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DHH OFFICE OF BEHAVIORAL HEALTH/ LOUISIANA BEHAVIORAL HEALTH PARTNERSHIP

The start-up of the state's public-private initiative to oversee services for mental health and addictive disorders has been costly and confusing for four human services districts or authorities that provide that care, according to an informational audit released Monday by Legislative Auditor Daryl Purpera.

Claims payments for these four agencies that participate in the Louisiana Behavioral Health Partnership "have been problematic and caused extra time and expense to track and reconcile," the report said. There also has been "confusion and a lack of understanding on how services were to be provided" for Medicaid-eligible substance abuse patients between 18 and 20, according to the report.

That confusion creates a possible gap in services for those young adult patients. Because of the changes under the partnership, the ability of the districts or authorities to deliver needed services may have been impaired and Medicaid-eligible persons between 18 and 20 years old may have been excluded from receiving in-patient substance abuse services.

The state launched the partnership in 2012 by contracting with Magellan Health Services to manage the behavioral health programs for two years, through Feb. 28, 2014, for about $354 million. The company has been paid about $156 million for the first part of the contract which ran from March 1, 2012 to Feb. 28, 2013.

The four districts or authorities in the partnership are the Capital Area Human Services District, centered in the Baton Rouge area; the South Central Louisiana Human Services Authority in Houma that covers the River and Bayou parishes; the Metropolitan Human Services District in New Orleans that covers most of the New Orleans area; and the Florida Parishes Human Services Authority in Amite that covers parts of the Florida parishes.

Under the partnership, the districts or authorities must file claims with Magellan to earn a fee for each service delivered but sometimes the payments from the private firm are weeks or months late and the agencies have trouble accessing the funds. The fees for the services in the past made up less than 2 percent of the agencies' budgets but under the new model fees are projected to be as much as 15 percent of their operating budgets, but they are having trouble getting paid.

As of April, the districts or authorities collected less than $2.8 million of the $10.5 million originally projected for them in self-generated revenues, which could possibly limit their ability to deliver services in the future.

The audit said that the new program set "overly-optimistic self-generated revenue budgets that are not being achieved." Before the partnership, Capital Area Human Services District used three employees to bill claims, and their salaries and benefits totaled about $180,000 a year. With the new program's claims payment and reconciliation process, the Baton Rouge area agency had to hire two more individuals to help with billing, detailed three more workers to claims processing and used nine temporary workers to perform administrative functions.

The new employees hired or shifted to claims and administrative functions cost approximately $450,000 a year -- an increase of $270,000. Officials at the South Central Louisiana Human Services Authority said the time spent correcting claims and billing errors equated to detailing one full-time staff employee for each of the authority's eight clinics to work on those problems. Because of lost revenues, the audit said, officials at the Florida Parishes Human Services Authority have furloughed all staff for three days and eliminated seven filled jobs and four vacant ones.

"Because of the changes in claims billing, fee schedules and coding issues, numerous district/authority claims have been rejected and denied" and the revenue from them may be permanently lost if the claims cannot be corrected before the billing expiration dates, the audit said.

The partnership required that any health care district or authority that had not implemented an electronic health records system had to use Magellan's system, known as "Clinical Advisor." As a result, districts in the capital area, the Florida parishes and the Bayou region each paid almost $86,000 toward purchasing a system, but instead they were required to cancel the contract and use Clinical Advisor, a program that has "been problematic." As a result, the agencies lost a combined $254,376 in the process.

Services provided by nurses and some services provided by unlicensed professionals are no longer billable in the partnership and billing rates have changed, the report said. The audit also said that some requirements in the Magellan contract dealing with planning and implementation for the changeover were not met.

The agreement required "Clinical Advisor" to meet the "meaningful use standard," a set of standards set by the Centers for Medicare and Medicaid Services that govern electronic health records, and that objective had not been met by Magellan. By not meeting that standard, the

districts or authorities may be subject to penalties in the future and have not been able to use potential federal incentive dollars.

The Department of Health and Hospitals' Office of Behavioral Health has not properly monitored the Magellan contract to see that all terms have been met. Although the agency has the authority to impose sanctions of $100 a day when required services are not provided, no sanctions have been applied, according to the audit.

In a response to the audit, Anthony Speier, assistant secretary of the Department of Health and Hospitals, said that the agency's Office of Behavioral Health "continues to work with Magellan to address" the problems the audit raised in order to "support smooth operations and ensure people with behavioral health needs receive necessary services."

Some improvements have been made, and others are projected to be finished later this year or next year. He said that the department is working to make money more easily accessible to the districts or authorities and that the "Clinical Advisor" program should meet the federal "meaningful use" standards in 2014 – which will still allow incentive payments to be paid to the state that the audit said now could be lost.

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