

ACCESS TO COMPREHENSIVE AND APPROPRIATE
SPECIALIZED BEHAVIORAL HEALTH SERVICES
IN LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH



PERFORMANCE AUDIT SERVICES
ISSUED FEBRUARY 14, 2018

**LOUISIANA LEGISLATIVE AUDITOR
1600 NORTH THIRD STREET
POST OFFICE BOX 94397
BATON ROUGE, LOUISIANA 70804-9397**

LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

ASSISTANT LEGISLATIVE AUDITOR
FOR STATE AUDIT SERVICES
NICOLE B. EDMONSON, CIA, CGAP, MPA

DIRECTOR OF PERFORMANCE AUDIT SERVICES
KAREN LEBLANC, CIA, CGAP, MSW

**FOR QUESTIONS RELATED TO THIS INFORMATIONAL REPORT, CONTACT
CHRIS MAGEE, PERFORMANCE AUDIT MANAGER,
AT 225-339-3800.**

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

February 14, 2018

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Taylor F. Barras
Speaker of the House of Representatives

Dear Senator Alario and Representative Barras:

This report provides the results of our evaluation of access to specialized behavioral health services in Louisiana. The purpose of this report is to evaluate whether Louisiana Medicaid recipients have access to comprehensive and appropriate specialized behavioral health services.

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

We would like to express our appreciation to the management and staff of the Louisiana Department of Health and other stakeholders interviewed for their assistance during this audit.

Sincerely,

A handwritten signature in blue ink that reads "Daryl G. Purpera". The signature is fluid and cursive.

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/aa

SPECIALIZED BEHAVIORAL HEALTH SERVICES ACCESS

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE



Access to Comprehensive and Appropriate Specialized Behavioral Health Services in Louisiana

February 2018

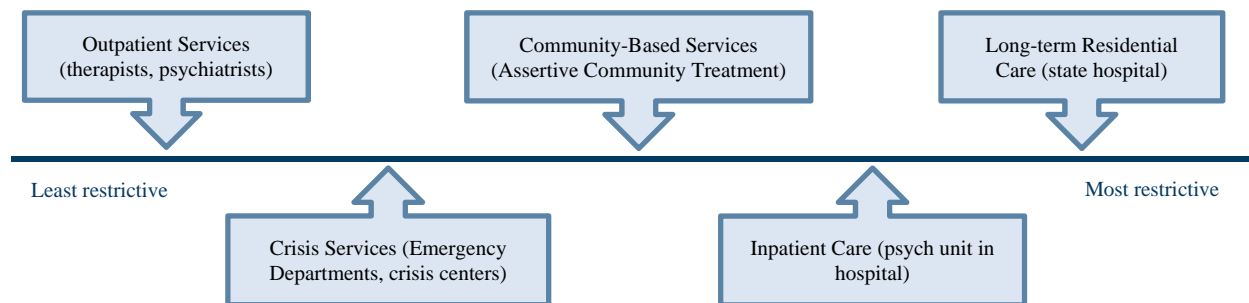
Audit Control #40160027

Introduction

We evaluated the access Medicaid recipients have to comprehensive and appropriate specialized behavioral health¹ (SBH) services in Louisiana. SBH services, which include services such as psychosocial rehabilitation (PSR), assertive community treatment, therapy, and crisis intervention, are designed to treat mental health and substance use issues.² Mental Health America’s 2015 report³ listed Louisiana as one of five states in the nation with the highest prevalence of mental illness and lowest rates of access to care, as Louisiana ranks 47th among states – 35th for adults and 48th for youth. Stakeholders⁴ we interviewed across Louisiana also stated that the current array of services offered to Medicaid recipients is not comprehensive because of gaps in community-based services and an insufficient number long-term behavioral health beds. See Appendix B for a summary of stakeholders we interviewed or surveyed.

Individuals with behavioral health needs should have access to appropriate and comprehensive services that range from least restrictive settings, such as outpatient therapy, to more restrictive settings, such as inpatient hospitalization.⁵ Exhibit 1 illustrates examples of SBH services from least to most restrictive.

Exhibit 1: Examples of Specialized Behavioral Health Services



¹ SBH services are provided in a behavioral health setting, while basic behavioral health services are not. Basic behavioral health services are provided by MCOs through primary (physical) care services, such as a physician.

² Although behavioral health services include substance use, this report primarily focuses on mental health services.

³ <http://www.mentalhealthamerica.net/sites/default/files/Parity%20or%20Disparity%202015%20Report.pdf>

⁴ We interviewed various stakeholders throughout the audit, including those from the Office of Behavioral Health, Local Government Entities, coroners, advocacy groups, sheriffs, state psychiatric hospitals, and private hospitals with emergency departments.

⁵ <https://www.turningpnt.org/programs-services-agencies/>;

http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Continuum-Of-Care-For-Children-And-Adolescents-042.aspx

Louisiana recently changed the way it delivers SBH services. Beginning in 2012, LDH transitioned to a managed care model for behavioral health services. Under this model, LDH paid a Prepaid Inpatient Health Plan (PIHP), Magellan, a per-member per-month fee to manage a recipient’s SBH services, in contrast to the fee-for-service model where LDH was responsible for managing the services. In December 2015, LDH integrated behavioral health services into the existing physical health contracts with five Managed Care Organizations.⁶ In addition, LDH has closed state-run public hospitals that historically served the SBH population. Providers involved in delivering SBH services to individuals are shown in Exhibit 2.

Exhibit 2 SBH Provider Roles	
Entity	Description
Office of Behavioral Health (OBH)	Within the Louisiana Department of Health and provides statewide authority and accountability for all behavioral health care for Louisiana citizens, which includes coordinating between other agencies and partnering with entities that deliver and manage components of care for the insured and uninsured.
Local Government Entities (LGE) such as Human Service Districts and Authorities	Provide community and safety net behavioral health services through themselves and contractors at the local level to Medicaid, indigent, and private pay clients at 10 locations throughout the state.
State Hospitals	Provide behavioral health inpatient care to forensic, civil, and intermediate patients to Medicaid, indigent, and private pay clients at two locations in Louisiana, one in Pineville and one in Jackson.
Medicaid Managed Care Organizations (MCOs)	These five MCOs provide insurance coverage for behavioral health services for Medicaid recipients enrolled in <i>Healthy Louisiana</i> plans.
Private Providers	Contract with insurance companies to provide behavioral health services to the insurance plan’s members. This includes providers such as psychiatrists, social workers, and counselors and facilities such as Psychiatric Residential Treatment Facilities, Mental Health Rehabilitation Agencies, and hospitals with emergency departments.
Source: Prepared by legislative auditor’s staff using information from OBH.	

This report is the second report on SBH services, and it primarily focuses on the impact managed care has had on access to comprehensive and appropriate services. In our first report, issued October 18, 2017, we found that OBH needed to strengthen its monitoring processes to ensure that there were an adequate number of qualified SBH providers to serve the Medicaid population. The objective of this report was:

To evaluate the access Medicaid recipients have to comprehensive and appropriate specialized behavioral health services in Louisiana.

The issues we identified are summarized on the next page and discussed in further detail throughout the remainder of the report. Appendix A contains LDH’s response, and Appendix B details our scope and methodology.

⁶ These MCOs include Aetna, Amerihealth Caritas, Healthy Blue, Louisiana Healthcare Connections, and United Healthcare.

Objective: To evaluate the access Medicaid recipients have to comprehensive and appropriate specialized behavioral health services in Louisiana.

We found that Louisiana does not always provide Medicaid recipients with comprehensive and appropriate specialized behavioral health services. The issues and challenges we identified, along with recommendations to assist LDH to address them, are:

- **Although the expenditures for SBH services increased from approximately \$213 million in 2012 to \$445 million in 2016, approximately \$266 million (60%) of 2016 expenditures were for psychosocial rehabilitation and community psychiatric support and treatment, which are not evidence-based services and are difficult for LDH to monitor.** In contrast, the number of individuals receiving two of the four Medicaid evidence-based services decreased after SBH services were moved into managed care. Providing evidence-based services is important because these services have been shown to produce positive outcomes and reduce costs.
- **Case management services help ensure that individuals receive appropriate and coordinated care. Although LDH requires that MCOs offer case management for SBH services, MCOs reported that only 7.4% of individuals served by case management had a behavioral health diagnosis.** Given that only a small number of individuals received these services and MCOs are required to identify and offer these services, LDH should develop a method to monitor these services beyond self-reported information by the MCOs.
- **MCOs are required by their contracts to maximize the availability of community-based SBH services to reduce the use of emergency rooms and eliminate preventable hospital admissions. However, according to surveys of both hospitals and coroners, there are not enough accessible community-based services in Louisiana. Also, data shows that Medicaid recipients continue to access emergency rooms for SBH services.** According to survey responses from 36 hospitals, 85% of respondents stated there are not adequate community-based services, and 76% of respondents do not believe that appropriate follow-up treatment and care services are available once they release patients. Coroners also cited the lack of community resources as a reason that commitments have increased.
- **Although Louisiana has two state psychiatric hospitals, they only serve adults. There are no state psychiatric hospitals for the adolescent or youth populations. In addition, the closure of state psychiatric hospitals and decrease in the number of funded long-term beds has resulted in longer waiting lists for individuals who need more restrictive care.** The waiting list at Central Louisiana State Hospital increased from 62 in June 2016 to 79 in

February 2017, while total beds available decreased from 354 in 2012 to 225 in 2016.

- **Individuals with behavioral health needs are served in inappropriate settings, such as prisons and nursing facilities, that do not always provide needed services. For example, of the 4,084 individuals with a primary behavioral health diagnosis in nursing facilities, 49% did not receive any SBH services.** According to the Department of Corrections, 25% of inmates have a mental illness. In addition, the United States Department of Justice filed a lawsuit against Louisiana in December 2016 for unnecessarily relying on nursing facilities to serve people with serious mental illness rather than providing services in the most integrated setting appropriate to their needs.
- **Budget cuts have affected the state's ability to provide comprehensive and appropriate SBH services to Medicaid recipients. These challenges have resulted in gaps in services and a lack of data integration among providers, which contributes to fragmented care.** Decreased funding and budget cuts have decreased the state's ability to pay for needed SBH services and have led to delays in providing services to address gaps in SBH services.

These issues are discussed in detail below.

Although the expenditures for SBH services increased from approximately \$213 million in 2012 to \$445 million in 2016, approximately \$266 million (60%) of 2016 expenditures were for psychosocial rehabilitation (PSR) and community psychiatric support and treatment (CPST), which are not evidence-based services and are difficult for LDH to monitor.

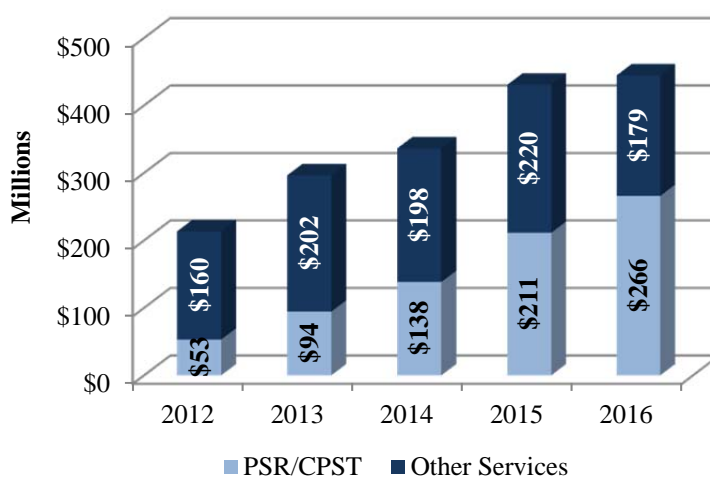
Expenditures for SBH services have more than doubled since 2012, from approximately \$213 million in 2012 to \$445 million in 2016,⁷ as shown in Exhibit 3. Approximately \$266 million (60%) of these expenditures in 2016 were for PSR and CPST; however, neither of these services is considered an evidence-based practice. PSR and CPST services as a percentage of overall SBH expenditures have increased from 24% in 2012 to 60% in 2016.

PSR services can be provided by unlicensed providers with a high school degree operating under an agency license. CPST services can also be performed by unlicensed individuals, as long as they meet educational or experience requirements. Both of these services are difficult to monitor because LDH requires that 51% of these services be provided in community settings where the individual lives, works, attends school, or socializes instead of an office setting. This makes it difficult for LDH to verify whether services are provided.

⁷ These numbers do not include the expansion population. If expansion were included, expenditures in 2016 would total \$470 million.

Monitoring is also difficult because unlicensed providers are not required to get a National Provider Identification number, so they are not included in Medicaid data. As a result, LDH cannot use Medicaid data to determine who specifically provided the services. The Attorney General’s Medicaid Fraud Control Unit (MFCU) and program integrity staff within the five MCOs stated that they have seen an increase in the number of fraud cases involving these services, including services billed that were never provided and services that were provided by unqualified staff.

Exhibit 3
SBH Expenditures
December 1, 2012 to November 30, 2016



Research has shown that evidence-based services, which include Assertive Community Treatment, Homebuilders, Functional Family Therapy, and Multi-Systemic Therapy, result in positive outcomes for recipients and reduce service costs in other areas.⁸ According to OBH staff, there are some instances where evidence-based services are not appropriate due to individuals having multiple behavioral health issues. The number of Medicaid recipients receiving evidence-based services increased in the years prior to the integration of behavioral health into managed care. In addition, the number of Medicaid recipients receiving Assertive Community Treatment services, which primarily serve adults, and Homebuilders, which primarily serves families with children, increased since SBH moved into managed care; however, the number of Medicaid recipients receiving the other two evidence-based services analyzed, which are primarily for youth, decreased as shown in Exhibit 4.

⁸ <http://www.mentalhealthamerica.net/positions/evidence-based-healthcare>;
<http://www.wsipp.wa.gov/BenefitCost?topicId=8>

Exhibit 4 Number of Individuals Receiving Evidence-Based Services* December 1, 2014 to November 30, 2016				
Service	Description	Prior to Integration	After Integration	Percent Change
Assertive Community Treatment	Addresses functional problems of primarily adult individuals with the most complex behavioral health conditions.	1,534	2,160	34.5%
Homebuilders	Targets families with children at imminent risk of out-of-home placement or being reunified from placement.	264	264	0.0%
Functional Family Therapy	Targets youth primarily demonstrating externalizing behaviors or at risk for developing more severe behaviors which affect family functioning.	1,647	1,414	-14.1%
Multi-Systemic Therapy	Provides an intensive home, family, and community-based treatment for youth at risk of out-of-home placement or who are returning from out-of-home placement.	1,957	1,843	-5.8%
<p>*According to Medicaid claim and encounter data, between December 1, 2012, and November 30, 2013, there were 1,198 individuals who received Assertive Community Treatment, 326 individuals who received Homebuilders services, 650 individuals who received Functional Family Therapy, and 2,214 individuals who received Multi-Systemic Therapy. Source: Prepared by legislative auditor’s staff using Medicaid data.</p>				

To help fund evidence-based services, Louisiana, like other states, receives federal Mental Health Block Grant funding, which is used to finance community-based mental health services that help to address service gaps and other mental health needs across the state.⁹ In Louisiana, these funds flow through OBH and are disbursed to the 10 LGEs. Louisiana’s 2016 Mental Health National Outcome Measures report, in which the state reports on how it used its block grant funding, shows that Louisiana ranks below the national average in providing state-run adult and child and adolescent evidence-based practices. For example, LGEs provided Multi-Systemic Therapy services to seven (0.4%) of the estimated 1,570 Louisiana children identified by the LGEs as having a severe mental illness in 2016, compared to 3.6% in the 18 other states that provide Multi Systemic Therapy.¹⁰ According to OBH staff, these reports are limited because states are not able to list all evidence-based practices offered on the report template. For example, cognitive behavioral therapy is an evidence-based service offered by the LGEs that is not captured in this report.

Recommendation 1: LDH should ensure that it funds evidence-based services, as these services have proven to demonstrate positive outcomes for individuals with behavioral health needs.

Summary of Management’s Response: LDH agrees with this recommendation and stated that it has seen a significant increase in members receiving two evidence-based practices. It has also worked with its provider organizations to ensure that only qualified providers are delivering services.

⁹ This grant funding is used by the states to deliver these services. Service providers report the number of services provided.

¹⁰ These reports show those individuals receiving evidence-based services through the LGE, and they include individuals on Medicaid, private insurance, and those without insurance. These reports do not include Medicaid recipients who receive these services from other, non-LGE providers in the Medicaid program.

Case management services help ensure that individuals receive appropriate and coordinated care. Although LDH requires that MCOs offer case management for SBH services, MCOs reported that only 7.4% of individuals served by case management had a behavioral health diagnosis.

Case managers assist individuals with identifying and locating necessary and appropriate services and supports, developing individualized treatment plans, and monitoring to ensure services and supports are provided; however, few SBH recipients actually received this service. In Louisiana, the MCO’s *Healthy Louisiana* contracts require them to develop and offer a case management program in which they work with Medicaid recipients who have high-risk, unique, chronic, or complex needs, including recipients with and without SBH needs. According to case management reports submitted by the five MCOs, Medicaid recipients with a behavioral health diagnosis code comprised 1,895 (7.4%) of the 25,726 Medicaid recipients receiving case management in December 2016. In addition, 249,277 Medicaid recipients who received a Medicaid service had a behavioral health diagnosis code in the year after moving into managed care. This means that 0.8% of Medicaid recipients with a behavioral health diagnosis received case management services from the MCOs. Exhibit 5 summarizes this information by MCO. According to the MCO contracts, the MCOs cannot require Medicaid recipients to participate in their case management programs.

Exhibit 5			
Percent of Members with Case Management Services by MCO			
December 2016			
MCO	Total Members with Case Management*	Members with Case Management Services with BH Diagnosis Code	% of Members with Case Management Services
Aetna	15,502	140	0.9%
AmeriHealth Caritas	3,471	1,083	31.2%
Healthy Blue	1,656	34	2.1%
Louisiana Healthcare Connections	1,869	443	23.7%
United Healthcare	3,228	195	6.0%
Total	25,726	1,895	7.4%
*Case management is also provided to other high-risk, unique, chronic, or complex need groups. These are unaudited numbers self-reported by the MCOs to LDH.			
Source: Prepared by legislative auditor’s staff using self-reported data from MCOs.			

Case management is an important tool for ensuring that individuals receive coordinated and appropriate SBH services and supports. Currently, OBH monitors these services through quarterly reports submitted by the MCOs because there is no way to identify case management services in Medicaid data. Given that only a small number of individuals received these services and MCOs are required to identify and offer these services, LDH should develop a method to monitor these services beyond self-reported information by the MCOs. According to OBH staff,

it is developing a new behavioral health case management report that will identify the Medicaid recipients receiving this service and help OBH monitor utilization of services.

Recommendation 2: LDH should develop a more effective method to ensure MCOs are offering required case management services, such as behavioral health specific reports that identify individuals with a behavioral health diagnosis.

Summary of Management’s Response: LDH agrees with this recommendation and stated that it is in the process of revising its case management report to identify all Medicaid members who are receiving case management services.

Recommendation 3: LDH should analyze Medicaid encounter data for services received by case management-enrolled recipients reported on MCO reports to determine whether their cases are actually being managed.

Summary of Management’s Response: LDH agrees with this recommendation and stated that it will monitor specialized behavioral health services delivered to individuals identified in its new case management report.

MCOs are required by their contracts to maximize the availability of community-based SBH services to reduce the use of emergency rooms and eliminate preventable hospital admissions. However, according to surveys of both hospitals and coroners, there are not enough accessible community-based services in Louisiana. Also, data shows that Medicaid recipients continue to access emergency rooms for SBH services.

According to hospitals we surveyed that have emergency departments, adequate community-based SBH services do not exist, emergency departments do not have adequate bed space to meet demand, and there is a lack of appropriate follow-up services upon release. According to staff interviewed from hospitals with emergency departments, these facilities are not the appropriate place for individuals to be treated for most mental illnesses, as they are not designed to provide the level of unique care needed by an individual with behavioral health needs. This is similar to national findings from the American College of Emergency Physicians, who conducted a survey of its members and found that 80% of emergency room physicians say the mental healthcare systems in their regions are dysfunctional and do not adequately serve patients.¹¹ High emergency department utilization can indicate that there are insufficient community-based SBH services.

“There are many times when behavioral [health] patients remain in the ER for several days when they could have been discharged to outpatient services if [they] were accessible.”

Source: LLA Stakeholder Survey

¹¹ This survey involved 1,500 members of the American College of Emergency Physicians.

We surveyed 101 hospitals with emergency departments across the state and received 36 responses.¹² Twenty-nine¹³ hospitals stated that because adequate SBH services do not exist in the community, individuals in need of SBH services end up in the emergency room. Exhibit 6 summarizes results of our survey.

Exhibit 6	
Hospitals with Emergency Departments Survey Responses	
Survey Statement	Percentage of Respondents Who Disagreed or Strongly Disagreed
My community has adequate community-based services and providers to meet the behavioral health needs of the community.	85%
My emergency department has enough bed space to meet local demand.	79%
Once released, patients with behavioral health needs have access to the appropriate follow-up treatment and care through community-based services.	76%
Source: Prepared by legislative auditor’s staff using information from an LLA survey of hospitals with emergency departments in Louisiana.	

In addition, because of a lack of inpatient beds at behavioral health facilities, Medicaid recipients may occupy emergency department beds for excessive periods of time while waiting for a bed to become available. Although individuals are normally held in emergency departments for no more than 72 hours until an appropriate facility is found, data from multiple hospitals shows that individuals were held in emergency departments for more than 10 days. One survey respondent stated they held a patient for three months. According to MCO medical directors, one factor in not getting Medicaid recipients placed in beds is that the emergency departments do not always reach out to the MCOs. According to OBH staff, the MCOs are educating emergency departments on how to contact them to help with appropriate placements.

The number of involuntary commitments issued by coroners in 13 parishes for individuals needing SBH services increased by 41.6% from calendar year 2012 through 2016. Louisiana is the only state where a coroner is involved in the involuntary commitment process for people with behavioral health needs. Coroners issue Coroner Emergency Certificates (CECs) to involuntarily commit someone to a doctor’s care or to assess an individual who has been committed involuntarily by a physician through a Physician’s Emergency Certificate (PEC). The patient must be either unwilling or lack the capacity to seek care on their own in order to be involuntarily committed. The CEC allows an individual to be involuntarily committed for up to 72 hours, after which a determination must be made by a physician as to whether or not the individual needs to continue to be held involuntarily for up to 15 days to receive behavioral health care.

We surveyed coroners throughout the state on the usage of CECs and the behavioral health system in Louisiana as a whole. We also received CEC statistics from the surveyed coroners. For the 13 coroners who had CEC statistics from calendar year 2012 through 2016, we

¹² Respondents included at least two hospitals from each of LDH’s nine regions, 14 responses from rural parishes, and 22 responses from urban parishes. In addition, 20 respondents operated emergency departments with no psychiatric unit or dedicated psychiatric beds, and 16 emergency departments had an emergency department and dedicated psychiatric unit (both stand-alone psychiatric units and dedicated psychiatric beds within the emergency department).

¹³ There were 34 hospitals who answered the question regarding this topic.

found that the number of CECs increased 41.6%, from 25,181 in calendar year 2012 to 35,654 in calendar year 2016. Coroners cited a lack of access to behavioral health services and drug use as the primary drivers of the increased usage. Exhibit 7 summarizes the number of CECs issued by parish.

Exhibit 7 CECs by Parish* Calendar Year 2012 to 2016						
Parish	2012	2013	2014	2015	2016	% Change 2012-2016
Allen	554	487	487	806	855	54.3%
Ascension	891	930	723	800	758	-14.9%
Bossier	130	149	176	189	207	59.2%
Caddo	5,438	5,948	6,039	6,328	6,519	19.9%
Calcasieu	2,151	2,255	2,302	2,478	3,145	46.2%
East Baton Rouge	4,362	5,277	6,518	7,785	8,201	88.0%
Iberia	64	73	44	104	72	12.5%
Iberville	253	235	242	235	266	5.1%
Jefferson	3,268	3,375	3,285	3,440	3,300	1.0%
Lafayette	3,215	3,878	3,973	4,007	4,516	40.5%
Ouachita	1,838	1,868	2,169	2,114	2,362	28.5%
St. Tammany	2,143	2,604	3,693	3,867	4,133	92.9%
Terrebonne	874	940	1,031	1,274	1,320	51.0%
Total	25,181	28,019	30,682	33,427	35,654	41.6%
*These numbers include all individuals, not only Medicaid recipients. Source: Prepared by legislative auditor's staff using information from parish coroners.						

Community-based SBH services, such as crisis intervention services, can help interrupt or mitigate a crisis and help prevent unnecessary emergency room visits and commitments. However, Louisiana does not have any crisis receiving centers. According to the Substance Abuse and Mental Health Services Administration, a lack of access to essential services and supports is a factor that can lead to a behavioral health crisis. Although crisis intervention services provided to individuals experiencing a behavioral health crisis increased by 9.4%, from 196,407 in the year prior to integration to 215,082 in the year after integration, no crisis receiving centers¹⁴ exist in Louisiana. Prior to its closure in 2013, the Mental Health Emergency Room Extension (MHERE) at Earl K. Long Medical Center in Baton Rouge, which was a state-run hospital, provided a behavioral health emergency room option for an individual in a crisis to receive the appropriate level of care. According to coroners and staff from emergency rooms in the Baton Rouge area, individuals who used to receive the appropriate level of care at the MHERE may now end up receiving a lower level of care through a traditional emergency room.

In December 2016, voters in East Baton Rouge Parish defeated a millage proposal to fund a new crisis stabilization center for the parish. This center would have helped fill the void left by the MHERE closure. St. Tammany Parish is moving forward with its Safe Haven crisis stabilization center, which is projected to produce \$1.8 million in savings by preventing

¹⁴ A crisis receiving center is a provider that has no more than 16 beds and is licensed by LDH to provide crisis identification, intervention, and stabilization services for people in behavioral crisis.

avoidable psychiatric admissions. In addition, this center could create annual savings from \$3.3 million to \$6.9 million through preventing individuals with behavioral health needs from entering the corrections system.¹⁵ OBH staff stated that funding and administrative costs are barriers to having crisis receiving centers in Louisiana.

While emergency department utilization for behavioral health reasons decreased in the year after integration for the non-expansion population, the total number of Medicaid recipients using emergency rooms for behavioral health reasons increased due to expansion. As mentioned previously, both coroners and hospitals cited the increased use of emergency rooms as an indicator of insufficient community services. According to OBH staff, it analyzes emergency room usage for behavioral health purposes by identifying anyone with a behavioral health diagnosis code who visits the emergency room. The limitation of analyzing the data this way is that it could include, for example, an individual who has a diagnosis of anxiety who is in the emergency room being treated by an orthopedic surgeon. However, it also does not include individuals who are in psychiatric hospitals who do not have a behavioral health diagnosis code. Exhibit 8 shows the number of behavioral health visits before and after integration.

Exhibit 8			
Behavioral Health Emergency Department Visits			
12/1/2014 through 11/30/2016			
ER Visit Population	Before Integration	After Integration	Percent Change
Number of ER Visits - Not Expansion	28,605	28,218	-1.4%
Number of ER Visits - Expansion	0	9,517	
Total	28,605	37,735	31.9%
Source: Prepared by legislative auditor's staff using Medicaid claims and encounter data.			

As shown in the exhibit above, there are individuals in need of SBH services going to the emergency room for services instead of receiving them in the community. While there is always a need for individuals experiencing a behavioral health crisis to have access to the emergency room setting, having appropriate SBH community-based services is important as more Medicaid members have access to emergency rooms since expansion. Community-based services are a quicker, more effective, and less expensive way to treat individuals with behavioral health needs, and ensuring access to them can help to decrease the dependence upon emergency departments and subsequently lower the cost to the state. For example, it would cost \$1,100 for an individual to receive assertive community treatment for one month, \$3,168 to receive psychosocial rehabilitation for one month, \$17,675 to receive care in a state hospital for one month, or \$25,136 to receive psychiatric care within a distinct part psychiatric hospital for one month.¹⁶

Recommendation 4: LDH should ensure the MCOs meet their contractual requirement to maximize community-based services to decrease emergency room utilization and reduce preventable hospital admissions.

¹⁵ According the Safe Haven staff, this figure is based off of the Bexar County scale.

¹⁶ This hypothetical is based on the Medicaid fee schedule and uses the monthly per diem rate for assertive community treatment, 62.5 hours of PSR during the month, which would be the average per month based on the Service Definition Manual's maximum of 750 hours per year, and a full month's stay at a state psychiatric hospital or distinct part psychiatric hospital.

Summary of Management’s Response: LDH agrees with this recommendation and stated that the number of non-expansion Medicaid members accessing emergency rooms has decreased. In addition, LDH stated that current *Healthy Louisiana* member access surveys reflect members are generally satisfied with services available and access to community-based services.

Recommendation 5: LDH should determine whether its current methodology for identifying SBH services in emergency rooms is the most valid and comprehensive way to monitor emergency room utilization.

Summary of Management’s Response: LDH agrees with this recommendation and stated that it is currently using nationally-recognized best practices to measure emergency room utilization, but that it would continue to review best practices and adjust methodology as appropriate.

Although Louisiana has two state psychiatric hospitals, they only serve adults. There are no state psychiatric hospitals for the adolescent or youth populations. In addition, the closure of state psychiatric hospitals and decrease in the number of funded long-term beds has resulted in longer waiting lists for individuals who need more restrictive care.

Nationally, there is a shift away from institutionalization and towards more community-based services. Although institutionalization is the most restrictive setting, according to OBH, some individuals need this type of care.

Louisiana currently has no state psychiatric hospitals and four psychiatric residential treatment facilities that serve the adolescent or youth populations. As mentioned earlier, Louisiana ranked 48th in the nation in terms of youth with the highest prevalence of mental illness and lowest rates of access to care in 2015.¹⁷ The study also ranked Louisiana last in terms of children who needed but did not receive mental health services, as 54,563 (59.6%) of children needing services did not receive them.

“There continues to be a need for long-term care [in state psychiatric hospitals] for people unable to be maintained in the community.”

Source: LLA Stakeholder Survey

In 2009, the state-run New Orleans Adolescent Hospital closed due to budget cuts, increasing the need for SBH services to be delivered in the community to these individuals. Psychiatric Residential Treatment Facilities (PRTFs) in Louisiana provide inpatient psychiatric services to boys aged 5 to 18 and girls aged 11 to 18, and there are four PRTFs in Louisiana with a total of 138 beds as of December 4, 2017.¹⁸ According to OBH, adequate access to PRTFs is a

¹⁷ <http://www.mentalhealthamerica.net/sites/default/files/Parity%20or%20Disparity%202015%20Report.pdf>

¹⁸ Northlake Youth Academy closed effective December 4, 2017, reducing the number of PRTF beds in the state by 58.

necessary component of a comprehensive array of services for children. OBH notes that PRTF access is affected by provider availability and also may be affected by providers rejecting referrals of youth with particular needs, such as rejecting referrals for youth based on the youth’s aggressive behaviors, multiple unsuccessful residential treatment episodes, or complex co-occurring needs such as individuals with both developmental disabilities and behavioral health needs.

The closure of state psychiatric hospitals for adults and the decrease in the number of funded long-term beds has resulted in longer waiting lists for individuals who need more restrictive care. OBH stated that it moved away from institutionalization in accordance with national trends beginning in 2010.¹⁹ OBH closed Southeast Louisiana State Hospital (SLSH) and repurposed both Central Louisiana State Hospital (CLSH) and East Louisiana Mental Health System (ELMHS). CLSH primarily serves adults from the general public, while ELMHS primarily serves individuals court-ordered for competency or those adjudicated as not guilty by reason of insanity. While stakeholders recognize that long-term institutional care should be the last resort, they also note that institutionalization may be necessary for some individuals. However, waiting lists show that there may not be an adequate number of psychiatric beds in Louisiana. While there were 354 state-run beds for the general adult public in 2012, the number of available beds decreased to 225 in 2016 (36.4%). This includes 120 beds at CLSH and 105 beds at privately-run hospitals through Cooperative Endeavor Agreements (CEAs).²⁰ See Exhibit 9 for a summary of Louisiana changes to state hospital bed capacity. While the number of beds has decreased, Louisiana’s 13.2 beds per 100,000 residents is higher than the national average of 11.7.

Exhibit 9 Changes to State-Run Psychiatric Bed Capacity Calendar Year 2012 through 2016		
Hospital	Location	Change
CLSH	Pineville	Beds increased from 60 to 120 in 2012
ELMHS	Jackson	Beds increased from 118 to 175* in 2016
SLSH	Mandeville	Beds decreased from 176 to 0 in 2012**
CEAs	Statewide	Beds increased from 0 to 105 beginning in 2012
Total		Beds decreased from 354 to 225*
*While beds actually increased from 218 to 275 at ELMHS over this timeframe, 100 of them continue to be used for competency restoration of forensic clients. The 175 remaining civil beds are being used to ensure bed flow for the forensic operation, so there are really 0 beds for the general public. **Transfers of beds included 60 beds to CLSH, 38 to ELMHS, and 82 to private hospitals through CEAs. Source: Prepared by legislative auditor’s staff using information from OBH.		

The number of individuals on CLSH’s waiting list increased 27.4%, from 62 in June 2016 to 79 in February 2017. As of February 2017, 34 (43%) of the 79 individuals on the waiting list had been on it for longer than three months, including six individuals who had been on for more than one year. While CLSH is licensed for 196 beds, only 120 of them are in use. Being able to utilize all 196 licensed beds at CLSH could almost entirely eliminate the waiting list. According to OBH, however, it cannot increase the number of beds because it does not have

¹⁹ From 2010 to 2016, approximately 6,000 state hospital beds across the nation were eliminated.

²⁰ These CEAs are agreements between LDH and private hospitals to fill some of the vacated beds. An example includes the CEA between Northlake and LDH, whereby 58 CEA beds are operated.

adequate funding to provide sufficient staff for the increase in patients. In fiscal year 2018, CLSH's budget was decreased by \$661,249, which led to a reduction in the ability to pay for outside medical services required by patients, fill a psychiatrist position, and pay for pharmaceutical supplies. In addition, OBH staff stated that certain parts of the hospital campus cannot be used due to poor facility conditions.

Recommendation 6: LDH should evaluate the number of institutional beds and determine whether additional community-based services could alleviate the need for these beds.

Summary of Management's Response: LDH agrees with this recommendation and stated that a needs assessment will be conducted on LDH behavioral health facilities. In addition, LDH has engaged a consultant to facilitate a multi-department discussion focused on the adolescent behavioral health network mix of residential and community-based services.

Individuals with behavioral health needs are served in inappropriate settings, such as prisons and nursing facilities, that do not always provide needed services. For example, of the 4,084 individuals with a behavioral health primary diagnosis in nursing facilities, 49% did not receive any SBH services.

The availability of appropriate community services can prevent individuals from having to receive needed behavioral health care in inappropriate settings, such as prisons and nursing facilities. According to the Department of Corrections, approximately 25% of state offenders have serious mental health issues. According to the Treatment Advocacy Center, 44 states, including Louisiana, have a prison or jail that holds more individuals with serious mental illnesses than the largest remaining state psychiatric hospital.²¹ Several LGEs offer crisis intervention training for law enforcement in their regions to educate law enforcement on how to handle individuals with behavioral health issues.

In addition, the U.S. Department of Justice (DOJ) in December 2016 found that Louisiana violates the Americans with Disabilities Act by unnecessarily relying on nursing facilities to serve approximately 4,000 people with serious mental illness, rather than providing services in the most integrated setting appropriate to their needs. The DOJ further stated that Louisiana's systemic failure to provide appropriate community services places individuals who currently live in the community at serious risk of unnecessary institutionalization in nursing facilities. Without adequate access to appropriate services, which help stabilize and maintain functionality, individuals are more likely to experience behavioral health crises or receive care in settings that are not equipped to effectively treat mental health needs.

²¹ <http://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf>

Although residents in nursing homes are not eligible for physical health services through MCOs, they do receive SBH services through the MCOs. Using Medicaid encounter data, we identified 4,084 individuals housed in nursing facilities with a behavioral health primary diagnosis, as shown in Exhibit 10.

Exhibit 10		
Individuals with Behavioral Health Diagnosis in Nursing Facilities		
Diagnosis	Number	Percent
Depression	1,364	33.4%
Schizophrenia	1,030	25.2%
Other Mental Disorder	419	10.3%
Psychosis	391	9.6%
Bipolar Disorder	376	9.2%
Anxiety	230	5.6%
Intellectual Disability	191	4.7%
Substance Abuse	78	1.9%
PTSD	5	0.1%
Total	4,084	
Source: Prepared by legislative auditor’s staff using Medicaid encounter data.		

According to MCO contracts, MCOs are required to provide access to SBH services for individuals who are identified as needing SBH services while in a nursing facility. In calendar year 2016, LDH paid the MCOs approximately \$10.8 million in per-member per-month payments for SBH coverage for approximately 26,000 nursing home residents. However, of the 4,084 nursing facility residents with a primary behavioral health diagnosis, 1,996 (48.9%) did not have any SBH services while they were in the nursing facility.²² According to Medicaid encounter data, the remaining 2,088 received approximately \$5 million in SBH services, including 1,051 residents with \$3.6 million in behavioral/psychiatric health hospital stays. Other types of SBH services provided were group therapy and CPST.

Recommendation 7: LDH should ensure that residents in nursing facilities receive appropriate SBH services as needed.

Summary of Management’s Response: LDH agrees with this recommendation and stated that it is improving its processes related to the program, which ensures appropriate placements in nursing homes as it related to individuals with behavioral health conditions.

²² Some of these individuals may have been prescribed psychotropic medications to address their behavioral health issues; however, most prescription drugs are covered by Medicare, and we do not have access to Medicare data.

Budget cuts have affected the state’s ability to provide comprehensive and appropriate SBH services to Medicaid recipients. These challenges have resulted in gaps in services and a lack of data integration among providers, which contributes to fragmented care.

Budget reductions and cuts have decreased the state’s ability to fund comprehensive SBH services. As stated previously, the number of people receiving evidence-based SBH services decreased for two of the four services analyzed since integration, and some services, such as crisis receiving centers and inpatient hospitals for adolescents, do not exist at all. Budget cuts have also led to the elimination of positions and service provider contracts at the 10 LGEs across the state while also delaying the implementation of specific services to fill service gaps, such as crisis intervention teams.

“There are not enough resources for this population and due to the severity of the state budget cuts it has gotten worse and will continue.”

Source: LLA Stakeholder Survey

According to one of the LGEs we surveyed, budget reductions have caused entire levels of care to collapse in some communities. In addition, there are not enough services for individuals who get discharged from hospitals to move from a more restrictive level of care to a less restrictive level of care. Similarly, there are not enough resources to step people up from a less restrictive level of care to a more restrictive one, so these individuals end up being hospitalized. Exhibit 11 below shows annualized cuts and budget reductions affecting OBH in fiscal year 2018.

Exhibit 11 Budget Reductions and Annualized Cuts Fiscal Year 2018*		
Service	Reduction/Cut	Description
Medicaid Behavioral Health Services	\$48,953,549	Reduce CPST and PSR services through tightened eligibility guidelines, which could impact providers’ fiscal solvency and reduce access to these services for youth and adults that qualify for this level of care.
Services for uninsured populations	\$4,426,700	Elimination of the Louisiana Care Authorization Management program for the authorization of uninsured services and the Access to Recovery program for addiction recovery support services.
CLSH	\$661,249	Reduces the ability to pay for outside medical services required by patients, to fill a psychiatrist position which would provide services to patients, and to pay for pharmaceutical supplies needed by patients.
*This list is not inclusive of all cuts to OBH. Source: Prepared by legislative auditor’s staff using information from OBH.		

A lack of data sharing among behavioral health providers affects Medicaid recipients’ ability to receive coordinated care. According to stakeholders, a lack of continuity of care is a challenge they face when attempting to provide appropriate care to an individual with behavioral health issues. While Louisiana attempted to address data sharing issues through the Louisiana Health Information Exchange (LaHIE),²³ providers throughout the state are not

²³ LaHIE is administered by the Louisiana Health Care Quality Care Forum, which filed a lawsuit against LDH in December 2016 due to alleged defamation and a lack of funding to carry out its job duties.

required to participate in this exchange²⁴ and there has been no focus on getting behavioral health providers in the exchange. Some providers choose to not participate since they feel their data is proprietary or patient information is too sensitive to share, while others cite a lack of funding and high costs. OBH staff and providers specifically cite the confidentiality of substance use disorder information about patients²⁵ as a barrier to sharing information, as it places restrictions on the sharing of this information.

Not having shared electronic records results in the provider relying on the patient to provide medical history and medications, which may not be reliable. According to stakeholders and LaHIE staff, emergency departments in different hospital systems are not connected to one another. As a result, they are not able to see all relevant patient information unless given consent. Lack of data sharing also exists amongst different provider types. For example, coroners performing emergency commitments do not know the person's past medical history unless the individual is a past patient.

We saw examples in the Medicaid data where individuals received a variety of services across the state, including emergency rooms and psychiatric hospitals, and received differing behavioral health diagnoses. For example, one individual went to 136 different providers across the state, including 52 visits to the emergency room at hospitals from Shreveport to Lafayette to New Orleans. In many of these claims, the provider gave a different diagnosis for this individual, from major depressive disorder, to schizophrenia, to suicidal ideation. Not having electronic data makes it difficult for providers to reliably know a patient's past history and determine the most appropriate treatment approach.

Recommendation 8: Because of limited funds and budget cuts, LDH should ensure that the services it chooses to fund are comprehensive, appropriate, and result in positive outcomes for Medicaid recipients.

Summary of Management's Response: LDH agrees with this recommendation and stated that it has worked with provider organizations and the MCOs to implement reform measures, which has led to a significant increase in certain evidence-based services.

Recommendation 9: LDH should work with providers to eliminate barriers to sharing data where possible.

Summary of Management's Response: LDH agrees with this recommendation and stated that it will work with providers to explore alternatives or eliminate barriers as they are identified by providers.

²⁴ According to NORC at the University of Chicago, 59% of states enacted legislation supporting health information exchange and/or electronic health records. Louisiana did not enact legislation;
<http://www.norc.org/PDFs/Evaluation%20of%20the%20State%20Health%20Information%20Exchange%20Cooperative%20Agreement%20Program.pdf>.

²⁵ 42 CFR Part 2

APPENDIX A: MANAGEMENT'S RESPONSE



State of Louisiana
Louisiana Department of Health
Office of the Behavioral Health

February 6, 2018

Daryl G. Purpera, CPA, CFE
Legislative Auditor
P.O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Access to Comprehensive and Appropriate Specialized Behavioral Health Services in Louisiana

Dear Mr. Purpera:

Thank you for the opportunity to respond to the findings of your Performance Audit report on Access to Comprehensive and Appropriate Specialized Behavioral Health Services in Louisiana. The Louisiana Department of Health (LDH) Office of Behavioral Health (OBH) is committed to ensuring access to specialized behavioral health (SBH) services in order to promote recovery and resiliency in the community through services and supports that are preventive, accessible, comprehensive and dynamic.

Recommendation 1: LDH should ensure that it funds evidence-based services as these services have proven to demonstrate positive outcomes for individuals with behavioral health needs.

Agree. Over the last few years, OBH has seen a significant increase in members receiving two major evidence based practices, namely, Assertive Community Treatment (ACT) and Functional Family Therapy (FFT) services, and utilization of both continues to rise. OBH has worked with provider organizations and the MCOs to implement reform measures such as increased utilization management and more stringent network monitoring to ensure only qualified providers are delivering services.

Recommendation 2: LDH should develop a more effective method to ensure MCOs are offering required case management services, such as behavioral health specific reports that identify individuals with a behavioral health diagnosis.

Agree. OBH is in the process of revising the MCO case management reporting. The new report, to be implemented by June 2018, will include a behavioral health

specific break out and identify all individual Medicaid members who are receiving case management services. However, according to federal regulation 42 CFR §441.18, case management service cannot be mandated. The MCO is required to “offer” this service to a member but may not force the member to participate in all or part of the service. Specifically, the MCO may not compel an individual to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

In addition, OBH utilizes an external quality review organization to review a sample of case management records to ensure that the MCOs are providing case management services in accordance with contract requirements.

Recommendation 3: LDH should analyze Medicaid encounter data for services received by case management-enrolled recipients reported on MCO reports to determine whether their cases are actually being managed.

Agree. As mentioned in the response to Recommendation 2, with the revised report identifying enrollees in the case management program, OBH will be monitoring specialized behavioral health services and associated outcomes related to people enrolled in case management and related services. However, monitoring for an increase in services does not equate to being actively case managed. Case management’s purpose may be to sustain current services, comply with regular services like appointment attendance or medication management, or referral to non-Medicaid managed care services like tobacco and gambling addiction services.

Recommendation 4: LDH should ensure the MCOs meet their contractual requirement to maximize community-based services to decrease emergency room utilization and reduce preventable hospital admissions.

Agree. This is currently done through the MCO rate setting process. The state’s contracted actuary performs analysis of MCO encounter data and identifies emergency department (ED) visits that are preventable or pre-emptible. The actuary then adjusts capitation rates assuming that MCOs will implement more effective, efficient, and innovative managed care practices to redirect members from the ED setting; thus, saving costs by reducing a targeted percentage of such Low-Acuity, Non-Emergent (LANE) visits in the upcoming rating cycle. These LANE efficiency adjustments are a key factor in incentivizing MCOs to maintain low non-emergent utilization.

OBH monitors ED utilization and current data indicates that, the number of behavioral health-related ED visits decreased by 1.35% and the number of unduplicated members accessing emergency department services for a behavioral

health-related reason decreased by 4.18% since 2015, for the non-expansion population. Current Healthy Louisiana member access surveys reflect members are generally satisfied with services available and access to community based services.

Recommendation 5: LDH should determine whether its current methodology for identifying SBH services in emergency rooms is the most valid and comprehensive way to monitor emergency room utilization.

Agree. OBH currently uses nationally recognized best practices to measure emergency room utilization. The Centers for Medicare and Medicaid Services (CMS) references a study by Owen et al (2007) regarding non-urgent use of EDs. The referenced study indicates the methodology consisted of reviewing ED visits across payer sources, excluding I/DD and dementia from the ICD 9. The methodology used in the study and referenced by CMS is similar to the current methodology used by OBH. OBH will continue to review best practices and adjust methodology as appropriate.

Recommendation 6: LDH should evaluate the number of institutional beds and determine whether additional community-based services could alleviate the need for these beds.

Agree. OBH has engaged the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) to conduct a needs assessment on the LDH behavioral health facilities. LDH has engaged a consultant to facilitate a multi-department discussion focused on the adolescent behavioral health network mix of residential and community based services.

Recommendation 7: LDH should ensure that residents in nursing facilities receive appropriate SBH services as needed.

Agree. OBH is working to improve processes related to its Preadmission Screening and Resident Review, Level II (PASRR) program which ensures appropriate placements in nursing homes as it relates to individuals with behavioral health conditions. Some of the PASRR improvements include:

- Agreements with the 5 Managed Care Organizations to conduct face to-face evaluations for individuals to make recommendations for 1) the need for Nursing Facility (NF) placement, 2) the need for specialized behavioral health services in the NF, and 3) recommendations for community-based services which could act as a diversion to NF placement.
- Strengthening of the PASRR process through revisions to the Level II assessment tool, documentation requirements related to individuals with dementia diagnosis, and collaborations with Medicaid and the Office of Adult and Aging Services (OAAS), the PASRR Level I authority.

- Standardize the process through which individuals in NF are re-evaluated at least annually to ensure they are in the least restrictive setting.

Recommendation 8: Because of limited funds and budget cuts, LDH should ensure that the services it chooses to fund are comprehensive, appropriate, and result in positive outcomes for Medicaid recipients.

Agree. OBH has worked with provider organizations and the MCOs to implement reform measures such as increased utilization management and more stringent network monitoring to ensure only qualified providers are delivering services. Over the last few years, OBH has seen a significant increase in members receiving two major evidence based practices, namely, Assertive Community Treatment (ACT) and Functional Family Therapy (FFT) services, and utilization of both continues to rise.

Recommendation 9: LDH should work with providers to eliminate barriers to sharing data where possible.

Agree. As barriers to data sharing are identified by providers, OBH will work with the provider to explore alternatives or eliminate the barriers.

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

Sincerely,



Karen Stubbs
Assistant Secretary, OBH
Louisiana Department of Health

APPENDIX B: SCOPE AND METHODOLOGY

This report provides the results of our performance audit of the Office of Behavioral Health (OBH). We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This audit primarily covered the time period of January 1, 2012, through December 31, 2016, although some analyses include information from fiscal years 2010 through 2017. Our audit objective was:

To evaluate the access Medicaid recipients have to comprehensive and appropriate specialized behavioral health services in Louisiana.

We conducted this performance audit in accordance with generally-accepted *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. To answer our objectives, we reviewed internal controls relevant to the audit objectives and performed the following audit steps:

- Researched and reviewed relevant state and federal statutes and regulations relating to OBH.
- Researched behavioral-health related audits and practices in other states and studies conducted by local and national organizations.
- Interviewed OBH staff and behavioral health stakeholders, such as the Local Governing Entities, hospitals with emergency departments, and the Treatment Advocacy Center.
- Used Audit Command Language and SQL to analyze Medicaid claims relating to behavioral health from January 2010 through December 2016, primarily focusing on claims from December 1, 2014, through November 30, 2016, for certain analyses.
- Conducted surveys of hospitals with emergency departments and coroners to determine how behavioral health issues affect their service delivery.
 - Respondents from the survey of hospitals with emergency departments included at least two hospitals from each of LDH's nine regions, 14 responses from rural parishes, and 22 responses from urban parishes. In addition, 20 respondents were emergency departments with no psychiatric unit or dedicated psychiatric beds, and 16 emergency departments had an emergency department and dedicated psychiatric unit (both standalone

psychiatric units and dedicated psychiatric beds within the emergency department).

- Respondents from the survey of coroners included all coroners, while statistics compiled on CECs were collected from 13 coroners who had statistics on them for calendar years 2012 through 2016.
- Discussed the results of our analyses with OBH management and provided OBH with the results of our data analyses.