

**Mental Health
Rehabilitation Services:
"Rehabilitation" or a
"Get Rich Quick" Scheme?**

**Advocacy Center
225 Baronne Street, Suite 2112
New Orleans, LA 70122
504-522-2337
800-960-7705**

September, 2003

**Mental Health Rehabilitation Services:
"Rehabilitation" or a "Get Rich Quick" Scheme?**

Table of Contents

Executive Summary.....	1
I. Introduction	2
II. Findings	5
III. Fiscal impact.....	17
IV. Recommendations	18
V. Conclusion	19
VI. List of Attachments	20
Attachments	

Executive Summary

The Advocacy Center (AC) is charged with protecting and advocating for the rights of persons with disabilities in Louisiana. In that capacity, the AC initiated an investigation of serious allegations concerning the Mental Health Rehabilitation Service (MHRS) program. It is a program through which Medicaid pays private providers to provide individualized community mental health services to persons with serious mental illness. This program is administered by Louisiana's Department of Health and Hospitals (DHH), and is monitored by staff within the Office of Mental Health (OMH).

AC has investigated the MHRS program in response to complaints about poor quality services to consumers, incompetent and/or fraudulent providers, and lack of meaningful state enforcement.

The following serious deficiencies were validated and are detailed in the full report:

1. Many providers of MHRS services fail to provide effective, individualized services.
2. Clients' needs often are not met by the MHRS program.
3. Some high need individuals are rejected, terminated, or "timed out" of the program; others are exploited within it.
4. Community mental health professionals are reluctant to refer clients to these programs.
5. Restrictive admission criteria and capitated payment structure result in insufficient services to children.
6. MHRS consumers lack awareness of their rights and/or fear to exercise them.
7. Many providers fail to meet standards for services.
8. Many providers have unqualified and untrained staff.
9. The monitoring process is ineffective in ensuring quality services, and imposes inconsistent remedies.
10. OMH has insufficient staff for annual monitoring and detailed follow up.
11. DHH has failed to impose legally required restrictions upon providers during appeal of suspensions.
12. DHH and the Attorney General's Medicaid fraud units have failed to protect consumers by fining or closing down fraudulent providers.
13. Louisiana has an acute, growing need for a quality MHRS program to serve individuals with serious mental illness in the community.

The report concludes that the MHRS program in Louisiana is failing mental health consumers. It is siphoning off large amounts of state and federal funds, intended to provide individualized community mental health services, into the pockets of private providers, many of whom are neither competent nor honest. DHH has meticulously recorded the deficiencies of many of these providers for years, yet they continue to operate with impunity. The agencies charged with enforcing and penalizing unscrupulous providers have not used the legal tools available to them to protect mental health consumers, and Louisiana taxpayers, from rampant fraud and violation of the public trust. Immediate, aggressive action to remedy these abuses, and to insure the availability of quality wrap-around mental health services, is imperative.

The report contains specific recommendations for immediate action.

Mental Health Rehabilitation Services: “Rehabilitation” or a "Get Rich Quick" Scheme?

I. Introduction

A. The Advocacy Center, Louisiana's Protection and Advocacy Program for Persons with Disabilities in Louisiana

The Advocacy Center (AC) has been designated by the governor as Louisiana's protection and advocacy program for persons with disabilities in Louisiana. Funded by federal and state grants, AC is an independent non-profit legal advocacy agency which provides an array of services on behalf of individuals with disabilities throughout the state. AC's Protection and Advocacy for Individuals with Mental Illness (PAIMI) program represents, and advocates on behalf of, individuals with significant mental illness, including those receiving mental health services in community settings.

B. The Mental Health Rehabilitation Services Program

The Mental Health Rehabilitation Services (MHRS) Program is a major component of the Louisiana's Department of Health and Hospital's (DHH) service system for individual community-based mental health treatment. This program, as revised in 1996, purports to provide services which are "medically necessary and can reasonably be expected to reduce the disability resulting from mental illness and restore the individual to his/her best possible functioning level in the community." To qualify for this program, adult Medicaid recipients must be determined to have a serious mental illness (such as schizophrenia, mood disorder, or severe personality disorder) which has endured for at least six months and has required hospitalization or intense, structured treatment, and which impairs at least two areas of functioning. Children are eligible if they have an emotional/behavioral disorder, have been diagnosed with a severe mental disorder which requires 24 hour care and supervision, evidence of severe, incapacitating functional limitations on their behavior, and their behavioral patterns have lasted for at least three months and are expected to persist for at least a year. See, Mental Health Rehabilitation Manual, July 1, 1999 pp. 4-2 - 4-10 (Attachment I).

Components of mental health services include: clinical management, supportive counseling for adults or individual intervention for children, family intervention, group counseling, psychosocial skills training, medication management, service integration, clinical management coordination, a clinical management team, and behavior intervention development. MHRS are provided by private agencies, who are reimbursed at specified rates for the services they reportedly provide. Reimbursements are made on a "capitated" (amount per person served) basis.

Within DHH, the Office of Mental Health (OMH) is responsible for monitoring these agencies' services, and enrolling new provider agencies, and the Surveillance and Utilization Review Section (SURS) is responsible for investigating allegations of fraud, misrepresentation, abuse, or other ill practices. The Louisiana Attorney General's office is also empowered with investigating fraud.

In theory, the MHRS model provides individualized, wrap-around services for individuals with significant mental illness, and provides those services in a variety of settings, including the home, school, work, and community. In theory, service recipients have a safety net of services, the exact nature and frequency of which are set forth in an individualized plan of services, which changes in accordance with their needs at any particular time. In theory, the services are of high quality, and are provided by trained professionals. In theory, the consumers of services are involved in the planning and critique of the nature and quality of the services provided, and understand their right to choose other providers if they wish to do so. Twenty-four hour support should be available through the MHRS program for those who need it.

The OMH web site currently lists 104 providers of MHRS statewide, with 35 in Regions I and X (Orleans and Jefferson Parishes).

C. The Advocacy Center's Interest in the MHRS Program

Unfortunately, professionals, consumers, and advocates in the mental health field report that the reality of the MHRS program in Louisiana is markedly different from the theory. The AC has received complaints from many mental health professionals about these programs during the past two years. These complaints, combined with its experience in representing consumers whose needs were not being well-served by this program, prompted AC to independently research the efficacy of the program, as well as DHH's monitoring of it.

The **allegations** which prompted this investigation fall into three basic categories:

1. Poor Quality Services to Consumers

Consumers in need of individualized community-based mental health services are not being well served by many of the MHR providers. As a result, many individuals with significant mental illness cycle in and out of crises and/or in-patient hospitalizations. This recidivism not only disrupts these individuals' lives and health, but also drains OMH acute care resources.

2. Incompetent and/or Fraudulent Providers

MHRS providers receive a great deal of money, especially when compared to the overall MH budget for community services. Yet, many providers do not meet minimum standards and provide few relevant or useful services while continuing to bill Medicaid. They maintain records of questionable validity, hire unqualified staff, provide inadequate training, and perform few individualized services. They receive payment for services that consumers report were never provided.

3. Lack of Meaningful Action by State Officials

DHH has not effectively monitored and/or enforced its standards for these programs. Even providers found to have significant, repeated deficiencies have continued to receive funding, and are allowed to serve new clients, while an "appeal" process lingers on. It is commonly believed that DHH is either unwilling or unable to police substandard and/or fraudulent providers because of political influence. They reportedly fear legislative retaliation regarding the DHH budget if meaningful enforcement occurs. It was further alleged that DHH's

Surveillance, Utilization and Review Section (SURS), and the Louisiana Attorney General's Office, both of which are required under state law to investigate Medicaid fraud, are aware of these problems, and have been ineffective in protecting vulnerable mental health consumers from unscrupulous providers, or in recouping funds obtained fraudulently.

D. Research Methodology

The Advocacy Center's investigation was designed to be comprehensive, independent, and objective. The investigation focused primarily, and in the most detail, upon the MHRS program in Regions I and X. However, general data on statewide services were also reviewed.

In the course of the investigation, Advocacy Center staff:

1. Reviewed relevant statutes, regulations, emergency rules, the DHH web site, a July 1, 1999, manual used by MHRS providers, and a 2001 emergency rule which increased reimbursement rates. (The emergency rule was provided by DHH in response to a request for any updates to the manual.)
2. Made records requests to DHH for monitoring and enforcement documents. (Attachment II.) On August 26, 2002, the Advocacy Center requested that DHH provide it with copies of the most recent monitoring/status reports for the Mental Health Rehabilitation Services Providers in Regions I and X. DHH sent AC documents and an updated list of providers on September 17, 2002. In January, 2003, AC requested updated information, and received that information, along with a chart showing the status of providers in Regions I and X, in March 2003. In July 2003, AC again requested and received an update, and answers to some specific questions, from DHH. DHH has been very cooperative in providing the information requested. (Attachments III & IV).
3. Reviewed and analyzed the documents received from DHH, as well as other documents related to the DHH budget, the MHRS program, and the monitoring of that program.
4. Talked informally to many professionals in the public community mental health sector who serve consumers of MHRS.
5. Interviewed individual adult consumers who receive MHRS.
6. Studied data on a group of high need individuals, comparing outcomes for those who receive MHRS and those who do not.
7. Examined Medicaid fraud statutes, obtained general information about the respective roles of SURS and the Attorney General's Office under those statutes, and requested information from DHH on actions taken by SURS and/or the Attorney General's Office regarding MHRS providers.

8. Reviewed civil district court records of cases involving appeals of recommended suspensions of MHRS providers.
9. Reviewed the Louisiana Secretary of State's data regarding the status of several providers.
10. Reviewed letters sent to the Louisiana Board of Ethics by Rep. Arthur Morrell notifying it of his representation of MHRS providers.

II. Findings

The Advocacy Center findings validated the concerns and allegations which sparked its investigation. Examples of specific findings are detailed below. Moreover, it should be noted the three general areas of investigation are all inter-related. The lack of effective monitoring allows substandard providers to continue to operate, which could, in whole or in part, result in poor services and outcomes for consumers. Indeed, no concrete conclusions about the theoretical design of the MHRS program can be reached, because the actual practices are so divergent from the stated practices and goals of the program.

A. Quality and Effectiveness of Services Received by Consumers

1. Lack of effective, individualized services in a variety of settings

DHH monitoring records revealed that many providers have little, if any, documentation of service activities that meet program requirements. Two areas of special concern were the failure of several agencies to provide services in the client's homes, and the failure to provide services for the entire family, a critical issue for clients who are children. Some agencies were cited repeatedly for these problems, but failed to make any demonstrable effort to improve. In addition, rather than providing individualized, needed services toward well-defined outcomes, some providers simply reported that clients went to group therapy.

For example, in a letter dated August 13, 2001, Family Care, Inc. was asked to provide a corrective action plan after a monitoring visit that was conducted on July 18, 2001. The letter indicated that DHH had determined that:

- The agency allowed services to lapse for 40% of its clients because the agency did not submit prior authorization requests timely.
- One consumer's record showed the child had been received only minimal skills training, and no work was done with the child's parent.
- Consumers complained about the lack of home visits and noted that some workers did not keep their appointments and did not reschedule them.
- Children reported dissatisfaction with their groups.
- Three parents out of ten interviewed requested information on changing providers because they were so disappointed with their services.

Family Care was monitored again in July, 2002, and DHH also investigated complaints from consumers and staff members. In a letter dated December 23,

2002, DHH made the following findings, and again asked Family Care, Inc. to provide a corrective action plan:

- Interviews with consumers indicated that the agency documented more services than were provided.
- Home visits by OMH staff identified at least two cases where individuals were living in deplorable conditions.
- Several consumers were reportedly dissatisfied with their services.
- "An excessive amount of time was billed with no documentation of specific skills training".
- The grievance procedure submitted with the corrective action plan had no timelines.

Family Care submitted a second corrective action plan in January, 2003, and continues to operate. No other action has been taken to date. During this entire period, Family Care has been allowed to accept new clients.

2. Clients' needs are not fully met by the MHRS program

For over fifteen years, the Advocacy Center has represented a class of individuals who have been, or may in the future become, patients of the Psychiatric Crisis Intervention Unit (CIU) at the Medical Center of Louisiana (formerly Charity Hospital). Under a Consent Decree agreed to by AC and DHH in *Adam A. vs. Edwards*, DHH must have a program of services designed to serve the needs of "repeaters", that is, those individuals with frequent presentations to the CIU. AC receives regular reports on services provided to class members within the hospital, and on services provided to "repeaters" in in-patient, clinic, and community settings. In the past two years, due to changes in the "repeaters" program, AC has been receiving detailed information about a group of approximately 50 high need, chronically mentally ill individuals. One-half of these individuals are reportedly receiving MHRS.

An analysis of information received in connection with the *Adam A.* reports on these individuals reveals that their stability does not appear to be related to whether they are receiving services from a Mental Health Rehab provider. Some people do well with MHRS and some people do well without. Some who receive MHRS are frequently in crisis, and many end up in jail on a regular basis.

Two years ago, despite skepticism from several of its own staff members who served this high needs population, OMH assured AC that its current community mental health service system in general, and the MHRS in particular, could fill most or all of the needs of the *Adam A.* "repeater" class members. It phased out its existing repeaters program, and, as noted above, began tracking the services and outcomes for former participants. Recently, the department has contracted with an outside consultant who has reviewed the services available to repeaters, and has concluded that a supplemental program of Assertive Community Treatment is needed for these class members. OMH is the planning stages of drafting and implementing such a program, in order to comply with the Consent Decree. In short, OMH now acknowledges that the MHRS program has failed to adequately

serve even these individuals, whose progress is being carefully watched, and who represent only a small proportion of the individuals with severe mental illness who the program is designed to serve.

3. Some high need individuals are rejected, terminated, or "timed out" of the program; others are exploited within it

The MHRS program is designed to serve high needs individuals, with the expectation that their needs will eventually decrease and lower levels of assistance will be required, until the client eventually phases out of the program. This model appears to fail to take into account that some chronically mentally ill individuals' needs for intensive, coordinated support are likely to continue indefinitely due to the nature of their illnesses, and that time-limited services are an artificial mechanism that ill serves them. Moreover, the providers get to select whom they will serve, and some very high needs individuals are not selected. It is not surprising that providers, especially those seeking maximum return for minimum efforts, would reject clients with the most intense needs.

Another scenario verified by AC, although the client is too fearful to file a formal complaint, involves a provider who has selected to serve individuals whom nobody else will serve, then has imposed upon them involuntary servitude, including long hours of mandatory work for the provider, with little or no pay. Such exploitation is undertaken with impunity because the consumer has no other options for any services.

AC also received reports of an individual who was terminated by his MHRS provider because he had been hospitalized "too many" times. If this program, which receives the lion's share of the funds available for coordinated, individualized community services, will not serve the most needy individuals, it is not surprising that such individuals continue to bounce from crisis to crisis, repeat incarcerations, and in-patient hospitalizations.

4. Restrictive admission criteria and capitated payment structure result in insufficient services to children

As noted above, the criteria for admitting children to the MHRS program include a SEVERE mental disorder WHICH REQUIRES 24 HOUR CARE AND SUPERVISION; SEVERE, INCAPACITATING functional limitations on their behavior; and problems that have persisted for a prescribed time period. Once clients are admitted, the capitated payment structure results in many clients receiving less than the amount of services they truly need.

Because of the State's obligations under the Early and Periodic Screening, Diagnosis, and Treatment provisions of federal Medicaid law, Medicaid-eligible persons under 21 must have access to ALL medically necessary health care and treatment that can correct or ameliorate their conditions, 42 U.S.C. 1396d(r)(5). The requirement that, to qualify, children must have an extremely severe level of need, and the de facto service limits imposed by the capitated payment structure for MHRS, result in many children whose conditions could be helped by MHRS

who instead receive no wrap-around services, or inadequate wrap-around services, in violation of federal law.

5. Reluctance of community mental health professionals to refer clients to these programs

Perhaps the most disturbing finding regarding the inadequacy of MHRS programs is that seasoned public mental health professionals in both Orleans and Jefferson parishes, whose primary job is to work with the very types of individuals which MHRS should serve, state that they cannot in good conscience refer clients to the program, even if no other services are available. Because these professionals are employed by, or funded by, OMH, they are understandably reluctant to state these concerns openly. However, they report that they are so appalled by the poor quality of services provided, DHH's failure to enforce standards, and the rampant fraud, that they feel that it would be unethical for them to refer persons with mental illness to such programs. Some of them also report that the neediest individuals are often "discharged" from MHRS programs, thus leaving their public programs to attempt to serve them using their already overtaxed resources and budgets.

6. MHRS consumers lack awareness of their rights and/or fail to exercise them

As noted above, OMH monitors reported dissatisfaction, discrepancies, and complaints from consumers and consumers' parents, whom it interviewed as part of its monitoring process. AC and other counsel attempted to directly interview adult MHRS consumers in order to determine what services they were receiving, and whether they were satisfied with them. It was difficult to access many clients. Those who were interviewed generally expressed satisfaction with the services they were getting. However, when questioned in more detail, most were unaware of the details of their plans, their rights to have those plans individualized, or their right to change service providers.

B. Incompetent and/or Fraudulent Providers Predominate

DHH monitoring reports illustrate a wide discrepancy among quality of service, and adherence to standards, by MHRS providers. A minority of those monitored had relatively few minor deficiencies that were promptly remedied when noted. Many, however, have been cited multiple times for serious deficiencies, and have not corrected them, despite citations, warnings, and opportunities for training and technical assistance.

1. Failure to meet standards for services

Specific statements written on monitoring reports of agencies that were asked to write corrective action plans include:

- "...the agency appears deficient in its ability to provide a coordinated program of service delivery..."
- "Your agency has numerous deficiencies that suggest an inability of the agency to provide adequate care in relations to the service agreements that were developed based upon clients' needs."

- “possible knowledge of false statements”
- “not providing a full range of services”

Some consumers or family members interviewed by OMH monitors reported that they received only a few of the services that were reported in the provider's records. For example, as described in more detail below, on July 12, 2000, Odeh Services, Inc. was suspended as a result of a monitoring visit conducted on May 24, 2000. One of many deficiencies cited in support of the suspension was the finding that consumer records had few if any service logs documenting that services were being provided. In other words, it appeared from the records that the agency may have billed for services that were not actually provided.

AC's own experiences, and interviews with other service providers who have regular contact with specific MHRS providers, confirmed that some providers understand the philosophy of MHRS, keep good records, and are very helpful to clients who are seeking to obtain or retain benefits. Others perceive themselves as landlords or case managers rather than clinicians or treatment professionals, and provide few, if any, individualized services. Services that are provided appear to be at the convenience, and according to the needs and schedules of, the providers, rather than the consumers.

2. Unqualified staff

MHRS program standards set forth in great detail the qualifications and training required of individuals whom providers hire to staff their programs. See, Definitions of Staff Qualifications, pp 7-4 through 7-11; July 1, 1999 MHR manual (Attachment V).

However, almost every monitoring report details deficiencies in agency adherence to, or documentation of, those standards.

For example:

- a. Bridging the Gap, which was suspended on December 14, 2001, yet continues to provide services, was first cited for personnel problems on April 30, 1997. It was again cited for personnel problems on September 9, 1998, September 27, 2000 and July 17, 2001 (the last citation led to the suspension). Monitoring revealed that:
 - Several employees had no diplomas.
 - Three staff members had no social service experience and one had conflicting information on his resume and his application.
 - There was no record of adequate staff training.

Despite AC's request for all such information, DHH provided nothing to indicate that any further monitoring has occurred while this suspension is being appealed.

- b. Divine Concepts was monitored by DHH on August 23, 2001, and a corrective action plan was requested on September 4, 2001.

The following personnel citations were noted:

- There were no time sheets for two of the three physicians with which the agency contracts; therefore, there was no evidence that the proper ratio of psychiatric doctor to consumer services was being provided.
- Many employee records lacked proof of required orientation, training and supervision.
- There were also twenty employee personnel records identified as lacking proof of qualifications.

Divine Concepts was again monitored by DHH in September 2002, and a corrective action plan was again requested, even though many of the citations are duplicative of those cited in August of 2001.

- The agency was again cited for numerous violations in its personnel files.
- The agency was also cited for not being able to show that it was providing adequate supervision.
- The agency was again cited for not providing required orientation and training.

Divine Concepts was again monitored in November 2002, as a follow-up to the September 2002 visit; the same citations were issued, and another corrective action plan was requested.

- The agency continued to be cited for not providing adequate supervision or training, and for not having proper documentation of qualifications in personnel files.

- c. Dolby Providers, Inc was suspended on April 4, 2002, and continues to provide services while it appeals. Dolby was reviewed by DHH in August 2000, October 2001 and again in December 2001.

- The agency was cited for not providing adequate supervision, not providing required orientation and training, and not having proper proof of staff qualifications in personnel files.

Eight other agencies were cited, many more than once, for similar deficiencies in staff qualifications, training, and supervision.

C. Lack of Meaningful Action by State Officials

1. Widespread Deficiencies / Inconsistent Remedies

A review of OMH monitoring reports, a chart (Attachment IV), and updates provided by DHH showed that, out of 32 MHRS agencies in the greater New Orleans area:

- a. Five agencies, whose opening dates varied from December 18, 1999 – October 1, 2001, have never been monitored by OMH.
- b. Three more agencies, whose opening dates ranged from November 2, 2001 to February 22, 2002, were reported as having no monitoring information available because of having "just completed" one year in operation.

- c. Two other agencies were listed as new agencies and the report indicated that no monitoring had been done for either agency.
- d. One agency, which never had clients, was never monitored.
- e. Specific monitoring information was not provided for two agencies, one of which was recommended for suspension, and the other which was closed. It is presumed that they have been monitored.
- f. Of the twenty-one agencies that were apparently monitored, eleven agencies were asked to develop corrective action plans showing that violations had been corrected, and why the violations for which the agency was cited would not recur.
- g. Eight agencies have been “suspended” as a result of violating program standards. Seven of these agencies continue to provide services while appealing their suspensions. One appears to have ceased operation, but it is not clear whether this was a direct result of its suspension by OMH.
- h. One agency that provided residential services was closed due to health and safety violations. This agency remains closed.
- i. Eleven agencies were referred to SURS for further investigation.

The monitoring reports showed inconsistency regarding which agencies were suspended and which were asked to prepare corrective action plans. Some agencies that were suspended had many of the same violations as those that were asked to write corrective action plans. For example, eight of the thirteen agencies that were asked to write corrective action plans were cited for not having staff with proper qualifications and/or not having staff that were properly trained. Three of the seven agencies suspended were also cited for not having staff with proper qualifications and/or training.

Some of the corrective action reports submitted by the agencies were also reviewed, and it is important to note that in some cases, the corrective action plans submitted did not fully address the issues for which agencies were cited. Though it was requested, no evidence was provided to indicate whether OMH accepted these inadequate plans or requested the corrective action plan be expanded.

2. Monitoring process is ineffective in insuring quality services

DHH's own records compel the conclusion that the monitoring system in its present form does not ensure that quality services are being delivered to people in need of mental health rehabilitation services. (See Attachment IV.) Some agencies have been in business for many years, but have never been monitored. In cases where monitoring has occurred, monitors have prepared detailed reports, made follow-up visits, and imposed suspensions. Nevertheless, deficient providers continue to be allowed to operate. Therefore, substandard services are knowingly being provided to a very vulnerable population.

3. Insufficient staff for annual monitoring and detailed follow up

It is obvious from the documents provided that OMH does not have adequate staffing to monitor all the providers on a regular basis. All agencies are supposed to be monitored at least one year after opening, and annually thereafter.

Ben Bearden, the Director of DHH's Bureau of Health Services Financing (Medicaid) stated in a letter dated September 17, 2002: "Not all monitoring/enrollment is current due to a staff shortage in the New Orleans area office. The Office of Mental Health recently reorganized and has designated staff to perform the monitoring/enrollment function in New Orleans. With this administrative change, all agencies will begin to be monitored timely." (Attachment III)

However, as detailed above, six months later DHH reported that four MHRS agencies had still never been monitored, and three "new" agencies, whose first anniversary of operation had passed, had not been monitored.

4. Detailed findings, and recommendations for suspensions are not acted upon due to appeals procedures

One of the major problems in the enforcement of quality control in the MHRS system is the virtually open-ended time for administrative and court appeals of any negative findings. Insider reports, and DHH's own records, indicate that after a report is issued recommending suspension, there is a lengthy administrative appeal process which can literally take years. The result of such delay is that all but two of the providers in Regions I and X cited for serious deficiencies several years ago are still in operation. Only one provider has been closed, for rampant public health violations, and this was a (rare) residential provider. One more has apparently ceased operations, although there is no evidence that OMH required it to do so. The rest continue to operate despite serious deficiencies. Consumers continue to receive inadequate services, and the providers continue to make money. The monitoring unit apparently no longer monitors them closely, if at all, because once an appeal is pending the matter is considered out of their hands.

There appear to be several reasons for the administrative appeal bottleneck. The administrative hearings are conducted by Administrative Law Judges within DHH's Office of Hearings and Appeals. Although hearings must be requested within a specific period of time, hearings may not be actually scheduled until much later. After the hearing, there are further delays while the decisions are being written. If a provider loses an administrative hearing, it may then appeal to civil court. Several cases have been pending in court for years.

A related factor is that several of the providers are represented by Rep. Arthur Morrell, a very prominent state legislator, who, co-incidentally, has been the author of most recent legislation or legislative direction regarding the MHRS program. A case involving a provider called Odeh Services, Inc., is illustrative:

According to court records, Odeh Services, Inc., was suspended on July 12, 2000, for serious deficiencies in provision of services to clients, including the following deficiencies observed at a monitoring visit in May of 2000:

- Having no records to show supervision of staff;

- Having no payroll records or any timesheets for employees, except for a brief period for one employee;
- Having no records of criminal background checks on some employees (required for agencies that serve children);
- Having no records showing qualifications and education for employees or for the Director;
- Having deficient records of required training of staff regarding mental illness and skills training;
- Billing for many more services than were documented in client records (e.g., billing for 90 services to one individual when only 9 services were documented; billing for 43, 7, and 40 services to three other individuals when no services were documented for the time periods at issue).

Odeh appealed the suspension. A hearing was held in February 2001 before the DHH Bureau of Appeals, and a decision was rendered in April 2001, upholding the suspension. At the hearing, the director of Odeh admitted that he had been previously suspended from providing MHRS for similar deficiencies.

The case was appealed to state district court in Baton Rouge. Arthur Morrell enrolled as counsel in August of 2001. He obtained an extension to file his appeal brief because of a special session of the legislature. The hearing on the appeal was not set until June of 2002. In June, Mr. Morrell obtained another legislative continuance. On May 12, 2003, when the court file was reviewed by AC staff, the last item in the file was an order postponing the hearing in the case, which was set for February 27, 2003, so that Mr. Morrell could attend a conference in Phoenix, Arizona.

Odeh continues to operate while it appeals its suspension. According to the chart provided by DHH, it has not been monitored again by OMH. It is listed on the OMH web site as a current MHRS provider.

5. Failure to impose legally required restrictions upon providers during appeal of suspensions

For at least the past two years, while all these appeals were pending, it has been "business as usual" for these providers, **even though the program's regulations require that such programs NOT be allowed to admit new clients once they have been suspended.**

In 1998, a Rule was issued which provided that if an agency was suspended from certification and enrollment, "the suspensive action would take place immediately upon written notification. Suspended agencies will **not** be allowed to admit new clients until final decision when all appeal rights have been exhausted." II. G. 2. Louisiana Register, Vol. 24, No. 7 July 20, 1998, p. 1303. (emphasis added)

(Attachment VI). The 1999 MHR Providers manual has a similar provision. (PP 6-11 - 6-13.) (Attachment VII)

The information DHH provided to AC indicates that this regulation has not been enforced in the past two years. Suspension letters issued in 2000 advised agencies, as per DHH regulation, that they would not be allowed to accept new clients while appeals of the suspension were pending. However, letters issued in 2001 and thereafter do not indicate that providers are barred from accepting new clients. It is clear that all but one of the "suspended" providers have continued to do business, and accept new clients, while their appeals are pending. OMH's web site lists them as available to provide services, and provides contact information, (Attachment VIII). In a recent telephone survey, several agencies recommended for suspension indicated that they are willing and able to accept new clients.

As the Advocacy Center began its investigation of this situation, it combed the statutes and regulations related to the MHRS program in an effort to determine why DHH permits providers to continue to provide services while they are appealing suspensions. The result of that investigation suggests that the reasons DHH has given for doing this are highly suspect.

In response to informal inquiries as to why the rule against accepting new clients was not being enforced, DHH staff informed us that the legislature had changed this provision "a couple of years ago." Further investigation revealed that in the Regular Session of the 2001 Legislature, a House Concurrent Resolution (HCR 87) (Attachment IX) was introduced by Rep. Morrell purporting to revise this regulation, and directing that DHH publish the revised rule in the Louisiana Register. According to the Louisiana Legislature's website, this resolution was referred to committee and never acted upon. DHH confirmed, in correspondence dated July 31, 2003 that, as far as it could determine, the resolution never made it out of committee. (Attachment II).

Nevertheless, DHH issued a Notice of Intent (NOI) on September 20, 2001, to amend its regulations, stating that it had been "directed" to do so by HCR 87. The proposed rule amendment changed section II. G. 2 to read: "The suspensive action will be effective as of the date indicated in the written notice issued by the Bureau or its designee. Suspended agencies may continued to admit new clients until all appeal rights have been exhausted and a final decision has been rendered." Louisiana Register Vol 27, No. 9, p 1602. (Attachment X). When questioned specifically about whether this rule change had ever been finalized, DHH stated that its records "reflect that it was decided to abandon this NOI and publish a codified NOI to amend and clarify the entire mental health rehabilitation rule. The new NOI has been prepared, and currently the new rules are being reviewed." (Attachment II). DHH did not provide AC with a copy of any new NOI or rules.

In short, DHH has been violating its own rules for several years by allowing agencies under suspension to continue to admit new clients.

Moreover, the process by which this informal "change" took place suggests that there is merit to the allegations that Rep. Morrell's wishes become DHH's commands, regardless of whether proper procedures are followed.

6. Inaction By SURS and the Attorney General's Office

Monitoring by OMH for compliance with program standards is only one of the tools available to the state to insure that quality MHRS services are provided.

Both the Surveillance and Utilization Review Section (SURS) within DHH, and the Louisiana Attorney General's office were empowered by the Louisiana Legislature in 1997 to "be agents of the state with the ability, authority, and resources to pursue civil monetary penalties, liquidated damages, or other remedies to protect the fiscal and programmatic integrity of the medical assistance programs from health care providers and other persons who engage in fraud, misrepresentation, abuse, or other ill practices." La. R.S. 46:437.2

Most, if not all, of the suspended agencies' cases have been referred to SURS for review and further action, if warranted. Staff of the Attorney General's office have also reportedly participated in monitoring visits, and received notice of repeat violations. Because of the program's capitated payment structure, SURS reviews are reportedly lengthy and take an average of 18 months to complete. Once SURS has completed such reviews, it may issue sanction letters. Sanctions may include: recoupment, posting of bond or other security, exclusion of a health care provider, and/or a monetary penalty. L.R.S. 46:437.3. Providers who receive sanction letters from SURS are entitled to an administrative hearing, and judicial review, if they wish to contest the imposition of sanctions.

In its written responses to AC requests, DHH did not provide any information regarding whether SURS has issued any sanction letters to MHRS providers in the past several years; however, staff within SURS report that some sanction letters have been issued, and then the cases were either settled or appealed. Apparently, even though this information was specifically requested by AC, neither the Medicaid office nor the Secretary of DHH contacted SURS to obtain it. DHH also reported that it has no knowledge of any action by the Attorney General's office against MHRS providers. Since this information has not been provided, and since virtually all the agencies which have reportedly been referred to SURS continue to operate and accept new clients, we can only assume that neither SURS nor the Attorney General's office's enforcement efforts have been any more effective than OMH's.

D. Recent changes and proposed changes are not likely to "fix" this program

During the time that the Advocacy Center has been investigating the MHRS program, DHH has begun to consider making some changes to this program.

An outside consultant, who is reportedly a national expert, has been hired to review and make recommendations for change in the design of the MHRS program. One area of

focus is believed to be changing the program from one of "capitated" payments to a "fee for service" model.

DHH has established a task force to review the consultant's report and recommendations. The task force met for the first time on August 5, 2003, and is scheduled to meet again in September. OMH is also holding a series of public meetings to discuss the consultant's recommendations for the MHRS program.

Act 246 of the 2003 Legislative Session authorized DHH to develop regulations to require that any provider of mental health rehabilitation services be accredited by an accreditation body. A provision in the original bill that would have placed a moratorium on the enrollment of new providers until July 1, 2005 was deleted in committee.

OMH has recently drafted a "repeaters" plan for *Adam A.* class members that will create an Assertive Community Treatment/Intensive Case Management Repeater Response Group to supplement, coordinate, and monitor other existing services for these high needs individuals.

While these processes might eventually yield improvements in the overall design of the program, and ensure that providers meet some basic accreditation requirements, they do not suggest any intent by DHH or the Attorney General's office to begin aggressively using the tools already at their disposal to suspend and sanction incompetent providers.

E. Louisiana has an acute, growing need for the type of services the MHRS program is supposed to provide

One of the saddest aspects of the current status of the MHRS program is that the services it was designed to provide are badly needed by mental health consumers throughout Louisiana. Moreover, each year the mental health system faces cuts, or threatened cuts, to most of its services, as the state struggles to balance its budget.

Community mental health programs have been chronically under-funded for years. Mental health centers, hospital emergency rooms, and in-patient psychiatric facilities, public and private, treat thousands of persons with chronic mental illness every year, and turn many more away because their illness is not yet serious enough. There is virtually no public funding for services, including preventive medication and/or counseling, for individuals with mild to moderate mental illness. The few services that are available are primarily for individuals with significant, chronic, mental illness. However, these services are offered via a band-aid, patchwork, approach that often fails to successfully support these individuals in the community. They return to emergency rooms, in-patient hospitals, substance abuse programs, jails, or the streets.

An effective MHRS program that is designed, administered, and monitored by mental health professionals, and that actually provides quality, individualized wrap-around services, could fill part of this acute need, and could make more public resources available for individuals whose illnesses are still in earlier stages or whose needs have not reached the acute level of those in the MHRS program. Instead, the current system puts almost all of its resources into inefficient services for the same group of high-needs individuals.

Fiscal prudence, if nothing else, demands that the state ensure that it receives the most comprehensive, highest quality services for each of the limited dollars available for community mental health treatment.

III. Fiscal impact

A. Cost/benefits analysis of the MHRS program

An internal DHH FY 2001-2002 budget analysis (Attachment XI) notes the MHRS program has received steadily increasing funding over several years, while at the same time serving fewer individuals. In addition, the rate of repeated in-patient hospitalization increased during the same time period, resulting in additional costs to the state mental health system. Moreover, a comparison of the Medicaid funds spent on this program, as compared to public community mental health programs, shows that the latter receive relatively few resources, even though they serve a great many more individuals, including those also served by MHRS.

DHH reported last month that while final actual expenditures for payments to MHRS providers in FY 2002 - 2003 were not yet available, in May 2003, the projected total was over \$39 million for approximately 6,154 individuals enrolled. It also projected payment to MHRS providers to total \$40 million for FY 2003 - 2004. (Attachment III).

B. Possible liability to repay federal government for misspent dollars

Recent news reports have indicated that both Congress and the federal General Accounting Office (GAO) are very concerned about Medicaid waste and fraud within the states. The House Energy and Commerce Committee, which has begun an investigation of Medicaid waste and fraud, recently sent a letter to all fifty governors stating that it will hold states accountable for the Medicaid reimbursements sought from the federal government.

The Congressional budget resolution this year requires all authorizing committees to examine their programs for evidence of waste, fraud and abuse. And in January, GAO added Medicaid to its high-risk list of government programs affected by fraud, waste, abuse or mismanagement. The results of the Commerce Committee findings will likely result in recommendations for changes to Medicaid, one of the stated aims of the Commerce Committee's Medicaid Task Force.

It is highly unlikely that Louisiana's MHRS program would bear up under close scrutiny by federal investigators. DHH's own monitors have detailed serious deficiencies, yet the providers have been allowed to continue to provide "services" and to receive Medicaid reimbursement for them, without being required to correct the deficiencies. Other responsible state agencies are also aware of this situation, and have failed to take action, even though the Legislature has clearly empowered them to do so. Thus, Louisiana is likely to eventually face demands from the federal government to repay millions of dollars in misspent Medicaid funds.

IV. Recommendations

- A. DHH should immediately notify all MHRS program providers who are appealing suspensions that they are barred from accepting any new clients while their appeals are pending, in accordance with program regulations that have been in effect since 1998.
- B. DHH should contact all clients who were allowed to enroll as new clients by agencies who were appealing suspensions, review their records, and determine: 1) whether they are receiving appropriate services that conform to individualized plans; 2) whether they are satisfied with the services, and 3) whether the provider is complying with all program standards in its delivery of those services. DHH should also notify each such client that the provider has been recommended for suspension, advise them of their right to choose another provider, and provide them information, and, if requested, assistance in doing so.
- C. SURS and the Attorney General's Office should each issue a report within 30 days indicating the status of their investigations of each MHRS provider referred to them.
- D. DHH should report the clinical and medical directors of all MHRS agencies that have been recommended for suspension to the appropriate licensing board for investigation.
- E. DHH should, within 60 days, develop and implement a plan to insure that MHRS services are only provided by qualified, licensed, professional staff.
- F. DHH should draft and publish regulations for accreditation of providers by September 20, 2003. These regulations should include strict time frames for obtaining accreditation, and penalties, including immediate suspension, for agencies which fail to timely obtain and document the required accreditation.
- G. DHH should require that any prospective enrollees in the MHRS program be required to document that they have met all accreditation standards before their enrollment is approved.
- H. DHH should develop a plan, which includes increased staff if necessary, to ensure that all MHRS providers are monitored at least annually, and that all necessary follow-up visits occur in a timely manner. Efforts should be made to improve the efficiency of the monitoring process without sacrificing quality. Face-to-face visits with consumers and/or their families should remain a required element of all monitoring visits.
- I. DHH should insure that agencies that are appealing suspensions and/or sanctions are monitored at least every six months while the appeals are pending.
- J. DHH should institute a properly monitored fee-for-service program that will assure the provision of all medically necessary wrap-around services to Medicaid-eligible children, consistent with EPSDT obligations; and to adults with chronic, high mental health needs who do not now have access to services.

V. Conclusion

The MHRS program in Louisiana is not serving mental health consumers. Rather, it is siphoning off large amounts of state and federal funds, intended to provide individualized community mental health services, into the pockets of private providers, many of whom are neither competent nor honest. DHH has meticulously recorded the deficiencies of many of these providers over at least the past five years, yet they continue to operate with impunity. None of the agencies charged with enforcing and penalizing unscrupulous providers has used the legal tools available to them to protect mental health consumers, and Louisiana taxpayers, from rampant fraud and violation of the public trust. Immediate, aggressive action to remedy this situation, and to insure the availability of quality wrap-around mental health services to consumers in Louisiana, is imperative.

Respectfully submitted,

THE ADVOCACY CENTER
September 2, 2003

Lois V. Simpson
Executive Director

Ann Maclaine
Director of Legal Services

Nell Hahn
Director of Systems Advocacy and Litigation

Jeanne Abadie
Compliance Specialist

List of Attachments

- I. Mental Health Rehabilitation Provider Manual July 1, 1999 pages 4-1 through 4-7
- II. Correspondence from Advocacy Center to Ben Bearden, DHH, dated August 26, 2002, January 23, 2003, and July 22, 2003
- III. Correspondence from Ben Bearden, DHH, to Advocacy Center, dated September 17, 2002, March 11, 2003, and July 31, 2003
- IV. Chart of Region I MHRS provider monitoring prepared by DHH
- V. Mental Health Rehabilitation Provider Manual July 1, 1999 pages 7-1 through 7-8
- VI. DHH Administrative Rule, Louisiana Register, Vol 24, No. 7, p. 1301-1304 July 20, 1998
- VII. Mental Health Rehabilitation Provider Manual July 1, 1999 pages 6-11 through 6-13
- VIII. DHH/OMH web site listing of MHRS providers in Regions I & X
- IX. House Concurrent Resolution No. 87, Regular Legislative Session, 2001
- X. DHH Notice of Intent, Louisiana Register, Vol. 27, No. 9, p. 1602 September 20, 2001
- XI. DHH Budget Analysis by William G. Black, May 9, 2002, p. 7

Attachment I.
Mental Health Rehabilitation Provider Manual
July 1, 1999
pages 4-1 through 4-7

Attachment II.
Correspondence from Advocacy Center to Ben
Bearden, DHH,
dated August 26, 2002,
January 23, 2003, and July 22, 2003

Attachment III.
Correspondence from Ben Bearden, DHH,
to Advocacy Center,
dated September 17, 2002,
March 11, 2003, and July 31, 2003

Attachment IV.
Chart of Region I MHRIS provider monitoring
prepared by DHH

Attachment V.
Mental Health Rehabilitation Provider Manual
July 1, 1999
pages 7-1 through 7-8

Attachment VI.
DHH Administrative Rule, Louisiana Register,
Vol 24, No. 7, p. 1301-1304
July 20, 1998

Attachment VII.
Mental Health Rehabilitation Provider Manual
July 1, 1999
pages 6-11 through 6-13

Attachment VIII.
DHH/OMH web site listing of
MHRS providers in Regions I & X

Attachment IX.
House Concurrent Resolution No. 87,
Regular Legislative Session, 2001

Attachment X.
DHH Notice of Intent,
Louisiana Register, Vol. 27, No. 9, p. 1602
September 20, 2001

Attachment XI.
DHH Budget Analysis
by William G. Black, May 9, 2002, p. 7