The General Assembly

Atlanta, Georgia 30334

FINAL REPORT

OF THE

JOINT MENTAL HEALTH, MENTAL RETARDATION,

SUBSTANCE ABUSE SERVICE DELIVERY STUDY COMMITTEE

SENATE MEMBERS:

Madden of 47th, Co-Chair

Burton of 5th, Hecht of 34th, Meyer Von Bremen of 12th,

Smith of 25th, Stokes of 43rd

HOUSE MEMBERS:

Childers of 13th, Co-Chair

Epps of 131st, Hudson of 120th, Manning of 32nd, Martin of 47th

1999

Prepared by the

Senate Research Office

TABLE OF CONTENTS

I INTRODUCTION

A. Charge of the Committee

The Joint Study Committee on Mental Health, Mental Retardation and Substance Abuse was created by Senate Resolution 116 during the 1999 Session of the Georgia General Assembly. The Committee was charged with conducting a study on the status of the reorganization of the delivery of mental health, mental retardation and substance abuse services to make the delivery of such services more responsive to the needs of consumers and their families. Furthermore, the Committee was charged with investigating the effectiveness of the regional boards and the community service boards in meeting the requirements established by House Bill 100 during the 1993 Session of the Georgia General Assembly.

The resolution provided that the Lieutenant Governor and the Speaker of the House appoint the Committee=s co-chairmen and members. The Lieutenant Governor appointed Senator Eddie Madden and the Speaker of the House appointed Representative E.M. (Buddy) Childers as the Co-Chairmen. The Senators serving on the Committee are as follows: Senator Joe Burton, Senator Greg Hecht, Senator Michael Meyer Von Bremen, Senator Faye Smith, and Senator Connie Stokes. The Representatives serving on the Committee are as follows: Representative Carl Von Epps, Representative Sistie Hudson, Representative Judy Manning, and Representative Jim Martin. The legislative staff members assigned to the Committee include: Charlotte Peters, legislative assistant to Senator Eddie Madden; Dodie Lawton, Office of Senate Research; Eden Fesshazion, Office of Senate Research; Phyllis Mitchell, Office of House Research; and Doug Carlyle, Office of Legislative Counsel.

The Committee held nine public meetings on the following dates in the following Georgia cities: September 2, 1999, in Atlanta; September 8, 1999, in Lawrenceville; September 23, 1999, in Macon; October 13, 1999, in Augusta; October 21, 1999, in Brunswick; October 28, 1999, in Rome; November 3, in Albany; November 10, 1999, in Athens; and November 16, 1999, in Atlanta.

B. Background: The Current State of MH/MR/SA Service Delivery System in Georgia

The state of the Mental Health, Mental Retardation and Substance Abuse (MH/MR/SA) Service Delivery System in Georgia underwent a dramatic reorganization due to the enactment of House Bill 100. The authority created by the legislation significantly changed the delivery of MH/MR/SA services in Georgia. This law, which created a new regional system, transferred the authority of these services from the county boards of health to the newly created regional boards and community service boards (CSBs).

The state works through the Department of Human Resources (DHR), the Division of Mental Health, Mental Retardation, and Substance Abuse (DMH/MR/SA), and Regional MH/MR/SA Boards to deliver its obligations and duties for MH/MR/SA services. The executive director of each Regional Board is appointed by the director of DHR=s MH/MR/SA Division and approved by the Regional Board. Most importantly, at least half of the regional board members are consumers and family members. The community service boards, which are successor boards to the lead county boards of health governing MH/MR/SA programs, are now the primary contractors used by DHR to provide community based services.

Currently, there are 13 regional boards , 28 community service boards, and 10 county board of health operated community programs located throughout the state. The 13 regional boards

are responsible for planning, contracting, budgeting, and overseeing that needed services are provided in response to the needs of the community. The community service boards, under contracts with the regional boards, are the principal providers of MH/MR/SA services at the community level throughout Georgia. The community service boards, in turn, deliver services through a variety of partnership arrangements within the community.[1]

On July 1, 1994, 28 community service boards succeeded county boards of health in the governance of public MH/MR/SA services. Ten individual programs, mostly mental retardation service centers, continue to operate under the governance of county boards of health.

On July 1, 1995, the new regional boards assumed the responsibility for planning, coordinating and contracting for all hospital and community services for MH/MR/SA services, in addition to administering over $300,000,000 in state and federal funds. By 1999, this figure had grown to almost $700,000,000. The number of persons served by community service boards for Fiscal Year 1998 was 165,867.[2] Of those served, 69 percent received mental health services, 7 percent received mental retardation services, and 24 percent received substance abuse services.[3] The total amount of funds used by community service boards for FY 1998 was $481,532,106.[4] Of that amount, 51 percent was allocated from DHR, 28 percent was allocated from Medicaid, and 21 percent was allocated from other funding sources. [5]

II The Current Status of the Mental Health, Mental Retardation, and Substance Abuse Delivery System in Georgia

1. Committee Observations: Major Problem Areas of the Mental Health, Mental Retardation, and Substance Abuse Delivery System in Georgia

1. Cuts in Medicaid Outpatient Clinic Funding

During the course of public hearings held throughout the state, the Committee heard testimony that emphasized the need for the state to restore the $12,000,000 reduction in Medicaid reimbursement rates made in FY 2000. This reduction in funding was to reflect the implementation of service utilization controls; however, the testimony given stated that this reduction will lead to the loss of jobs and a reduction in services provided.

The total funding for the 28 CSBs and 10 county boards of health for community MH/MR/SA programs in FY 1999 was $109,000,000. A $12,000,000 reduction in FY 2000 left a budget of $97,000,000.[6] Currently, indications lead to the actualization of these reductions in Medicaid receipts for FY 2000 to be $27,000,000.[7]

---

[1] AStudy Committee on the Structure and Function of Community Service Boards,@ 1998 Final Report, page 4.

[2] 1999 Data from the Department of Audits and Accounts, Audit Report of the Community Based MHMRSA Programs, page 13.

[3] 1999 Data from the Department of Audits and Accounts, Audit Report of the Community Based MHMRSA Programs, page 13.

[4] 1999 Data from the Department of Audits and Accounts, Audit Report of the Community Based MHMRSA Programs, page 7.

[5] 1999 Data from the Department of Audits and Accounts, Audit Report of the Community Based MHMRSA Programs, page 7.

[6] 1999 Georgia Budget Report

[7] Georgia Medicaid Outpatient Clinic Option.

The 1999 State Auditors Report indicates that, AMedicaid consumers received significantly more services than non-Medicaid consumers with the same diagnoses. These unallowable claims represented $1,079,229.15 in Medicaid payments to the nine providers that were subjected to the audit. Additionally, there were numerous instances in which the services billed exceed the maximum services authorized on recipients= Individual Service Plans (ISPs).@

Despite the aforementioned findings of the State Auditors Report, the Committee finds that the reduction in Medicaid reimbursement rates has led to the closing of MH/MR/SA service delivery facilities leaving many consumers with no alternatives or transportation for care. The full effect of utilization management has not been fully realized.

2. Lack of Uniform Administrative Reporting Policies and Guidelines

The Committee finds that there is no uniform administrative reporting policy guidelines administered or controlled by DHR to either the community service boards or regional boards. The Committee is concerned with high administrative salaries and costs. Administrative expenses are highly variable. The testimony provided to the Committee from various boards all over the state cited administrative expenses ranging from 4.82 percent within the Haralson County Board of Health=s budget to 16.94 percent within the Fulton County Community Service Board=s budget.

The amount of case loads associated with the variation in administrative expenses is noteworthy. For example, Region 5, Fulton County reports 19,988 clients served in 1998, whereas Region 6, DeKalb County reports 9,049 clients served in 1998.[8] Corresponding administrative costs are $3,958,499 for Fulton County and $3,082,397 for DeKalb County.[9] Without uniform administrative policies and guidelines, it is impossible to determine if differences like these in administrative costs are due to efficiencies in better run systems or simply different reporting policies.

The Committee heard testimony at the Brunswick hearing that raised concerns about excessive rental costs. For example, the annual rental expenditure for Tidelands CSB is $700,000 with an inflation clause in their contract to provide for $900,000 by the year 2004. Whereas Gateway CSB maintains an annual rental expenditure of $118,000. Such variation seems excessive given the fact that the DHR Provider Manual used as part of the contract between the regional boards and the community service boards contains explicit guidelines for payment of rent requirements and requirements for the provision of comparable rent statements to support the renting of any property by the CSBs. Therefore, the Committee is concerned about the uniform application of these policies and procedures by the regional boards.

3. Clarification of the Role of Regional and Community Service Boards and Duplication of Services

The nature and role of a community service board is unclear due to the need for statutory clarification of their relationship between both the regional boards and DHR. Community service boards are essentially a quasi-state entity with the authority to utilize public funds. They are defined under O.C.G.A ' 37-2-6.1(d) as:

> *(d) Each community service board exists for nonprofit and public purposes, and it is found and declared that the carrying out of the purposes of each community service board is exclusively for public benefit and its property is public property. Thus, no community service board shall be required to pay any state or local ad valorem,*

[8] Office of Planning and Budget, DHR

[9] Office of Planning and Budget, DHR

sales, use, or income taxes.

Further clarification of the role of a community service board may be dependent upon statutory clarification of the current language in Code Section O.C.G.A. ' 37-2-6 which reads as follows:

> *(a) There shall be created community mental health, mental retardation, and substance abuse service boards, in conformity with the areas established pursuant to the subsection (b) of Code Section 37-2-3, which shall govern publicly funded programs for the purpose of providing certain disability services not provided by other public or private providers under contract with the regional board. The programs shall be governed by the community service boards, which shall be established as public agencies.*

Public agencies in Georgia, other than planning entities, are either aligned with the state or a county, or operate as public corporations. This is not the case with community service boards, and the ensuing ambiguity generates uncertainty regarding the exact nature of their authority and rights.[10]

Duplication of services is undoubtedly a hindrance to people who need costly MH/MR/SA services. An example of the duplication of services that has led to an increase in state expenditures is in regards to inmates in the custody of the Georgia Department of Corrections who have excellent medical records. State funded providers will not consistently accept these medical records for eligibility purposes of released offenders, and therefore costs are unnecessarily increased to provide for documentation that already exists.[11]

Secondly, while DHR appears to have a template contract to guide regional boards, testimony indicated that several contracts between boards and providers were often created by executive directors or other personnel without sufficient legal or provider experience to ensure accountability.

4. Fiscal and Programmatic Accountability

There needs to be more Ahands onA oversight of the community service boards by the state to assure programmatic and fiscal accountability. The MH/MR/SA delivery system needs a strong system of accountability and oversight to ensure that the needs of the community are being met. Accountability must be a priority. By law, the regional boards and the MH/MR/SA Division are accountable for these services; however, there have been significant system failures that have proven otherwise. It is estimated that cumulatively, $500,000,000 is spent each year on implementing

programs, but they still lack proper accountability standards.

Some facilities have recently begun to implement various outcome measurement systems, but the implications of their impact has yet to be determined. The Department of Human Resources has developed a two year plan entitled *Seeking Results and Accountability*, outlined to accomplish improved services, organization, and management.

---

[10] AStudy Committee on the Structure and Function of Community Service Boards,@ 1998, page 11.

[11] Letter to Joint MH/MR/SA Service Delivery Study Committee from State Board of Pardons and Paroles, November 29, 1999.

In February 1999, the State Department of Audits and Accounts released their audit on Community Based MH/MR/SA programs. The audit assessed the quality of care and operations and accountability of community service boards.

Another point of concern is that there is a real lack of uniformity among the community service boards in their roles of implementing individual programs of performance measurement outcomes.

5. Appointment Processes of Regional and Community Service Board Members

The Committee found that there were several instances of conflict of interest in the board appointment process. In one case, Dr. Ricci testified in Macon that there was a conflict of interest between a board member and the spouse of a private provider. The requirements of House Bill 100 establish that the boards be representative of their respective communities. Most boards are composed of more than 50 percent consumers or immediate family members of consumers. Board members who are not consumers or representatives of their immediate family and are appointed by county governments need more input. They need to be educated and partake in the decision making process and trained in a beneficial manner to serve the needs of the community.

6. The Need for a MH/MR/SA Ombudsman Program

During public testimony, the committee realized the need for a MH/MR/SA Ombudsman Program. Currently, 18 states have some type of mental health specific Ombudsman Program. The development and implementation of a MH/MR/SA specific Ombudsman Program would place special consideration on the needs of mental health consumers, particularly those in the public sector. Programs of this nature ideally, are in tune to the unique challenges faced by individuals with MH/MR/SA service needs.

The four key responsibilities of a mental health ombudsman should be to educate consumers, provide individual assistance, collect and analyze data, and work with all stakeholders to improve the system. More specifically, it should:

- educate prospective enrollees about their options;
- educate current enrollees on their rights and responsibilities;
- provide assistance to customers who have problems navigating the mental health system;
- collect and analyze comprehensive information regarding the true scope of consumers= problems with access to quality services, as well as the health plan=s strengths and weaknesses in addressing those problems; and
- work with all components of the healthcare system.[12]

7. Qualifications of Personnel Delivering MH/MR/SA Services

Good training along with effective management are the keys to successful programs. Many group homes of MH/MR/SA consumers are staffed with people that in many instances are under-trained and under-paid. Consequently, they can not effectively and safely meet resident needs. An
example of this is the testimony that was presented to the Committee that the safety and health of diabetic residents is in jeopardy due to improper nutrition.

These homes are not properly maintained due to the lack of financial compensation

[12] AMental Health Ombudsman Programs: Working to Improve Mental Health Delivery Systems for Consumers,@ June 1999, page 2-4.

that the employees receive, and residents feel that the individuals hired to work in these homes do not have adequate training or the background in the delivery of MH/MR/SA services. The quality of service system shall be designed to provide the highest quality services utilizing flexibility in funds and incentives which reinforce quality and efficiency.

8. Conflict of Interest Between Regional Boards and Community Service Boards

The Committee found in some areas of the state a conflict of interest where members of a regional board had family members employed on community service boards in the same region.

B. Recommendations of the Committee

1. Restore the Medicaid Outpatient Clinic Option

The committee recommends that the $12,000,000 reduction in Medicaid reimbursement rates be restored to the MH/MR/SA Service Delivery System. The loss of these funds has jeopardized and in some cases eliminated the ability of consumers to receive services. Given that there will never be sufficient resources to meet the total demands of people with mental health needs, these public funds shall be allocated to ensure the needs of consumers who are most in need are met at the appropriate service levels.

Because Medicaid is the public sector=s safety net for the provision of mental health services, consumers and family members with MH/MR/SA treatment needs have a right to be meaningfully involved in the governance of these programs.[13] Georgia is ranked 46th nationally for developmental disabilities community spending, therefore, we need to maximize the utilization of federal dollars by increasing our state expenditures on MH/MR/SA services and in turn decreasing the waiting list.[14]

2. Establish Uniform Administrative Reporting Policies

The Committee recommends that standardized, uniform administrative reporting policies be established for community service boards and regional boards to prevent abuse and mismanagement of funds. The Department of Human Resources needs to establish and maintain these policies and procedures.

3. Clarify the Role and Structure of Regional and Community Service Boards

The Committee recommends the clarification of the role and structure of community service boards. Accountability has to be established at all levels of the delivery of care whether it be public or private.

Additionally, there is a need for DHR=s development of standardized contracts or standard contract considerations for regional boards to use with providers and in some instances CSBs could help cover certain problems. If there are standard requirements and form contracts for which provisions may be added, the Committee did not hear about these standardized contracts. Rates of pay, levels of education and experience for hands on care provided by employees could be issues that could be covered in each contract to ensure that better paid and qualified personnel are rendering care.

---

[13] 1998 NMHA Standards for Consumer-Centric Managed Mental Health and Substance Abuse Programs, page 18.

[14] 1998 5th Edition, The State of the State in Developmental Disabilities, page 49.

4. Appointment of a Deputy Commissioner by DHR

The Committee recommends a deputy commissioner within DHR to provide advocacy for the MH/MR/SA consumers of Georgia. Presently, there is no strong state leadership for MH/MR/SA consumers in Georgia. The committee feels that this individual needs to have leadership abilities with a strong community service background in the delivery of MH/MR/SA services.

5. Establish a MH/MR/SA Ombudsman Program

The Committee recommends the development of an ombudsman program for MH/MR/SA services. It is important that an ombudsman representative understands the unique challenges faced by mental health consumers and is equipped to provide the services that will most effectively enable an individual to obtain necessary services. Typically, low-income people with mental health needs are often those in the most need of assistance. Money devoted to this program would be very well spent.

In addition, all regional boards should have a policy of unannounced spot checks of providers and contractual provisions which allow for these unannounced spot checks. After each unannounced spot check is performed, a copy of the formal written report will be distributed to the provider, the regional board, and DHR.

6. Enactment of Penalties for Failures of Reporting Data

Penalties for failures by CSBs, regional boards and private providers to provide data for PERMES, DHR and DMA should be enacted. Often, the data required to be contributed by CSBs, Regional Boards, and other providers to determine whether appropriate care and efficient care is being administered is not being provided. Financial penalties or holding back of a certain portion of funding should be considered for CSBs, Regional Boards, and other providers who are not providing required and necessary information. At the same time, incentives for CSBs, Regional Boards, and other providers which exceed goals and such success can be quantified and verified, may be in order as well.

7. Formation of an Independent Complaint Board

The formation of an independent complaint board with confidentiality allowances and legislation to protect whistleblowers, improve reporting systems and penalize providers who retaliate against people who report abuse, a lack of proper care, and fiscal mismanagement is needed. Families

must be able to bring their concerns without fear of retribution or fear that a family member may be kicked out of a program as a result of reporting abuse, neglect or mismanagement of funds. An independent complaint board with confidentiality allowances for complaints and referral to the proposed ombudsman program or oversight organization may be part of the solution.

8. Emphasize the Need for Independent Living

The Committee recommends a much stronger emphasis on independent living goals to be incorporated in treatment plans. Presently, few treatment plans emphasize this need.

9. Specific Criteria for Board Members of Regional Boards and CSBs

A member serving on a regional board cannot have a member of their immediate family employed by a CSB. Immediate family member pertains to a mother, father, brother,

sister, husband, or wife.

10. Revisit and Analyze in 2001 the Implementation of These Recommendations

The Committee strongly urges that the implementation of these recommendations be revisited and analyzed in the year 2001.

C. Conclusion

With adequate MH/MR/SA services, it has been shown that clients of mental health services can lead productive lives and contribute to the communities in which they live. We know that if consumers get these services, the personal and civic benefits generally repay the expense. The quality of life for every Georgia citizen is enhanced given the opportunity to capitalize on their strengths.

The MH/MR/SA service system in Georgia is facing many challenges in the delivery of services. Several problematic administrative and financial hurdles pose difficulties in achieving the goals of moving toward an efficient and effective system.
The reform effort of House Bill 100 during the 1993 Session of the Georgia General Assembly has come under scrutiny due to these inefficiencies. The productive effort of the creation of the Joint MH/MR/SA Service Delivery Study Committee=s primary goal was to identify and recommend solutions to moving toward a more sound and cohesive system.

The regional and community service boards were created to deliver public services to those most in need. The internal administrative barriers preventing the delivery of these services have been identified, and the Committee=s recommendations should be met in order to rectify these systematic abuses. Restoring the Medicaid outpatient clinic funding; establishing uniform administrative reporting policies; clarifying the role and structure of regional and community service boards; appointing a deputy commissioner through DHR; establishing a MH/MR/SA Ombudsman Program; enactment of penalties for failure of reporting data; emphasizing the need for independent living; specify criteria for board members of regional boards and CSBs; and revisiting and analyzing in 2001 the implementation for these recommendations will assist the state in maximizing the state=s funding and accessibility for clients of MH/MR/SA services in Georgia.

The appendix of this report contains *Actions Taken by DHR as a Result of CSB Audit Report*. The Committee felt that these actions to date by the Department of Human Resources should be included in this report.

Respectfully Submitted,

Senator Eddie Madden District 47 Co-Chair	Representative Buddy Childers District 13 Co-Chair

Senator Joe Burton
District 5

Representative Carl Von Epps
District 131

Senator Greg Hecht
District 34

Representative Sistie Hudson
District 120

Senator Michael S. Meyer Von Bremen
District 12

Representative Judy Manning
District 32

Senator Faye Smith
District 25

Representative Jim Martin
District 47

Senator Connie Stokes
District 43