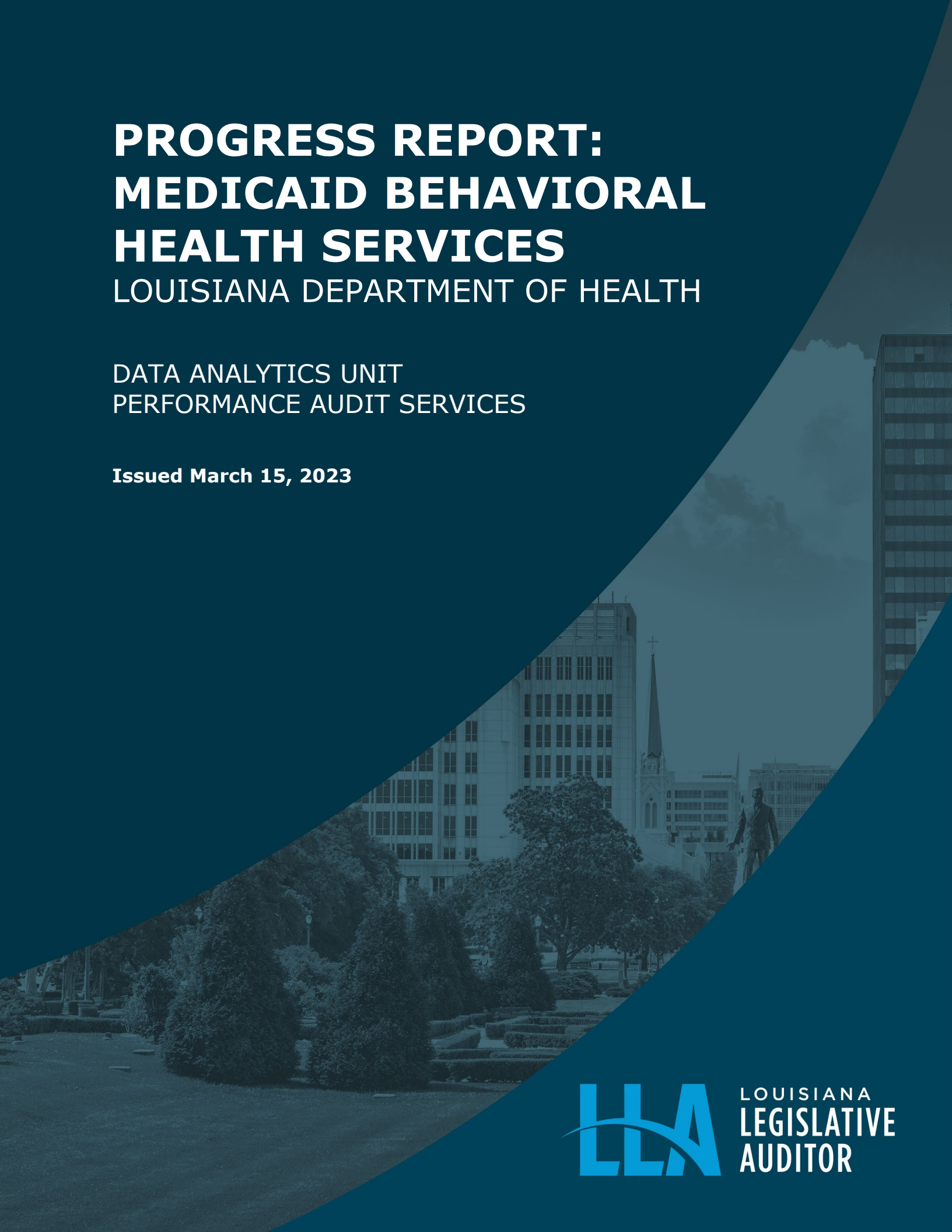
PROGRESS REPORT: MEDICAID BEHAVIORAL HEALTH SERVICES

LOUISIANA DEPARTMENT OF HEALTH

DATA ANALYTICS UNIT
PERFORMANCE AUDIT SERVICES

Issued March 15, 2023



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March 15, 2023

The Honorable Patrick Page Cortez,
President of the Senate
The Honorable Clay Schexnayder,
Speaker of the House of Representatives

Dear Senator Cortez and Representative Schexnayder:

The purpose of this audit report was to evaluate the progress the Louisiana Department of Health (LDH) has made in addressing issues previously identified in the behavioral health program and to suggest additional analyses LDH could perform to identify risky provider billings.

Between May 2019 and March 2021, we released five Data Analytics Unit audit reports that identified ways LDH could strengthen its monitoring of requirements in state law, LDH's Behavioral Health Provider Manual, and LDH Informational Bulletins as they relate to the Behavioral Health and Specialized Behavioral Health (SBH) services offered by Louisiana's Medicaid Behavioral Health Program.

We found that LDH has implemented three recommendations to identify and correct certain SBH claims and encounters improperly billed. For example, the department established controls to ensure that all claims and encounters identify the individual providing services and that the individuals providing services do not provide more than 12 hours of services in a single day. As a result, the amount of potential improper payments decreased from $10,798,003 to $631,195. However, one provider did not include a required National Provider Identifier (NPI) because they have a special contracted rate approved by LDH. In addition, LDH suspended the edit check that identified providers billing over 12 hours in April 2021.

In addition, we found that LDH has not yet implemented two recommendations to identify and correct other SBH improper payments but has contracted with a vendor to do so. For example, LDH has not implemented controls or monitoring to ensure that all claims and encounters are properly coded and paid at the correct rate. As a result, we identified approximately $11,267,643 paid for services that were potentially improperly billed.

We also found LDH has not implemented two recommendations to develop edit checks to prevent or flag certain potentially improper billings for review. For example, LDH has not developed controls to monitor claims and encounters for

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services billed when the recipient is actually located in an inpatient facility or when the recipient is billed as receiving services from two providers on a single day, or to ensure telehealth services are properly coded. As a result, we identified approximately $2,297,499 paid for services that were potentially improper or were not properly coded.

In addition to the above, we identified additional edit checks, controls, and procedures LDH could implement to identify high risk providers and potentially improper SBH claims and encounters such as monitoring for (1) services provided to children on school days, (2) services provided to children under age two, (3) individuals who receive more than four hours of services during a single day, (4) services provided to individuals who no longer reside in Louisiana, and (5) SBH providers who do not appear to be reporting wages to the Louisiana Workforce Commission.

This report contains our findings, conclusions, and recommendations. I hope it will benefit you in your legislative decision-making process.

We would like to express our appreciation to the Louisiana Department of Health for its assistance with this report.

Respectfully submitted,

Michael J. “Mike” Waguespack, CPA
Legislative Auditor

MJW/aa

Louisiana Legislative Auditor

Michael J. "Mike" Waguespack, CPA

Progress Report: Medicaid Behavioral Health Services
Louisiana Department of Health

March 2023

Audit Control # 82220002

Introduction

We evaluated the Louisiana Department of Health's (LDH) progress towards addressing issues identified in five Data Analytics Unit audit reports published between May 2019 and March 2021. These reports identified ways LDH could strengthen its monitoring of requirements in state law, LDH's Behavioral Health Provider Manual (Provider Manual),[1] and LDH Informational Bulletins (Informational Bulletins) as they relate to the Behavioral Health and Specialized Behavioral Health[2] (SBH) services offered in Louisiana's Medicaid Behavioral Health Program. We also analyzed additional monitoring LDH could perform to identify risky provider billings within the program.

Enforcing program requirements through routine data analyses and/or edit checks is important because noncompliance may indicate improper payments or potential fraud. Monitoring the SBH program is also important because of ongoing concerns with the integrity of SBH services and providers. LDH and other stakeholders, such as the Medicaid Fraud Control Unit (MFCU) within the Attorney General's Office, have identified SBH providers as an area of potential risk and noncompliance. For example, from August 2019 through February 2023,

Community Psychiatric Support and Treatment (CPST) is a comprehensive service, which focuses on reducing the disability resulting from mental illness, restoring functional skills of daily living, building natural supports, and solution-oriented interventions intended to achieve identified goals or objectives as set forth in the individualized treatment plan.

Psychosocial Rehabilitation (PSR) services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community and/or culture with the least amount of ongoing professional intervention.

Crisis Intervention (CI) services are provided to a person who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience, through a preliminary assessment, immediate crisis resolution and de-escalation and referral and linkage to appropriate community services to avoid more restrictive levels of treatment.

Source: LDH Provider Manual as of October 10, 2022.

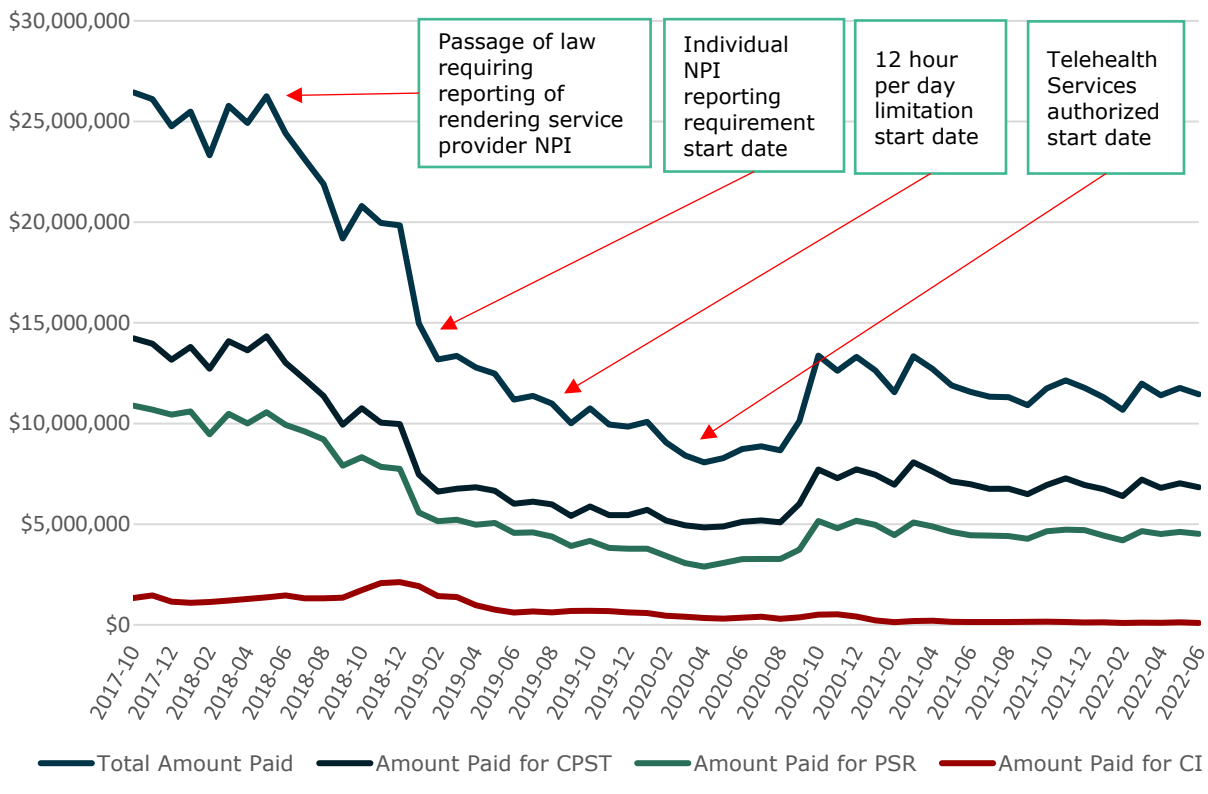
[1] The Provider Manual outlines rules for the behavioral health program, including service limitations, utilization, allowed provider types and specialties, and eligibility criteria. Providers are responsible for ensuring services are delivered in accordance with the Provider Manual.

[2] SBH services are distinguished from basic behavioral health services (basic BH services) in that basic BH services are provided to recipients in their primary care physician's office as part of primary care service activities. SBH services can include PSR, CPST, and CI.

798 of the 1,971 (40.5%) fraud referrals and case notices[3] received by LDH were for behavioral health providers or behavioral health services. In response to issues with the integrity of the SBH program, the legislature passed laws during the 2018[4] and 2019[5] Regular Legislative Sessions to create additional controls within the SBH program. Further changes were made to the 2019 law during the 2022 Regular Legislative Session to redesign certain SBH services.

Monitoring controls and preventing potentially improper payments in the SBH program are critical because of the amount paid for Psychosocial Rehabilitation (PSR), Community Psychiatric Support and Treatment (CPST), and Crisis Intervention (CI) claims and encounters, which totaled $824.3 million from October 2017 through June 2022. Exhibit 1 shows the amount paid for these services, the effects of the passage of laws cited above, and LDH's authorization of the use of telehealth.

Exhibit 1
All PSR, CPST, and CI Paid Services
October 1, 2017, through June 30, 2022



* National Provider Identifier (NPI) is a unique identification number for health care providers assigned by the United States Department of Health and Human Services.
Source: Prepared by legislative auditor's staff using LDH Medicaid data.

[3] Includes fraud referrals and case notices received from the five managed care organizations (MCOs), Magellan Complete Care of Louisiana, Inc. (Magellan), and its dental care organizations.
[4] Louisiana Revised Statutes (La. R.S.) 40:2162
[5] La. R.S. 46:460.77.1

Previous LLA audits evaluated LDH oversight and provider compliance with these requirements and found issues, such as SBH providers not complying with state laws requiring PSR and CPST services billed to identify the individual providing services and limiting the number of hours of service an individual provider can bill as providing on a single day. Previous LLA audits also found issues related to SBH providers not complying with LDH policies regarding the proper coding of services and how services are delivered. The objective of this audit was:

To analyze progress made by LDH to address previously identified issues in the behavioral health program and to identify additional analyses LDH could perform to identify risky provider billings.

Our results are summarized on the next page and discussed in detail throughout the remainder of the report. Appendix A contains LDH's response, while Appendix B details our scope and methodology.

Objective: To analyze progress made by LDH to address previously identified issues in the behavioral health program and to identify additional analyses LDH could perform to identify risky provider billings.

Overall, we found that LDH has taken some steps to identify and correct certain improperly billed SBH claims and encounters and has procedures planned to identify and correct others. However, we found that LDH needs to further strengthen its oversight of SBH providers because certain potentially improper billing patterns continue to exist and have not been addressed by LDH.

- **LDH implemented three recommendations made in previous audit reports to identify and correct certain SBH claims and encounters improperly billed, thereby reducing potential improper payments.** For example, LDH implemented controls to ensure all claims and encounters identify the individual providing services and to ensure that the individuals providing services do not bill more than 12 hours of CPST and PSR in a single day. As a result, the amount of potential improper payments decreased from $10,798,003 to $631,195. However, one provider did not include a required NPI because they have a special contracted rate approved by LDH. In addition, LDH suspended the edit check that identified providers billing over 12 hours in April 2021.

- **LDH has not yet implemented two recommendations made in a previous audit report to identify and correct SBH improper payments but has contracted with a vendor to do so.** For example, LDH has not implemented controls or monitoring to ensure that all claims and encounters are properly coded and paid at the correct rate. As a result, we identified approximately $11,267,643 paid for services that were potentially improperly billed.

- **LDH has not implemented two recommendations made in a previous audit report to develop edit checks to prevent or flag for review certain potentially improper billings.** For example, LDH has not developed controls to monitor for claims and encounters for services billed when the recipient is actually located in an inpatient facility, when a recipient is billed as receiving services from two providers on a single day, or to ensure proper coding of telehealth services. As a result, we identified approximately $2,297,499 paid for services that were potentially improper or were not properly coded.

In addition to the above analyses, we identified additional edit checks, controls, and procedures LDH could implement to identify high risk providers and potentially improper SBH claims and encounters such as monitoring for services provided to children under age two and instances where individuals received more than four hours of services during a single day. Our findings and our recommendations are discussed in more detail in the sections below.

LDH implemented three recommendations made in previous audit reports to identify and correct certain SBH claims and encounters improperly billed, thereby reducing potential improper payments.

State law, the Provider Manual, and Informational Bulletins each provide guidance regarding the requirements and exceptions for how SBH services should be rendered, billed, and reimbursed. This guidance details areas such as how providers should be identified when billing services and the maximum number of hours an individual provider can bill on a single day. LDH implemented controls to identify and correct issues related to these requirements.

We found that 411 claims totaling $48,658 were paid by Managed Care Entities (MCEs)[7] and submitted as encounters[8] to LDH by 28 providers for PSR and CPST services billed from March 20, 2019, through April 16, 2020,[9] but did not include the National Provider Identifier (NPI)[10] of the individual who provided the service, which is required by state law.[11] In addition, we found that another provider, which has a special contracted rate approved by LDH, submitted and was paid for 3,920 claims totaling $3,486,555 between April 4, 2019, and September 22, 2022, that did not include the required NPI and may violate this state law. Prior to January 1, 2019,

Our previous report[6] found that from January 1, 2019, through March 31, 2019, 114,963 (40.2%) of the 286,307 billed services representing $10.5 million (40.4%) of the $26.0 million paid by MCEs for PSR and CPST services and submitted as encounters to LDH were in violation of this state law.

[6] https://app.lla.state.la.us/publicreports.nsf/0/466e17299aac9851862583fc0053761d/$file/id_behavioral_health.pdf?openelement&.7773098

[7] As of June 2022, MCEs include five MCOs, a Behavioral Health Prepaid Inpatient Health Plan operated by Magellan, and two Dental Prepaid Ambulatory Health Plans. The MCEs analyzed in this report include the five MCOs and Magellan.

[8] An encounter is a distinct set of healthcare services provided to a Medicaid member enrolled with an MCE on the date that the services were delivered. It is a claim paid by the MCE but submitted to LDH.

[9] Providers have 365 days to bill for services rendered, so these numbers represent a subset of the overall claims that will eventually comprise this period. However, the claims currently included in this timeframe were paid by the MCEs and accepted by LDH.

[10] We used the Centers for Medicare and Medicaid Services NPI database, which is a publicly-available database that identifies individual and business NPIs.

[11] La. R.S. 40:2162

individuals rendering PSR and CPST services were not required to be identified on claims or to have an NPI. Because of this, SBH providers billing for these services could list a business NPI as the rendering service provider and were not required to identify the individual who provided the services. From January 1, 2012, through December 31, 2018 (prior to the law being in place), business NPIs were identified as the rendering service provider for approximately $1.2 billion (88.2%) of the $1.4 billion in claims and encounters paid for PSR and CPST services. This limited LDH, the MCEs, and MFCU's ability to properly manage and monitor the SBH program, because it prevented them from identifying the individuals who were providing the services and the number of hours of services they provided each day. The passage of this law provided LDH with additional program oversight and resulted in a decrease in the amount of PSR and CPST services billed and paid. For example, $24.8 million was paid for these services provided in May 2018 compared to $13.0 million (52.4%) being paid for the same services in January 2019, the first month in which Medicaid claims and encounters were required to identify the individual providing the service.

In our previous report, we recommended that LDH and the MCEs establish edit checks to ensure that PSR and CPST encounters meet requirements in state law, and LDH agreed with the recommendation. LDH stated that it and the MCEs implemented edit checks to deny encounters not meeting the requirements in state law. Of the 4,331 encounters identified by our analysis, 3,920 (90.5%) of them were billed by one provider. According to LDH, it does not require this provider to comply with the NPI requirements because the provider has a provider-specific rate listed on LDH's SBH fee schedule (fee schedule) allowing it to bill for PSR services in units of one month, whereas the fee schedule requires all other providers to bill for PSR services in units of 15-minute blocks. However, state law does not appear to allow LDH to make any exceptions to these reporting requirements. As a result, this provider billed and was paid $3,486,555 for services without identifying the individual(s) providing the service, meaning LDH does not have the same level of oversight for this provider as it does all other SBH providers subject to this requirement.

We found that 825 individual providers billed for more than 12 hours of combined PSR and/or CPST services during a single calendar day from August 2, 2019, through September 7, 2022. These

Our previous report[12] identified 315 individual providers who, from August 1, 2019, through March 9, 2020, billed for providing more than 12 hours of PSR and/or CPST services during a single calendar day, resulting in improper billings of at least $293,080.

[12] https://app.lla.state.la.us/publicreports.nsf/0/6038e4b99c8ceb17862585bb006bf73b/$file/rr_obh.pdf?openelement&.7773098

providers improperly billed at least $582,537[13] for the services provided in excess of 12 hours, which appears to violate state law.[14] According to LDH, although it is responsible for ensuring that providers do not bill more than 12 hours of services in a day, it relies on the MCEs to ensure that reimbursements comply with state law. However, monitoring compliance with this law is difficult for the MCEs because most SBH providers contract with more than one MCE and MCEs only have access to their own claims data. For example, one provider billed and was paid for providing 30.25 hours of services on July 30, 2021. This provider billed these services through all five MCEs and did not bill more than 12 hours of services through a single MCE. See Exhibit 2 for a breakdown of the billing of these services.

Exhibit 2
Services Billed as Provided on July 30, 2021

MCE	Hours Billed and Paid	Amount Paid
Aetna Better Health of Louisiana	2.0	$101.36
Amerihealth Caritas Louisiana	2.0	134.80
Healthy Blue	4.25	257.19
Louisiana Healthcare Connections	12.0	754.46
United Healthcare of Louisiana	10.0	506.80
Total Paid	**30.25**	**$1,754.61**

Source: Prepared by legislative auditor's staff using LDH Medicaid data.

As a result, a single MCE may not be able to monitor for compliance with this law if a provider contracts and bills for services through more than one MCE. For example, 3,430 of the 4,795 (71.5%) instances we identified where providers billed more than 12 hours in a day was not detectable by a single MCE because the provider did not bill more than 12 hours of services to a single MCE. One MCE was responsible for allowing 955 (70.0%) of the 1,365 instances where more than 12 hours were billed by a provider to one MCE during a single day. In addition, like the above example, we identified 16 instances where providers billed and were paid for providing more than 24 hours of services in a single day across multiple MCEs without billing more than 12 hours to a single MCE.

After recommending in our previous report that LDH monitor for compliance with this law since they are the only entity that has access to all Medicaid claims and encounter data, LDH implemented edit checks for this issue. However, LDH stated that it stopped using this edit check as of April 2021 because the majority of providers were complying with the law. This means providers could begin to bill for more than 12 hours and not be identified as quickly by LDH.

[13] Since the starting and ending times for behavioral health services are not included as a part of the encounters that are sent to LDH by the MCEs, we could not determine which services were rendered after 12 hours of services were provided. Therefore, we used the lowest cost per service billed by the rendering service provider on each day to calculate the minimum amount of overbilled services.
[14] La. R.S. 46:460.77.1

Matter for Legislative Consideration 1: The legislature may wish to clarify whether exceptions are allowed in La. R.S. 40:2162.

Recommendation 1: LDH should re-implement the edit check to identify providers billing for more than 12 hours in a day to identify any instances of improper billing and to identify potentially risky providers.

Summary of Management's Response: LDH partially agreed with this recommendation and stated that it instead reinstituted the quarterly report to identify providers billing a single Managed Care Entity (MCE) for more than 12 hours in a day and that its Program Integrity Section identifies providers who render services above the 12-hour limit to recipients enrolled in different MCE plans on the same calendar day. See Appendix A for LDH's full response.

LDH has not yet implemented two recommendations made in a previous audit report to identify and correct SBH improper payments but has contracted with a vendor to do so.

LDH's fee schedule details billing codes for procedures and the corresponding fee per unit of service that providers are paid for SBH services. While providers can enter into agreements with MCEs to be paid using special rates outside of this fee schedule, most providers are required to bill in accordance with the fee schedule.

We found that the MCEs and LDH have not implemented sufficient edit checks to ensure SBH services are properly billed, as we identified approximately $11,267,643 paid for 178,342 claims and encounters for services provided between July 1, 2021, and September 19, 2022, even though they did not comply with LDH's fee schedule. It is important that claims and encounter data is accurate and complies with LDH's fee schedule because it includes information that indicates the service provided, location where it was provided, age of the recipient, educational background of the person providing the service, and license(s) of the provider. In

Our previous reports[15] identified approximately $66.5 million in claims and encounters for services between December 2015 and June 2021 that were paid by LDH and the MCEs even though the claims and encounters did not comply with LDH's fee schedule.

[15] https://app.lla.state.la.us/publicreports.nsf/0/8737fac23fdc46d38625846b008009cc/$file/0001e10f.pdf?openelement&.7773098
https://app.lla.state.la.us/publicreports.nsf/0/dc0dad8e8d15867f862586b9004fca30/$file/00023459b.pdf?openelement&.7773098
https://app.lla.state.la.us/publicreports.nsf/0/0cd676c564443e6886258867007a7b84/$file/00027310.pdf?openelement&.7773098

addition, LDH and other stakeholders such as MFCU use this data to identify improper payments and potential fraud. LDH also uses encounter data to establish per member per month (PMPM) rates for the MCEs. We specifically found the following issues for SBH services provided between July 1, 2021, and September 19, 2022:

- Providers were paid $10,704,047 for 162,499 claims and encounters that were billed using incorrect procedure and modifier codes for SBH services provided between July 1, 2021, and September 19, 2022.

- Providers were paid $563,596[16] more than the amounts indicated on the fee schedule[17] based on the procedure code and modifier codes for the service for 15,843 claims and encounters for SBH services provided between July 1, 2021, and September 13, 2022.

LDH stated that it has contracted with a vendor to sample encounters against the fee schedule on a biannual basis to determine if they were paid appropriately, which is scheduled to be completed for the first time prior to the end of state fiscal year 2023.

Recommendation 2: LDH should use the results of its new sampling reviews to identify and correct improperly billed claims and encounters.

Summary of Management's Response: LDH agreed with this recommendation and stated that it has begun implementation of this recommendation and the results will be compiled and utilized to identify instances of claims for which the payment cannot be justified and to inform any necessary system changes and/or recoupments by the MCEs. See Appendix A for LDH's full response.

Recommendation 3: LDH should adjust the number of encounters and claims sampled and how frequently they are sampled based on the results of the reviews.

Summary of Management's Response: LDH agreed with this recommendation and stated that it will adjust the frequency and volume of encounter sampling and validation by the vendor if indicated. See Appendix A for LDH's full response.

[16] We removed all providers with special rates from our analysis. In addition, we removed all claims submitted by providers who do not specialize in providing behavioral health services from our population to ensure that our analysis only included behavioral health services. For example, a claim submitted by a physician for an established patient office visit uses the same procedure code (99214) as a claim for an established patient office visit submitted by a Psychiatrist.
[17] Providers were paid a total of $1,493,184 for these 15,843 encounters and claims. However, they would have been paid $929,588 if the encounters and claims were paid using the rates listed on the fee schedule.

LDH has not implemented two recommendations made in a previous audit report to develop edit checks to prevent or flag for review certain potentially improper billings.

We found that LDH has not planned or implemented edit checks or processes previously recommended by the LLA to identify possible high-risk providers within the SBH program. Implementing controls to prevent and/or flag the claims and encounters identified in this finding could strengthen the integrity of the SBH program by enforcing requirements outlined in its Provider Manual and Informational Bulletins.

We identified $223,372 paid for 2,367 encounters billed from September 9, 2020, through September 22, 2022, where a recipient received PSR, CPST, or CI services while in an inpatient setting, which is prohibited by the Provider Manual. According to the Provider Manual, Medicaid recipients residing in an inpatient hospital setting are not permitted to receive PSR, CPST, or CI services from any provider other than the inpatient hospital.[19] However, we identified payments for PSR, CPST, and CI services that were billed as occurring while the recipients were in an inpatient setting, which could be an indicator of fraudulent billings. For example, one recipient was admitted to a behavioral health hospital on January 1, 2022, and discharged on January 7, 2022. According to Medicaid data, a different provider billed the Medicaid program and was paid $334 for providing SBH services to this recipient on each day that they were hospitalized from January 3, 2022, through January 6, 2022.

Our previous report[18] identified $455,846 in payments for 4,249 claims and encounters from December 2015 to August 2020 where an individual received PSR, CPST or CI services while in an inpatient setting, which is prohibited according to the Provider Manual.

We identified at least $75,349 paid for 1,688 instances billed from August 24, 2017, through September 15, 2022, where two different SBH providers were paid for providing

Our previous report[20] identified $806,898 in payments that potentially violated program requirements from December 1, 2015, through March 2, 2020. Our prior report only included instances where two providers were paid for providing the same service to the same recipient on the same day.

[18] https://app.lla.state.la.us/publicreports.nsf/0/05e02e4a5c97cbc98625869400655c46/$file/oversight%20of%20behavioral%20health%20provider%20requirement.pdf?openelement&.7773098

[19] If the Medicaid recipient is a resident of an institute for mental disease, such as a free-standing psychiatric hospital or psychiatric residential treatment facility, then these services are delivered as part of the institutional service and are not separately reimbursable by Medicaid.

[20] https://app.lla.state.la.us/publicreports.nsf/0/05e02e4a5c97cbc98625869400655c46/$file/oversight%20of%20behavioral%20health%20provider%20requirement.pdf?openelement&.7773098

PSR or CPST services[21] to the same Medicaid recipient on the same day, which is prohibited by the Provider Manual. According to the Provider Manual, recipients may only receive PSR or CPST services from one provider at a time, with exceptions.[22] A Medicaid recipient receiving the same service on the same day from two different providers may indicate that one of the services was not actually provided.

For example, during a prior audit of an SBH provider,[23] we identified 44 services involving two workers providing one-on-one services to the same recipient, on the same day during overlapping times. However, LDH currently does not receive the starting and ending times of services as a part of claim and encounter data that is submitted. As a result, LDH cannot determine if services billed for a single recipient by two providers on the same day overlap without obtaining further documentation. LDH requires starting and ending times of service for direct care workers providing home and community-based services as a result of providers not complying with program requirements, so there is precedent for capturing this information within the Medicaid program. In addition, the Task Force on Coordination of Medicaid Fraud Detection and Prevention Initiatives recommended in December 2018[24] that LDH conduct a feasibility study to determine if there was value in pursuing an electronic visit verification system for behavioral health services. However, LDH did not pursue the feasibility study, because it stated that other reforms were being put in place to strengthen oversight of the program.

We identified $1,998,778 in payments for 29,406 encounters billed from March 31, 2020,

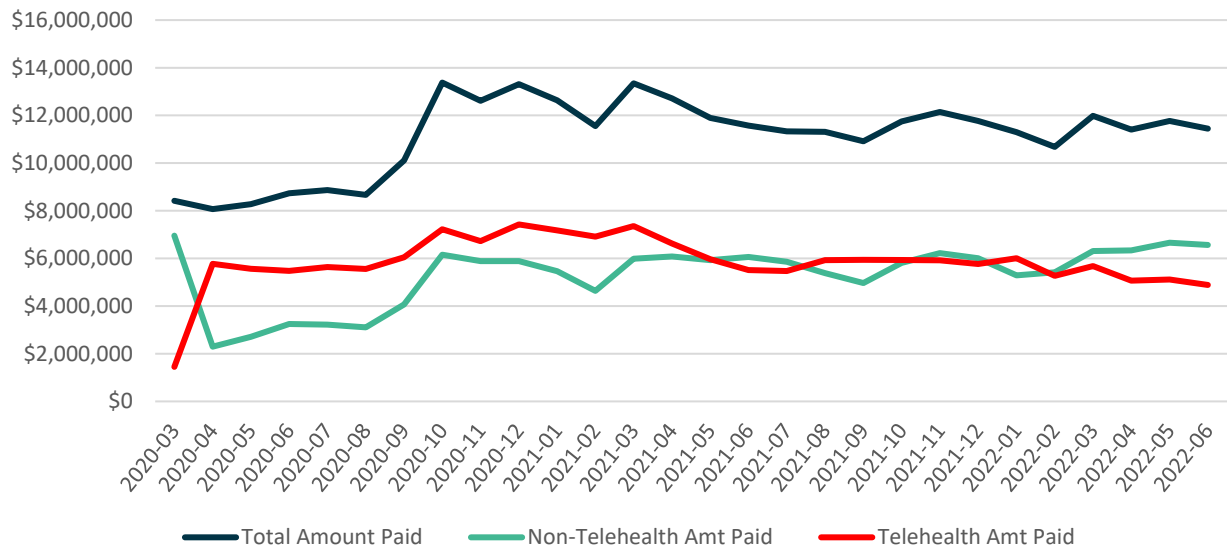
Our previous report[25] identified $219,965 in payments that were not properly coded for telehealth services provided from March 20, 2020, through September 12, 2020.

[21] This report contains additional transactions that were not identified in our prior report because one provider billed for providing CPST while the other provider billed for providing PSR to the same individual on the same day, whereas our prior report only identified instances where the same service was bill by two providers for the same individual on the same day.
[22] There are three exceptions that allow this to occur, including (1) if a recipient is receiving tenancy support through the permanent supportive housing program, (2) if the behavioral health medical director for the member's health plan makes the determination that it is medically necessary and clinically appropriate to receive services from more than one provider, or (3) if the recipient is transferring to a new provider. The Medicaid claims and encounter data does not contain information regarding medical necessity or appropriateness, but we removed all instances where a recipient was receiving tenancy support through permanent supportive housing since this is identifiable within Medicaid claims and encounter data.
[23] https://app.lla.state.la.us/publicreports.nsf/0/786993bd4c0df24f8625858a0067a03d/$file/new_horizon.pdf?openelement&.7773098
[24] https://app.lla.state.la.us/publicreports.nsf/0/df615498414217f886258369006586ba/$file/0001b23e.pdf?openelement&.7773098
[25] https://app.lla.state.la.us/publicreports.nsf/0/05e02e4a5c97cbc98625869400655c46/$file/oversight%20of%20behavioral%20health%20provider%20requirement.pdf?openelement&.7773098

through September 22, 2022,[26] where SBH providers did not properly code SBH services delivered via telehealth. Through Informational Bulletins 20-4[27] and 20-6,[28] LDH issued approval for SBH services to be rendered by SBH providers via telehealth beginning on or after March 20, 2020. According to these bulletins, when providing SBH services via telehealth, providers must use specific modifier and place-of-service codes when submitting these claims for reimbursement. However, these 29,406 encounters were missing either the required modifier or one of the required place-of-service codes.

Requiring providers to use these codes but not enforcing the requirement undermines the integrity of the program, as telehealth services account for $163.4 million (52.4%) of all PSR and CPST services paid for the period March 1, 2020, through June 30, 2022, as shown in Exhibit 3.

Exhibit 3
Analysis of Telehealth PSR and CPST Services
March 1, 2020 through June 30, 2022



Source: Prepared by legislative auditor's staff using LDH Medicaid data.

For example, it is difficult to determine if an individual provider who bills for providing 12 hours of services during a day to individuals in their homes would be physically able to provide these services when the claim is not properly coded as telehealth. In addition, we found that LDH does not currently have any policies or guidance regarding the location, setting, or environment in which a provider should be located when providing telehealth services. For example, we identified instances where providers billed for providing telehealth services while they were on

[26] The scope of this audit overlaps with the scope of our prior audit because providers have 365 days to bill for services rendered, and our prior audit only covered six months of telehealth services.
[27] https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2020/IB20-4_rev_5.17.22.pdf
[28] https://ldh.la.gov/assets/docs/BayouHealth/Informational_Bulletins/2020/IB20-6_rev_5.17.22.pdf

vacation. Currently LDH has no guidance regarding whether an environment such as a vacationing provider's hotel room is an appropriate location to provide telehealth services.

According to the Inspector General for the United States Department of Health and Human Services (HHS OIG), state efforts to evaluate and oversee telehealth are critical to meet Medicaid enrollees' behavioral health needs and to safeguard the Medicaid SBH program from potential fraud, waste, and abuse. In addition, the HHS OIG recommends that states evaluate the effects of telehealth to ensure the effective use of it to improve health outcomes for different populations. After performing this audit and providing our initial results, LDH implemented an edit check in January 2023 that denies telehealth claims and encounters that do not contain the required modifier or place-of-service codes.

Recommendation 4: LDH should develop policies and guidance to obtain the beginning and ending times for each PSR and CPST claim and encounter received.

Summary of Management's Response: LDH disagreed with this recommendation and stated that this field is not a requirement of federal claim forms and that its provider manual requires service/progress notes to document the start and stop time of service contact. LDH further stated that the beginning and ending time is reviewed as part of Program Integrity's audit record review of time-based procedure codes. See Appendix A for LDH's full response.

LLA Additional Comments: Capturing beginning and ending times for all claims and encounters, similar to the requirement for other home and community-based services in the Medicaid program, would allow LDH to flag any claims and encounters that meet risky behavior instead of only those reviewed as part of an audit record review.

Recommendation 5: LDH should enforce the inpatient services requirement in the Provider Manual.

Summary of Management's Response: LDH partially agreed with this recommendation and stated that these services provided by an MHR provider should not occur during an inpatient stay with certain exceptions. See Appendix A for LDH's full response.

Recommendation 6: LDH should enforce the telehealth coding requirements of Informational Bulletins 20-4 and 20-6.

Summary of Management's Response: LDH agreed with this recommendation and stated that it has implemented the recommendation by establishing an edit to deny encounters that do not have the appropriate

telehealth modifier and place of service coding combination. See Appendix A for LDH's full response.

Recommendation 7: LDH should develop policies and guidance regarding the environment from which telehealth services should be provided.

Summary of Management's Response: LDH partially agreed with this recommendation and stated that per CMS, federal Medicaid law and regulations do not specifically address telehealth service delivery methods and that underlying services must continue to meet the requirements of the overarching provisions of the Social Security Act. See Appendix A for LDH's full response.

LDH could implement additional edit checks, controls, and procedures to identify high-risk providers and potentially improper SBH claims and encounters.

As mentioned previously, state law, the Provider Manual, and Informational Bulletins each give guidance regarding how SBH services should be provided, billed, and reimbursed. Past LLA reports on SBH services identified various issues or "red flags" associated with the billing practices of SBH providers, which were then combined together and used to create a risk-matrix of high-risk providers. In comparing the results of our risk-matrix to fraud referrals and case notices received by LDH from MCE Special Investigative Units (SIUs) and open and closed cases investigated by MFCU, we found that the risk-matrix identified both "high-risk" providers with cases and ones without cases. We conducted audits of two of the providers[29] without cases and found that the risk-matrix is a good indicator of high-risk activities.

LDH has developed its own risk-matrix (scorecard) to rank overall non-compliance and risk for potential overpayments for all provider types and individual providers. This is important since only LDH can comprehensively monitor individual provider behavior by analyzing all claims and encounters in the Medicaid program. Combining the results of the analyses described above and additional ones described below could allow LDH to supplement its scorecard to focus its monitoring activities on the riskiest providers. We used the results from the following analyses and identified two SBH business providers which appeared in all five analyses and 51 SBH business providers which appeared in four of the five

[29] LLA conducted audits of the SBH providers Destined for A Change, Inc. and New Horizon Counseling Agency, LLC after identifying them using our risk-matrix. Audit reports for these two providers can be found: https://app.lla.state.la.us/publicreports.nsf/0/2e6ddebff529792286258663006a80f7/$file/00022661_1.pdf?openelement&.7773098 and https://app.lla.state.la.us/publicreports.nsf/0/786993bd4c0df24f8625858a0067a03d/$file/new_horizon.pdf?openelement&.7773098

analyses, all of which could be considered high-risk providers. Further, LDH has not received any fraud referrals or case notices for 13 (24.5%) of these 53 providers.

We found that from January 23, 2019, through September 22, 2022, providers billed and were paid $4,748,007 for providing eight or more hours of non-group PSR and/or CPST services to children between ages 6 and 17, on school days, in their home (outside of school).[30] These providers would potentially need to work at questionable times of the day in order to provide the services at the recipients' homes outside of school hours. For example, one provider billed and was paid $1,110 for providing 16.5 hours of non-group PSR and CPST services to six children in their homes on a school day. This means that, not including drive time between locations, if this provider began working at 7:00 a.m., they had to provide services non-stop and during school hours, until 11:30 p.m. In addition, the children seen during school hours would have missed a portion of their school day. This provider also billed these services to two MCEs, meaning all hours worked by this provider on this day were not visible to a single MCE.

A previous LLA audit identified instances where providers were able to bill for providing services to two recipients during the same periods of time because the starting and ending times for each service are not included in the billing data. For example, a prior LLA report identified 15 instances involving a worker billing and being paid for providing individual (one-on-one) services to two recipients during time periods which overlapped. However, as discussed previously, LDH currently cannot use Medicaid data to identify overlapping billings because it does not require providers to submit service starting and ending times.

We found that from August 28, 2017, through September 22, 2022, providers billed and were paid $2,364,791 for providing PSR, CPST, or CI services to 553 children who were under age two on the date of service. We also found that $516,715 of these services were billed as being provided via telehealth. According to LDH's provider manual, PSR, CPST, and CI services should provide skills building and supports that build on existing strengths and target goals related to these key developmental needs and protective factors. The Provider Manual requires a standardized assessment be performed on all recipients ages six and up prior to receiving PSR or CPST services and does not require a standardized assessment for children under age six. However, providers are required to obtain prior authorization from MCEs before providing services to these recipients.

While conducting previous audits, OBH's Medical Director told auditors that it may not be appropriate for children ages two and under to receive PSR, CPST, or CI and that they instead may need to receive a different, evidence-based service.

[30] Our analysis only covered the months of January, February, March, April, September, October, and November. We also excluded the following dates during each year from our analysis: the first week of January, Martin Luther King Jr. Day, the week of Mardi Gras, Good Friday, Labor Day, and the week of Thanksgiving.

However, LDH stated that it does not currently monitor the amount of services provided to children under age six because it is the responsibility of the MCEs. Our analysis of claims and encounters identified these high-risk services paid by MCEs and accepted by LDH for children under the age of two. For example, one provider was paid $3,703 for providing 25 hours of services from Sunday, July 26, 2020, through Tuesday, July 28, 2020, to a five-month-old. In a second example, one provider was paid $1,101 for nine hours of services that were billed as being provided to a nine-month-old on November 16, 2021.

We found that from December 1, 2015, through September 10, 2022, 12,046 recipients received more than four hours of PSR and/or CPST services during a single day. The providers of these services were paid at least $3,085,434 for providing the services that occurred after the first four hours. State law and LDH policies do not limit the amount of SBH services a recipient can receive on a single day, but state law does limit the amount of PSR and CPST services an individual provider can bill for performing during a single day to 12 hours. While conducting previous audits, OBH's Medical Director told auditors that, in their opinion, recipients should be limited to three hours of PSR and/or CPST per day, three days per week. OBH's Medical Director also stated that recipients who receive 10 to 15 hours or more of PSR and/or CPST may need intensive care services rather than outpatient services.

According to LDH, it currently does not perform procedures to monitor, flag, and review instances where large amounts of services are received by a recipient on a single day. However, repeated billing for unusual amounts of services per day for individual recipients could be a sign of possible fraudulent billing practices. For example, one provider billed and was paid $730 for providing nine hours of services to a six-year-old child on a Saturday in January 2020. Identifying a threshold to flag and review services provided over a certain amount could identify potentially risky behavior. Other states[31] have implemented limitations on the amount of PSR and/or CPST services that recipients may receive during a single day. For example:

- Virginia limits PSR to 45 minutes per day,
- New York limits CPST to 1.5 hours per day and PSR to two hours per day,
- Oklahoma limits the amount of PSR that recipients can receive up to 1.5 hours per day but allows for exceptions when documentation demonstrates the medical necessity of the amount services. According to the state of Oklahoma's policies and rules, these "service limitations were designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits.", and

[31] As of July 2021, 41 states used managed care models to deliver services in Medicaid.

- Ohio pays providers at 50% of their reimbursement rate for any PSR or CPST services provided to a single recipient in excess of 1.5 hours on the same day.

We found that from August 29, 2017, through September 22, 2022, 122 providers billed and were paid $716,708 for providing services to 216 recipients who appear to have resided outside of the State of Louisiana on the days the services were billed as being provided. Being a resident of Louisiana is one of the primary requirements for recipients to be eligible for Louisiana's Medicaid program. As part of this audit, we obtained notices sent to the Louisiana Office of Motor Vehicles (OMV) by other states to notify OMV that an individual(s) with a Louisiana driver license or identification card recently obtained a driver's license or identification card in another state. We compared this data to Medicaid recipients who received SBH services and identified 216 recipients who were billed by providers as receiving services after the date they obtained a driver's license or identification card in another state. For example, OMV was notified in June 2021 that an individual obtained a new driver's license in the State of Missouri. However, a provider billed for providing 231 services totaling $12,328 to this recipient between July 2, 2021, and August 26, 2022. Based on these 216 recipients appearing to now reside in other states, these providers may have submitted fraudulent encounters for services not actually provided.

We found that from January 2019 through June 2022, 397 behavioral health providers billed and were paid $682.3 million for providing services[32] during quarters[33] in which they did not report any employee wages to the Louisiana Workforce Commission (LWC). Further, 209 (52.6%) of these providers were paid $476.7 million (69.9%) and appear to have reported no wages to LWC during this time period or reported wages under a different tax identification number.[34] LDH implemented a new provider enrollment portal through which all individuals and businesses had to register by September 30, 2022, in order to provide SBH services through Louisiana's Medicaid program. As part of this registration, all businesses must register using their tax identification number and all individuals must register using their social security number. Since LDH receives this information, it could perform a data match of its providers to LWC wage data to ensure that providers enrolled to provide SBH services in its Medicaid program are complying with state law[35] which requires employers to electronically report employee wages quarterly to the LWC.

[32] This amount includes all services provided during this time period.
[33] A quarter is comprised of three months with January, February, and March comprising the first quarter; April, May, and June the second quarter; July, August, and September the third quarter; and October, November, and December the fourth quarter.
[34] These providers were paid for Medicaid services but did not report wages between one and 14 quarters during this time.
[35] La. R.S. 23:1531.1

This is important because, as previously reported by the LLA,[36] failure to report employee wages is a possible indicator of worker misclassification which occurs when an employer improperly classifies a worker as an independent contractor instead of an employee. Improperly classifying workers can result in nonpayment of state and federal unemployment taxes, income taxes, and payroll taxes; loss of worker protections under occupational health and safety laws; less access to workers' compensation insurance coverage; and unfair competitive advantages for companies. These costs can be significant to the state and because misclassified workers typically do not have workers' compensation insurance, the state may ultimately pay for their care if they are injured on the job. During fiscal year 2018, LDH's Medicaid program paid more than $1 billion for uncompensated care, which includes care for misclassified workers injured on the job.

Worker misclassification involves the misclassification of employees as independent contractors by employers in order to gain a competitive advantage through reduced labor costs.

Although it is LWC's responsibility to monitor for employee misclassification, LDH is in a unique situation in that it is aware of the individuals who are providing SBH services and the businesses to which the payments are being made for their services, unlike LWC which is unaware unless wages are reported to them by the SBH business provider. Due to this, LDH has access to data that can identify possible misclassified workers that is not available to LWC. A provider that is willing to misclassify its employees could be considered a high-risk provider who may be willing to improperly bill for services. However, LDH stated that it does not have plans to identify providers not complying with this state law, which could also be used to inform its scoring model.

Recommendation 8: LDH should incorporate the analyses listed throughout this report into its oversight of behavioral health providers.

Summary of Management's Response: LDH agreed with this recommendation and stated that its Program Integrity unit developed its own internal risk scoring matrix for all Medicaid provider types and is implementing a new fraud detection solution that will incorporate this matrix and additional information. See Appendix A for LDH's full response.

[36] https://app.lla.state.la.us/publicreports.nsf/0/f196798490a63b418625841f0070c89f/$file/0001d0de.pdf?openelement&.7773098

APPENDIX A: MANAGEMENT'S RESPONSE

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

March 9, 2023

VIA E-MAIL ONLY

Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Progress Report: Medicaid Behavioral Health Services

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor dated February 24, 2023, regarding progress toward addressing issues identified in five Data Analytics Unit audit reports published between May 2019 and March 2021. LDH appreciates the opportunity to provide this response to your office's findings.

Finding: LDH implemented three recommendations made in previous audit reports to identify and correct certain SBH claims and encounters improperly billed, thereby reducing potential improper payments.

Recommendation 1: LDH should re-implement the edit check to identify providers billing for more than 12 hours in a day to identify any instances of improper billing and to identify potentially risky providers.

LDH Response: LDH partially concurs with this recommendation.

While we did not implement an edit check, LDH has reinstituted the quarterly report generated to identify providers billing a single Managed Care Entity (MCE) for more than 12 hours in a day, for circulation to, and, if necessary, remediation by the MCE. Further, the internal SURS Unit under the direction of the LDH Medicaid Program Integrity Section also identifies agencies that have individual behavioral health service providers who rendered services above the 12 hour limit to recipients enrolled in different MCE plans on the same calendar day.

Finding: LDH has not yet implemented two other recommendations made in a previous audit report to identify and correct SBH improper payments but has contracted with a vendor to do so.

Recommendation 2: LDH should use the results of its new sampling reviews to identify and correct improperly billed claims and encounters.

LDH Response: LDH concurs with this recommendation.

LDH has begun the implementation of this recommendation, as our vendor has audited the MCEs' SBH encounter data for quarter 2 of calendar year 2022. Myers & Stauffer disseminated examples of potential, improperly paid encounters to each of the MCEs, and requested that they review these examples and provide support for the modifiers used and the amount paid. This support could include age information, provider billing instructions for these services, or specific provider payment arrangement which would be used to determine the appropriate fee and support the payment on the claim. The results of this initial review have been received from all of the MCEs, and are currently being analyzed. The results will be compiled and utilized to identify instances of claims for which the payment cannot be justified, and to inform any necessary systems changes and/or recoupments by the MCEs.

Recommendation 3: LDH should adjust the number of encounters and claims sampled and how frequently they are sampled based on the results of the reviews.

LDH Response: LDH concurs with this recommendation.

If indicated, LDH will adjust the frequency and volume of encounter sampling and validation by the vendor.

Finding: LDH has not implemented two other recommendations made in a previous audit report to develop edit checks to prevent or flag for review certain potentially improper billings.

Recommendation 4: LDH should develop policies and guidance to obtain beginning and ending times for each PSR and CPST claim and encounter received.

LDH Response: LDH does not concur with this recommendation.

Neither the CMS 1500, nor the EDI 837-P have a time of service field, as this is not a requirement of those federal claim forms. However, the Medicaid BHS Provider Manual Record Keeping chapter (Ch. 2.6, p. 7) requires that the service/progress notes document the start and stop time of service contact.

As part of Program Integrity's audit record review, for any provider type billing time-based procedure codes (i.e. waiver, physicians, therapy), the beginning and end time is reviewed. The time documented is compared to the unit that was billed. Program Integrity's impossible day (+12 hours) audits focus on this area of review.

Recommendation 5: LDH should enforce the inpatient services requirement in the Provider Manual.

LDH Response: LDH partially concurs with this recommendation.

LDH agrees that Psychosocial Rehabilitation (PSR), Community Psychiatric Support and Treatment (CPST), and Crisis Intervention (CI) services provided by MHR providers during an inpatient psychiatric hospital stay should not occur during the stay, but may occur on the patient's admission or discharge day. However, MHR services provided in a general hospital may be allowed. Professional services provided above and beyond general services in an acute care hospital are allowable, including Licensed Mental Health Professional (LMHP) services and MHR services. MHR services are not a standard hospital service.

Recommendation 6: LDH should enforce the telehealth coding requirements of Informational Bulletins 20-4 and 20-6.

LDH Response: LDH concurs with and has implemented this recommendation.

LDH, via LIFT 12637, has implemented an edit to deny encounters that do not have the appropriate telehealth modifier and place of service coding combination.

Recommendation 7: LDH should develop policies and guidance regarding the environment from which telehealth services should be provided.

LDH Response: LDH partially concurs with this recommendation.

Per CMS, federal Medicaid law and regulations do not specifically address telehealth delivery methods or the criteria for implementation of telehealth. However, underlying services must continue to meet the requirements of the overarching provisions in Title XIX of the Social Security Act (the Act), regulations, and the federal policy framework of the covered Medicaid benefit.

Recommendation 8: LDH should incorporate the analyses listed throughout this report into its oversight of behavioral health providers.

LDH Response: LDH concurs with this recommendation.

The Program Integrity unit developed its own internal risk scoring matrix which includes all 100+ Medicaid provider types. Program Integrity is implementing a new fraud detection solution that will incorporate its internal risk scoring matrix and other data sources including those provided by the LLA.

You may contact Karen Stubbs, OBH Assistant Secretary by telephone at (225) 342-1435 or by e-mail at karen.stubbs@la.gov with any questions concerning this matter.

Sincerely,

Jacques Molaison
Chief of Staff

APPENDIX B: SCOPE AND METHODOLOGY

This report provides the results of our data analytics unit audit of the Louisiana Department of Health (LDH). We conducted this audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This audit covered December 1, 2015, through September 22, 2022. Our audit objective was:

To analyze progress made by LDH to address previously identified issues in the behavioral health program and to identify additional analyses LDH could perform to identify risky provider billings.

To conduct this analysis, we performed the following steps:

- Obtained Medicaid data from LDH, including claims and encounters, recipients, and providers.
- Obtained driver's license data from the Louisiana Office of Motor Vehicles.
- Obtained employee wage data from the Louisiana Workforce Commission.
- Obtained the National Provider Identification database from the Centers for Medicaid and Medicare website.
- Researched relevant laws, rules, and regulations.
- Researched relevant LDH policies, procedures, and informational bulletins.
- Obtained from Managed Care Organizations and Magellan lists of providers with special rates outside of LDH's fee schedule.
- Met with LDH staff to gain an understanding of the program, monitoring activities and to discuss preliminary results.
- Used SQL, Audit Command Language, and Excel to analyze Medicaid data to determine compliance with state law, LDH's Provider Manual and Informational Bulletins.