) A letter of support from the sheriff of any county where the applicant proposes to provide assisted outpatient treatment;

(8) A flowchart representing the proposed assisted outpatient treatment process, from initial case referral to transition to voluntary care; and

(9) A description of the applicant's plans to establish a stakeholder workgroup, consisting of representatives of each of the agencies, entities, and communities deemed essential to the functioning of the assisted outpatient treatment program, for purposes of internal oversight and program improvement.

(d) The department shall not provide direct assistance or direct guidance to any potential applicant in developing the content of an application. Any questions directed to the department from potential applicants concerning the grant application process or interpretation of the funding opportunity announcement may only be entertained at a live webinar announced in advance in the funding opportunity announcement and open to all potential applicants, or may be submitted in writing and answered on a webpage disclosed in the funding opportunity announcement and freely accessible to any potential applicant.

(e) No later than December 31, 2022, the department shall publicly announce awards for funding support, subject to annual review, to the five applicants whose applications received the highest scores under the scoring rubric, provided that:

(1) The department shall seek to ensure, to the extent practical and consistent with other objectives, that at least three of the regions designated pursuant to Code Section 37-2-3 are represented among the five grantees. In pursuit of this goal, the department may in its discretion award a grant to a lower-scoring applicant over a higher-scoring applicant or may resolve a tie score in favor of an applicant that would increase regional diversity among the grantees; and

(2) In no case shall a grant be awarded to an applicant whose application has failed to attain the minimum required score as stated in the funding opportunity announcement.

This requirement shall take precedence in the event that it comes into conflict with the requirement that a total of five grants be awarded.

37-1-124.

There shall be established within the department an assisted outpatient treatment unit to provide supervision, coordination, and support to the assisted outpatient treatment grantees. The assisted outpatient treatment unit shall, in collaboration with the assisted outpatient treatment advisory council established pursuant to Code Section 37-1-125, develop fidelity protocols for the grantees and a training and education program for use by the grantees to train and educate staff, community partners, and others. No later than December 31 of each year that this article is in effect, the assisted outpatient treatment unit shall submit an annual report on the assisted outpatient treatment grant program to the Governor and chairpersons of the House Committee on Health and Human Services and the Senate Health and Human Services Committee.

37-1-124.1.

The assisted outpatient treatment unit shall establish a state-wide repository of information on persons residing in this state with behavioral health issues who have had high utilization of services, involuntary outpatient treatment or assisted outpatient treatment orders, are under guardianships, are incarcerated or have had multiple incarcerations, have had multiple long-term hospitalizations, have had multiple behavioral health emergency services, have had numerous encounters with law enforcement, or other high usage of resources for the purposes of improving outcomes for persons diagnosed with mental health or substance use disorders and assisting law enforcement agencies, courts, case managers, and clinicians in providing safe treatment while reducing fragmentation. Any such repository shall be developed and utilized in conformance with all federal and state privacy laws. When such repository is established, the assisted outpatient treatment unit

shall submit a report detailing all elements, analysis, findings, and outcomes of the previous year's activity to the commissioner no later than the January 15 following the establishment of the repository, and no later than January 15 annually thereafter. The commissioner shall make such report available to the General Assembly no later than January 30 of each year.

37-1-125.

(a) There shall be established by the department an assisted outpatient treatment advisory council consisting of:

(1) The President of the Council of Probate Court Judges of Georgia, or his or her designee, who shall serve as chairperson;

(2) The chairperson of the Behavioral Health Reform and Innovation Commission established pursuant to Code Section 37-1-111, or his or her designee;

(3) The disability services ombudsman appointed pursuant to Code Section 37-2-32, or his or her designee;

(4) A representative of the Georgia Association of Community Service Boards who shall not be an employee or agent of any grantee;

(5) A representative of the Georgia Advocacy Office;

(6) A representative of the Georgia Mental Health Consumer Network;

(7) A representative of the National Alliance on Mental Illness;

(8) A representative of the Georgia Behavioral Health Services Coalition;

(9) An immediate family member of an individual who has struggled to maintain engagement with treatment for a mental health or substance use disorder, to be appointed by the commissioner; and

(10) A nationally recognized expert on assisted outpatient treatment, to be appointed by the commissioner.

(b) The advisory council shall:

(1) Advise the assisted outpatient treatment unit on the development of fidelity protocols for the grantees and a training and education program for use by the grantees to train and educate staff, community partners, and others;

(2) Provide consultation to the department in the selection of an organization or entity to perform research pursuant to Code Section 37-1-127;

(3) Provide consultation to the department in the development of rules and regulations pursuant to Code Section 37-1-128;

(4) Review and offer comments on the assisted outpatient treatment grant program's annual report, prior to its public release; and

(5) Provide recommendations to the department for improvements or addressing challenges facing the assisted outpatient grant program.

(c) The assisted outpatient treatment advisory council shall convene upon the call of the chairperson but no less frequently than quarterly. Meetings shall be held at the grant sites on a rotating basis and shall each include a presentation on progress from the host grantee.

37-1-126.

Throughout the term of the assisted outpatient treatment grant program, the department shall contract on an annual basis with an organization or entity possessing expertise in the practice of assisted outpatient treatment to serve as a technical assistance provider to the grantees. Prior to the conclusion of each of the first two years of the assisted outpatient treatment grant program, the department, in consultation with the grantees, shall review the performance of the technical assistance provider and determine whether it is appropriate to seek to contract with the same technical assistance provider for the following year.

37-1-127.

(a) Prior to the commencement of funding under the assisted outpatient grant program, the department shall contract with an independent organization or entity possessing expertise in the evaluation of community based mental health programs and policy to evaluate:

(1) The effectiveness of the assisted outpatient grant program in reducing hospitalization and criminal justice interactions among vulnerable individuals with mental health or substance use disorders;

(2) The cost-effectiveness of the assisted outpatient grant program, including its impact on spending within the public mental health system on the treatment of individuals receiving assisted outpatient treatment and spending within the criminal justice system on the arrest, incarceration, and prosecution of such individuals;

(3) Differences in implementation of the assisted outpatient treatment model among the grantees and the impact of such differences on program outcomes;

(4) The impact of the assisted outpatient grant program on the mental health system at large, including any unintended impacts; and

(5) The perceptions of assisted outpatient treatment and its effectiveness among participating individuals, family members of participating individuals, mental health providers and program staff, and participating probate court judges.

(b) As a condition for participation in the grant program, the department shall require each grantee to agree to share such program information and data with the contracted research organization or entity as the department may require, and to make reasonable accommodations for such organization or entity to have access to the grant site and individuals. The department shall further ensure that the contracted research organization or entity is able to perform its functions consistent with all state and federal restrictions on the privacy of personal health information.

(c) In contracting with the research organization or entity, the department shall require such organization or entity to submit a final report on the effectiveness of the assisted

outpatient grant program to the Governor, the chairpersons of the House Committee on Health and Human Services and the Senate Health and Human Services Committee, and the Office of Health Strategy and Coordination no later than December 31, 2025. The department may also require the organization or entity to report interim or provisional findings to the department at earlier dates.

37-1-128.

The department may adopt and prescribe such rules and regulations as it deems necessary or appropriate to administer and carry out the grant program provided for in this article."

SECTION 3-2.

Said title is further amended in Code Section 37-3-1, relating to definitions, by revising paragraphs (9.1) and (12.1) as follows:

"(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 reasonably likely to realize an improvement in that person's psychiatric symptoms or a reduction in that person's mental health deterioration due to inpatient treatment;

(C) Who will not receive adequate benefit from less restrictive alternatives to inpatient treatment;

(D) Who has declined voluntary inpatient treatment; and

~~(B)~~(E) 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."

SECTION 3-3.

Said title is further amended in Code Section 37-3-42, relating to emergency admission of persons arrested for penal offenses, report by officer, and entry of report into clinical record, by revising subsection (a) as follows:

"(a) A peace officer or a mobile crisis team that meets the requirements established by the department may take any person to a physician within the county or an adjoining county for emergency examination by the physician, as provided in Code Section 37-3-41, or directly to an emergency receiving facility if ~~(1) the person is committing a penal offense, and (2)~~ the peace officer or mobile crisis team has probable cause for believing that the person is a mentally ill person requiring involuntary treatment. ~~The peace officer need not formally tender charges against the individual prior to taking the individual to a physician or an emergency receiving facility under this Code section.~~ The peace officer or mobile crisis team shall execute a written report detailing the circumstances under which the person was taken into custody; and this report shall be made a part of the patient's clinical record. If the person is committing a penal offense, the peace officer need not formally tender charges against the person prior to taking the person to a physician or an emergency receiving facility under this Code section. The mobile crisis team or the law enforcement agency employing a peace officer who takes any person to a physician or an emergency

receiving facility for emergency evaluation and examination pursuant to this Code section shall be responsible for ensuring the initial safety and security of such person during such emergency evaluation and examination. The emergency receiving facility shall coordinate all subsequent transports with such law enforcement agency or a qualified private nonemergency transport provider or ambulance service."

PART IV

Mental Health Courts and Corrections

SECTION 4-1.

Title 15 of the Official Code of Georgia Annotated, relating to courts, is amended by adding a new Code section to Chapter 1, relating to general provisions, to read as follows:

"15-1-23.

(a) As used in this Code section, the term 'accountability court' has the same meaning as in Code Section 15-1-18.

(b) The Criminal Justice Coordinating Council shall 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 gender-specific trauma treatment.

(c) The Criminal Justice Coordinating Council shall provide a dedicated employee to provide technical assistance to accountability courts. Such technical assistance shall include, but not be limited to, assistance interpreting data analysis reports to better identify and serve the mental health population. Such grant funds may also be used for costs associated with transporting individuals to and from emergency receiving, evaluating, and treatment facilities as such terms are defined in Chapters 3 and 7 of Title 37."

SECTION 4-2.

Said title is further amended by revising subsection (b) of Code Section 15-21-101, relating to collection of fines and authorized expenditures of funds from County Drug Abuse Treatment and Education Fund, as follows:

"(b) Moneys collected pursuant to this article and placed in the 'County Drug Abuse Treatment and Education Fund' shall be expended by the governing authority of the county for which the fund is established solely and exclusively:

(1) For drug abuse treatment and education programs relating to controlled substances, alcohol, and marijuana for adults and children;

(2) If a drug court division has been established in the county under Code Section 15-1-15, for purposes of the drug court division;

(3) If an operating under the influence court division has been established in the county under Code Section 15-1-19, for the purposes of the operating under the influence court division; ~~and~~

(4) If a family treatment court division has been established in the county under Code Section 15-11-70, for the purposes of the family treatment court division; and

(5) If a mental health court division 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."

SECTION 4-3.

Article 1 of Chapter 53 of Title 31 of the Official Code of Georgia Annotated, relating to general provisions regarding the Office of Health Strategy and Coordination, is amended by revising Code Section 31-53-3, relating to the establishment of the office and its powers and duties, as follows:

″31-53-3.

(a) There is established within the office of the Governor the Office of Health Strategy and Coordination. The objective of the office shall be to strengthen and support the health care infrastructure of the state through interconnecting health functions and sharing resources across multiple state agencies and overcoming barriers to the coordination of health functions, including coordinating mental health policy across state agencies. To this end, all affected state agencies shall cooperate with the office in its efforts to meet such objective. This shall not be construed to authorize the office to perform any function currently performed by an affected state agency.

(b) The office shall have the following powers and duties:

(1) Bring together experts from academic institutions and industries as well as state elected and appointed leaders to provide a forum to share information, coordinate the major functions of the state's health care system, and develop innovative approaches for lowering costs while improving access to quality care;

(2) Serve as a forum for identifying Georgia's specific health issues of greatest concern and promote cooperation from both public and private agencies to test new and innovative ideas;

(3) Evaluate the effectiveness of previously enacted and ongoing health programs and determine how best to achieve the goals of promoting innovation, competition, cost reduction, and access to care, and improving Georgia's health care system, attracting new providers, and expanding access to services by existing providers;

(4) Facilitate collaboration and coordination between state agencies, including, but not limited to, the Department of Public Health, the Department of Community Health, the Department of Behavioral Health and Developmental Disabilities, the Department of Human Services, the Department of Economic Development, the Department of Transportation, ~~and~~ the Department of Education, the Department of Early Care and Learning, the Department of Juvenile Justice, and the Department of Corrections;

(5) Evaluate prescription costs and make recommendations to public employee insurance programs, departments, and governmental entities for prescription formulary design and cost reduction strategies and create a comprehensive unified formulary for mental health and substance use disorder services under Medicaid, PeachCare for Kids, and the state health benefit plan no later than December 1, 2022;

(6) Maximize the effectiveness of existing resources, expertise, and opportunities for improvement;

(7) Review existing State Health Benefit Plan contracts, Medicaid care management organization contracts, and other contracts entered into by the state for health related services, evaluate proposed revisions to the State Health Benefit Plan, and make recommendations to the Department of Community Health prior to renewing or entering into new contracts;

(8) Coordinate state health care functions and programs and identify opportunities to maximize federal funds for health care programs;

(9) Oversee collaborative health efforts to ensure efficient use of funds secured at the federal, state, regional, and local levels;

(10) Evaluate community proposals that identify local needs and formulate local or regional solutions that address state, local, or regional health care gaps;

(11) Monitor established agency pilot programs for effectiveness;

(12) Identify nationally recognized effective evidence based strategies;

(13) Propose cost reduction measures;

(14) Provide a platform for data distribution compiled by the boards, commissions, committees, councils, and offices listed in Code Section 31-53-7; ~~and~~

(15) Assess the health metrics of the state and recommend models for improvement which may include healthy behavior and social determinant models~~.~~;

(16) Partner with the Department of Corrections and the Department of Juvenile Justice to provide ongoing evaluation of mental health wraparound services and connectivity to local mental health resources to meet the needs of clients in the state reentry plan;

(17) Partner with the Department of Community Supervision to evaluate the ability to share mental health data between state and local agencies, such as community service boards and the Department of Community Supervision, to assist state and local agencies in identifying, tracking, and treating those under community supervision who are also receiving community based mental health services;

(18) Oversee coordination of behavioral health services for infants, children, and adolescents and monitor plans to expand access to children's behavioral health services across the state as needed. The commissioner of the Department of Behavioral Health and Developmental Disabilities shall annually submit a report to the office including information collected by the department indicating the changes, trends, improvements, and needs of children's behavioral health. Such annual report shall be made publicly available. The office and the Department of Behavioral Health and Developmental Disabilities shall periodically identify nationally available clearinghouses of children's behavioral health research and best practices to disseminate to schools, practitioners, and others through training, technical assistance, and educational materials;

(19) Partner with community service boards to ensure that behavioral health services are made available and provided to children, adolescents, and adults through direct services, contracted services, or collaboration with state agencies, nonprofit organizations, and colleges and universities, as appropriate, utilizing any available state and federal funds or grants;

(20) Provide for the establishment of advisory committees pursuant to Code Section 31-53-5 to evaluate specific issues and report related findings and recommendations to the office, including:

(A) Identifying methods to create pathways of care, including physical, behavioral, and dental health care, for infants, children, and adolescents, regardless of an individual's specific insurance carrier or insurance coverage; and

(B) Developing and implementing a solution to ensure appropriate health care services and supports, including better care coordination, for pediatric patients residing in this state who have mental health or substance use disorders and who have had high utilization of emergency departments, crisis services, or psychiatric residential treatment facilities, for the purpose of streamlining care, improving outcomes, reducing return visits to emergency departments, and assisting case managers and clinicians in providing safe treatment while reducing fragmentation; and

(21) Centralizing the ongoing and comprehensive planning, policy, and strategy development across state agencies, Medicaid care management organizations and fee for service providers, and private insurance partners.

(c)(1) The office shall examine methods to increase access to certified peer specialists in rural and other underserved or unserved communities and identify any impediments to such access. Such examination shall include strategies to:

(A) Increase access to training and implementation in perinatal care community settings and birthing hospitals in order to reach families impacted by substance use and to improve coordination and monitoring of plans of safe care;

(B) Expand capacity for and support of implementation of research based practices, including behavioral health services for children from birth through five years of age and their parent or caregiver;

(C) Expand training for certified peer support specialists to promote long-term recovery for individuals with substance use disorder; and

(D) Facilitate coordination between behavioral health care providers in school settings and students' primary care providers.

(2) The office shall examine the option of fully implementing certain requirements under the federal SUPPORT for Patients and Communities Act, P.L. 115-271, regarding youth in the juvenile justice system to allow for successful transition to community services upon release.

(3) No later than December 31, 2023, the office shall provide a report to the General Assembly and the Governor regarding its findings and recommendations pursuant to paragraph (1) of this subsection and pursuant to paragraph (2) of this subsection.

(4) This subsection shall stand repealed by operation of law on December 31, 2023.

(d)(1) The office shall conduct a survey or study on the transport of individuals to and from emergency receiving, evaluation, and treatment facilities pursuant to Chapters 3 and 7 of Title 37. Such survey or study shall identify what method of transport is used in each county of the state, such as the sheriff, a law enforcement agency, a private nonemergency transport provider, or an ambulance service. Such survey or study shall be completed, compiled into a report, and provided to the General Assembly and the Governor no later than January 1, 2023.

(2) This subsection shall stand repealed by operation of law on January 1, 2023."

SECTION 4-4.

Title 37 of the Official Code of Georgia Annotated, relating to mental health, is amended by adding two new Code sections to Chapter 1, relating to governing and regulation of mental health, to read as follows:

"37-1-7.

(a) It is the intent of the General Assembly that this state participate in initiatives:

(1) To assist local communities in keeping people with serious mental illness out of county and municipal jails and detention facilities, including juvenile detention; and

(2) Facilitated by nationally recognized experts to improve outcomes for individuals who have frequent contact with criminal justice, homeless, and behavioral health systems, termed 'familiar faces.'

(b) A task force shall be established to coordinate such initiatives. Task force members shall be appointed by the Governor and composed of relevant state and local officials, experts, and stakeholders.

(c) The task force shall be authorized to:

(1) Monitor the operations of the state-wide technical assistance center established pursuant to subsection (e) of this Code section;

(2) Serve as liaison to state and local leaders and create a feedback loop to inform future policy and funding priorities;

(3) In consultation with relevant mental health, judicial, and law enforcement officials and experts, develop a shared definition of 'serious mental illness';

(4) Explore funding options to implement universal screening upon admission into a county or municipal jail or detention facility; and

(5) Seek guidance from the Attorney General's office in developing state guidelines, tools, and templates to facilitate sharing of information among state and local entities in compliance with state and federal privacy laws.

(d) The task force shall develop and adopt recommendations to:

(1) Promote the use of pre-arrest diversion strategies as well as initiatives that reduce revocations for such population;

(2) Reduce unnecessary contact with the justice system by developing diversion strategies implemented by law enforcement agencies or courts; and

(3) Build and scale community based behavioral health, housing, and other relevant social services for such population through initiatives such as:

(A) Adopting a shared definition for high utilization in consultation with relevant behavioral health, criminal justice, and housing experts;

(B) Developing state-wide guidance, tools, and templates to facilitate appropriate information sharing across behavioral health, criminal justice, housing, and other relevant agencies in accordance with all state and federal privacy laws;

(C) Implementing improvements to data sharing across and between local and state agencies;

(D) Improving strategies to refer and connect individuals to needed community based health and social services, including addressing gaps in continuity of care;

(E) Expanding the use of and support for forensic peer monitors; and

(F) Analyzing best practices to address and ameliorate the increase in chronic homelessness among persons with behavioral health and substance abuse disorder, particularly the challenges of unsheltered homelessness, and formulating recommendations for policies and funding to address such issues, considering the best practices of other states and the permissible use of all available funding sources.

The task force shall compile a report including such recommendations and shall submit such report to the Governor, General Assembly, Office of Health Strategy and Coordination, and the Georgia Behavioral Reform and Innovation Commission by December 31, 2022, and annually thereafter.

(e)(1) The department shall establish a state-wide technical assistance center to provide assistance to counties, municipalities, and appropriate state agencies in implementing the initiatives. Such technical assistance center shall, in coordination with other related state initiatives and efforts:

(A) Disseminate information and resources and serve as a clearinghouse to share information across counties state wide in support of the initiatives;

(B) Provide on-demand, one-on-one, and peer cohort assistance and consultation;

(C) Issue a biannual survey to all counties to gather information about specific successes, remaining challenges, and feedback on the center's offerings; and

(D) Produce an annual report for the task force and state leadership to capture lessons learned, notable successes, and ongoing needs of the counties to inform future state investments.

(2) The technical assistance center shall provide planning and implementation grants to counties, municipalities, and appropriate state agencies for direct funding to support implementation of the initiatives in such jurisdiction. Such grants may be used to support a subset of counties or any municipality that has 25,000 parcels or more of real property within the municipality, for data capacity, for designating a coordinated position to coordinate work, or for other purposes to further the objectives of the initiatives. Grant recipients shall be required to report data on key metrics and interim progress measures to the center.

(3) The department shall contract with an outside entity to obtain the expertise of nationally recognized experts, provide staff support, and manage the center's operations.

37-1-8.

(a) It is the intent of the General Assembly that this state implement a network of local co-response teams to increase access to pre-arrest diversion and improve connection to community based services for individuals with behavioral health conditions who come into contact with law enforcement.

(b) Such co-response teams shall be composed of at least one peace officer and one trained behavioral health professional, such as a social worker, psychiatric nurse, psychologist, peer specialist, or other appropriate behavioral health professional. To the extent practicable and when appropriate, co-response teams shall utilize culturally and linguistically capable personnel or materials to assist in such interactions. Such co-response teams shall respond to 9-1-1 emergency and other calls for service or law enforcement interactions involving a person in behavioral health crisis. As appropriate, a co-response team may refer an individual to community based treatment or supports or

transport the individual to receive emergency behavioral health care in lieu of issuing an arrest.

(c) The state shall implement a minimum of three to five teams in geographically diverse local jurisdictions, including a mix of rural, suburban, and urban jurisdictions, with the goal of implementing additional teams across the state pending the successful operation of the initial teams for one year. Such program shall be administered by the department and shall include cultural sensitivity training for co-response teams.

(d)(1) The Mental Health Courts and Corrections Subcommittee of the Georgia Behavioral Health Reform and Innovation Commission, in consultation with relevant law enforcement and behavioral health experts, shall be authorized to submit recommendations to the department regarding the development of the initial program and future expansions of the program relative to areas such as:

(A) Standards for initial and ongoing training;

(B) Metrics and data collection procedures for co-response teams in order to evaluate and improve the operations of co-response teams across the state; and

(C) Strategies to improve connections to community based care.

(2) This subsection shall stand repealed by operation of law on June 30, 2025.″

SECTION 4-5.

Said title is further amended by adding a new Code section to Article 6 of Chapter 1, relating to the Behavioral Health Reform and Innovation Commission, to read as follows:

″37-1-115.1.

The Mental Health Courts and Corrections Subcommittee of the Georgia Behavioral Health Reform and Innovation Commission shall continue its exploration of community supervision strategies for individuals with mental illnesses, including:

(1) Exploring opportunities to expand access to mental health specialized caseloads to reach a larger share of the supervision population with mental health needs, including prioritizing equitable access to specialized caseloads;

(2) Assessing the quality of mental health supervision and adherence to evidence based standards to determine how mental health supervision could be improved and identifying services, supports, and training that could equip law enforcement officers to more successfully engage with and reduce recidivism for individuals on community supervision;

(3) Developing new approaches for law enforcement officers to utilize nonarrest and noncustodial responses to technical violations for individuals with mental health needs, as such individuals appear no more likely than others to commit additional crimes or violent crimes while on supervision;

(4) Assessing the availability of mental health treatment providers by supervision region to estimate accessability to treatment across the state; and

(5) Tracking qualitative and quantitative metrics on the outcomes of any changes made to community supervision strategies for individuals with mental illness to determine the effectiveness of such strategies.″

SECTION 4-6.

Said title is further amended by revising Code Section 37-2-4, relating to the Behavioral Health Coordinating Council, membership, meetings, and obligations, as follows:

″37-2-4.

(a) There is created the Behavioral Health Coordinating Council. The council shall consist of the commissioner of behavioral health and developmental disabilities; the commissioner of early care and learning; the commissioner of community health; the commissioner of public health; the commissioner of human services; the commissioner of juvenile justice; the commissioner of corrections; the commissioner of community supervision; the

commissioner of community affairs; the commissioner of the Technical College System of Georgia; the Commissioner of Labor; the State School Superintendent; the chairperson of the State Board of Pardons and Paroles; a behavioral health expert employed by the University System of Georgia, designated by the chancellor of the university system; two members, appointed by the Governor; the ombudsman appointed pursuant to Code Section 37-2-32; the Child Advocate for the Protection of Children; an expert on infant and early childhood mental health, appointed by the Governor; an expert on child and adolescent health, appointed by the Governor; a pediatrician, appointed by the Governor; an adult consumer of public behavioral health services, appointed by the Governor; a family member of a consumer of public behavioral health services, appointed by the Governor; a parent of a child receiving public behavioral health services, appointed by the Governor; a member of the House of Representatives, appointed by the Speaker of the House of Representatives; and a member of the Senate, appointed by the Lieutenant Governor.

(b) The commissioner of behavioral health and developmental disabilities shall be the chairperson of the council. A vice chairperson and a secretary shall be selected by the members of the council from among its members as prescribed in the council's bylaws.

(c) Meetings of the council shall be held quarterly, or more frequently, on the call of the chairperson. Meetings of the council shall be held with no less than five days' public notice for regular meetings and with such notice as the bylaws may prescribe for special meetings. Each member shall be given written or electronic notice of all meetings. All meetings of the council shall be subject to the provisions of Chapter 14 of Title 50. Minutes or transcripts shall be kept of all meetings of the council and shall include a record of the votes of each member, specifying the yea or nay vote or absence of each member, on all questions and matters coming before the council, and minutes or transcripts of each meeting shall be posted on the state agency website of each council member designee. No member may abstain from a vote other than for reasons constituting disqualification to the satisfaction of a majority of a quorum of the council on a recorded vote. No member of the

council shall be represented by a delegate or agent. Any member who misses three duly posted meetings of the council over the course of a calendar year shall be replaced by an appointee of the Governor unless the council chairperson officially excuses each such absence.

(d) Except as otherwise provided in this Code section, a majority of the members of the council then in office shall constitute a quorum for the transaction of business. No vacancy on the council shall impair the right of the quorum to exercise the powers and perform the duties of the council. The vote of a majority of the members of the council present at the time of the vote, if a quorum is present at such time, shall be the act of the council unless the vote of a greater number is required by law or by the bylaws of the council.

(e) The council shall:

(1) Develop solutions to the systemic barriers or problems to the delivery of behavioral health services by making recommendations in writing and publicly available that implement funding, policy changes, practice changes, and evaluation of specific goals designed to improve ~~services delivery and~~ delivery of behavioral health services, increase access to behavioral health services, and improve outcome for individuals, including infants, children, adolescents, and adults, served by the various departments;

(2) Focus on specific goals designed to resolve issues for provision of behavioral health services that negatively impact individuals, including infants, children, adolescents, and adults, serviced by ~~at least two~~ the various departments;

(3) Monitor and evaluate the implementation of established goals and recommendations; and

(4) Establish common outcome measures that are to be utilized for and represented in the annual report to the council.

(f)(1) The council ~~may~~ shall consult with various entities, including state agencies, councils, and advisory committees and other advisory groups as deemed appropriate by the council.

(2) All state departments, agencies, boards, bureaus, commissions, and authorities are authorized and required to make available to the council access to records or data which are available in electronic format or, if electronic format is unavailable, in whatever format is available. The judicial and legislative branches are authorized to likewise provide such access to the council.

(g) The council shall be attached to the Department of Behavioral Health and Developmental Disabilities for administrative purposes only as provided by Code Section 50-4-3.

(h)(1) The council shall submit annual reports no later than October 1 of its recommendations and evaluation of its implementation and any recommendations for funding to the Office of Health Strategy and Coordination, the Governor, the Speaker of the House of Representatives, and the Lieutenant Governor.

(2) The recommendations developed by the council and the annual reports of the council shall be presented to the board of each member department for approval or review at least annually at a publicly scheduled meeting.

(i) For purposes of this Code section, the term 'behavioral health services' has the same meaning as 'disability services' as defined in Code Section 37-1-1.″

PART V

Child and Adolescent Behavioral Health

SECTION 5-1.

Title 37 of the Official Code of Georgia Annotated, relating to mental health, is amended by revising Code Section 37-1-20, relating to obligations of the Department of Behavioral Health and Developmental Disabilities, as follows:

″37-1-20.

The department shall:

(1) Establish, administer, and supervise the state programs for mental health, developmental disabilities, and addictive diseases;

(2) Direct, supervise, and control the medical and physical care and treatment; recovery; and social, employment, housing, and community supports and services based on single or co-occurring diagnoses provided by the institutions, contractors, and programs under its control, management, or supervision;

(3) Plan for and implement the coordination of mental health, developmental disability, and addictive disease services with physical health services, and the prevention of any of these diseases or conditions, and develop and promulgate rules and regulations to require that all health services be coordinated and that the public and private providers of any of these services that receive state support notify other providers of services to the same patients of the conditions, treatment, and medication regimens each provider is prescribing and delivering;

(4) Ensure that providers of mental health, developmental disability, or addictive disease services coordinate with providers of primary and specialty health care so that treatment of conditions of the brain and the body can be integrated to promote recovery, health, and well-being;

(5) Have authority to contract, including performance based contracts which may include financial incentives or consequences based on the results achieved by a contractor as measured by output, quality, or outcome measures, for services with community service boards, private agencies, and other public entities for the provision of services within a service area so as to provide an adequate array of services and choice of providers for consumers and to comply with the applicable federal laws and rules and regulations related to public or private hospitals; hospital authorities; medical schools and training and educational institutions; departments and agencies of this state; county or municipal governments; any person, partnership, corporation, or association, whether public or private; and the United States government or the government of any other state;

(6) Establish and support programs for the training of professional and technical personnel as well as regional advisory councils and community service boards;

(7) Have authority to conduct research into the causes and treatment of disability and into the means of effectively promoting mental health and addictive disease recovery;

(8) Assign specific responsibility to one or more units of the department for the development of a disability prevention program. The objectives of such program shall include, but are not limited to, monitoring of completed and ongoing research related to the prevention of disability, implementation of programs known to be preventive, and testing, where practical, of those measures having a substantive potential for the prevention of disability;

(9) Establish a system for local administration of mental health, developmental disability, and addictive disease services in institutions and in the community;

(10) Make and administer budget allocations to fund the operation of mental health, developmental disabilities, and addictive diseases facilities and programs;

(11) Coordinate in consultation with providers, professionals, and other experts the development of appropriate outcome measures for client centered service delivery systems;

(12) Establish, operate, supervise, and staff programs and facilities for the treatment of disabilities throughout this state;

(13) Disseminate information about available services and the facilities through which such services may be obtained;

(14) Supervise the local office's exercise of its responsibility concerning funding and delivery of disability services;

(15) Supervise the local offices concerning the administration of grants, gifts, moneys, and donations for purposes pertaining to mental health, developmental disabilities, and addictive diseases;

(16) Supervise the administration of contracts with any hospital, community service board, or any public or private providers without regard to regional or state boundaries for the provision of disability services and in making and entering into all contracts necessary or incidental to the performance of the duties and functions of the department and the local offices;

(17) Regulate the delivery of care, including behavioral interventions and medication administration by licensed staff, or certified staff as determined by the department, within residential settings serving only persons who are receiving services authorized or financed, in whole or in part, by the department;

(18) Classify host homes for persons whose services are financially supported, in whole or in part, by funds authorized through the department. As used in this Code section, the term 'host home' means a private residence in a residential area in which the occupant owner or lessee provides housing and provides or arranges for the provision of food, one or more personal services, supports, care, or treatment exclusively for one or two persons who are not related to the occupant owner or lessee by blood or marriage. A host home shall be occupied by the owner or lessee, who shall not be an employee of the same community provider which provides the host home services by contract with the department. The department shall approve and enter into agreements with community providers which, in turn, contract with host homes. The occupant owner or lessee shall not be the guardian of any person served or of their property nor the agent in such person's advance directive for health care. The placement determination for each person placed in a host home shall be made according to such person's choice as well as the individual needs of such person in accordance with the requirements of Code Section 37-3-162, 37-4-122, or 37-7-162, as applicable to such person;

(19) Provide guidelines for and oversight of host homes, which may include, but not be limited to, criteria to become a host home, requirements relating to physical plants and supports, placement procedures, and ongoing oversight requirements;

(20) Supervise the regular visitation of disability services facilities and programs in order to assure contracted providers are licensed and accredited by the designated agencies prescribed by the department, and in order to evaluate the effectiveness and appropriateness of the services, as such services relate to the health, safety, and welfare of service recipients, and to provide technical assistance to programs in delivering services;

(21) Establish a unit of the department which shall receive and consider complaints from individuals receiving services, make recommendations to the commissioner regarding such complaints, and ensure that the rights of individuals receiving services are fully protected. No later than October 1, 2023, and annually thereafter, such unit shall provide to the Office of Health Strategy and Coordination annual reports regarding such complaints;

(22) With respect to housing opportunities for persons with mental illness and co-occurring disorders:

(A) Coordinate the department's programs and services with other state agencies and housing providers;

(B) Facilitate partnerships with local communities;

(C) Educate the public on the need for supportive housing;

(D) Collect information on the need for supportive housing and monitor the benefit of such housing; ~~and~~

(E) Identify and determine best practices for the provision of services connected to housing; and

(F) No later than October 1, 2023, and annually thereafter, provide to the Office of Health Strategy and Coordination an annual status report regarding successful housing placements and unmet housing needs for the previous year and anticipated housing needs for the upcoming year;

(23) Exercise all powers and duties provided for in this title or which may be deemed necessary to effectuate the purposes of this title;

(24) Assign specific responsibility to one or more units of the department for the development of programs designed to serve disabled infants, children, and youth. ~~To the extent practicable, such~~ Such units shall cooperate with the Georgia Department of Education, ~~and~~ the University System of Georgia, the Technical College System of Georgia, the Department of Juvenile Justice, the Department of Early Care and Learning, the Department of Public Health, and community service boards in developing such programs. No later than October 1, 2023, and annually thereafter, such department shall provide to the Office of Health Strategy and Coordination annual reports regarding such programs;

(25) Have the right to designate private institutions as state institutions; to contract with such private institutions for such activities, in carrying out this title, as the department may deem necessary from time to time; and to exercise such supervision and cooperation in the operation of such designated private institutions as the department may deem necessary;

(26) Establish policies and procedures governing fiscal standards and practices of community service boards and their respective governing boards and no later than October 1, 2023, and annually thereafter, provide to the Office of Health Strategy and Coordination annual reports regarding the performance and fiscal status of each community service board; and

(27) Coordinate the establishment and operation of a data base and network to serve as a comprehensive management information system for behavioral health, addictive diseases, and disability services and programs."

SECTION 5-2.

Said title is further amended by revising subsection (a) of Code Section 37-2-6, relating to community service board creation, membership, participation of counties, transfer of powers and duties, alternate method of establishment, bylaws, and reprisals prohibited, as follows:

"(a) Community service boards in existence on June 30, 2014, are re-created effective July 1, 2014, to provide mental health, developmental disabilities, and addictive diseases services to children and adults. Such community service boards may enroll and contract with the department, the Department of Human Services, the Department of Public Health, or the Department of Community Health to become a provider of mental health, developmental disabilities, and addictive diseases services or health, recovery, housing, or other supportive services for children and adults. Such boards shall be considered public agencies. Each community service board shall be a public corporation and an instrumentality of the state; provided, however, that the liabilities, debts, and obligations of a community service board shall not constitute liabilities, debts, or obligations of the state or any county or municipal corporation and neither the state nor any county or municipal corporation shall be liable for any liability, debt, or obligation of a community service board. Each community service board re-created pursuant to this Code section is created for nonprofit and public purposes to exercise essential governmental functions. The re-creation of community service boards pursuant to this Code section shall not alter the provisions of Code Section 37-2-6.2 which shall apply to those re-created community service boards and their employees covered by that Code section and those employees' rights are retained."

SECTION 5-3.

Title 49 of the Official Code of Georgia Annotated, relating to social services, is amended in Article 7 of Chapter 4, relating to medical assistance generally, by adding a new Code section to read as follows:

"49-4-159.2.

(a) The department shall convene a task force composed of care management organizations, pediatric primary care physicians, family medicine physicians, a representative of a pediatric hospital, pharmacy benefits managers, other insurers, an expert on infant and early childhood mental health, and pediatric mental health and substance use disorder care professionals.

(b) The task force shall examine:

(1) How to provide training and support for multidisciplinary staff in neonatal intensive care units and nursery units to implement and sustain developmentally supportive and evidence based practices and interventions that enhance caregiver/infant attachment;

(2) Expanding postpartum Medicaid coverage from six months to 12 months;

(3) How to address Medicaid coverage and billing codes to provide behavioral health services for children from birth to age four;

(4) How to develop and implement a mechanism for Georgia's managed care program for children, youth, and young adults in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system to work directly with the foster caregivers, parents and relatives or kinship caregivers, and prospective adoptive caregivers to meet the mental and behavioral health needs of infants, children, and adolescents;

(5) How to develop and implement a mechanism for Georgia's managed care program for infants, children, youth, and young adults in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system to work directly with the parents and relative/kin caregivers and adoptive caregivers to meet the mental and behavioral health needs of infants, children, and adolescents for the first 12 months post-discharge from foster care; and

(6) How to develop and implement a mechanism to provide adoptive caregivers with the support necessary to meet the mental and behavioral health needs of infants, children, and adolescents for the first 12 months after finalization of adoption.

(c) The examination conducted pursuant to subsection (b) of this Code section shall include:

(1) Identification of best practices, potential cost savings, decreased administrative burdens, increased transparency regarding prescription drug costs, and impact on turnover on the mental health and substance use disorder professionals workforce; and

(2) Evaluation of best practices for community mental health and substance use disorder services reimbursement, including payment structures and rates that cover the cost of service provision for outpatient care, high-fidelity wraparound services, and therapeutic foster care homes, within the bounds of federal regulatory guidance."

SECTION 5-4.

Said title is further amended by revising subsection (b) of Code Section 49-5-24, relating to interagency efforts to gather and share comprehensive data, legislative findings, state-wide system for sharing data regarding care and protection of children, interagency data protocol; interagency agreements, and waivers from certain federal regulations, as follows:

"(b) No later than October 1, 2024, the ~~The~~ department, working with the following agencies, shall develop and implement a workable state-wide system for sharing data relating to the care and protection of children between such agencies, utilizing existing state-wide data bases and data delivery systems to the greatest extent possible, to streamline access to such data:

(1) Division of Family and Children Services of the department;

(2) Department of Early Care and Learning;

(3) Department of Community Health;

(4) Department of Public Health;

(5) Department of Behavioral Health and Developmental Disabilities;

(6) Department of Juvenile Justice;

(7) Department of Education; and

(8) Georgia Crime Information Center."

SECTION 5-5.

Said title is further amended in Article 10 of Chapter 5, relating to children and adolescents with severe emotional problems, by revising Code Section 49-5-222, relating to guiding principles for coordinated system of care, as follows:

"49-5-222.

(a) The following ideals shall be the guiding principles for the coordinated system of care:

(1) Services shall be child and family centered and give priority to keeping children with their families. Families shall be fully involved in all aspects of planning and delivery of services; however, no family shall be required to accept services for any family member;

(2) Services shall be community based, with decision-making responsibility and management at the community level;

(3) Services shall be comprehensive, addressing the child's physical, educational, social, and emotional needs;

(4) Agency resources and services shall be shared and coordinated with written interagency agreements detailing linkages;

(5) Services shall be provided in the least restrictive setting consistent with effective services and as close to the child's home as appropriate;

(6) Services shall address the unique needs and potential of each child and shall be sufficiently flexible to meet the individual needs of the child and family;

(7) Services shall promote early identification and intervention;

(8) Services shall be culturally and ethnically sensitive;

(9) All legal rights of these children shall be protected; and

(10) The parent or guardian shall be involved in the development of the individualized plan and the delivery of services as defined by the individualized plan.

(b) The Multi-Agency Treatment for Children (MATCH) team is established within the department. The state MATCH team shall be composed of representatives from the Division of Family and Children Services of the department; the Department of Juvenile Justice; the Department of Early Care and Learning; the Department of Public Health; the Department of Community Health; the department; the Department of Behavioral Health and Developmental Disabilities; the Department of Education; the Office of the Child Advocate, and the Department of Corrections. The chairperson of the Behavioral Health Coordinating Council or his or her designee shall serve as the chairperson of the state MATCH team. The state MATCH team shall facilitate collaboration across state agencies to explore resources and solutions for complex and unmet treatment needs for children in this state and to provide for solutions, including both public and private providers, as necessary. The state MATCH team will accept referrals from local interagency children's committees throughout Georgia for children with complex treatment needs not met through the resources of their local community and custodians. The state agencies and entities represented on the state MATCH team shall coordinate with each other and take all reasonable steps necessary to provide for collaboration and coordination to facilitate the purpose of the state MATCH team."

PART VI

Behavioral Health Reform and Innovation Commission

SECTION 6-1.

Chapter 2 of Title 31 of the Official Code of Georgia Annotated, relating to the Department of Community Health, is amended by adding new Code sections to read as follows:

"31-2-17.

(a) The department shall undertake a study of the following:

(1) Comparison of reimbursement rates for mental health services under Medicaid, PeachCare for Kids, and the state health benefit plan with other states;

(2) Reimbursement for health care providers providing mental health care services under Medicaid, PeachCare for Kids, and the state health benefit plan and comparison with other states;

(3) Reimbursement for hospitals caring for uninsured patients with mental health and substance abuse disorders in the emergency department for extended periods of time while the patient is waiting on placement and transfer to a behavioral health facility for evaluation and treatment; and

(4) An accurate accounting of mental health fund distribution across state agencies, including, but not limited to, the department, the Department of Behavioral Health and Developmental Disabilities, the Department of Human Services, and the Department of Juvenile Justice.

(b) The department shall complete such study and submit its findings and recommendations to the Governor, General Assembly, the Office of Health Strategy and Coordination, and the Behavioral Health Reform and Innovation Commission no later than December 31, 2022.

(c) This Code section shall stand repealed in its entirety by operation of law on December 31, 2022."

SECTION 6-2.

Title 37 of the Official Code of Georgia Annotated, relating to mental health, is amended by revising Code Section 37-1-116, relating to abolishment and termination of the Behavioral Health Reform and Innovation Commission, as follows:

"37-1-116.

The commission shall be abolished and this article shall stand repealed on June 30, ~~2023~~ 2025."

SECTION 6-3.

Part 3 of Article 4 of Chapter 12 of Title 45 of the Official Code of Georgia Annotated, relating to the Georgia Data Analytic Center, is amended by adding a new Code section to read as follows:

"45-12-154.1.

The administrator of the GDAC Project shall prepare an annual unified report regarding complaints filed for suspected violations of mental health parity laws. Such annual unified report shall comprise data received from the Department of Insurance pursuant to subsection (f) of Code Section 33-1-27 and data received from the Department of Community Health pursuant to subsection (f) of Code Section 33-21A-13. Such annual unified report shall be completed and made publicly available beginning April 1, 2024, and annually thereafter."

SECTION 6-4.

Title 49 of the Official Code of Georgia Annotated, relating to social services, is amended in Article 7 of Chapter 4, relating to medical assistance generally, by adding new Code sections to read as follows:

"49-4-152.6.

(a) The department shall ensure that Medicaid and PeachCare for Kids provide for same-day reimbursement for a patient who sees more than one health care provider in one day, including receiving mental health care services after a primary care visit.

(b) If necessary to implement the provisions of this Code section, the department shall submit a Medicaid state plan amendment or waiver request to the United States Department of Health and Human Services.

49-4-152.7.

(a) The department shall provide Medicaid coverage for any prescription drug prescribed to an adult patient and determined by a duly licensed practitioner in this state to be medically necessary for the treatment and prevention of schizophrenia and schizotypal or delusion disorders if:

(1) During the preceding year, the patient was prescribed and unsuccessfully treated with a preferred or generic drug; or

(2) The patient has previously been prescribed and obtained prior approval for the nonpreferred prescribed drug.

(b) If necessary to implement the provisions of this Code section, the department shall submit a Medicaid state plan amendment or waiver request to the United States Department of Health and Human Services."

PART VII

Repealer

SECTION 7-1.

All laws and parts of laws in conflict with this Act are repealed.