Georgia Department of Audits and Accounts
Performance Audit Division
Greg S. Griffin, State Auditor
Leslie McGuire, Director

Behavioral Health Providers and Practitioners

Requested Information on Duplicative Administrative Practices

Why we did this review

The House Appropriations Committee asked that we assess duplication faced by behavioral health care entities. Based on the request, we determined whether administrative requirements behavioral health care practitioners and providers must meet to work with Georgia Medicaid clients are duplicative and costly. We identified actions that could reduce duplication and cost to the entities and determined whether licensure requirements were outside norms.

About Behavioral Health Care in Georgia

Behavioral healthcare practitioners offer services in a clinical setting and include counselors, therapists, nurses, physicians, and psychologists. They must be board-licensed to practice.

Behavioral health care providers are individuals or groups working in settings such as clinics, Community Service Boards, or hospitals.

To serve Medicaid clients, providers and practitioners must be approved through multi-step processes overseen by the Department of Community Health (DCH) and the Department of Behavioral Health and Developmental Disabilities (DBHDD).

What we found

While the administrative requirements behavioral health care practitioners and providers must meet to serve Georgia's Medicaid population are not overly duplicative, we identified several areas for improvement. Practitioners generally face requirements similar to those in other states. Providers go through a lengthier process, and inefficiencies likely increase their perception of burden. It should be noted that agencies have taken steps to address some of the issues.

Providers face a long process to become approved to offer services to Georgia's Medicaid population.

To serve the Medicaid population, providers must enroll and be approved by the Department of Community Health (DCH). Those providing services to certain populations also have to enroll and be approved by the Department of Behavioral Health and Developmental Disabilities (DBHDD). Those offering DBHDD's core benefits package, which includes an array of services, must also be licensed by DCH's Health Facility Regulation Division (HFRD). The application process takes at least two to nine months.

Inefficiencies likely increase the providers' perception of a burdensome process, and while the agencies have taken steps to address some of these issues, additional action could be taken. For example, removing requirements that non-residential Drug Abuse Treatment and Education Programs (DATEP) be licensed through HFRD could shorten the process by approximately three months. Additionally, tracking application status through the process could help DCH identify other efficiencies.

Actions already taken include combining monitoring reviews to reduce the number of site visits providers undergo, creating provider groups to increase communication, and consolidating the provider credentialing process.

Providers and practitioners are subject to ongoing administrative costs associated with background checks.

Although a single background check is not costly, the duplication for renewals and multiple agency checks can become burdensome and costly. For example, providers that employ 15 practitioners serving populations from 3 agencies would have to pay approximately $2,340 for 45 background checks. Recent legislation and interagency cooperation helped mitigate the issue. Under "Rap Back" legislation, certain agencies can retain fingerprints with the Georgia Bureau of Investigation, which will continuously obtain criminal histories and notify agencies of results. Additionally, DBHDD recently began waiving its required background checks for individuals who receive federally mandated ones through DCH.

Administrative requirements to become a licensed behavioral health practitioner are reasonable.

Requirements and fees for initial licensure and renewal for the behavioral health care professions reviewed are comparable to those in other states. We reviewed requirements and fees for the six most common behavioral health professions that are subject to state level professional licensure: psychologists, physicians (including those with a psychiatry specialty), nurses, social workers, professional counselors, and marriage and family therapists. Licensure requirements include an application, official academic transcript, national qualifying exam scores, documentation of clinical hours and proof of citizenship and an application fee. Neither initial application nor renewal requirements were more stringent than those in other states. Additionally, the state has joined three interstate compacts that permit professionals in good standing with their home state licensing board to practice in the new state without completing additional steps. Finally, Georgia's fees do not exceed what one would pay in another state.

What we recommend

This report is intended to answer questions posed by the House Appropriations Committee and to help inform policy decisions. In addition to the information provided, we recommend that DCH revise the licensure requirements for non-residential DATEP facilities enrolled with DBHDD. Removing unnecessary requirements should shorten the licensing process. We also recommend that DCH collect and analyze application processing information to identify areas for improvement.

We recommend that DBHDD pursue methods to allow providers to electronically submit pre-qualification documents.

We recommend that the General Assembly consider opening the "Rap Back" legislation to other agencies, such as the Department of Juvenile Justice, that employ behavioral health care professionals. We also recommend the General Assembly consider revising the DATEP Act to allow non-residential facilities to forego HFRD licensure if they have enrolled with DBHDD.

See Appendix A for a detailed listing of recommendations.

Agency Response: DCH and DBHDD generally agreed with our recommendations. Specific responses are included at the end of each relevant finding.

Report Revision: *In January 2020, minor revisions were made to the number of states cited (page 4) and a statutory reference in Exhibit 5 (page 9). The revisions do not change the report's findings, conclusions, or recommendations.*

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Purpose of the Special Examination

This review of the behavioral health care administrative requirements was conducted at the request of the House Appropriations Committee. Based on the Committee's request, we addressed the following questions:

1. Are the administrative requirements behavioral health care practitioners have to meet to work in Georgia duplicative and costly (to the practitioner)? If so, what actions can be taken to reduce duplication and cost?
2. Are the administrative requirements behavioral health care providers have to meet to work with Medicaid clients in Georgia duplicative and costly (to the provider)? If so, what actions can be taken to reduce duplication and cost?
3. Are Georgia's licensure requirements aligned with other states?

Based on the questions asked, cost savings to the state was not part of the scope of this review. A description of the objectives, scope, and methodology used in this review is included in Appendix B. A draft of the report was provided to the Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Department of Community Health (DCH) for their review, and pertinent responses were incorporated into the report.

Background

The Substance Abuse Mental Health Services Administration (SAMHSA) defines "behavioral health" as the promotion of mental health, resilience, and wellbeing. Behavioral health care is the treatment of mental and substance use disorders as well as the support of those who are experiencing and/or recovering from these conditions, their families, and communities. Common behavioral health care services include mental healthcare, psychiatric care, marriage and family counseling, substance abuse prevention, substance abuse treatment and recovery, and management of chronic diseases. According to a SAMHSA survey on drug use and health, there is widespread need for behavioral health services to connect care and resources with the one in five American adults living with a behavioral health disorder.

State Agencies Involved with Behavioral Health

Georgia's Medicaid[1] population, as well as those under- or un-insured, can receive behavioral health services through entities that contract with the state. The contracting behavioral health entities must be approved by several agencies. In Georgia, the Department of Community Health (DCH) oversees the administration of Medicaid funds, and the Department of Behavioral Health and Development Disabilities (DBHDD) oversees the quality of behavioral health services. Within DCH, the Healthcare Facilities Regulation Division (HFRD) oversees physical facilities as well as services.

[1] Medicaid is a joint federal and state program that provides free health coverage to low-income families and children, pregnant women, the elderly, and people with disabilities. PeachCare is Georgia's Child Health Insurance Program, which provides low-cost health coverage to uninsured children in families that earn too much income to qualify for Medicaid.

Department of Community Health (DCH)

DCH's mission is to provide Georgians with access to affordable, quality health care through effective planning, purchasing, and oversight. DCH administers the Medicaid and PeachCare for Kids (PeachCare) programs. Medicaid and PeachCare members are insured either directly from DCH through the Fee-For-Service (FFS) program or through one of the four Care Management Organizations (CMOs) contracted by DCH to provide services.

- **FFS** – DCH pays providers directly for each covered service received by a Medicaid beneficiary. DCH also enrolls providers to participate in the Medicaid program and ensures beneficiaries statewide have access to care. DCH sets provider payment rates, which are required by federal law (Section 1902 (a)(30)(A) of the Social Security Act) to be consistent with efficiency, economy, and quality of care and sufficient to provide access equivalent to the general non-Medicaid population. In addition to processing and paying claims, DCH is responsible for identifying potential fraud and abuse and monitoring improper claims.
- **CMOs** – In 2006, Georgia implemented a statewide system of four CMOs to deliver services to certain Medicaid and PeachCare members. DCH contracts with Amerigroup, CareSource, Peach State Health Plan, and WellCare.[2]

  The CMOs are responsible and accept full financial risk for providing and authorizing covered services. CMOs contract with and pay doctors, hospitals, and other care providers to establish a network that provides healthcare services for plan participants.

DCH's Health Facilities Regulations Division (HFRD) oversees services, facilities, and physical structures of regulated providers. Behavioral healthcare facilities regulated by HFRD include Psychiatric Residential Treatment Facilities, Drug Abuse Treatment and Education Programs, Community Mental Health Centers, Comprehensive Outpatient Rehabilitation Facilities, Community Living Arrangements, Narcotic Treatment Programs, and Traumatic Brain Injury Treatment Facilities.

Department of Behavioral Health and Developmental Disabilities (DBHDD)

DBHDD's mission is to lead an accountable and effective continuum of care to support Georgians with behavioral health challenges and/or intellectual and developmental disabilities. DBHDD's target populations include the underinsured, uninsured, Medicaid FFS, and those needing crisis services that are not covered by traditional insurance. Though most children have PeachCare or private insurance, DBHDD also serves a small population of children not eligible for PeachCare or managed care. The opposite is true for adults; most adults who receive Medicaid behavioral health services do so through FFS. DBHDD has five divisions:

- The Division of Behavioral Health's goal is to build a recovery-oriented, community-based system of care with the capacity to provide timely access to high-quality behavioral health treatment and support services. It manages programs and services delivered by DBHDD's community-based behavioral health providers. The services are delivered by Community Service Boards

[2] Georgia's WellCare and Peach State Health Plan are currently in the process of merging.

(CSBs)—which are the most comprehensive providers—as well as community Medicaid providers and specialty providers.

- The Division of Intellectual and Developmental Disabilities (IDD) supports people with intellectual and developmental disabilities and provides them with opportunities to live independently.
- The Division of Performance Management and Quality Improvement focuses on provider relations, performance analysis, quality improvement, Medicaid coordination, and the oversight of DBHDD's contract with the Georgia Collaborative Administrative Services Organization. The Divisions of Behavioral Health and IDD partner with this division to set direction, provide resources, and implement initiatives though targeted councils.
- The Division of Finance, Accountability, and Compliance manages the community provider incident management and investigations with a subunit that collects and validates provider performance measures.
- The Division of Hospital Services and Chief Medical Officer operates five hospitals offering inpatient adult mental health care, which includes serving individuals in the state's custody.

Other State Agencies

Two state agencies work with DCH and DBHDD to enroll children in the state's custody into the Georgia Families 360° program, which is a specialized managed care program designed specifically for this population.

- The mission of the Department of Juvenile Justice (DJJ) is to transform young lives by providing evidence-based rehabilitative treatment services and supervision, strengthening the well-being of youth and families, and fostering safe communities. While children in secured facilities are not eligible for Medicaid, children in non-secured juvenile justice placement receive Medicaid services through the Georgia Families 360° program.
- The Division of Family and Children Services (DFCS) is housed at Georgia's Department of Human Services (DHS). Its mission is to "prioritize the safety of Georgia's children in the decisions [made] and actions [taken]" by partnering with families and communities. Children in foster care and adoption assistance programs receive Medicaid services through the Georgia Families 360° program.

Approximately 27,000 children are Georgia Families 360° members and receive coordinated care and services, including behavioral health services, through the Amerigroup Community Care of Georgia CMO.

Practitioners and Providers

This special examination focused on behavioral health practitioners (individuals who serve clients) and providers (the entity who bills for services, whether as an entity or individual). These same entities may also provide intellectual and developmental disability and crisis stabilization services. However, we did not review any additional requirements related to these additional duties.

Practitioners

For the purposes of this report, a behavioral health practitioner is someone who directly administers behavioral health services in a clinical setting. We identified six commonly licensed professions related to behavioral health: professional counselors, marriage and family therapists, social workers, nurses, physicians/psychiatrists, and psychologists (see **Exhibit 1** for the number of active licensees). Practitioners may work independently or with a company, state agency, or private non-profit. The report focused on these six licensed professionals, but other practitioners could include less common licensed professionals as well as paraprofessionals not licensed through the state, such as peer support counselors.

Exhibit 1
As of September 2020, Six Behavioral Health Designations had more than 1,000 Licensees[1]

Profession	Total
Licensed Professional Counselor	8,351
Associate Professional Counselor	1,622
Licensed Clinical Social Worker	4,705
Master Social Worker	3,348
Licensed Marriage & Family Therapist	1,007
Associate Marriage & Family Therapist	125
Psychologist	2,537
Nurse[2]	179,301
Physician	38,138
Psychiatrist[3]	1,540

[1] The number of practitioners licensed through the Secretary of State or Composite Medical Board as of September 1, 2020.

[2] This represents the entire nursing population. Behavioral health nurses could not be separated out.

[3] The number of psychiatrists is a subset of the reported number of physicians and was calculated using the licensure renewal survey responses.

Source: Secretary of State licensing boards and Composite Medical Board

To work in Georgia, practitioners in these six professions must meet their respective licensing board's requirements. These include passing a national exam, meeting established educational requirements, and—for psychologists and those joining the nursing or medical interstate compact—passing a background check.[3]

Licensed professionals in other states may also seek Georgia licensure. For many professions this requires repeating an initial licensure process. Georgia has recently joined three interstate compacts to facilitate movement between states and telehealth services without additional licensure requirements. Member states agree on a uniform set of standards for participation and agree to recognize compact membership.

- **Psychology** – In April 2019, Georgia joined PSYPACT, which currently has 15 member states. An additional 13 states have pending legislation to permit their participation.

[3] For the remainder of professionals, background checks are only prompted by reported activity on application or renewal forms.

- **Nursing** – In January 2018, Georgia nurses became eligible to practice in other states through the enhanced Nurse Licensure Compact (eNLC). There are currently 26 member states.
- **Physicians** – In July 2019, Georgia joined the Interstate Medical Compact, which includes 29 states, the District of Columbia, and the Territory of Guam.

Providers

Behavioral health providers are the billing entity on Medicaid claims and include individual therapists, groups of individual practitioners working together, specialty clinics, and large organizations such as CSBs and hospitals. The number of active Medicaid providers is shown in **Exhibit 2**. While providers can work exclusively with CMOs or FFS, agency staff report that most FFS providers work with both.

Exhibit 2
Georgia Behavioral Health Medicaid Providers are Enrolled as Businesses and Individuals[1]

Service Enrolled with	Businesses	Individuals
Care Management Organizations (CMOs) only	119	1,125[2]
DCH Fee-For Service (FFS)	1	1,746[3]
DBHDD FFS	213[4]	N/A

[1] Counts are based on October 2020 enrollment data. The number of businesses reflects one location and does not include additional counts for businesses with multiple locations. Similarly, individuals is a unique count of practitioners; those working at multiple locations for multiple buisnesses are not counted twice.

[2] DCH Data showed of the 1,125 individuals, 11 are also eligible to serve DCH FFS clients.

[3] Of the 1,746 individuals,1,571 are also under contract with a CMO to serve the population.

[4] Of the 213 businesses, 194 are also under contract with a CMO, and 21 also serve DCH FFS clients.

Source: Department of Community Health Medicaid Provider Enrollment data and the Healthcare Facilities Regulation Division

Providers electing to work with the DBHDD's FFS population must select and be approved to offer either DBHDD's Core Benefits Package or a specific specialty service (see **Exhibit 3**). According to agency staff, the majority of DBHDD's FFS providers select the core benefits package.

Exhibit 3
Services Offered by DBHDD's FFS Providers[1]

Core Benefits Package
Providers must offer all services listed and have a Drug Abuse Treatment Program license

- Addiction services
- Behavioral health assessments
- Case management and skill building
- Crisis intervention
- Diagnostic assessment
- Individual, family, and group counseling
- Nursing evaluations
- Peer support services
- Psychiatric evaluations

Specialty Services
Providers choose which service(s) to offer

- Opioid Maintenance Treatment
- Assertive Community Treatment (ACT)
- Behavioral health crisis service centers
- Crisis stabilization units (youth and adult)
- Intensive case management
- Intensive family intervention
- Peer wellness centers
- Psychosocial rehabilitation
- Supported employment
- Youth clubhouses

[1]Not all services offered are listed. Some specialty services are funded with state funds only (non-Medicaid).

Source: DBHDD records

Obtaining Approval to Bill Medicaid

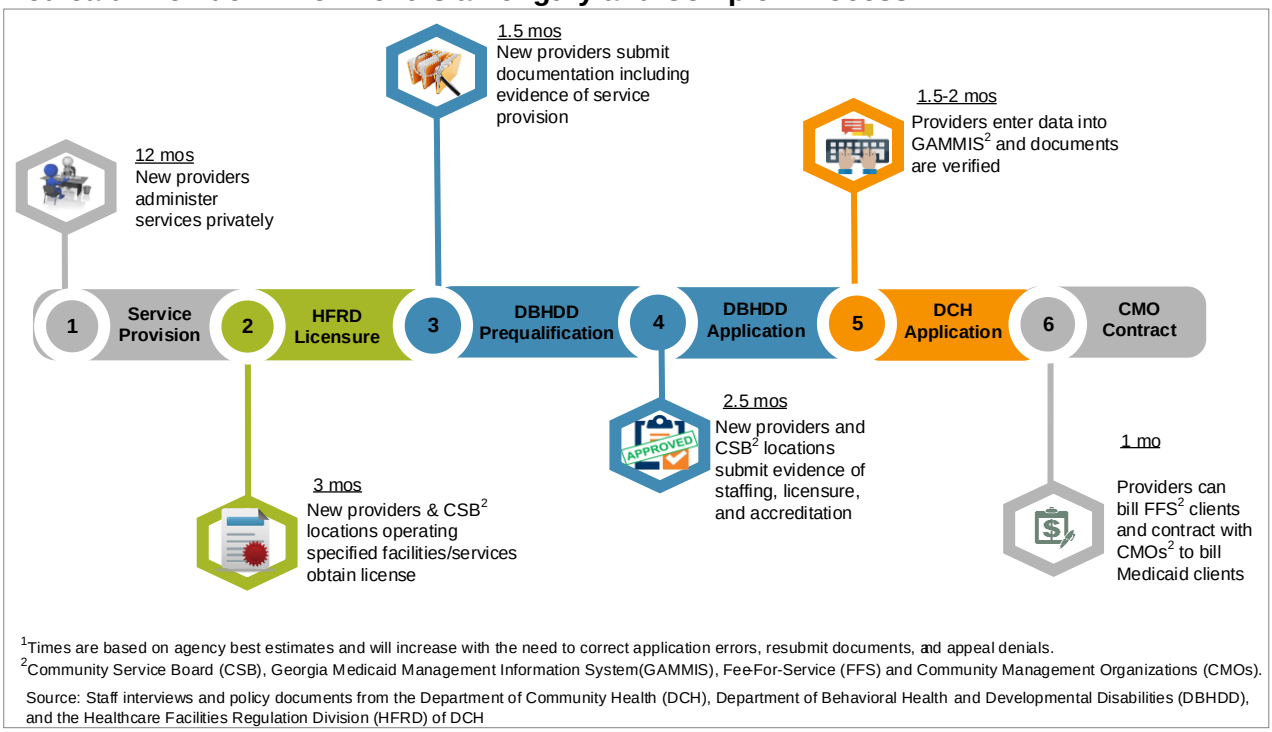
Providers seeking to participate in the state's Medicaid program must apply to up to three state entities for approval—and then complete an additional step if they choose to work with CMOs (see **Exhibit 4**). According to DBHDD and DCH, the extensive process helps ensure providers are competent and appropriately established.

Based on discussions with DBHDD and DCH, we focused on three common types of providers for our review:

- New individual provider (e.g., individual therapist) enrolling to provide managed care services;
- Existing Community Service Board (CSB) adding a location; and
- New privately owned drug treatment center providing Drug Abuse Treatment and Education Program (DATEP) services and managed care services.

The application process varies by provider type and services offered. For example, a new DATEP provider that wishes to participate in managed care must go through Steps 1 through 6 (see **Exhibit 4**), while existing CSBs opening a new location would have to complete Steps 2, 4, 5, and 6. A new individual provider signing up with managed care would only have to complete Steps 5 and 6.

Exhibit 4
Medicaid Provider Enrollment is a Lengthy and Complex Process[1]



[1]Times are based on agency best estimates and will increase with the need to correct application errors, resubmit documents, and appeal denials.
[2]Community Service Board (CSB), Georgia Medicaid Management Information System(GAMMIS), Fee-For-Service (FFS) and Community Management Organizations (CMOs).
Source: Staff interviews and policy documents from the Department of Community Health (DCH), Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Healthcare Facilities Regulation Division (HFRD) of DCH

Applicants must complete each required step before advancing to the next rather than obtaining approval concurrently. Details on each licensure step are provided in the sections below.

HFRD Licensure

HFRD oversees 25 types of facilities that are statutorily required to be licensed. Providers that operate of one these facilities must be licensed by HFRD prior to being approved to offer Medicaid services. Applicants' initial licensure fees currently range from $550 to $1,800 depending on the type of facility. Licenses are valid unless revoked; however, providers must pay annual fees (ranging from $250 to $1,500[4]) to remain in good standing. Existing providers opening a new location must acquire a facility license for each location. The process includes the following:

- Application – Applicant submits paper copies of required documents such as facility floor plan, fire safety inspection report, and documentation of the current governing board.
- Site Visit – HFRD survey staff conducts the initial site visit and issues facility license after reviewing documents such as personnel files, patient files, incident reports, and, when applicable, grievance logs.

DBHDD Enrollment

Fees providers must pay include:

HFRD – Initial $550-$1,800 Annual fees - $250-$1,500

DCH - $595 federally required triennial fee

DBHDD – no fees required for enrollment; however, must be accredited. Initial accreditation is for three years and fees range from $8,400 to $16,400 depending on the type; renewal is triennially.

To offer behavioral health services to FFS participants, providers must apply to be a registered provider through DBHDD; there is no state cost to providers to enroll. While there is no application fee, new providers must demonstrate they have already successfully served clients in the applicable service area for one year before beginning the process. According to DBHDD staff, this requirement ensures only providers with a proven track record are approved. Additionally, providers must prove they are accredited, which requires a separate fee.

After operating for one year, providers must complete DBHDD's prequalification and application stage, as described below. Prior to the prequalification, prospective providers must attend one of three informational sessions hosted annually by DBHDD. According to staff, these sessions help deter those without the necessary experience and expertise from applying.

- **Pre-qualification** – Applicant submits to DBHDD contractor hard-copy documents, including recommendation letters, evidence of prior successful service provision, and evidence of successful business operations (e.g., tax statements).[5]
- **Application** – Successful pre-qualification results in an invitation to apply. Providers submit evidence that the appropriate number and type of qualified staff have been hired to cover each service and location, including employee attestations and copies of professional licenses. They must also show they are accredited by one of four DBHDD-approved national accrediting bodies[6], have a business license and any applicable facility licenses, and provide proof of insurance.

[4] Providers receive a 25% discount on annual fees if accredited by a DCH approved accrediting body.

[5] DHBDD contracts with a vendor to manage the pre-application and application processes. It should be noted that, during the pandemic, the contractor accepted emailed documents instead of hard copies.

[6] The four accrediting bodies are the: Commission on Accreditation of Rehabilitation Facilities, Council on Accreditation, Council on Quality and Leadership, and Joint Commission.

DCH Enrollment

Providers must be credentialed and assigned a Medicaid number by DCH to bill for Medicaid services provided. Applicants pay $595 in federally-set fees once every three years and must provide required documentation. Providers also must be re-credentialed every three years to meet National Committee for Quality Assurance standards, which is required by the federal Centers for Medicaid and Medicare Services.

New providers must go through the following steps:

- **Application** – Providers enter electronic data into DCH's Georgia Medicaid Management Information System (GAMMIS, which is managed by the contractor DXC Technologies/Gainwell), and DCH staff reviews documents for completeness.
- **Credentialing Process** – DCH contracts with a Credentialing Verification Organization (CVO) to review documents for content and accuracy and verify against national databases.

After receiving a Medicaid ID number, providers may begin billing for FFS services or continue the process into managed care. Those who continue may reach out to the four CMOs and contract with them individually. While all providers are eligible to contract with a CMO based on completion of the CVO process, a CMO may have additional criteria a provider must meet. For example, WellCare of Georgia has an access standard that a provider must get a client to urgent behavioral health care within 48 hours.

Credentialing Verification Organization (CVO)

Created in 2015, CVO is a private entity through which Georgia consolidated the process for enrolling in the four CMOs. The CVO establishes processes that follow the guidelines of the National Council on Quality Accrediting, a private organization that verifies organizations have met federal Medicaid criteria.

Background Checks

Four state agencies have at least one federal mandate to use criminal history information to determine the fitness of staff and contractors with direct access to vulnerable clients such as children, the elderly, and the disabled. All four must also determine fitness of certain fiscal agents based on ownership and financial leadership positions. Georgia state law mirrors these requirements and also requires some practitioners to have a background checks as part of their initial licensure. An individual background check currently costs approximately $38-$60.[7] As shown in **Exhibit 5**, the background check requirements have multiple sources.

[7] Range will depend on whether the applicant requires a state or federal background check and the medium used (paper or electronic). Most state agencies will use a combined state and federal check, which costs $51.50 for an electronic check.

Exhibit 5
State and Federal Laws Require Background Checks [1]

Requirement	DJJ	DHS/DFCS	DBHDD	DCH	Interstate Compacts[2]
Federal	Prison Rape Elimination Act	CAPTA, NCPA[3], Title IV-E Section 471 Social Security Act	NCPA[3], Affordable Care Act	Affordable Care Act	N/A
State O.C.G.A.	§ 35-3-34.2 (4)	§ 49-5-62, § 49-5-65	§ 37-1-28[4], § 35-3-34.2 (4)	§ 31-7-354	§ 43-39-6, § 43-34-13
Initial	Yes	Yes	Yes	Yes	Yes
Renewal	5 years	N/A	N/A	3 years[5]	No

[1] Requirements above reflect practitioners subject to criminal background checks on initial licensure and for state affiliated employment.

[2] All applicants for licensure as a psychologist are subject to background checks to make Georgia eligible for interstate compact participation as well as applicants for licensure as a physician or nurse applying for interstate compact membership. See report on the Composite Medical Board for more details on the implementation of the physician background check licensure requirement.

[3] Child Abuse Prevention and Treatment Act (CAPTA) and National Child Protection Act (NCPA).

[4] Exception to DBHDD check, individuals who have already been subject to a background check through DCH.

[5] The requirement for renewal is every five years or at re-enrollment/revalidation, for which CMS has a requirement of every three to five years. Georgia's CVO requires the recredentialing process at three-year intervals.

Source: Official Code of Georgia, United States Code

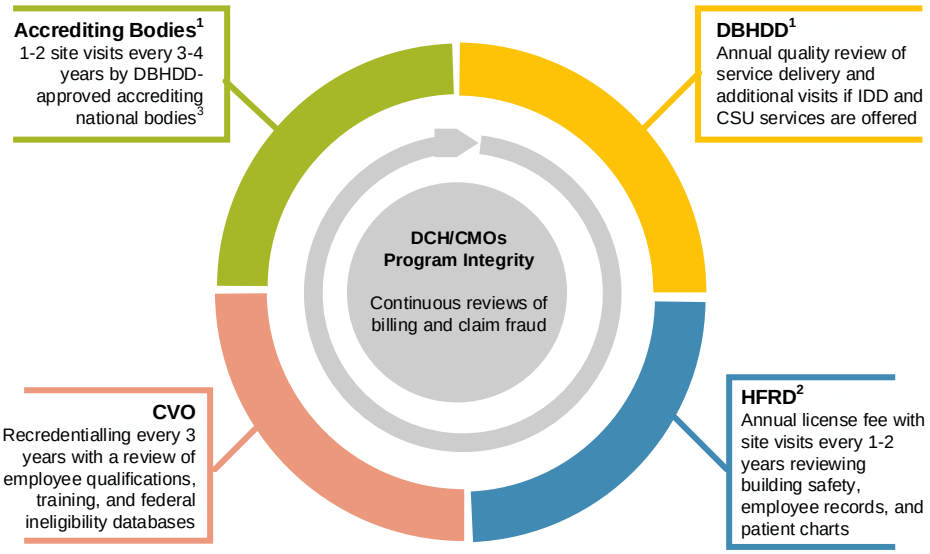
DBHDD and DCH do not employ direct service staff but manage these requirements for Medicaid providers. Both DJJ staff and in-house contractors, as well as community placement vendors, are subject to requirements. DHS issues licenses for certain residential facilities and has direct staff and various community contracts, all of whom are subject to these requirements.

Post-Enrollment Monitoring

In addition to initial approvals, all providers are subject to ongoing monitoring. As shown in **Exhibit 6**, DBHDD[8] and DCH conduct annual quality reviews and continuous program integrity reviews. Additionally, HFRD does not have a set interval for site visits of its licensed facilities, but, according to staff, typically conducts them every one to two years. Problems identified during these reviews, or complaints, can prompt additional reviews and investigations. Accrediting bodies also conduct two site visits during a three- or four-year cycle.

[8] The pandemic has temporarily halted these site visits, but they are expected to resume in the future.

Exhibit 6
Providers Undergo a Constant Cycle of Oversight from Various Oversight Bodies



[1]Applicable to DBHDD Fee-For-Service providers.
[2]Applicable to providers requiring a facility license, such as core benefit package providers with a DATEP. Beginning in 2020, national accrediting reviews were "deemed" a substitute for HFRD visits.
[3]Accrediting cycle for is three years for three national bodies, and four years for one national body.

Source: Policies and procedures of DBHDD and HFRD; DCH contract for CVO; and DOAA Performance Audit 18-05

Requested Information

Finding 1: Georgia's professional licensure requirements and fees are within industry norms.

Requirements and fees for Georgia's behavioral health practitioners' initial or renewed professional licensure are comparable to other states. It is important to establish such minimum requirements for these professions to ensure vulnerable populations are served by qualified individuals.

We reviewed licensure requirements and fees for the six most common behavioral health professions that are subject to state level professional licensure: psychologists, physicians (including those with a psychiatry specialty), nurses, social workers, professional counselors, and marriage and family therapists. While DBHDD does not track the number of practitioners working in its provider network, these professions represent the majority of staff in DBHDD's network.

While practitioners may elect to hold multiple licenses, the training required for each profession is tailored to match the particular scope of practice, and different licensing boards oversee the review. Therefore, any overlap experienced by practitioners with multiple licensures is not considered unnecessarily duplicative.

Licensure Requirements

As shown in **Exhibit 7**, Georgia's initial licensure generally requires an application, official academic transcripts, national qualifying exam scores, documentation of clinical hours, proof of citizenship, and an application fee.[9] Professions vary on background check requirements—for example, the Board of Examiners of Psychologists requires a background check while other professional boards determine the need based on questionnaire responses. Renewal requirements, which professionals are subject to every two years, include proof of continuing education hours and a renewal fee.

We reviewed licensure requirements of other states and found that Georgia's requirements are generally not more stringent than others.[10] For example, 26 states and the District of Columbia require 3,000 hours of post-degree supervised experience for social workers. All states also required continuing education hours for social workers. Most states also require practitioners in the six professions reviewed to receive a passing exam score from a nationally administered exam.

[9] Licensing board members use professional judgment to determine appropriate educational and training requirements to be qualified in a field. We did not attempt to review the appropriateness of these requirements as our review was limited to the administrative requirements for licensure.

[10] For psychologist, nurses, and physicians, we reviewed requirements for states participating in interstate compacts. For social workers, professional counselors, and marriage and family therapist, we reviewed summary information collected by the national exam organizations for each of these professions for licensure requirements. Generally, they included all 50 states and the District of Columbia.

Exhibit 7
Licensing Requirements for Georgia Behavioral Health Professionals[1]

Requirement	Physician	Nurse	Psychologist	Social Worker	Professional Counselor	Marriage & Family Therapist
Application	Yes	Yes	Yes	Yes	Yes	Yes
Fee	$500	$40	$100	$100	$100	$100
Transcripts	Doctor of Medicine or Doctor of Osteopathy	Bachelor's	Doctor of Philosophy	Master's	Master's	Master's
Exam Scores[2]	Steps 1,2,3; NBOME; COMLEX[3]	NCLEX	EPPP	ASWB	NCE/ NCMHCE	MFT
Clinical Hours	3-year residency	500[4]	1,500	3,000	2,400	2,000
Background Check	Application Response Dependent[5]	Application Response Dependent[5]	Yes	Application Response Dependent	Application Response Dependent	Application Response Dependent
Citizenship[6]	Required	Required	Required	Required	Required	Required
References	Evidence of moral character	n/a	3	2	2	2
Interstate Compact	Interstate Medical Compact	Nurse Licensure Compact	Psychology Interjurisdictional Compact	-	-	-
Continuing Education Hours	40	30	40	35	35	35

[1] Requirements above reflect administrative requirements supplied at the time of licensure.

[2] National Board of Osteopathic Medical Examiners (NBOME); Comprehensive Osteopathic Medical Licensing Examination (COMLEX); National Council Licensure Examination (NCLEX); Examination for Professional Practice in Psychology (EPPP); Association of Social Work Boards (ASWB); National Counselor Examination (NCE); National Clinical Mental Health Counseling Examination (NCMHCE); and, Marriage and Family Therapy exam (MFT).

[3] Physician exams listed are currently administered for Medical Doctor and Doctor of Osteopathy program graduates. Different exams are required for graduates of foreign medical programs, and exams used in prior years are accepted when taken on or before June 1, 1985.

[4] Clinical hours for nursing are only required for reinstatement.

[5] Background checks are required for interstate compact membership in these professions.

[6] Or proof of legal residence.

Source: Official Code of Georgia, Secretary of State Licensing Board Rules, Georgia Composite Medical Board Rules

While in-state requirements are not duplicative, practitioners who work in multiple states—either due to relocation or telemedicine—would have to submit multiple licensure applications. To alleviate the duplication, Georgia has joined three interstate compacts[11] in which out-of-state professionals in good standing with their respective boards do not have to resubmit licensure requirements. For example, a member registered nurse can relocate to Georgia and immediately begin work without first

[11] Georgia is a member of the Psychology Interstate Compact, the Interstate Medical Compact, and the Interstate Nursing Compact.

seeking licensure; similarly, a Georgia psychologist can provide teletherapy to clients in Texas without obtaining a Texas license.

It should be noted that practitioners who wish to take advantage of the interstate compacts must pay membership fees. For example, nurses in Georgia who add a multi-state rider to their Georgian nursing license must pay an additional $50.

Fees

As shown in **Exhibit 8**, Georgia's professional licensing fees range from $40 to $500, while renewal fees range from $65 to $230. These do not appear to be excessive or unreasonable considering the typical compensation of the respective profession. For example, the average professional therapist—who must pay $100 in initial fees—earns approximately $48,000 in Georgia. By contrast, a behavioral health physician—who pays $500 in initial fees—earns approximately $237,000.

Exhibit 8
Professional Licensing and Fees[1]

Profession	Interstate Compact Fee[2]	Initial Licensing Fee	Renewal Fee
Professional Counselor		$100	$100
Social Worker		$100	$100
Marriage & Family Therapist		$100	$100
Psychologist	$200	$100	$250
Nurse	$50	$40	$65
Physician	$700	$500	$230

[1] Fees for initial and renewal licensure in Georgia.

[2] The fee does not pertain to all practitioners. Psychologist fee is required for all initial applications for services by the entity that administers the compact and would also be used if the applicant pursues interstate compact benefits. Nurses with existing single state licenses only pay fee for conversion; new applicants are automatically awarded multi-state privileges. Physicians who do not elect to participate are not subject to compact related fees.

Source: Secretary of State licensing boards and Composite Medical Board

Additionally, these fees do not exceed what one would pay for similar professional licensure in other states. For example, professional counselors in other states pay an average of $200 with a range of $85 to $400 for initial professional licensure, while physicians pay an average of $400 with a range of $300 to $800. Other state renewal fees range from $50 to $300 for professional counselors and $155 to $600 for physicians.

Finding 2: Behavioral health care practitioners and providers working with the state are subject to ongoing administrative costs associated with background checks, which should be mitigated by recent legislative changes and interagency cooperation.

Practitioner *refers to clinical staff working directly with individuals with behavioral health care needs.*

Provider *may refer to an individual practitioner working as a business entity or an organization such as a Community Service Board or a nonprofit agency.*

Practitioners and providers who comprise the state's provider network may be subject to multiple state and federal fingerprint background checks. Although a single background check is not costly, the duplication for renewals and multiple agency checks can become burdensome. This has been mitigated with recent legislation and interagency cooperation, though additional action may further decrease costs.

DBHDD, DJJ, and DFCS each utilize providers and practitioner vendors to secure behavioral health services in the community. Given the large provider network needed to meet the state's needs, individual behavioral health practitioners and providers likely work with multiple state agencies.[12] For example, a provider organization may support adults with developmental disabilities for DBHDD as well as assist DFCS with placing foster children.

Each state agency is subject to federal and/or state requirements to perform fingerprint background checks to ensure those serving their constituents have no criminal history that would render them unfit. DJJ requires renewal checks every five years, and DCH requires background checks whenever a provider enrolls a new location. Due to the following reasons, a provider's background check at one agency may not be transferred to other agencies.

- Federal law does not allow criminal history information to be shared between agencies that do not have a similar mission (i.e., "unrelated agencies"). Few agencies are similar enough to earn the status of related agencies. For example, the Federal Bureau of Investigation has rejected recent attempts for DJJ and DHS to be classified as similar.
- Agencies may share the fitness for employment determinations that they have made based on a criminal history. However, these determinations would not be relevant for an agency if the purpose code is not an exact match. A purpose code determines what criminal history information comes back to the agency according to law governing what is released for that purpose. For example, a purpose code for "employment" would not pull the same information as the code indicating direct contact with vulnerable populations.
- Agencies that must have criminal history on file for audit may be required to pull and maintain their own confidential records. This would not be possible if they relied on information from another agency, because the fingerprints used to pull the criminal history information can only be associated with a single originating agency.[13]

With the requirements and restrictions described above in place, practitioners and/or providers who contract with multiple agencies may have to undergo multiple background checks each renewal cycle. As described in the following scenarios, while

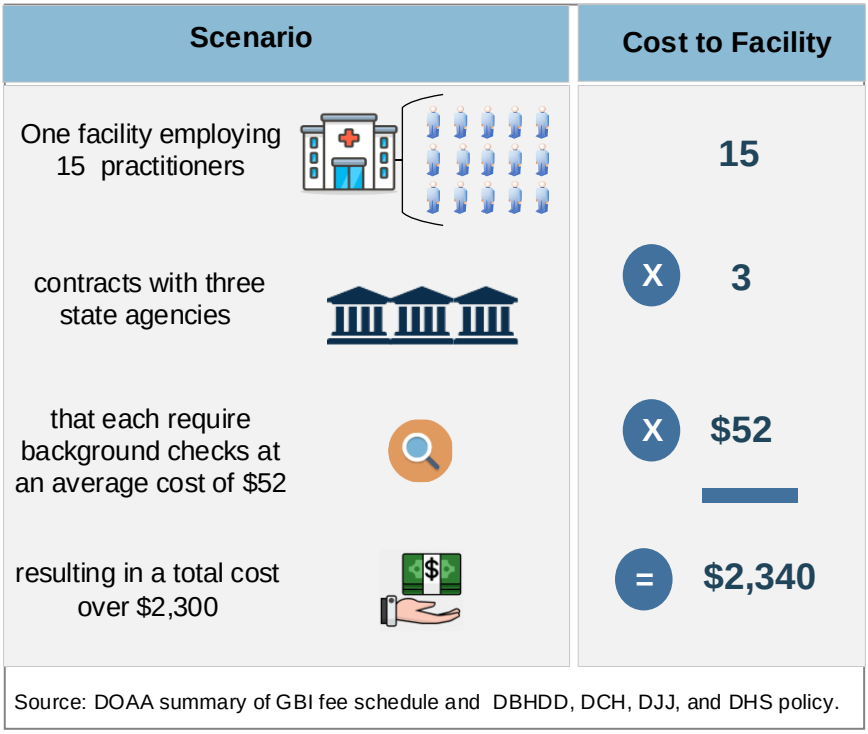
[12] State agencies do not track providers at the practitioner level. As a result, it is not possible to determine the number of practitioners who work through or within multiple agencies or the frequency of practitioners moving from one agency to another.
[13] The originating agency has an identified number which indicates both the agency and the purpose code.

a single background check generally costs $51.50, the cost can become burdensome, particularly for providers employing multiple practitioners.

- **Scenario 1: Provider pays for background checks** – A Psychiatric Residential Treatment Facility (PRTF) offers several programs and employs 15 practitioners who serve all types of youth.[14] Three agencies (DJJ, DBHDD, and DFCS) contract with the PTRF so their youth can occupy beds in the facility. As such, staff are subject to background checks by each agency, and the PRTF must pay for 45 background checks, costing approximately $2,340 (see **Exhibit 9**). The PRTF would also be responsible for renewing the background checks for DJJ, which would cost an added $775 in year five.[15]

  While initial and renewal costs would decrease if the PRTF assigned its 15 staff exclusively to specific programs within the facility, this would significantly limit the PRTF's flexibility. If staff moved between programs, they would have to obtain a new background check, even though they have remained with the same employer.

Exhibit 9
Business can Incur Ongoing Costs from Meeting Employee Background Check Obligations



Source: DOAA summary of GBI fee schedule and DBHDD, DCH, DJJ, and DHS policy.

- **Scenario 2: Practitioner pays for background checks** – An individual social worker is employed at the PRTF described above. If they served all three agencies, they would be subject to three background checks at a total cost of

[14] PRTFs are a high demand vendor for state agencies.
[15] Because only DJJ requires background checks for renewal, only 15 renewal background checks would be performed.

$155. In five years, they would also have to pay $51.50 for a background check upon renewal.

If the social worker began working with a second PRTF that also serves DBHDD, DJJ, and DFCS, they would have to pay for three new background checks at an additional cost of $155.

It should be noted that even if the employer pays for practitioners' background checks, the practitioner must still take the time to get fingerprints. This could be perceived as burdensome if required multiple times in a short period of time.

As described below, the General Assembly and state agencies have taken action to decrease the number of background checks necessary to work with multiple state agencies. Additional action could further reduce the potential duplication.

- **Inter-agency Coordination** – DBHDD recently began waiving its required background checks for individuals who receive federally mandated ones through DCH. It is not yet possible to determine how much duplication this has eliminated because background checks were temporarily paused during the COVID-19 pandemic. Other state agencies—such as DJJ and DFCS—may also benefit providers by making similar arrangements; however, they have yet to be explored.
- **"Rap Back" Legislation** – In October 2019, the General Assembly passed legislation that allows certain agencies requiring background checks to retain agency employees' and contractors' fingerprints with the Georgia Bureau of Investigation's Georgia Criminal Information Center. Expected to begin in early 2021, the Bureau will continuously obtain criminal history information on subscribed employees. Participating agencies will be immediately notified when any relevant criminal history is available for those individuals, eliminating the need for background check renewals.

  Legislation currently allows DHS, DBHDD, and DCH to participate in the program. DCH and DHS have indicated they will participate. DBHDD staff indicated it will likely not participate because it waives background checks for those DCH has already reviewed (see above). While DJJ also employs many behavioral health professionals, it does not yet have legislation permitting the program.

RECOMMENDATIONS

1. The General Assembly should evaluate its "Rap Back" legislation as it is implemented and consider opening the program to other agencies, such as DJJ, that employ behavioral health care practitioners.
2. DHS should determine whether there are required background checks for some or all individuals employed as providers that could be waived if those same individuals receive federally mandated background checks through another state agency such as DCH or DJJ.

DBHDD Response: DBHDD generally agreed with this finding and stated, "The Department will continue to periodically review administrative expectations including those related to Fingerprint and Background Checks and cooperate with our partner agencies where appropriate."

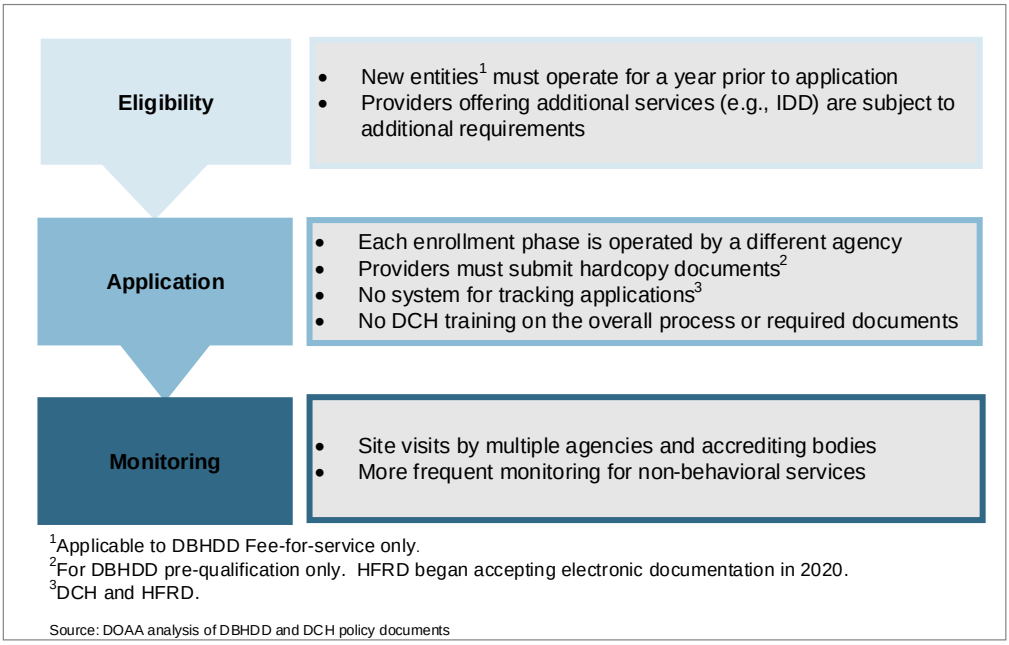
Finding 3: While the administrative requirements to operate as a behavioral health care Medicaid provider are not duplicative, the process is lengthy, and inefficiencies increase the perception of a burdensome process.

Administrative requirements to become a Medicaid provider are not duplicative, and agencies must balance efficiency with the need to confirm that applicants can effectively serve a vulnerable population. However, the enrollment and renewal process can be challenging—particularly for providers operating multiple locations or offering multiple services—and result in delays that cost providers time and money. Additionally, monitoring requirements after enrollment can increase providers' perception of burden. State agencies have instituted reforms to improve enrollment and subsequent monitoring processes; however, additional improvements are needed.

The complexity of the enrollment and renewal process depends on the types of services and clients a provider intends to serve. For example, as shown in **Exhibit 4** on page 6, a therapist working with a Care Management Organization (CMO) could apply and be approved by DCH in as little as two months. After contracting with the CMO, the therapist could begin billing Medicaid.

Conversely, a new entity that wants to offer DBHDD's core benefit package may have to wait up to two years before billing Medicaid. In this example, a provider would have to have a facility open and staffed for over a year and a half, incurring the associated costs without income from Medicaid billing. The provider is responsible for these interim costs and may cover them by serving privately insured clients, shifting funds from other locations, relying on reserves or other grants, or other means. It should be noted that behavioral health providers offering additional services such as Intellectually and Developmentally Disabled (IDD) and Crisis Service Units (CSU) are subject to additional requirements.

Exhibit 10
Georgia's Execution of the Medicaid Provider Application Process contains Areas for Improvement



Agency staff indicated that by operating for a year prior to approval, the provider is proving an ability to offer quality services to Medicaid clients and comply with all related rules and regulations. However, as shown in **Exhibit 10**, challenges and inefficiencies in the process can prolong a provider's wait before being able to bill for Medicaid services:

- **Various Enrollment Systems** – Each phase of Medicaid enrollment is operated by a different state agency that uses its own contractor and enrollment system (See **Exhibit 4** on page 6). For example, a new provider will interact with three agencies, and their two contractors, in eight months. As a result, the provider will have to coordinate feedback and questions from multiple staff.

- **Manual Processes** – DBHDD's pre-qualification process (see **Exhibit 4** on page 6) requires providers to submit hardcopy documents that are then electronically imaged by the reviewing contractor. DBHDD could save applicants time and better track information if it allowed applicants to submit forms and documents electronically. DBHDD staff report that the size of the files prohibited submission via email, though allowances were being made during the pandemic. Alternative methods of submission, such as uploading to a common server or electronic drop box, are widely available and relatively inexpensive.

  HRFD's applications are also paper based. However, staff indicated they plan to implement an electronic application system by the end of calendar year 2021.

State agency efforts to improve provider experience and reduce administrative duplication

*In 2015, DCH created the **Credentialing Verification Organization** to consolidate the enrollment of providers with Georgia's four CMOs. Prior to the change, providers had to be credentialled separately by each CMO.*

*In 2015, DBHDD combined the IDD, BH, and CSU **Quality Review Monitoring** visits, which reduced the number of site visits from three per year to one. One CSB staff member we interviewed stated they are satisfied with the change, even though the visit results in the same amount of work and interaction for their staff and takes about the same amount of calendar time. (It should be noted that during the pandemic, all site visits were suspended.)*

*In 2018, DCH and DBHDD staff created a **Joint Working Group** to identify ways to reduce inefficiencies for providers. As a result, DBHDD revised its policy language to apply the same standards across providers, and it continues to review and update its monitoring forms. Additionally, in February 2020, HFRD eliminated its periodic monitoring visits by accepting accrediting bodies' review as evidence the facility has been deemed safe. (It should be noted that "deemed" status does not eliminate the requirements for initial licensure or those related to investigations of misconduct.)*

*In 2018, DBHDD created the **Provider Issues Management System (PIMS)** and* the ***Provider Communications Relations Team** to ensure questions are answered and providers are put in touch with the appropriate parties in a timely manner. The communication team also sends out monthly newsletters and regular communications to its provider network. In 2019, DBHDD created a **Behavioral Health Provider Advisory Council** to increase provider communication and input.*

- **Application Not Tracked** – DCH and HFRD do not have a system for tracking applications through the process, which would allow them to determine where the problems that result in denials or rejections occur. DCH staff report that tracking and data analysis capabilities will be utilized once GAMMIS[16] is restructured in three to five years. Other states utilize tracking information for Medicaid provider enrollment and facility licensing to ensure application processing time is low and that areas for improvement are identified.
- **Lack of Training** – DCH's training focuses on specific data entry points rather than descriptions of the overall process or required documents. Providers reported a lack of clarity regarding processes and requirements, and DCH staff agreed that the process is not intuitive for inexperienced applicants. Additionally, DCH staff noted that those lacking administrative staff would have difficulty navigating the complexities of the process.

Once providers have been approved, they are still subject to monitoring requirements, including site visits. As a result, provider employees must devote time to interfacing with state agency staff for services (DBHDD) and billing (DCH).[17] In addition, providers face periodic site reviews from accrediting bodies and more frequent monitoring for non-behavioral health care services (if offered), such as intellectual and developmental disabilities and crisis service units.

[16] As described on page 8, GAMMIS is DCH's Medicaid information system, which is currently undergoing updates.

[17] Previously, providers were subject to facility site visits by HFRD as well. However, HFRD now accepts accreditation site visit results in lieu of their own periodic visits (see text box above).

RECOMMENDATIONS

1. DBHDD should pursue methods to allow electronic submissions of pre-qualification documents.
2. DCH should collect and analyze application processing information to identify areas for improvement; this information should be used to develop training that is well-advertised.
3. HFRD should implement an application tracking and information management process to identify areas for improvements; information should be used to establish goals and metrics for application review.

DCH Response: DCH agreed with recommendations 2 and 3, noting that it "recently implemented several improvements to the license application process, including the implementation of a payment portal for annual license fees." DCH indicated it is "working to fully automate the application process to allow for online submission of the paperwork, tracking features for both DCH and the applicant, status notifications and banner messaging."

DBHDD Response: DBHDD generally agreed with these recommendations and stated that during the 3rd quarter of fiscal year 2021, "DBHDD will convene a workgroup to evaluate the possibility of allowing electronic submissions of pre -qualification documents."

Finding 4: Drug Abuse Treatment and Education Program (DATEP) licensing rules should be revised to distinguish residential and non-residential facilities.

Behavioral health providers offering DBHDD's "core benefit package" must include drug abuse treatment services, which requires a specific license. Medicaid providers with Drug Abuse Treatment and Education Programs (DATEP) can have residential facilities, though most operate a non-residential outpatient facility (see **Exhibit 11**). To obtain the necessary licensure for operating a DATEP facility, these providers must undergo the same approval process as residential facilities, and pay the same fees, which prolongs the time and increases the cost prior to Medicaid billing.

Exhibit 11
Most DATEP Facilities Operated by Medicaid Providers are Nonresidential[1]

Residential	9
Nonresidential	189
Total	198

[1] Limitations of DCH and HFRD data did not provide for a one for one match between enrolled providers and licensed facilities.

Source: Department of Community Health Medicaid Provider Enrollment data and the Healthcare Facilities Regulation Division

To address the needs of clients with co-occurring diagnoses of both behavioral health and substance abuse, DBHDD requires the 150 core service providers[18] to offer substance abuse treatment services. To comply, many behavioral health providers establish DATEPs, which are statutorily required to carry a license issued by DCH.

[18] Each provider may operate more than one DATEP facility.

DCH assigns this responsibility to its Healthcare Facilities Regulation Division (HFRD).

Residential facilities *(inpatient) are those in which the patients live on the premises.*

DCH rules do not distinguish between residential and non-residential facilities when granting DATEP licensure. The requirements for licensure are the same for residential and non-residential DATEPs (the majority of DBHDD-funded DATEPs are non-residential), and a DBHDD provider must obtain this license prior to enrolling its location(s) in DBHDD's core benefit package. Those applying must first lease or purchase a building and fully staff it with the minimum number of physicians, nurses, and counselors required to serve DATEP clients. According to HFRD staff, the requirement adds approximately three months[19] to the Medicaid enrollment process, which, according to DBHDD documents, takes approximately four to six months. Additionally, DATEP providers pay a $500 annual fee for facility licensure.[20]

The added delay can be costly for providers—particularly new ones—because they cannot bill for any Medicaid services until all licensures have been obtained. Established providers reported that during the waiting periods, they often shifted newly hired staff to existing Medicaid-approved facilities to keep them from remaining idle (this would not be possible for new enrollees).

While requirements imposed on the residential DATEPs are intended to ensure that their facilities are not a danger to clients, DBHDD and DCH staff noted this is generally less of a risk for providers offering only outpatient services. Staff at both agencies agreed that the current oversight these providers are receiving is sufficient, rendering the additional licensure through HFRD unnecessary. As such, the law could be changed to eliminate requirements for non-residential DATEPs without risking patient safety.[21]

It should be noted that HFRD has attempted to reduce the burden on DATEPs by making changes to its ongoing monitoring processes. For DATEPS that have undergone a DBHDD-required accrediting body site visit, HFRD grants "deemed" status and does not conduct an additional site visit.

RECOMMENDATIONS

1. DCH should revise its rules to distinguish between residential and non-residential DATEPs enrolled with DBHDD and set requirements appropriately.
2. The General Assembly should consider revising the DATEP Act to allow non-residential facilities to forego the legal requirement to obtain a facility license if they have enrolled with DBHDD. DCH should accordingly update their HFRD rules to accommodate any statutory changes.

[19] Time may increase based on the availability of HFRD inspection staff and the need for providers to make corrective actions prior to opening.

[20] As noted earlier, deeming status reduces the fee by 25%.

[21] During our review, DBHDD staff noted other areas that could be changed to the DATEP Act, which has not been updated since it was passed in 1972. For example, the term "drug abuse" used by the Act is not up to date with the more widely accepted term "substance abuse."

3. In consultation with DBHDD and DCH policy experts, the General Assembly should consider updating other language in the DATEP Act to currently utilized terminology.

DCH Response: DCH partially agreed with these recommendations. DCH agreed some type of exemption for DATEPs is appropriate. DCH recommended that "linking the exemption to DBHDD enrollment, instead of residential status, would ensure that some state agency oversight remains in place for private pay citizens who may be vulnerable." In addition, they concurred that the General Assembly should consider updating language in the DATEP Act in consultation with policy experts.

DBHDD Response: DBHDD generally agreed with these recommendations and stated, "[s]hould the General Assembly determine to revise the DATEP Act, DBHDD would provide policy expertise to support the effort."

Finding 5: Georgia's administrative requirements for behavioral health providers are generally in line with other states.

Georgia has taken steps to simplify enrollment for providers; however, providers have indicated challenges exist within certain parts of the administrative process. Georgia's practices are similar to those in other states we reviewed, though additional improvements may further reduce perceived burdens.

While many federal requirements dictate licensure and enrollment of behavioral health care Medicaid providers, states have discretion regarding how they operationalize and execute those requirements. For example, all states must ensure high risk providers be validated through a federally required screening process. A state may allow providers or Care Management Organizations (CMOs) to take this role; however, Georgia has created a Credentialing Verification Organization (CVO) that performs a consolidated credentialing on behalf of all CMOs to reduce the providers' administrative burden.

However, there are areas in Georgia's process that providers have viewed as burdensome or challenging. We contacted three states[22] and determined that they are generally similar, as described below.

- **Accreditation by a national body** – Providers stated accreditation was an expensive extra step they had to take outside of the basic fee-for-service eligibility process. Each state we spoke with uses one or more of the accrediting bodies valid in Georgia for maintaining provider quality assurance.
- **Separate Enrollment and Licensing** – Providers expressed frustration with having to coordinate with staff from both an enrollment agency (DBHDD) and a separate facility licensing agency (HFRD). Separate licensing and enrollment offices were present in both North and South Carolina, but in

[22] DCH staff identified North and South Carolina as similar states within our CMS region and Indiana as a state which uses the same vendor for provider enrollment and facility licensing.

Indiana they were both issued by the state's Division of Mental Health and Addiction.

Though similarities exist, there may be opportunities for improvement within Georgia's process. For example, North Carolina and South Carolina accept electronic applications, while Indiana accepts both electronic and paper forms. As discussed on page 18, applicants may submit electronically in some phases of Georgia's enrollment process but not others.[23] In addition, while Georgia has deliverables written into its vendor contract, they are not as detailed as those in other states or, as discussed on page 19, tracked to identify where system improvements can be made. By contrast, North Carolina reviews its enrollment vendor's activity to ensure timely review of applications and timely response to customer service requests, and Indiana is implementing a system to identify what provider types need help with enrollment to target additional education efforts.

[23] Exceptions have been made during the pandemic.

Appendix A: Table of Recommendations

Finding 1: Georgia's professional licensure requirements and fees are within industry norms. (p. 11)
None
Finding 2: Behavioral health care practitioners and providers working with the state are subject to ongoing administrative costs associated with background checks, which should be mitigated by recent legislative changes and interagency cooperation. (p. 14)
1. The General Assembly should evaluate its "Rap Back" legislation as it is implemented and consider opening the program to other agencies, such as DJJ, that employ behavioral health care practitioners.
2. DHS should determine whether there are required background checks for some or all individuals employed as providers that could be waived if those same individuals receive federally mandated background checks through another state agency such as DCH or DJJ.
Finding 3: While the administrative requirements to operate as a behavioral health care Medicaid provider are not duplicative, the process is lengthy, and inefficiencies increase the perception of a burdensome process. (p. 17)
3. DBHDD should pursue methods to allow electronic submissions of pre-qualification documents.
4. DCH should collect and analyze application processing information to identify areas for improvement; this information should be used to develop training that is well-advertised.
5. HFRD should implement an application tracking and information management process to identify areas for improvements; information should be used to establish goals and metrics for application review.
Finding 4: Drug Abuse Treatment and Education Program (DATEP) licensing rules should be revised to distinguish residential and non-residential facilities. (p. 20)
6. DCH should revise its rules to distinguish between residential and non-residential DATEPs enrolled with DBHDD and set requirements appropriately.
7. The General Assembly should consider revising the DATEP Act to allow non-residential facilities to forego the legal requirement to obtain a facility license if they have enrolled with DBHDD. DCH should accordingly update their HFRD rules to accommodate any statutory changes.
8. In consultation with DBHDD and DCH policy experts, the General Assembly should consider updating other language in the DATEP Act to currently utilized terminology.
Finding 5: Georgia's administrative requirements for behavioral health providers are generally in line with other states. (p. 22)
None

Appendix B: Objectives, Scope, and Methodology

Objectives

This report examines the administrative requirements of behavioral health providers. Specifically, our examination set out to determine the following:

1. What is the current population of behavioral health care practitioners and providers?
2. Are the administrative requirements behavioral health care practitioners have to meet to work in Georgia duplicative and costly (to the practitioner)? If so, what actions can be taken to reduce duplication and cost?
3. Are the administrative requirements behavioral health care providers have to meet to work with Medicaid clients in Georgia duplicative and costly (to the provider)? If so, what actions can be taken to reduce duplication and cost?
4. Are Georgia's licensure requirements aligned with other states?

Scope

This special examination generally covered activity related to the application, renewal, and ongoing monitoring of behavioral health care practitioners and providers in fiscal year 2021, with consideration of earlier or later periods when relevant. Information was obtained by reviewing relevant laws, rules, and regulations; interviewing agency officials and staff from DCH, DBHDD, and other state agencies as necessary; analyzing data from the Georgia Medicaid Management Information System (GAMMIS) Provider Enrollment system; and analyzing professional licensing data provided by the Secretary of State's (SoS) office. Based on the questions asked, cost savings to the state was not part of the scope of this review.

Government auditing standards require that we also report the scope of our work on internal control that is significant within the context of the audit objectives. While objectives two, three, and four contain elements of Georgia's Medicaid enrollment and monitoring processes, our review was limited to a description of these processes and whether any of them were duplicative or uncommon. Although providers we interviewed questioned the effectiveness of these process controls, they did not question the purposes of qualification checks or ongoing monitoring.

Methodology

To identify the populations of behavioral health care practitioners and providers, we obtained provider enrollment data from the DCH Provider Enrollment system managed through GAMMIS. DCH provider enrollment includes records for all providers with a contract for DBHDD-FFS (Community Based Services), or for providers with another contract type (either CMO only or a DCH-FFS contract) that had a behavioral health related specialty. We compared the data provided by DCH to a similar query of GAMMIS created by the Department of Audits and Accounts and determined the data was reliable for the purposes of our analysis. However, because individual practitioners had records for each specialty, contract, location, and business they worked with, we modified records in order to produce a single Medicaid ID number (MCD) record for each individual. This data was limited by the fact that for billing purposes, DCH assigns an MCD to both businesses and individuals, with identifiers representing each location where that business or individual works. Providers enrolled as businesses were modified by the audit team to produce a single

tax identification number although each might have multiple locations (MCDs) with multiple individuals working at each.

To identify the number of licensed behavioral health practitioners, we obtained licenses counts for a single point in time (September 2020) from the website of the SoS licensing boards for five professions and verified this information with the SoS office. We obtained similar data from the Composite Medical Board for their current number of actively licensed physicians. A data analyst with the Board of Health Care Workforce provided a subset of psychiatrists based on licensure renewal survey data. **This information is reflected in background sections of the report.**

To determine the extent to which administrative requirements of behavioral health care practitioners were costly and duplicative, we interviewed six practitioners about administrative burden they may have experienced in either licensure or working with the state. We also interviewed one professional organization that assists applicants with the initial licensure process. We reviewed SoS board rules and policies as well as the Georgia code associated with them. We compared these requirements with national reviews completed for objective 4. We interviewed staff within DCH, DBHDD, DJJ, and DHS to determine criminal history background check requirements. We interviewed the Georgia Bureau of Investigation's Georgia Criminal Information Center and reviewed Georgia code regarding the Rap Back program. **This information supports Findings 1 and 2.**

To determine the extent to which the administrative requirements of behavioral health care providers were costly and duplicative, we interviewed staff from HFRD, DBHDD, and DCH to identify the processes and procedures used to review provider applications. We also interviewed six providers to identify their experiences with state agencies and the application procedures. These providers represented different geographic locations and provider sizes throughout Georgia, and all had recently passed through the provider enrollment process. We also reviewed state law and agency rules and policies to identify the specific qualifications and documents required for successful enrollment and compliance of providers. We requested estimates of application processing time, because neither DCH nor HFRD could produce verifiable data. **This information supports Findings 3 through 5.**

To determine the extent to which Georgia's practices were in line with other states, we interviewed Medicaid program staff from Indiana, North Carolina, and South Carolina about their structural differences, application process for Medicaid providers, ongoing monitoring processes, and uses of credentialing and deeming. These states were identified in consultation with DCH and DBHDD as having similar organizational structures to Georgia. We also reviewed summaries of national organizations, including two that create and administer professional licensing examinations for three professions and required criteria to join interstate compacts for three additional professions. **This information supports Finding 5.**

We conducted this special examination in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Performance Audit Division was established in 1971 to conduct in-depth reviews of state-funded programs. Our reviews determine if programs are meeting goals and objectives; measure program results and effectiveness; identify alternate methods to meet goals; evaluate efficiency of resource allocation; assess compliance with laws and regulations; and provide credible management information to decision makers. For more information, contact us at (404)656-2180 or visit our website at www.audits.ga.gov.