HSRI

Louisiana Needs Assessment: Final Report

August 2021

Contents

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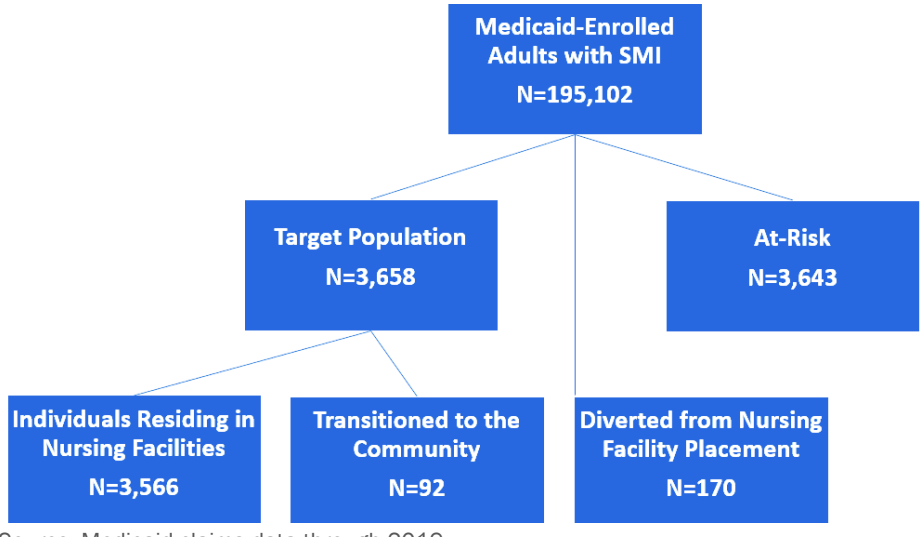
Executive Summary

Background and Purpose

In 2014, the United States Department of Justice (DOJ) initiated an investigation of the State of Louisiana's mental health service system to assess compliance with Title II of the Americans with Disabilities Act ("ADA"). In December 2016, the DOJ issued findings that the State unnecessarily relies on nursing facilities to serve adults with serious mental illness instead of serving them in the most integrated setting appropriate to their needs as required by the ADA. The State agreed to rectify noncompliance with the ADA in a manner detailed in a document entitled Agreement to Resolve Department of Justice Investigation ("Agreement"). Among the conditions of the Agreement was to commission a needs assessment, which was conducted by the Human Services Research Institute (HSRI). This report presents the results of that needs assessment.

The Agreement identified a "target population" defined as either "(a) Medicaid-eligible individuals over age 18 with SMI currently residing in nursing facilities" or "(b) individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement." For the latter, the Louisiana Department of Health (LDH) has developed a diversion plan to provide intervention and services to prevent unnecessary institutionalization of these individuals. LDH elected to expand the focus beyond the specification of the Agreement to include not only needs of the target population but also an "at-risk" population—defined for the purposes of this analysis as individuals with a mental illness, two or more comorbid medical conditions, and six emergency room visits in the past two years. In addition, LDH elected to extend the scope of the needs assessment to include the broader population of adults with serious mental illness (SMI) receiving services in the public behavioral health system.

Evaluation groups examined in this needs assessment



Source: Medicaid claims data through 2019.

Data Sources and Methods

The needs assessment draws upon three types of information: (1) quantitative data including Medicaid claims and other quantitative data described further below; (2) documents such as policy directives, previous studies, legislative regulations, government and foundation reports, etc.; and (3) interviews with key informants (to obtain a variety of perspectives from individuals knowledgeable about the system).

The primary sources of quantitative data are:

- Medicaid claims – Paid claim/encounter data for calendar years 2018 and 2019, and for the year prior to transition/diversion date for individuals in the transitioned and diverted groups (explained further below).
- Sample of PASRR Level II evaluations conducted 2/1/2020 – 4/15/2020. We developed a systematic random sampling strategy to obtain a representative sample of the 604 evaluations conducted during that timeframe (N=222).
- Transition assessment –A person-centered tool developed by OBH and OAAS to identify service and support needs in the community. We obtained data from 856 assessments conducted between April 2018 and November 2019, in addition to selected data fields from a revised version of the instrument for 214 individuals assessed between November 2019 and April 2020.

Key Findings

The publicly funded behavioral health service system

Behavioral health services in Louisiana are delivered through a complex array of organizations. At the most general level, the system consists of three entities: 1) The LDH Office of Behavioral Health (OBH); 2) ten regional Local Governing Entities (LGEs); and 3) six Managed Care Organizations (MCOs), one of which exclusively manages the Coordinated System of Care for children.

OBH assists in setting policy and establishing standards while providing surveillance and monitoring of the statewide system including LGEs and MCOs. Relationships among these entities are not hierarchical or even highly formal and are determined to some extent by historical changes in the state's health care funding and policy.

System assets, strengths, and challenges

HSRI's approach to needs assessment builds upon assets and challenges identified through document reviews and interviews with key informants. Assets include:

- Commitment on the part of LDH and OBH leadership to addressing limitations and promoting the quality of the public behavioral health system
- The foundation for a system of integrated mental health, substance use disorder treatment and primary care at the plan (MCO) and provider level

- An adequate supply of inpatient psychiatric beds
- Several value-based payment initiatives designed to improve the quality and efficiency of Healthy Louisiana services
- Some initiatives to promote the use of health information technology
- Several Medicaid waivers and demonstration projects relevant for the adult behavioral health population
- An extensive permanent supportive housing program

Major challenges facing the Louisiana behavioral health system:

- The most immediate need is to rebalance the system of care from institutional to community-based services in accordance with the Agreement.
- Funding is a challenge, as it is for most states; however, the level of funding in Louisiana is lower than that of most states.
- The complex, decentralized management structure presents a challenge for promoting accountability and care coordination.
- Key informant interviews identified the quality of behavioral health services as a problem, a perception supported by MCO scores on HEDIS quality measures related to behavioral health, which are generally below national benchmarks.
- Social determinants of health are a challenge for mental health and well-being, with Louisiana being comparatively disadvantaged on social determinants of health such as poverty, educational attainment, and crime.

Prevalence of behavioral health conditions

Based on the SAMHSA's National Survey of Drug Use and Health (NSDUH), the prevalence of both mental illness and substance use disorder (SUD) in Louisiana is similar to national averages with a little over 5% with serious mental illness, about 8% with a substance use disorder, and about 15% of the population receiving mental health services.

DEMOGRAPHIC CHARACTERISTICS

The four groups (those residing in nursing facilities, transitioned to the community, diverted, and at-risk) differed in some respects, notably that those residing in nursing facilities are older on average than the transitioned group, while the at-risk group is primarily under age 65 (a function of how this group was defined). Race and ethnicity identification is not required for the process of Medicaid enrollment and therefore was missing for a large proportion of all groups; consequently, we were unable to assess the distribution of services among these subgroups.

SERVICE AND SUPPORT NEEDS

We used data from transition assessments and from a sample of PASRR Level II evaluations to examine needs for services and supports in the community. The support need indicated most frequently was transportation (82%), followed by managing medications (75.7%), meals and meal preparation (60.8%), light housework (60.8%), shopping (58.7%), managing finances (57.1%) and bathing (55.6%). Support with personal hygiene, walking/wheeling, and transferring (e.g., in and out of bed, a chair, or wheelchair) was indicated by just under one third of transition assessment respondents. Over three quarters (77%) of respondents indicated the need for assistance with at least one Instrumental Activity of Daily Living (IADL) suggesting that up to three quarters of individuals transitioning to the community need some form of in-home personal care service.

The transition assessment asks respondents to rate the importance of behavioral health treatment/supports in the community, as well as finding work or educational opportunities in the community:

- 70% identified behavioral health treatment as somewhat or very important;
- 13% identified SUD treatment as somewhat or very important; and
- 12% identified finding employment as somewhat or very important. However, many respondents to the transition assessment have been residing in nursing facilities for many years with little knowledge of opportunities for employment.

As challenges to consider in transition planning, Transition Coordinators identified lack of housing for more than half (60.6%) of those assessed, inadequate family support for 58.5%, mental health symptoms for 49.8%, and physical health challenges for about one-third of individuals assessed. Transition Coordinators determined about one-quarter of the group to have "extensive service needs," meaning they need an array of services from a variety of providers (e.g., medical, behavioral health, personal care assistant, etc.).

SERVICE UTILIZATION

A greater proportion of the group that had transitioned to the community received support services (ACT, CPST, and PSR) compared to the SMI population as whole.

- ACT—Transitioned: 26%; Diverted: 17%; At-risk: 5%; Adult SMI: 2%
- CPST—Transitioned: 23%; Diverted: 6%; At-risk: 10%; Adult SMI: 9%
- PSR— Transitioned: 32%; Diverted: 7%; At-risk: 11%; Adult SMI: 10%

The proportion of the transitioned and diverted groups with an ER visit for mental health reasons was 13% and 47%, respectively, with inpatient psychiatric admissions 12% and 57%, respectively, and with inpatient medical admissions 40% and 32%, respectively. A much smaller proportion received the state's crisis intervention service—only 1% across all groups.

The proportion of the transitioned, diverted, and at-risk groups that received SUD screening was 0%, 1%, and 2%, respectively, and primary prevention care 5%, 6%, and 24%, respectively. ER admissions for physical health among the transitioned increased from 52.2% of the group in the year prior to transition to 63% in the year post-transition.

The following proportion of each group did not receive any of the specialized services included in the analysis: 39.1% of the transitioned, 29.4% of the diverted, and 46.5% of the at-risk group.

Community Choices Waiver (CCW) and Adult Day Health Care (ADHC) Waiver Service Utilization. In the year prior to transition, 46% of those who transitioned to the community received CCW Transition Intensive Support Coordination; in the year post-transition, 59% received CCW Support Coordination and 57% received CCW Personal Assistance. Only a negligible number (1%-2%) of the diversion population received any waiver services in either the pre or post one year period.

MEDICAID-ENROLLED ADULTS WITH SMI

Of 195,000 individuals with a diagnosis of SMI identified in the claims analysis, about two-thirds were female. Among those for whom race was identified (about half the sample), the proportion identified as White and the proportion identified as Black were about equal. Overall, approximately one in five adults with SMI received psychotherapy, approximately one in four received psychological evaluation or testing, around 10% received CPST or individual-based PSR, and 2% received ACT in 2019. About 20% received evaluation and management (E&M) from a mental health practitioner. Roughly 12% had at least one emergency room visit for mental health compared to only 1% who received the state's crisis intervention service.

Only 2% of adults with SMI received SUD screening or assessment—a rate that did not increase between 2018 and 2019—and 4.2% participated in a treatment program in 2019.

Half did not receive any of the behavioral health services tracked in this report. Of the half of Medicaid-enrolled adults with SMI who did receive services, 39.5% received mental health services and no SUD services, 2.6% received SUD services and no mental health services, and 7.7% received both mental health and SUD services.

Crisis Services

MCO contracts require provision of crisis services (crisis intervention), but utilization is limited as shown in the analysis of claims. Key informants report that while some crisis intervention does exist, it is extremely limited and varies by region and provider. Just over 2,000 (0.2%) Medicaid-enrolled adults received the crisis intervention service in 2019; in contrast, over 38,000 (3.3%) visited emergency rooms for a mental health or SUD issue. As indicated in Exhibit 30 in Section 4.2, a total of 22,356 Medicaid-enrolled adults with SMI presented to the ER for mental health

reasons. LDH has developed a detailed plan for a comprehensive crisis service system that will fill this gap in accordance with the Agreement. The system will be operational in FY 2022 and will provide four new crisis services to adults enrolled in the Medicaid program: mobile crisis, community-based crisis services, behavioral health urgent care, and crisis stabilization units.

Recommendations

The recommendations based on the needs assessment are summarized here; detailed discussion is provided in the main body of the report. Overall, these recommendations correspond to the conditions of the Agreement, which HSRI supports.

Recommendation 1: Address critical gaps in the service continuum

- Crisis services
- Case management
- Peer services
- Personal care and in-home supports
- Housing for adults with SMI
- Evidence-based practices, including supported employment

Recommendation 2: Develop a multi-level crisis service system

- Coordination with LGEs and MCOs will be critical for ensuring transition between levels of care, but more challenging given Louisiana's decentralized behavioral health system. Coordination with law enforcement will be essential. An "air traffic control" system may be a means of ensuring coordination and triage.
- The training provided to Transition Coordinators focusing on planning for crisis and engagement and intervention techniques should be incorporated into the training curriculum for ACT teams, MCO case managers, and the future community case managers.
- Protocols and cross-training will be needed to ensure coordination between case managers and crisis teams.

Recommendation 3: Strengthen and expand case management

- Implement Medicaid case management benefit for the target population; explore enhanced care coordination models for the broader population of adults with SMI.
- Case manager functions and performance should be reviewed in the context of the MCOs' poor performance on NCQA measures for follow-up from inpatient care. This may be a candidate for an MCO Performance Improvement Project (PIP).

Recommendation 4: Expand peer supports to be available for the broader population of individuals with behavioral health conditions

- Review opportunities to expand the foundation of Medicaid peer support (established for the target population) to the broader adult behavioral health population beyond the current LGE network.

Recommendation 5: Maximize availability of personal care services and in-home supports

- Ensure that individuals at risk of nursing home placement receive the fullest range of Medicaid and waiver-funded support services.
- Develop educational materials for consumers and training for providers on adherence to medications, one of the major factors contributing to nursing home placement.

Recommendation 6: Develop evidence-based supported employment programs

- Expand MCO and LGE capacity to provide employment support and make the service available to the broader population of adults with SMI through a Medicaid benefit.
- Implement training for MCO and LGE service providers on providing employment services.

Recommendation 7: Widely expand use of evidence-based practices

- Continue the process initiated with consultants of reviewing and implementing Medicaid benefits on the basis of evidence of their value.

Recommendation 8: Improve care coordination among service providers

- Develop shared protocols and training to improve care coordination among transition coordinators, MCO case managers, and HCBS direct service providers.

Recommendation 9: Increase SUD screening among adults with SMI

- Consider developing a target for screening for SUD among Medicaid-enrolled adults with SMI as a quality improvement initiative.

Recommendation 10: Address housing needs for the broader population of adults with SMI

- Continue efforts to expand the supply of appropriate housing (especially accessible housing) for the target population while ensuring that these do not occur at the expense of also addressing housing needs of the broader population of adults with SMI.

Recommendation 11: Promote integration of primary care and behavioral health

- Conduct a Quality Improvement analysis to identify the causes of ER and inpatient admissions, and the extent to which these adverse events are the result of barriers to primary care preventive services; identify strategies for reducing the frequency of these events.
- Support scaling up integrated care models throughout the state.
- MCO and proposed community case managers should ensure that physical health care needs including preventive care are addressed.
- Review MCO compliance with the required and recommended activities to promote integrated care.

Recommendation 12: Maximize quality initiatives for behavioral health

- Draw upon the 2019-2020 combined MCO PIP as a model for further collaboration to address MCO performance issues related to behavioral health indicated by HEDIS measures; consider ways of involving LGEs in these efforts.
- Consider adding two additional measures to the NCQA measures for which incentive payments are provided: access to preventive care and adherence to medication for individuals with behavioral health conditions.

Recommendation 13: Consider value-based payment and alternative payment methodologies

- Conduct an analysis of utilization and outcomes data for service recipients with SMI in these various integrated models to determine which should receive priority support for that population, and what adaptations would improve effectiveness and efficiency.

1. Background and Approach

1.1. Purpose of this Report

In 2014, the United States Department of Justice (DOJ) initiated an investigation of the State of Louisiana's mental health service system to assess compliance with Title II of the Americans with Disabilities Act ("ADA"). In December 2016, the DOJ issued findings that the State unnecessarily relies on nursing facilities to serve adults with serious mental illness instead of serving them in the most integrated setting appropriate to their needs as required by the ADA. Rather than contesting the DOJ's findings, the state agreed to rectify noncompliance with the ADA in a manner detailed in a document entitled Agreement to Resolve Department of Justice Investigation ("Agreement"), and has developed a series of Implementation Plans to achieve the goals identified in the Agreement.

One condition in the Agreement is that the State supports a needs assessment to identify requirements and gaps in the service system that must be addressed to achieve the goal of providing community-based alternatives for the target population. In short, the needs assessment is to establish the groundwork necessary to achieve the task identified in the Implementation Plan: "Conduct a gap analysis that identifies gaps in services and proposes goals and timeframes to remedy gaps in services."[1] The needs assessment was conducted by the Human Services Research Institute (HSRI). This report presents the results of that assessment.

The Agreement also commits the State to perform a gap analysis of crisis services including a crisis receiving system that is offered in community-based settings.[2] Section 5 of this report is focused on examining the need for crisis services more broadly within the state.

The Agreement identified a "target population" defined as "(a) Medicaid-eligible individuals over age 18 with SMI currently residing in nursing facilities; (b) individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement." For the latter, the Louisiana Department of Health (LDH) has developed a diversion plan to provide intervention and services to prevent unnecessary institutionalization of these individuals.

In discussions among LDH, the subject matter expert (SME), and HSRI during the early stages of planning the needs assessment, LDH elected to expand the focus of the needs assessment beyond the specification of the Agreement to include not only the needs of the target population (individuals transitioning and diverted from nursing homes to the community) but also an "at-risk" population (individuals in the

[1] Louisiana Department of Health. My Choice Louisiana Phase III Annual Implementation Plan: January 2021-December 2021

[2] Louisiana Department of Health, "My Choice Louisiana In-Reach Plan: Louisiana Department of Health Agreement to Resolve the Department of Justice Investigation", Paragraph 66. June 2018.

community with profiles similar to those of the target population), and furthermore, to assess the needs of the broader population of adults with serious mental illness receiving services in the public behavioral health system. These groups are described in detail in the following section. The purpose of the needs assessment is not to monitor the state's compliance with the Agreement; instead, it is to assess the adequacy of the system to meet the needs of these three groups separately and together, and to make recommendations for addressing unmet needs.

As described in LDH's Initial Implementation Plan, there are two main goals of the Agreement: "Divert individuals with serious mental illness away from inappropriate nursing facility placements by requiring comprehensive evaluations and providing services designed to enable them to live in community-based settings; and identify people with serious mental illness who have been admitted to nursing facilities but are able to and would like to transition to the community, and provide them with transition planning and community-based services sufficient to meet their needs."[3]

Consistent with these twin goals, two types of analysis were conducted: an assessment of the target population's needs for treatment and supports in the community and an assessment of the services and supports that are available in the community necessary to achieve the individualized, personal goals for community living desired by the individual.

The following is a brief summary of the Agreement and Implementation Plan action items. These are directed specifically to the target population but will likely benefit the broader Medicaid population and thereby provide the primary drivers for the needs assessment.

Services for the target population specified in the Agreement:

- Transition planning services
- Transition coordinators
- Post-Discharge Community Case Management
- Crisis System: crisis hotline, mobile crisis teams, crisis intervention services
- Detoxification, rehabilitation, and intensive outpatient substance use disorder (SUD) treatment
- SUD recovery services
- Development and training of Crisis Intervention Teams
- Assertive Community Treatment expansion to ensure network adequacy
- Intensive Community Support Services (ICSS)
- Continue (a) Community Psychiatric Support and Treatment (CPST); (b) Psychosocial rehabilitation (PSR); and (c) Crisis intervention (CI)

[3] Louisiana Department of Health. Initial Implementation Plan: June 6, 2018 – December 6, 2019: Agreement to Resolve the Department of Justice Investigation

- Waivers and/or Centers for Medicare & Medicaid Services (CMS) approvals for services for individuals needing assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
- Integrated Day Activities: access to supported employment and rehabilitation services
- Peer Support Services incorporated into rehabilitation services, CPST, PSR, CI, ACT, Crisis Services, Residential Supports, Integrated Day, SUD Recovery, and Supported Employment systems
- Housing and Tenancy Supports

As stated in the introduction to the Implementation Plan, the focus will be "to complete the needs assessment/gaps analysis, continued implementation of both housing and crisis plans, implementation of community case management services, implementation of peer supports, and identification and implementation of necessary provider and stakeholder training. In most instances, the additional services and supports will require the State to amend or create new Medicaid authorities. The State also recognizes that additional funding from the State Legislature will be needed to create these new service opportunities."

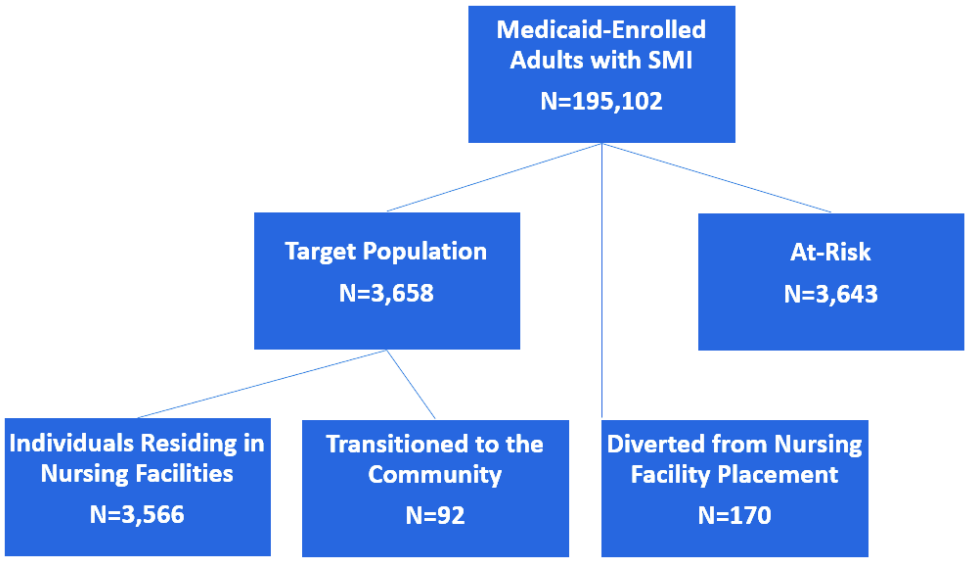
1.2. Data Sources and Methodology

This needs assessment draws on three types of information:

- Quantitative data including Medicaid claims and other available secondary data, which were analyzed to obtain an understanding of service utilization and population characteristics and to report statistics for these areas.
- Documents such as policy directives, previous studies, legislative regulations, government and foundation reports, etc., which were reviewed to gain an understanding of the service system structure and operations, and the context in which they exist.
- Interviews with key informants selected to obtain a variety of perspectives from individuals knowledgeable about the system, especially in relation to factors that result in inappropriate or avoidable nursing facility referrals. We conducted key informant interviews with as large and diverse a group as was feasible within the timeframe and resources available for the project.

As mentioned previously, this needs assessment focused not only on the target population specified under the Agreement but also on a broader population that included individuals at-risk for nursing home placement as well as all Medicaid-enrolled adults with SMI. Exhibit 1 shows the relationship and size of each of the evaluation groups included in our analysis. These groups are defined in detail in Section 3. In addition to these groups, Section 5 examines all Medicaid enrollees in Louisiana in discussing the needs and utilization of crisis services for the population as a whole.

Exhibit 1. Evaluation groups examined in this needs assessment



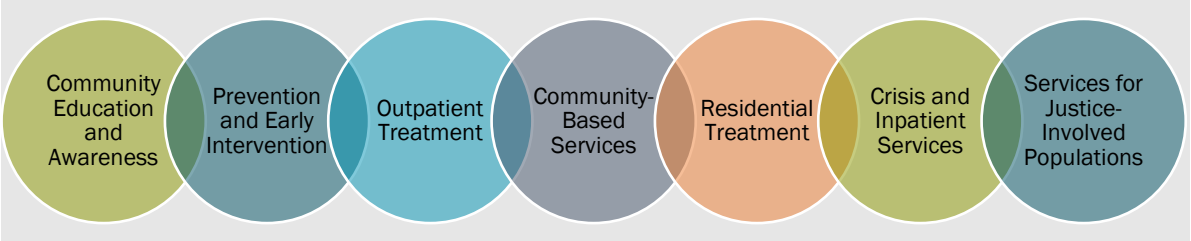
Note: the size of each group is as of the end of calendar year 2019; numbers based on Medicaid claims data.

Experts in needs assessment methodology stress the importance of specifying the model or desired state as the basis for, and prior to, defining "need.[4] For this purpose, we refer to a SAMHSA report titled "Description of a good and modern addictions and mental health service system"(2011)[5] which describes the array of services that should exist in a comprehensive and robust service system. Exhibit 2 shows an adapted overview of the "Good and Modern" system configuration. The framework consists of a continuum of broad service types, progressing left to right from those generally the least to the most restrictive in nature, as well as from those with a broader population focus (e.g., community members) to those focused on more of a discrete, specific population (e.g., criminal justice–involved individuals). Such a system provides a variety of service types with different levels of intensity, with an emphasis on "upstream" prevention and diversion—resolving potential crises at the community level to the maximum extent possible in order to minimize involvement of law enforcement and "downstream" utilization of emergency departments and inpatient admissions.

[4] Watkins, R. W. M., Maurya; Visser, Yusra Laila, (2012). A Guide to Assessing Needs: Essential Tools for Collecting Information, Making Decisions, and Achieving Development Results, World Bank.

[5] Substance Abuse and Mental Health Services Administration (2011). Description of a good and modern addictions and mental health service system.

Exhibit 2. A comprehensive behavioral health service array spans numerous program types and agencies to provide the right mix of services at the right time.



In addition to listing a set of essential services in the continuum of care, the 'Good and Modern" model is also informed by a set of key principles:

1. Funding supports the triple aim of improving the experience of care, improving population health, and reducing per capita costs: evidence-based services are maximized, and legacy services discontinued
2. Services are suited to a range of acuity, disability, and engagement levels and consumer preferences
3. Leadership promotes a culture that is person-centered, trauma-informed and resilience/recovery-oriented
4. Services are provided equitably across all subpopulations
5. Services are coordinated (communication among providers)
6. Behavioral health is integrated with health care
7. Behavioral health service systems collaborate with other sectors to broadly address population health and social determinants of health (SDOH)
8. Health technology (data systems, electronic health records, telehealth) is used to monitor and improve quality, coordinate care, and expand access

2. Louisiana Behavioral Health Service System

This section describes the broad landscape of behavioral health in Louisiana: the prevalence of behavioral health disorders, characteristics of the service system, patterns of service utilization as well as challenges, barriers and assets. We consider the existing service system in the context of the "Good and Modern" model described in Section 1, identifying features of the model that are part of the existing system and those that are lacking or less developed.

A note on "public" vs. "private" behavioral health systems: The LDH Office of Behavioral Health's request for this needs assessment specified that it was to focus on the *public* behavioral health system, meaning publicly funded services. In a broader sense, however, following the large-scale shift to privatization of behavioral health systems facilitated by the establishment of Medicaid in the 1960s, there are no longer any purely public state or local behavioral health systems in the United States, in the sense of services being both funded and delivered by publicly owned organizations. Most inpatient and outpatient services are now rendered by privately owned for-profit or nonprofit organizations supported not only by public funds (Medicaid and general revenues) but also by private insurance and self-pay; these organizations serve not only the populations targeted by public funds but anyone in the general public. As a result, there are many features and functions of the system that are partially or entirely outside the control of public agencies. A prime example is the behavioral health workforce. Public agencies establish licensure criteria and to some extent staffing requirements; beyond this, however, private vendors are wholly responsible for hiring, training, and supervising workers. Public agencies may require certain practice standards through contracting, but many features of the "Good and Modern" behavioral health system—such as maintaining a recovery-oriented culture—are difficult to put into contract language.

2.1. Prevalence of Behavioral Health Conditions

A primary feature of a needs assessment is summarizing the proportion of the population that consists of people with behavioral health conditions (prevalence rate) and the proportion of the population of people with behavioral health conditions that receives services in a given time period (penetration rate). Two commonly used sources of data about state-level behavioral health prevalence and penetration rates are SAMHSA's National Survey of Drug Use and Health (NSDUH), which provides a sample survey estimate of prevalence, and the Uniform Reporting System, which uses data provided by state mental health authorities to present an overview of state mental health systems including outcomes and service utilization (the basis for estimating penetration rates). Exhibit 3 presents data on the prevalence and treatment of behavioral health conditions for Louisiana adults taken from NSDUH. As shown in the table, the prevalence of both substance use disorder and mental illness

in Louisiana are similar to the national averages. The differences are not statistically significant.

Exhibit 3. Prevalence of substance use disorder and mental illness in Louisiana compared to national average from NSDUH data, ages 18+, 2018-2019

	Louisiana N (thousands)	Louisiana Population %	U.S. Population %
Substance use disorder in past year[1]	279	8.06	7.74
Needing but not receiving treatment at a specialty facility for substance use[2]	251	7.24	7.18
Any mental illness in past year[3]	734	21.21	19.86
Serious mental illness in past year[4]	183	5.30	4.91
Received mental health services in past year[5]	521	15.05	15.57

2018-2019 SAMHSA National Surveys on Drug Use and Health (NSDUH) https://www.samhsa.gov/data; [1]Table 23; [2]Table 26; [3]Table 27; [4]Table 28; [5]Table 29.

SAMHSA's Uniform Reporting System (URS) collects data annually from all states to support the Community Mental Health Services Block Grant program. State Mental Health Authorities (SMHA) report on a set of measures that provides an overview of states' mental health delivery systems. Exhibit 4 presents data on service system penetration rates for Louisiana compared to national averages from the URS. Although the table shows penetration in Louisiana to be much lower than the national average (for example, it shows 7.79 people per 1,000 population are served by Louisiana's mental health authority compared with 24.81 per 1,000 nationally), Louisiana's URS data are based only on data provided by local governing entities, or LGEs (discussed in Section 2.2.2) and do not include data for Medicaid-funded services; therefore, the data are not comprehensive and underestimate community penetration rates. Notably, however, the rate of state hospital utilization in Louisiana is lower than the national average (0.22 per 1,000 vs. 0.41 per 1,000 nationally), which may be considered a positive.

Exhibit 4. Rates of persons served by the state mental health authority in Louisiana compared to national averages, FY2019

	Louisiana Rate	U.S. Rate
Penetration rate per 1,000 population	7.79	24.81
Community utilization per 1,000 population	7.57	23.88
State hospital utilization per 1,000 population	0.22	0.41
State hospital adult admissions	0.52	0.80
Community adult admissions	0.65	2.44
Percent of clients who meet federal SMI definition	39%	71%
Percent of adults served through the SMHA who had a co-occurring MH/SUD disorder	42%	28%

Source: SAMHSA 2019 Uniform Reporting System (URS) Table for Louisiana. Accessed April 2021 from: https://www.samhsa.gov/data/sites/default/files/reports/rpt27948/Louisiana%202019%20URS%20Output%20Tables/Louisiana%202019%20URS%20Output%20Tables.pdf

2.2. Structure of the Behavioral Health Service System

The public behavioral health system in Louisiana at the most general level consists of three entities: (1) The Louisiana Department of Health (LDH) Office of Behavioral Health, (2) ten regional Local Governing Entities (LGEs), and (3) six Managed Care Organizations (MCOs), one of which exclusively manages the Coordinated System of Care for children. Relationships among these entities are not hierarchical or even highly formal and are determined to some extent by historical changes in the state's health care funding and policy. Behavioral health services are provided by an extensive network of providers contracted by LGEs and MCOs, including Mental Health Rehabilitation (MHR) provider organizations, individual licensed clinicians, Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), substance use disorder (SUD) treatment providers, and many others. The following briefly describes these organizational entities and provider types.

2.2.1. Louisiana Department of Health and Office of Behavioral Health

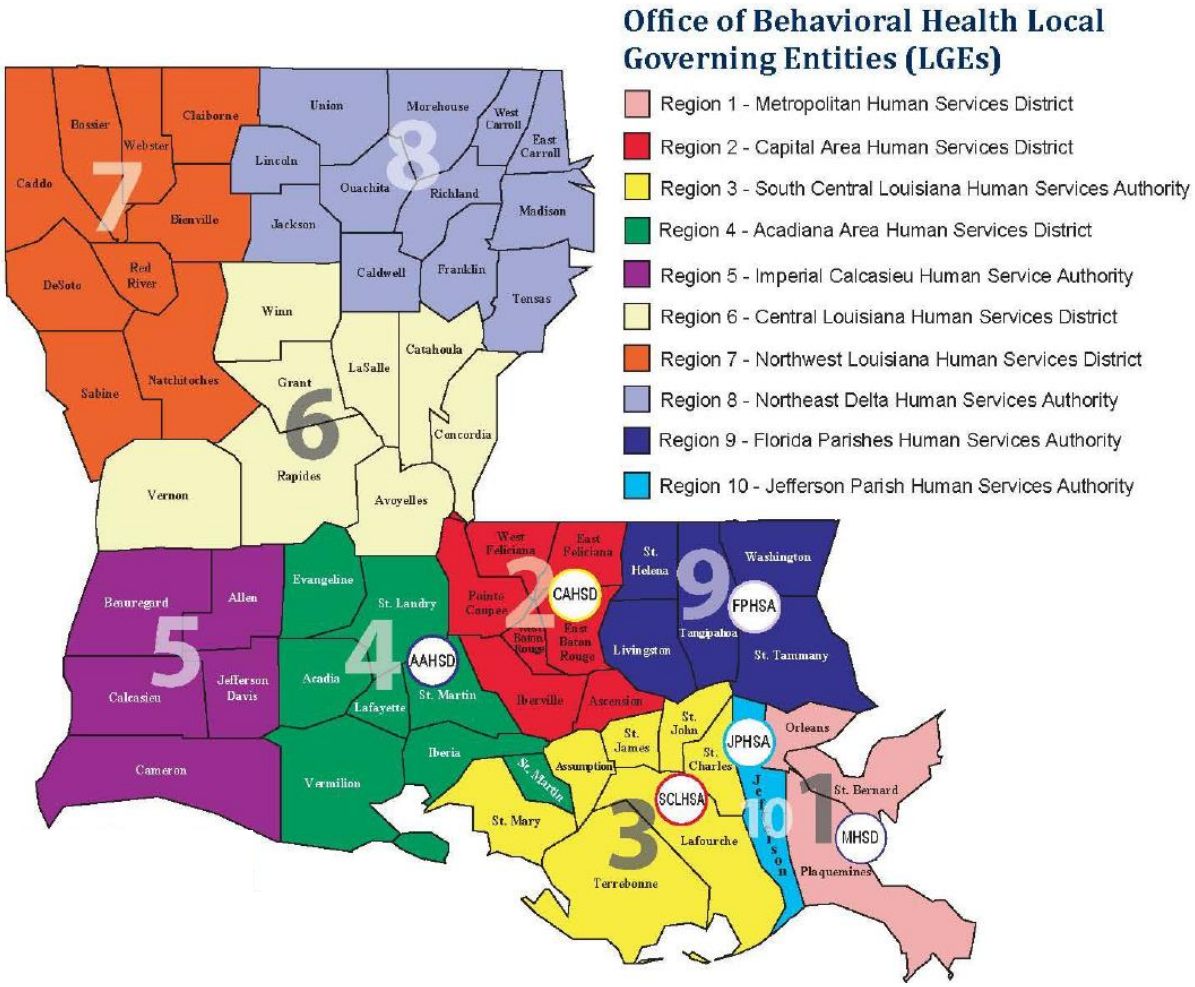
OBH's responsibilities include surveillance and monitoring of the statewide behavioral health system including both LGEs and MCOs. OBH assists in setting policy, establishing standards for the operation of the service system and expectations for service utilization and outcomes, and developing a statewide outcomes measurement system. OBH ensures coordination between the LGE services and the state-operated psychiatric hospitals. In addition, OBH provides guidance to the LGEs to ensure federal Block Grant requirements are met. With regard to MCOs, OBH collaborates with the LDH health care licensing office and Medicaid to establish qualifications and requirements for behavioral health providers, and OBH monitors MCO compliance with these requirements. OBH contracts with several hospitals to provide acute inpatient psychiatric, psychosocial, and medical services for adults, children, and adolescents. In addition, OBH directly operates two state psychiatric facilities—Central Louisiana State Hospital (CLSH) and Eastern Louisiana Mental Health System (ELMHS)—which provide mental health evaluation, treatment, and rehabilitation services for adults with severe and persistent mental illness including those requiring forensic services and competency restoration.

2.2.2. Local Governing Entities

Louisiana's ten LGEs, which predate the introduction of managed care, are human services districts or authorities that direct the operation and management of community-based programs and services relative to mental health, developmental disabilities, and substance use disorders. LGEs have contractual agreements with LDH and with OBH; while LGEs are part of the LDH structure, they do not have a direct reporting line to OBH. The LGEs serve adults and children with serious mental illnesses or emotional disturbances in each of ten regions, with a total of 50 behavioral health clinics throughout the state. Services are rendered across payor

source, with the LGEs serving those with Medicaid as providers within the MCO networks. In FY2018, LGEs served approximately 40,000 children and adults. Services include screening and assessment, emergency crisis care, individual evaluation and treatment, medication administration and management, clinical casework services, services for children and adolescents, criminal justice services, services for the elderly, and pharmacy services. Services are partially funded by block grant allocations and provided for individuals who are uninsured. Exhibit 5 maps the ten LGEs' catchment areas onto a map of Louisiana.

Exhibit 5. Map of Louisiana's ten Local Governing Entities' catchment areas



Source: Louisiana Office of Behavioral Health, 2019

2.2.3. Medicaid Managed Care Organizations

In February 2012, Louisiana Medicaid initiated its transition from its legacy fee-for-service (FFS) program to a managed health care delivery system that offers medical services to many Louisiana Medicaid enrollees. The managed care delivery system is known as Healthy Louisiana. Most Medicaid enrollees receive their health care through the managed care delivery model, with the exception of the following services/individuals that are excluded from managed care: long-term care, the

Program for All-Inclusive Care for the Elderly (PACE) and HCBS waiver services, individuals with a limited period of eligibility, and individuals in specific programs such as Refugee Cash Assistance and Qualified Disabled Working Individuals.

Healthy Louisiana provides full coverage of both physical and specialized behavioral health (SBH) to 84.2% of Medicaid enrollees and SBH-only coverage to an additional 7.6% of enrollees. Specialized behavioral health services are mental health services and substance use disorder services, specifically defined in the Medicaid State Plan and/or applicable waivers. These services are administered under the authority of the Louisiana Department of Health in collaboration with the Healthy Louisiana plans. Some managed care enrollees may receive services through FFS; for example, individuals enrolled in Healthy Louisiana for specialized behavioral health only will continue to receive all eligible coverage for physical health, pharmacy, long-term care and waiver services under FFS.

2.2.4. Coroner Offices

Although Parish Coroners are not a part of OBH (as elected officials, they are independent state officers), they play an important role in Louisiana behavioral health care in being authorized by law (along with district court judges) to order involuntary admissions of persons with mental illness or substance use disorders. Involuntary commitments are initiated through procedures known as Orders for Protective Custody (OPC)[6] and Coroners Emergency Certificates (CECs).[7] OPCs authorize a 72-hour involuntary admission; to extend the involuntary commitment beyond 72 hours, a treating medical professional must issue a Physician Emergency Certificate (PEC), which is reviewed and either approved by means of a CEC, or rejected—in which case the individual must be discharged. In some cases, the CEC is issued by a psychiatrist as a Deputy Coroner.[8] OPCs and CECs are issued using OBH forms (OBH-2 and OBH-20, respectively).

2.2.5. Behavioral Health Service Providers

While the focus of this report is on the "public behavioral health system"—defined as mental health and SUD services funded by the state through the organizational structure described above—for reference purposes, we provide a listing and count of Louisiana licensed or certified provider organizations that provide behavioral health services or other services that are vital for access to behavioral health care. Some of these are represented in the claims and utilization analysis in this report, but claims do not represent all of the services these organizations provide. The following is a summary of the primary types of specialized behavioral health service providers in Louisiana.

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[6] RS 28:53.2
[7] RS 28:53
[8] http://www.stpcoroner.org/mental-health.html

- **Mental Health Rehabilitation (MHR) providers**. MHR provider agencies provide rehabilitative services in the home and community to individuals with functional impairments resulting from an identified mental health disorder diagnosis. These services include Community Psychiatric Support Services (CPST), Assertive Community Treatment (ACT), Psychosocial Rehabilitation (PSR), and Crisis Intervention. These MHR services comprise a comprehensive specialized psychiatric program designed to promote the maximum reduction of symptoms and restoration to age-appropriate functional levels.

- **Individual licensed clinicians**. A licensed mental health professional (LMHP**)** is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license. An LMHP includes the following individuals who are licensed to practice independently:
    - Medical psychologists
    - Licensed psychologists
    - Licensed clinical social workers (LCSWs)
    - Licensed professional counselors (LPCs)
    - Licensed marriage and family therapists (LMFTs)
    - Licensed addiction counselors (LACs)
    - Advanced practice registered nurses (APRNs)

- **Federally Qualified Health Centers (FQHCs)**. FQHCs, though not under direct oversight by OBH, represent another source of publicly funded behavioral health services along with primary care and other social support services. Louisiana has 39 centers that operate more than 300 facilities in medically underserved areas throughout the state. Services funded by federal grants and private and public health insurance are provided on a sliding fee scale based on federal poverty guidelines. FQHCs offer the important benefit of providing truly integrated primary and behavioral healthcare.

- **Community Mental Health Centers (CMHCs)**. Louisiana has 47 Community Mental Health Centers (counting branch offices of individual provider organizations).[9] Like FQHCs, CMHCs are not licensed by LDH but instead are certified by the federal government—in this case, CMS.

- **Substance use disorder service providers**. In Louisiana, these providers offer outpatient, intensive outpatient, withdrawal management, residential and inpatient hospital treatment services, based on medical necessity, to individuals diagnosed with substance use disorders.

[9] Certified Providers Spreadsheets https://ldh.la.gov/index.cfm/page/3008

Exhibit 6 presents information derived from listings of licensed or certified providers on the LDH Health Standards Section website, giving a sense of the volume of providers by type.

Exhibit 6. Number of licensed and certified providers by provider type

Certified Providers	Number
FQHCs	222
CMHCs	47
Licensed Providers	**Number**
Behavioral health service providers	574
HCBS providers	586
Home health	191
Hospitals	211
Nursing homes	278
Psychiatric Residential Treatment Facilities	7
Rural health	283
Therapeutic group home	12
Non-emergency medical transportation	183

Source: Licensed Provider Spreadsheet, accessed 5/24/2021 at: https://ldh.la.gov/index.cfm/page/3008

Exhibit 7 presents the number of behavioral health providers by LDH service region, derived from a listing of licensed providers on the LDH Health Standards Section website.

Exhibit 7. Number of behavioral health providers by region

Region	# of Providers
Region 1	125
Region 2	98
Region 3	28
Region 4	61
Region 5	22
Region 6	35
Region 7	88
Region 8	80
Region 9	42

Source: Licensed Provider Spreadsheet, accessed 5/24/2021 at: https://ldh.la.gov/index.cfm/page/3008

2.3. Array of Adult Behavioral Health Services

Publicly funded behavioral health services in Louisiana are divided into two levels: basic and specialized. Basic behavioral health services include screening, prevention, early intervention, medication management, treatment and referral provided in the primary care setting. MCOs are responsible for the management and provision of basic behavioral health services including services for individuals who can be

appropriately screened, diagnosed, or treated in a primary care setting. Specialized behavioral health services include services specifically defined in the Medicaid State Plan, which include services provided by licensed behavioral health specialists, mental health rehabilitation services such as Assertive Community Treatment (ACT), as well as services for substance use disorder treatment across the ASAM levels of care. These services are covered by MCOs for all Medicaid-eligible adults meeting medical necessity criteria for the services.

In the following table (Exhibit 8), we map the available adult behavioral health services in Louisiana to the "Good and Modern" service continuum described in Section 1.2. In addition to behavioral health services, we include several other service types, such as preventive medicine services and services available under the Community Choice Waiver (CCW) for eligible adults, as these are key services within a "Good and Modern" service continuum for individuals with behavioral health conditions. The columns in the table indicate which services are behavioral health and which are included in our analysis of Medicaid claims data.

There are several important considerations for the service array shown in Exhibit 8. First, these represent only Medicaid-funded services. Services funded by grants or other funds are not reflected. For example, some provider organizations provide employment support or mobile crisis services, but since they are not widely available or billable to Medicaid, they are not reflected in the table. The table includes services provided to the target population under the Agreement, such as in-reach to the target population, case management, and peer support, but since these services are not Medicaid-billable (or were not at the time of our analysis in early 2020) they are not included in our analysis of service use.

Exhibit 8. Array of available services for adults across the "Good and Modern" behavioral health service continuum in Louisiana

Service Category from SAMHSA's 'Good & Modern' Service Continuum[10]	Available Service in Louisiana	Is the service behavioral health?	Is the service included in analysis in this report?
Prevention (including promotion)	Substance use disorder screening/assessment	Yes	Yes
	Preventive medicine services* (physical health)	No	Yes
Engagement Services	Psychiatric diagnostic evaluation and/or psych. testing	Yes	Yes
	Target population in-reach (not Medicaid-funded)	No	No
	Case management (provided by MCOs, not billable to Medicaid)	No	No
Outpatient Services	Psychotherapy (individual, family, and group)	Yes	Yes
	SUD counseling	Yes	Yes
	Evaluation & management with a behavioral health practitioner (includes medication management)	Yes	Yes
Community Support (Rehabilitative) and Other Supports (Habilitative)	Community Psychiatric Support and Treatment (CPST)	Yes	Yes
	Psychosocial Rehabilitation (PSR) – individual and group	Yes	Yes
	Permanent Supportive Housing (PSH)^	Yes	No
	Halfway House	Yes	Yes
	Community Choice Waiver (CCW) services for eligible adults	No	Yes
Intensive Support Services	Assertive Community Treatment (ACT)	Yes	Yes
	Subacute detoxification (ASAM 3.2)	Yes	Yes
	SUD intensive outpatient (IOP, ASAM 2.1)	Yes	Yes
Out-of-Home Residential Services	SUD residential services (ASAM 3.3)	Yes	Yes
	SUD treatment program (ASAM level 3.5, 3.7)	Yes	Yes
Acute Intensive Services	Acute detoxification (ASAM 3.7)	Yes	Yes
	Crisis intervention	Yes	Yes
	Crisis follow-up	Yes	Yes
	Emergency room (ER)	Yes	Yes
	Medical and psychiatric inpatient	Yes	Yes
Recovery Support	Peer support (peer support became Medicaid-funded on March 1, 2021 but was not at the time of our analysis)	Yes	No

*Preventive medicine services are defined as CPT codes 99381-99429

^Because housing for the target population is available from other (non-Medicaid) funding, we did not include PSH in our analysis of claims data.

[10] Substance Abuse and Mental Health Services Administration (2011). Description of a good and modern addictions and mental health service system. Accessed at: https://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf

2.4. System Assets, Strengths and Challenges

Assets, strengths, and challenges are another aspect to be considered for a behavioral health system needs assessment. The following is a brief summary; more detail is presented in Section 6. Much of the information in this section comes from key informant interviews and a review of documents. It is important to obtain a comprehensive understanding of what works well as a platform and guide for further enhancement and improvement.

2.4.1. Assets and Strengths

2.4.1.1. LEADERSHIP

Perhaps the most important system asset, without which any progress would be unlikely and which was universally cited by key informants, is the commitment on the part of LDH and OBH leadership to addressing limitations and promoting the quality of the public behavioral health system. A prime example is the Agreement wherein LDH has committed to an ambitious program of system improvement that will have a positive impact not only for the target population but the entire population of individuals with behavioral health needs. A partial list of these improvements and additions is enhancement of ACT programs, increase in employment programs, development of peer support services, expansion of crisis services, and an increase in housing availability. Expanding the scope of the needs assessment beyond that required by DOJ, which is the basis of this report, is an additional example of this commitment. Also noted by a number of informants is OBH's commitment to public outreach, information, and input through meetings and listening sessions held throughout the state on an ongoing basis, such as the Conversation on Behavioral Health Listening Tour.

2.4.1.2. INTEGRATED CARE

A second strength is the foundation for a system of integrated mental health, substance use, and primary care at the plan (MCO) and provider level. The current managed care contractual requirements for promoting integration, which replaced the earlier carve-out model, was a major step in this direction. At the provider level, Louisiana has been awarded several grants from SAMHSA to promote integration of primary and behavioral health care. These grants provide funding to develop integrated care models by four provider organizations, which will provide lessons for future expansion in the state.

OBH is establishing an integration advisory workgroup to assist in developing sustainability plans around integrated care and build upon the progress LDH has already achieved. The workgroup will focus on developing strategies to preserve integrated services developed through targeted initiatives like the PIPBHC (Promoting Integration of Primary and Behavioral Health Care), an OBH-held grant funded by SAMSHA.

FQHCs also provide integrated care to various degrees, and LDH created an alternative payment methodology for behavioral health services provided by clinicians in FQHCs so that patients can access behavioral health services on the same day that they access primary care.

2.4.1.3. INPATIENT BEDS

Key informants reported that Louisiana has an adequate supply of inpatient psychiatric beds and does not often experience the problem of emergency room backups that occurs in many other states. If this perception is accurate, it could be counted as another asset as long as it is not due to an overreliance on institutional care at the expense of sufficient community-based services.

2.4.1.4. VALUE-BASED PAYMENT AND EVIDENCE-BASED APPROACHES

In recent years, LDH has launched several value-based payment (VBP) initiatives designed to improve the quality and efficiency of Healthy Louisiana services. In 2016, LDH revised the set of quality measures to standardize across the MCO plans and selected a subset to be linked to payment incentives. LDH Medicaid has participated in the Health Care Payment Learning & Action Network; it adopted that organization's Alternative Payment Models (APM) framework for Medicaid Managed Care Incentive Payment Program (MCIPP), which went into effect in 2018. The program provides incentive payments for "achieving quality reforms that increase access to health care, improve the quality of care, and/or enhance the health of members the MCOs serve."[11] Incentive payments are offered for outcomes known as Approved Incentive Arrangements (AIA), which MCOs enter into voluntarily. Incentive payments may be up to 5 percent, in total, above the approved capitation payments. Current AIAs directly related to behavioral health care are "Follow-up after hospitalization for mental illness - within 30 days of discharge" and, as of this year, "Follow-up after ED visits for mental illness or SUD within 30 days of discharge," and several others that are not specific to behavioral health but are important for the quality of care for individuals with SMI, such as Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, diabetes screening, and ED visits. CAHPS measures the patient experience with health care. In the Section 6.2, under "Recommendations," we discuss ways in which these mechanisms may be expanded to improve the quality of behavioral health services.

An additional VBP initiative by LDH is a provision within MCO contracts that allows the MCOs to establish Physician Incentive Plans to encourage increased efficiency by providers in their networks. The contract language specifies that payment may not serve as an inducement to reduce medically necessary services.[12]

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[11] Medicaid Managed Care Quality Incentive Program: Response to HR 252 of the 2018 Regular Legislative Session | December 1, 2018 ldh.la.gov/assets/docs/LegisReports/HR252RS201812.pdf

[12] Louisiana Department of Health Bureau of Health Services Financing: Louisiana Medicaid Managed Care Organization Model Contract ldh.la.gov/assets/medicaid/RFP_Documents/RFP3/AppendixB.pdf

LDH has contracted with the Oregon Health and Science University Medicaid Evidence-based Decisions project to develop a process for reviewing covered services policies and using an evidenced-based approach to identify policy changes.[13] The purpose of this initiative is to ensure that decisions about covered benefits are based on evidence for the effectiveness of these benefits.

2.4.1.5. HEALTH TECHNOLOGY INITIATIVES

Although key informants indicated that Louisiana is not highly advanced in the use of health technology, there have been some initiatives to promote this development. Notably, the Louisiana Health Care Quality Forum (LHCQF), formed in 2007, has identified health technology as a priority area. In 2010 LHCQF received $18.4 million in federal grant funds to establish the Louisiana Health Information Technology (LHIT) Resource Center, designed to assist health care providers with adopting electronic health records and to implement the Louisiana Health Information Exchange (LaHIE). To date, the LHCQF has assisted more than 2,000 priority primary care and specialty care providers adopting and optimizing EHRs to maintain patients' health information.[14]

2.4.1.6. STEPS TO ADDRESS SOCIAL DETERMINANTS

Although Louisiana faces many challenges in relation to social determinants of health (SDOH) as discussed below, LDH has acknowledged this challenge and has taken a variety of steps to address it. SDOH are a range of factors and policies external to an individual that affect the person's health—factors such as economic stability, education, health care quality and access, neighborhood environment, and social and community context. In a 2019 interview with the Center for Health Care Strategies, Louisiana's Medicaid Director Jen Steele discussed the state's commitment and strategies to address SDOH and reduce health care disparities, including collaboration with the Office of Public Health.[15] Additionally, Louisiana does have several advantages compared to the national average, including a higher ratio of behavioral health providers to the population as a whole and a lower proportion of housing that is sub-standard.

2.4.1.7. WAIVER AND DEMONSTRATION PROJECTS

Additional assets also include several waivers and demonstration projects that are relevant for the adult Medicaid behavioral health population, especially those in the target and at-risk population.

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[13] Using Medicaid Levers to Improve Health Outcomes and Reduce Disparities: A Q&A with Louisiana's Medicaid Director Jen Steele https://www.chcs.org/

[14] http://www.lhcqf.org/for-providers/lapact

[15] Using Medicaid Levers to Improve Health Outcomes and Reduce Disparities: A Q&A with Louisiana's Medicaid Director Jen Steele, accessed at: https://www.chcs.org/using-medicaid-levers-to-improve-health-outcomes-and-reduce-disparities-qa-with-louisianas-medicaid-director-jen-steele/

- My Place Louisiana (Money Follows the Person Rebalancing Demonstration) provides home and community supports for individuals who qualify by virtue of nursing facility and/or hospital length of stay criteria, nursing facility Level of Care, and financial eligibility. Services are provided through various Medicaid waivers programs.
- The Community Choices Waiver provides a variety of home and community-based services including case management, transition from NF services, personal assistance service, adult day health care and other services for elders or adults with disabilities who qualify for NF level of care.
- The Adult Day Health Care waiver provides supervised day medical/nursing services, medication supervision/administration, social services, personal care and dietary services for individuals 22 and older who meet Medicaid eligibility and Nursing Facility Level of Care
- The Program of All-Inclusive Care for Elderly (PACE) provides a wide range of primary care, long-term care, and social services for individuals age 55 or older who live in a PACE provider service area.
- Long Term – Personal Care Services provide support for ADLs for individuals age 21 or older, meet nursing facility level of care, and require assistance with at least one ADL and are currently in an NF or living in the community and at risk based on several criteria. A variety of services are provided, including reminders about medication and help with medical appointments, but not giving medicine or providing nursing care.

2.4.1.8. PERMANENT SUPPORTIVE HOUSING

Louisiana's very extensive Permanent Supportive Housing (PSH) program is another important asset that benefits individuals with SMI and SMI with co-occurring SUD, among other types of disabilities. LDH partners with the Louisiana Housing Authority to manage the cross-disability PSH program, which provides access to more than 3,300 affordable housing units. PSH services are billed as a component of CPST and PSR, and are also reimbursable under several Medicaid HCBS programs. MCOs are responsible for outreach application assistance for members with a potential need for PSH, and they work with PSH program management to assure an optimal network of qualified services.

2.4.2. Challenges

The most immediate challenge LDH is taking on is, of course, to meet the requirements of the DOJ Agreement for the target and at-risk populations. In doing so, the State will achieve significant progress toward narrowing the gap between the system as it currently exists and the model Good and Modern system. Specifically, this involves a rebalancing away from institutional to community-based care; filling gaps in the continuum of care—notably crisis, peer support, and employment services; improving the quantity and quality of existing evidenced-based practices; increasing

supportive housing capacity; and developing data tracking systems to identify and respond to the needs of individuals at risk for nursing home placement or unnecessary emergency room or inpatient hospital utilization. Below are the central challenges we identified through our document review and discussions with key informants; we discuss actions and initiatives to respond to these challenges in further detail in the Recommendations section.

2.4.2.1. FUNDING

Like most states, the most critical challenge that Louisiana faces is inadequate funding for behavioral health services. The need for behavioral health treatment in a population, as measured by prevalence, outstrips available resources even under the most generous provisions. The starting question is therefore: What is the level of the public and government commitment to funding behavioral health services given other priorities? One method used to rate a state's funding on mental health is per capita expenditures for behavioral health care.[16] The limitation of this method is that it penalizes poorer states such as Louisiana, which ranks 43rd among the states in per capita income. While per capita spending is an important statistic for understanding available resources, it is not a fair measure of a state's commitment to behavioral health. A more meaningful measure is that used by Mental Illness Policy Org, which calculated spending on mental health as a percentage of the overall state budget, based on 2013 data (the most recent available).[17] This method separates a state's economy, which is an unavoidable resource constraint, from a state's public and political commitment to mental health. Even with this adjustment for poorer states, however, Louisiana was still among the lowest-ranked states, tied with Delaware and Oklahoma at 45.

Although more recent data are not available for comparisons with other states on percent of budget for behavioral health, a more general report may serve as a proxy: the U.S. Government Spending Website (https://www.usgovernmentspending.com) ranks states on the basis of state and local spending on welfare as a percent of state GDP (which like the Mental Illness Policy Org method, adjusts for state economy). On this measure, Louisiana was ranked fourth from the bottom with welfare spending 0.53% of GDP. This compares to the national average of 0.97% and the highest, Oregon, at 2.4%.

[16] National Association of State Mental Health Program Directors Research Institute, Inc (NRI), http://www.nri-incdata.org/. Table 1: SMHA Mental Health Actual Dollar and Per Capita Expenditures by State (FY2004 - FY2013)

[17] Funds for Treating Individuals with Mental Illness: Is Your State Generous or Stingy? A Report from Mental Illness Policy Org. Researched by DJ Jaffe and Dr. E. Fuller Torrey December 12, 2017 https://mentalillnesspolicy.org/

2.4.2.2. COMPLEX, DECENTRALIZED STRUCTURE

After resource constraints, a second important challenge is the fragmentation that results from the decentralized structure of Louisiana's behavioral health system, with OBH, Medicaid, MCOs, LGEs, Community Mental Health Centers, FQHCs and private behavioral health provider organizations having many loose interconnections, undefined boundaries, and overlapping functions tied together by a variety of contracts, MOUs, indirect reporting lines, and informal collaborations. Another example is that Coroner Offices perform a key role in authorizing involuntary holds, yet have limited relationship with other parts of the system. This loose, decentralized system is not unique to Louisiana, though perhaps more extreme, and like elsewhere, it results from a series of historical policy developments including the introduction of Medicaid, privatization, decentralization, Medicaid expansion and managed care carve-outs and carve-ins, all of which have taken place in Louisiana (and which illustrate the principle of complexity that informs HSRI's needs assessment framework).

This structure presents obvious challenges for monitoring, accountability, efficiency, and quality assurance; it also limits the capacity for coordination, which is one factor that likely contributes to inappropriate nursing home placement. Although key informants identified various specific examples of lack of coordination, such as the difficulty of coordinating the five MCOs to address systemwide issues, and the variability in services such as case management and crisis response, key informants did not specifically identify this decentralized structure as a specific problem, and it may offer various advantages such as responsiveness to local conditions.

2.4.2.3. QUALITY AND CARE COORDINATION

A limitation identified by a number of key informants is the quality of the Louisiana public behavioral health services, a perception that is supported by the MCOs' scores on behavioral health-related HEDIS[18] measures. The LDH Medicaid Managed Care Quality Dashboard[19] presents results of five HEDIS performance measures that apply specifically to adult mental health, all of which are relevant to risk factors for nursing facility referral:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia: The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
- Antidepressant Medication Management: The percentage of members 18 years of age and older with a diagnosis of major depression and who were newly

[18] The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures that provide consumers with information to compare across health plans.
[19] https://qualitydashboard.ldh.la.gov/

treated with antidepressant medication, and who remained on an antidepressant medication treatment.

- Diabetes Screening for People with Schizophrenia or Bipolar Who Are Using Antipsychotic Medications: The percentage of members 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 7 days of discharge.
- The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days of discharge.

In 2020, performance by all five MCOs was below average on all of the behavioral health-related measures except for diabetes screening. Moreover, ratings for all but the diabetes score declined over the period from 2016-2017 to 2020; for example, Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge declined from 29.94% in 2017 to 22.15% in 2020, and Adherence to Medication for Individuals with Schizophrenia declined from 59.88% in 2016 to 51.03% in 2020. Although these are averages across the five MCOs, and there was some variation among them in the early measurement years, by 2020, MCO scores varied by only a few points, meaning that no single poor performer pulled down the average for the state. Especially in the context of risk factors contributing to inappropriate nursing facility referrals, this substandard performance should be a matter of concern.

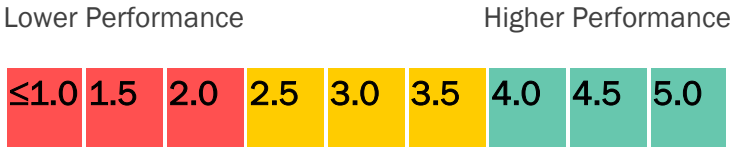
To put these measures into context, two other websites provide comparison among the states on HEDIS measure scores and ranking: the CMS Medicaid and CHIP Scorecard[20] and the NCQA Health Insurance Plan Ratings.[21] Additionally, the CMS website provides an 18+ age breakout for follow-up after hospitalization and the NCQA website presents scores for additional measures related to behavioral health:

- Mental and behavioral health overall (composite score)
- Follow-up after ED for mental illness
- Follow-up after ED for alcohol and other drug abuse or dependence
- Alcohol or drug abuse or dependence treatment engaged

NCQA reports two types of measure scores: one is a percentage compared to a benchmark, which is the 50th percentile score of plans or states reporting, and the other is a ranking on a five-point scale from equal to or less than 1.0 to 5.0, with 0.5 increments. For purposes of identifying areas where there is a need for performance improvement, especially with respect to some particular quality improvement focus such as reducing inappropriate nursing home placement, the percentage scores can be

[20] https://www.medicaid.gov/state-overviews/scorecard/state-health-system-performance/index.html
[21] https://www.ncqa.org/hedis/reports-and-research/ratings-2019/

misleading when they appear to be near the benchmark standard. In such cases, there may be a tendency to assume that this represents an acceptable standard of care; however, it is important to keep in mind that the benchmark score is a median or 50th percentile of states reporting—not a measure of superior performance, and in some cases, such as follow-up after hospitalization for mental illness, the median is far from what is desirable for a high-performing system. For these purposes, areas for improvement are more immediately evident with the five-point rating scale: where the 10th, 33.33rd, 66.67th and 90th measure percentiles are used for ratings, as shown below:



A plan that is in the top decile of plans.....5
A plan that is in the top 3rd of plans, but not in the top 10th percent.....4
A plan in the middle 3rd of all plans.....3
A plan that is in the bottom 3rd of plans, but not in the bottom 10 percent.....2
A plan that is in the bottom 10 percent of plans 1

Exhibit 9 presents the NCQA 2019-2020 ranking of Louisiana's five MCO's (not including the CSOC plan) on the seven NCQA HEDIS measures for adult behavioral health according to the percentile rankings described above. Out of the total 35 measures for the five plans, 22—or nearly two-thirds—were in the bottom third of plans. A detailed definition of each measure presented in Exhibit 9 can be found on the NCQA website (healthinsuranceratings.ncqa.org/2019/HprPlandetails.aspx?id=1557).

Exhibit 9. NCQA rating of Louisiana MCOs' performance on behavioral health-related HEDIS measures

Plan	Depression: Adhering to medication for 6 months	Follow-up after hospitalization for mental illness	Follow-up after ED for mental illness*	Follow-up after ED for alcohol and other drug abuse or dependence*	Alcohol or drug abuse or dependence treatment engaged	Schizophrenia: Diabetes screening for schizophrenia or bipolar	Adherence to antipsychotic medications for individuals with schizophrenia
AmeriHealth Caritas	2.0	2.0	2.0	2.0	5.0	3.0	2.0
United Healthcare	2.0	2.0	2.0	2.0	3.0	3.0	2.0
Aetna	4.0	1.0	1.0	3.0	3.0	4.0	3.0
Healthy Blue	2.0	2.0	2.0	2.0	4.0	3.0	2.0
Healthcare Connections	1.0	2.0	2.0	2.0	3.0	3.0	2.0

Source: Adapted from NCQA Health Insurance Plan Ratings 2019-2020 - Detail Report (Medicaid); retrieved at: https://www.ncqa.org/hedis/reports-and-research/ratings-2019/

*Follow-up for after ED for alcohol and other drug abuse or dependence were adopted by LDH in FY2021 as incentive-based measures.

In addition, CMS maintains a web-based file known as the Medicaid and CHIP Scorecard that presents quality measures voluntarily reported by the states.[22] While the results shown above in Exhibit 9 rate the performance of the five MCOs, the CMS scorecard compares Louisiana's performance across states and includes fee-for-service (FFS) and managed care populations. Of the behavioral health measures presented in the scorecard, Louisiana performed in the bottom quartile of states reporting measures for follow-up after hospitalization for mental illness (16.4% vs. national median 32.3%), adherence to antipsychotic medications for individuals with schizophrenia (49.9% vs. national median 59.1%), and antidepressant medication management (47.2% vs. national median 51.3%). Louisiana performed in the top quartile of states for three measures: diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (83.0% vs. national median 79.8%), use of opioids at high dosage in persons without cancer (1.7% vs. national median 6.4%), and initiation and engagement of alcohol and other drug abuse or dependence treatment (48.7% vs. national median 42.0%). CMS defines initiation as "initiating treatment within 14 days of diagnosis" and engagement as "continued treatment with two or more additional AOD services or medication treatment within 34 days of the initiation." Of the 38 states reporting on these measures, Louisiana had the second highest rate for initiation at 48.7% (median 42.0%) and for engagement 16.6%, above the median of 15.7%.[23] It should be noted that the denominator for initiation is the number who are diagnosed (as opposed to population prevalence) and therefore will be affected by the thoroughness of screening, an issue that is discussed in Section 3.3.

2.4.2.4. CASE MANAGEMENT

Another limitation noted by various key informants was inadequacies in the case management system. Comments were that there were many case managers but their activities primarily consisted of administrative functions for the MCOs, and also that case managers needed more training especially in their ability to anticipate and forestall behavioral health crises. Although we were not able to obtain a definitive explanation for the low rate of follow-up after hospitalization shown above, the role of case managers in this process should be investigated.

2.4.2.5. PEER SUPPORT SERVICES

Compared to other locales, peer services are relatively undeveloped in the Louisiana behavioral health system, one of the needs recognized by OBH in the 2018/2019 Block Grant application and confirmed by key informants.

[22] https://www.medicaid.gov/state-overviews/stateprofile.html?state=louisiana
[23] https://www.medicaid.gov/state-overviews/scorecard/initiation-engagement-alcohol-drug-dependence-treatment/index.html

2.4.2.6. SOCIAL DETERMINANTS OF HEALTH

Another challenge for Louisiana's behavioral health system is the impact of social determinants of mental health, which includes factors such as low economic status, discrimination and inequity, unemployment, food insecurity, lack of transportation, inadequate housing, unsafe neighborhoods, and access to care that are known to be risk factors for poor behavioral health in adulthood.[24] Exhibit 10 compares Louisiana against the national average on numerous SDOH relevant to behavioral health. Louisiana is comparatively disadvantaged on measures of social and economic factors such as educational attainment, poverty, and violent crime. There is wide variation at the county level in social determinants of health, as also shown in Exhibit 10.

Exhibit 10. Comparison of Louisiana and US on selected social determinants of health

	US Average	Louisiana Average	Louisiana County Minimum	Louisiana County Maximum
Social & Economic Factors				
High school completion	88%	85%	71%	91%
Some college	66%	57%	24%	70%
Unemployment	3.7%	4.8%	3.8%	10.7%
Children in poverty	17%	26%	13%	54%
Income inequality (ratio of household income at the 80th percentile to income at the 20th percentile)	4.9	5.7	4.2	7.7
Violent crime (number of reported violent crime offenses per 100,000 population)	386	541	55	1,378
Percent of households in unsatisfactory housing	18%	16%	6%	26%
Health Outcomes				
Percentage of adults reporting poor or fair health	17%	21%	16%	41%
# of poor mental health days past month	4.1	5.0	4.5	6.2
# of poor physical health days past month	3.7	4.3	3.7	6.7
Clinical Care				
Uninsured	10%	9%	7%	12%
Ratio of population to primary care providers	1,320:1	1,140:1	11,240:1	860:1
Ratio of population to mental health providers	380:1	330:1	4,750:1	150:1
Preventable hospital stays (rate of hospital stays for ambulatory-care sensitive conditions) per 100,000 Medicare enrollees	4,236	5,651	3,083	16,394

Source: County Health Rankings, accessed May 2021 at: https://www.countyhealthrankings.org/

2.5. Organization of This Report

The remainder of this report consists of four general sections. The first focuses on services for the target population, which is further divided into subsections focusing on those residing in nursing facilities, those who have transitioned to the community or were diverted from nursing home placement through the My Choice Louisiana program, and those identified as "at-risk". The second focuses more broadly on the system of behavioral health services for the entire population of adults with serious mental illness (SMI) enrolled in Healthy Louisiana, the state's Medicaid managed care organization. The third section focuses on the crisis service system, which LDH

[24] Alegria, M., A. NeMoyer, et al. (2019). "Social Determinants of Mental Health: Where We Are and Where We Need to Go." Curr Psychiatry Rep 20(11): 95.

is considering for expansion. The fourth puts forth Recommendations for addressing the service gaps identified throughout the report.

3. My Choice Louisiana: Target Population and At-Risk

Among current initiatives, certainly the most important is My Choice Louisiana, the program initiated in response to the DOJ suit. As described in the Agreement, the intent of the program is "to achieve the goals of serving individuals with serious mental illness in the most integrated setting appropriate to their needs, to honor the principles of self-determination and choice, and to provide quality services in integrated settings to achieve these goals." LDH has named the program My Choice Louisiana to emphasize the two key principles of self-determination and choice.[25]

The analysis in this section seeks to identify the service needs, service utilization, and potential service gaps for the target population and others identified as high risk for nursing home placement, described in detail below. In this analysis, the My Choice target population is divided into three subgroups, which are described below. In addition, the state is tracking individuals who are not in the target population but who have been identified as high risk for nursing home placement based on mental illness with physical health comorbidities and frequent emergency room use. (Various provisions in the Agreement require the State to enact efforts to ensure that referrals to nursing facilities—generally through hospital referrals—are reduced to further divert individuals at risk of placement; thus, this "at-risk" group is included in our analysis.) The following describes how each group is defined in this analysis.[26]

- **Target Population – Residing in Nursing Facilities**: Individuals in the target population who are still residing in nursing facilities.
- **Target Population - Transitioned**: Individuals in the target population who have transitioned from nursing homes to the community.
- **Target Population - Diverted**: Individuals with SMI who at admission meet NF Level of Care (LOC) criteria but for whom a PASRR Level II review recommends placement in the community prior to admission to an NF.
- **At-Risk**: Medicaid-enrolled individuals with presence of the following: a) age 50-79 with mental illness, b) at least two major physical health comorbidities, and c) at least six emergency room visits in the past two years.

In addition to these groups, our analysis in the following sections compares the service use of the target and at-risk populations to the broader population of Medicaid-enrolled adults with SMI in Louisiana (Adult SMI). The purpose of this comparison is to determine if members of the target population are receiving services consistent with patterns of service utilization for Medicaid-enrolled individuals with SMI. This will

[25] https://ldh.la.gov/index.cfm/page/3264
[26] Since the time of our analysis, OBH has changed the definitions of the diverted and at-risk groups. The definitions stated here are those used for the analysis in this report.

allow the State to determine whether any differences suggest the need for additional or specific types of services and supports for the target population. If, for example, individuals in the target population are found to be less likely to receive ACT or waiver services than Medicaid-enrolled adults with SMI, this would suggest an unmet need that resulted in avoidable nursing home placement.

Exhibit 11 presents the numbers in the target population that have been transitioned and diverted, overall and by region, as of the end of calendar year 2019 (the latest year of data available at the time of analysis for this report). As of the end of 2019, the target population consisted of 3,658 individuals, of which 92 (2.5%) had transitioned to the community through the My Choice program; an additional 170 individuals had been diverted from nursing home placement. An important consideration throughout the following discussion is that these data represent an early stage of the transition process (which has been slowed by the pandemic); therefore, the small numbers in the transitioned and diverted groups requires that any comparison among them be considered as tentative. As of the writing of this report (April 2021), the numbers transitioned and diverted have increased to 163 and 277, respectively.

Exhibit 11. Number and percentage of the My Choice target population who were transitioned through CY2019, by Human Service Region

	Target Population Total N	Number Transitioned Through CY19	% Transitioned Through CY19
TOTAL	**3,658**	**92**	**2.5%**
Acadiana	611	10	1.6%
Capital	602	18	3.0%
Central Louisiana	383	9	2.3%
Florida Parishes	211	5	2.4%
Imperial Calcasieu	327	12	3.7%
Jefferson Parish	204	3	1.5%
Northeast	357	5	1.4%
Metropolitan	228	10	4.4%
Northwest	520	10	1.9%
South Central	208	9	4.3%

Source: Medicaid claims data. Not shown above are seven individuals (one transitioned) with Parish unknown.

3.1. Demographic Characteristics

Exhibit 12 addresses the following evaluation questions: 1) What are the demographic characteristics of the target population (by subgroups of those residing in nursing facilities, transitioned, and diverted) and the at-risk? and 2) Are there differences in the demographic characteristics across groups that would indicate a need for different types of services and supports for specific groups?

Exhibit 12 shows the gender, age, and race/ethnicity of individuals in the target population subgroups and the at-risk group. Among the target population residing in nursing facilities, 52.6% are female, but among the transitioned slightly more than half are male (53.3%). Two thirds of the at-risk group are female (66.9%).

As indicated in the table, among the target population still in nursing facilities, 95% are over age 50, and over half (56.8%) are over age 65. Given the older nature of these individuals, LDH may need to consider treatment and support services that are more age-appropriate to assist with the transition and community integration. For instance, while many of these individuals may seek employment opportunities, others may be more likely to participate in integrated activities that are more focused on seniors. In addition, as the charts later in this document indicate, it will also be critically important to coordinate between OBH and the Office of Aging and Adult Services (OAAS) in providing adequate physical health care (general and specialty medical care), long-term services and supports, and community supports.

Compared to the target population residing in nursing facilities, of which only 38.2% are ages 50-64, the transitioned and diverted groups have a greater percentage in this age group (60.9% and 51.2%, respectively). It will be important to explore whether there is some barrier to transitioning older adults that needs to be addressed, although as noted previously, these data represent an early stage in the transition process. Nearly all the at-risk group (99.7%) are ages 50-64 which is due to the method by which this group was identified in Medicaid claims data; since eligibility for Medicare begins at age 65 and we did not have access to Medicare data, the group was defined as adults up to age 65 years.

It is noteworthy that race and ethnicity are unknown for 50% of the target population group and 60% of the at-risk group, according to Medicaid enrollment data. This is the case for Medicaid enrollees in Louisiana generally; for example, the Louisiana Medicaid 2019 Annual Report[27] shows about one third (31.2%) of all Medicaid enrollees are "Other" race, a category that includes all individuals who are not African American or White, therefore presumably constituted primarily by those whose race is unknown. Due to the large amount of missing data on race/ethnicity, we could not examine racial equity or disparities in service utilization for this report.

[27] https://ldh.la.gov/assets/medicaid/AnnualReports/MedicaidAnnualReport2019.pdf

Exhibit 12. Demographic characteristics of the target population subgroups and at-risk group, 2019

	Target Population Residing in NFs*		Target Population - Transitioned		Target Population - Diverted		At-Risk	
	N	%	N	%	N	%	N	%
Total	3,658	100.0%	92	100.0%	170	100.0%	3,643	100.0%
Gender								
Female	1,923	52.6%	43	46.7%	97	57.1%	2,436	66.9%
Male	1,735	47.4%	49	53.3%	73	42.9%	1,207	33.1%
Age								
0-17	0	0.0%	0	0.0%	0	0.0%	0	0.0%
18-25	6	0.2%	0	0.0%	1	0.6%	0	0.0%
26-49	174	4.8%	8	8.7%	18	10.6%	0	0.0%
50-64	1,399	38.2%	56	60.9%	87	51.2%	3,631	99.7%
65+	2,079	56.8%	28	30.4%	64	37.6%	12	0.3%
Race/Ethnicity								
Hispanic/ Latino	19	0.5%	1	1.1%	3	1.8%	45	1.2%
Asian	0	0.0%	0	0.0%	0	0.0%	4	0.1%
American Indian	7	0.2%	0	0.0%	2	1.2%	18	0.5%
Black	909	24.8%	25	27.2%	46	27.1%	976	26.8%
White	889	24.3%	10	10.9%	17	10.0%	404	11.1%
Race unknown	1,834	50.1%	56	60.9%	102	60.0%	2,196	60.3%

Source: Medicaid claims data.
*The data in this column are technically for the overall target population including the 92 transitioned; however, the numbers are overwhelming representative of those residing in nursing facilities. Due to the specifications of our data request, we did not obtain demographic data separately for those residing in nursing facilities.

Exhibit 13 addresses the following evaluation question: Are there regional differences in the distribution of the population groups that would indicate a need for proportionate allocation of resources by district? The table presents the distribution of each of the target population subgroups and the at-risk group across the ten Human Service Districts and Authorities; the distribution of the broader population of Medicaid-enrolled adults with SMI is also included for comparison. As Exhibit 13 indicates, the distribution of the target population across regions generally corresponds to that of the broader population of adults with SMI, as would be expected, but with some variation. For example, 5.8% of the overall target population resides in Florida Parishes, while 11.8% of Medicaid-enrolled adults with SMI reside in that region. District comparisons of the transitioned and diverted population are less meaningful given the small size of these groups; however, as time goes on, regional patterns can be monitored to identify potential barriers to transition in certain regions or successes that can provide insights to quality improvement for other regions that are more or less successful.

Exhibit 13. Distribution of the target population subgroups, at-risk group, and Medicaid-enrolled adults with SMI across Human Service Districts and Authorities Regions, 2019

	Target Population Overall		Target Population Transitioned		Target Population Diverted		At-Risk		Adult SMI	
	N	%	N	%	N	%	N	%	N	%
Total	3,658	100.0%	92	100.0%	170	100.0%	3,643	100.0 %	95,102	100.0%
Acadiana	611	16.7%	10	10.9%	25	14.7%	581	15.9%	29,557	15.1%
Capital	602	16.5%	18	19.6%	27	15.9%	364	10.0%	23,499	12.0%
Central Louisiana	383	10.5%	9	9.8%	17	10.0%	263	7.2%	15,537	8.0%
Florida Parishes	211	5.8%	5	5.4%	10	5.9%	458	12.6%	23,064	11.8%
Imperial Calcasieu	327	8.9%	12	13.0%	11	6.5%	236	6.5%	14,034	7.2%
Jefferson Parish	204	5.6%	3	3.3%	12	7.1%	242	6.6%	13,286	6.8%
Northeast	357	9.8%	5	5.4%	24	14.1%	286	7.9%	16,140	8.3%
Metropolitan	228	6.2%	10	10.9%	9	5.3%	424	11.6%	18,745	9.6%
Northwest	520	14.2%	10	10.9%	25	14.7%	398	10.9%	22,751	11.7%
South Central	208	5.7%	9	9.8%	8	4.7%	391	10.7%	17,785	9.1%
Parish Unknown	7	0.2%	1	1.1%	2	1.2%	0	0.0%	704	0.4%

Source: Medicaid claims data.

3.2. My Choice Participants' Service and Support Needs

The evaluation also sought to understand the needs for services and supports for individuals in the target population, in order to provide the State with critical information to develop needed services across the state and more specifically in areas where the target population was likely to transition. Several data sources provided valuable information on service needs, including the following.

Preadmission Screening and Resident Review (PASRR) Level II Evaluation. PASRR is guided by federal regulations that require individuals being considered for admission to a Medicaid-certified nursing facility be screened for mental illness and intellectual disability. If an individual screens positive at the PASRR Level I, a PASRR Level II Evaluation is implemented to confirm the diagnosis and determine if nursing facility placement is appropriate. The PASRR Level II also provides information regarding the specialized behavioral health services recommended for the individual. We developed a systematic random sampling strategy to obtain a subset of fields from the PASRR Level II for a representative sample of 604 evaluations conducted between February 1, 2020 and April 15, 2020. The final sample included data for 222 individuals.

The **Transition Assessment** is a person-centered tool developed by OBH and OAAS in response to the DOJ agreement. Transition Coordinators implement the assessment face-to-face with members of the target population residing in nursing facilities to identify what services and supports (behavioral health and long-term services and supports) they would need to transition to the community and to gauge their interest in transitioning. The tool was first implemented in 2018 and then revised in November 2019. Much of the information collected during the assessment is narrative and was not available in digitized format for analysis; however, we obtained a subset of fields

related to supports needed in the community. Data from the 2018 version of the assessment were available for 856 evaluations conducted between April 2018 and November 2019. Data from the revised instrument were available for 214 individuals assessed between November 2019 and April 2020. Therefore, we had some transition assessment data for 1,070 individuals—roughly one third of the target population residing in nursing facilities as of March 2020.

Unlike many other states, Louisiana funds a more generous array of specialty behavioral health services for individuals residing in nursing facilities. Following the PASRR Level II evaluation, which is conducted by an MCO PASRR Level II evaluator, the evaluation is then sent to OBH for review and determination of service provision. OBH makes the final authorization on nursing facility placement. Exhibit 14 shows the specialized behavioral health service recommendations for individuals for whom OBH approved nursing facility care (note, the data include evaluations for pre-admission, resident review, and extension requests). Notably, there is some discrepancy between the specialized services recommended by MCOs PASRR Level II evaluator and by OBH, with MCOs more likely to recommend specialized services. For example, MCOs recommended CPST and PSR for twice as many individuals as OBH. This discrepancy should be examined and monitored by OBH to ensure individuals in nursing facilities are getting behavioral health services to meet their needs.

Exhibit 14.Specialized behavioral health service recommendations for individuals approved for nursing facility placement (February 2020 - April 2020)

	MCO Recommended Specialized Services (N=90)		OBH Recommended Specialized Services (N=90)	
	N	%	N	%
ACT	12	13.3%	10	11.1%
CPST	24	26.7%	14	15.6%
Psychosocial Rehab - Individual	18	20.0%	9	10.0%
Psychosocial Rehab - Group	7	7.8%	3	3.3%
Permanent Supportive Housing	3	3.3%	0	0.0%
Medication Management	59	65.6%	50	55.6%
Outpatient Therapy (Individual)	13	14.4%	7	7.8%
Outpatient Therapy (Family)	0	0.0%	0	0.0%
Outpatient Therapy (Group)	8	8.9%	6	6.7%
SUD Residential Treatment	0	0.0%	0	0.0%
SUD Halfway House	0	0.0%	1	1.1%
SUD IOP	5	5.6%	1	1.1%
SUD Ambulatory Detox	0	0.0%	0	0.0%
SUD Outpatient Therapy (Individual)	0	0.0%	0	0.0%
SUD Outpatient Therapy (Family)	0	0.0%	0	0.0%
SUD Outpatient Therapy (Group)	0	0.0%	0	0.0%
None	17	18.9%	30	33.3%
Other specialized services	1	1.1%	0	0.0%
Total	**90**	**100.0%**	**90**	**100.0%**

Source: PASRR Level II evaluations conducted February 2020 - April 2020. The data in this table are limited to individuals approved for nursing facility placement and for whom data on both MCO and OBH recommended specialized services were available.

In addition, data from the transition assessment provided information on service and support needs, as well as interest in transition among the target population residing in nursing facilities. Exhibit 15 shows individuals' initial reported interest in transitioning to the community following the person-centered assessment interview. This initial reported interest indicates that slightly under half (42.5%) expressed interest in transition following the initial interview, and only 35.5% ultimately expressed interest as a result of the assessment process. It is important to note that when Louisiana initiated this process, some members of the target population had been living in nursing facilities for many years. The low proportion of individuals interested in transitioning highlights the important role of Transition Coordinators and other regional staff in educating the target population about the supports available in the community. Given the renewed in-reach efforts by LDH, we would expect as time goes on a greater proportion of individuals assessed will be interested in transition. Exhibit 15 also displays the small proportion of assessments for which Transition Coordinators indicated "Transition would not be pursued"; the top reasons Transition Coordinators indicated for not pursing transition were the person requires 24-hour care or were not in the target population. This data element was collected on the initial (2018) version of the transition assessment; as noted above, the instrument was revised in November 2019 to improve data quality.

Exhibit 15. Transition assessment respondents' initial reported interest in transition to the community

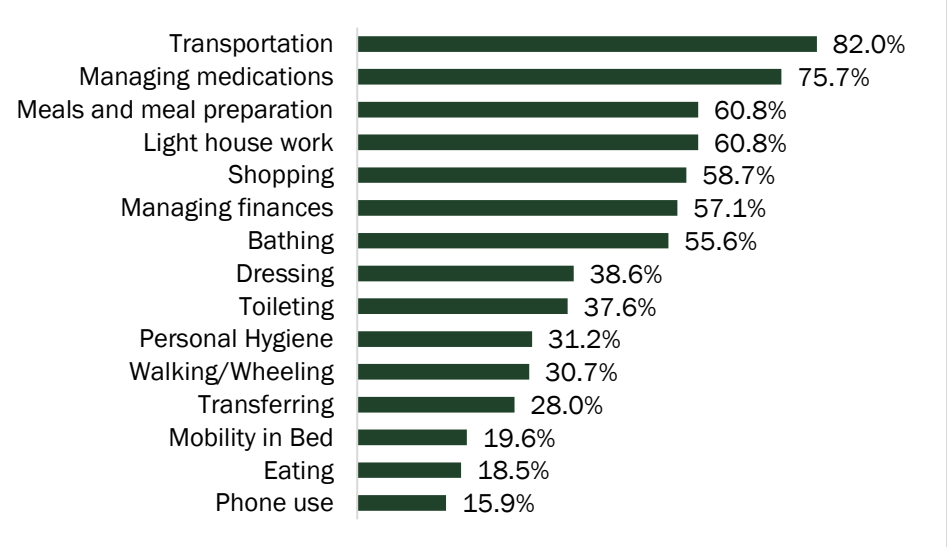
	Outcome of Initial Transition Assessment Interview		Final Transition Assessment Outcome	
	N	%	N	%
Interested in returning to community	255	42.5%	231	35.5%
Not interested in returning to community	329	54.8%	399	61.3%
Transition will not be pursued	16	2.7%	21	3.2%
Total	600	100.0%	651	100.0%

Source: Transition Assessment, Apr 2018-Nov 2019.

We used data from the transition assessments to examine the needs for services and supports and supports in the community; it is important to note, however, that these data are as reported by Transition Coordinators—or by respondents at the initial assessment phase, when they may be unaware of the availability of services in the community. Exhibit 16 shows the personal supports needed in the community as reported by transition assessment respondents (N=189). These items are from a list of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), for which we coded any indication of need for support as a need; on the assessment, responses are provided in an open-text format. The support need indicated by the most respondents was transportation (82%), followed by managing medications (75.7%), meals and meal preparation (60.8%), light housework (60.8%), shopping (58.7%), managing finances (57.1%) and bathing (55.6%). Support with personal hygiene, walking/wheeling, and transferring (e.g., in and out of bed, a chair, or wheelchair) was indicated by just under one third of respondents. Together, Exhibit 16 shows a high

need for in-home personal care supports for individuals transitioning to the community. Over three quarters (77%) of respondents indicated the need for assistance with at least one ADL (not including transportation, medication management, or financial management). These data suggest up to 75% of individuals transitioning to the community need some form of in-home personal care service.

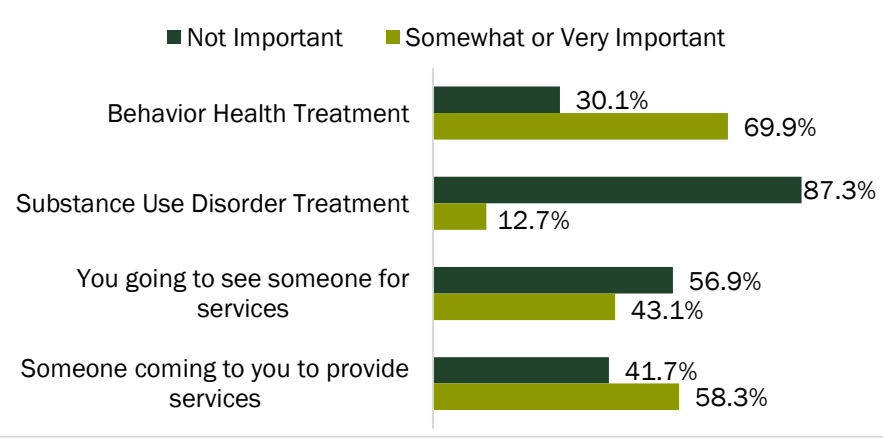
Exhibit 16. Supports for Activities of Daily Living and Instrumental Activities of Daily Living needed in the community as reported on the transition assessment



Source: Transition Assessment, Nov 2019-Apr 2020. N=189.

Exhibit 17 shows the transition assessment respondents' rating of the importance of behavioral health supports. Over two thirds (69.9%) rated behavioral health treatment as somewhat or very important to them; for SUD treatment, 12.7% rated treatment as somewhat or very important. More respondents indicated it is important that someone come to them to provide behavioral health services (58.3%) compared with going to see someone for services (43.1%).

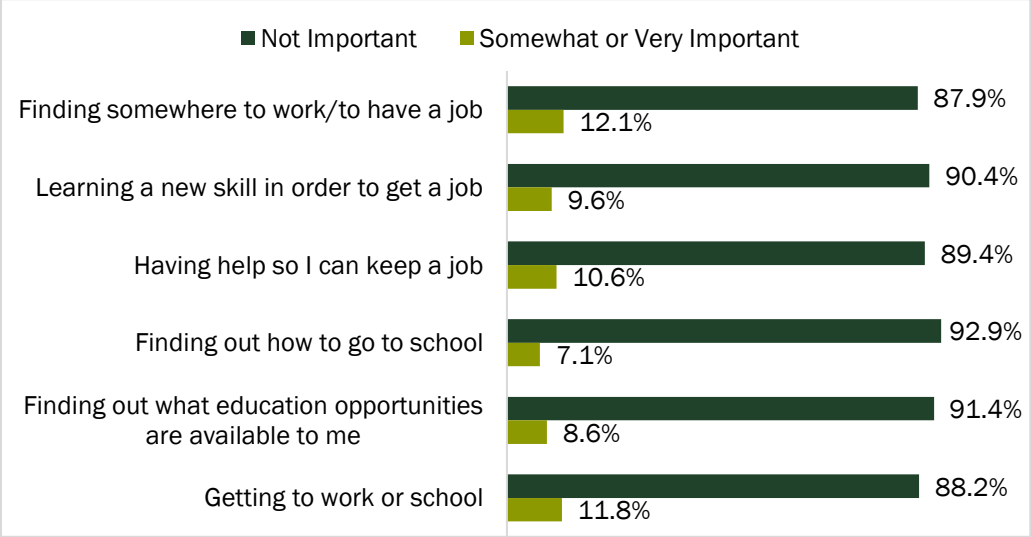
Exhibit 17. Transition assessment respondents' rating of the importance of behavioral supports



Source: Transition Assessment, Nov 2019-Apr 2020. N=206. The question is worded, "How important to you is…"

In addition, the assessment collects information regarding services and support to find work/educational opportunities in the community. As shown in Exhibit 18, 12% of transition assessment respondents rated "finding somewhere to work/having a job" as somewhat or very important. An open-ended question asking about respondents' interest in work yielded similar results (Exhibit 19): while only 7.7% said yes, an additional 5.2% suggested they might be interested or feel unable but would otherwise have interest. However, it is important to keep in mind these responses were given by individuals residing in nursing facilities, many of whom reportedly were not interested in transition at that time, as shown previously in Exhibit 15, and who may have been residing in a nursing facility for many years, with little knowledge of opportunities for employment. We consulted with a subject matter expert who suggested a much greater proportion of people—up to 50% of those under age 65—would likely be interested in employment support if made aware of the opportunity. We used this information for a separate exercise to project the proportion of the target population that would be interested in employment based on the age distribution of those transitioned through 2019; the result was 27% of the overall target population, which we and the subject matter expert believe is a more accurate estimate of the percentage who would be interested in employment support services.

Exhibit 18. Transition assessment respondents' rating of the importance of finding work or educational opportunities in the community



Source: Transition Assessment, Nov 2019-Apr 2020. The question is worded: "Let's talk about some things that may be important to you when thinking about where you would like to live." N=198 except for the last item, 'Getting to work or school' N=195.

Exhibit 19. Transition assessment respondents' desire for employment

	N	%
No or unable	169	87.1%
Maybe or yes but feel unable	10	5.2%
Yes	15	7.7%
Total	194	100.0%

Source: Transition Assessment, Nov 2019-Apr 2020. The question is worded: "Do you want to work?" HSRI classified the open text responses into the above categories.

Data from the initial (2018) version of the transition assessment provide information on the challenges noted by Transition Coordinators that they will need to address when planning transition from a nursing facility to the community. Exhibit 20 shows these challenges in descending order. Over half of individuals assessed (60.6%) did not have housing apart from the nursing facility; this data point highlights the importance of the state's provision of housing opportunities under the DOJ Agreement. Inadequate family support and mental health symptoms were the next most commonly cited challenges (58.5% and 49.8%). Roughly one third of individuals had physical health challenges, and one quarter were determined by Transition Coordinators to have extensive service needs, meaning they need an array of services from a variety of providers (e.g., medical, behavioral health, personal care assistant, etc.).

Exhibit 20. Challenges to consider when transition planning

	N	%
Lack of housing	321	60.6%
Inadequate family support	310	58.5%
Mental health symptoms	264	49.8%
Physical health	184	34.7%
Cognitive impairment	168	31.7%
Extensive service needs	135	25.5%
Criminal history	35	6.6%
No income	23	4.3%
Housing available but does not meet physical/ functional needs	7	1.3%
Housing available but inadequate for habitation	7	1.3%
Other	46	8.7%
Total	**530**	**100.0%**

Source: Transition Assessment, Apr 2018-Nov 2019.

3.3. Target Population and At-Risk Group: Service Utilization

This section examines service penetration for the target population and at-risk group based on analysis of Medicaid claims data. The standard definition of service penetration is "the percentage of members with a mental health service need who received mental health services in the measurement period."[28] It does not differentiate among reasons why some number in the population did not receive services, such as that services were unavailable or inaccessible, or were available but declined, etc. Our analysis is based on paid Medicaid claims and therefore only captures individuals who received Medicaid-funded services; services funded by other sources, such as Medicare or grant funds are not captured in this analysis. These and other limitations are discussed in Section 7.

First, we compare service penetration rates for the target population and at-risk group to that of the broader population of adults with SMI, with the assumption that

[28] https://www.qualishealth.org/sites/default/files/BH-Perf-Measures-030916.pdf

penetration for these groups should be at least equivalent, and preferably greater than that for the larger population. We also discuss service penetration rates for the target population residing in nursing facilities in comparison to the service needs indicated on the PASRR Level II evaluation. Then, we present service penetration rates pre- and post-transition and diversion to examine whether and how service use changes in the year following transition or diversion.

Initially we reviewed and analyzed data to determine if the My Choice groups vary in the amount and type of services received (Exhibit 21). The services examined include mental health and SUD services as well as medical emergency room and hospital admissions, which are likely pathways to nursing home placement, and certain types of preventive care that are important for avoiding hospital admissions. The preventive care service category included in the analysis includes services codes 99381-99429, a group of codes required under the Affordable Care Act to be covered at no charge by insurance companies. Services in this category include annual "well visits" for people of all ages as well as periodic preventive evaluation and age-appropriate anticipatory guidance/risk factor reduction (e.g., dietary counseling, injury prevention counseling), as well as alcohol/drug screening and brief intervention and tobacco/smoking cession. We included preventive care in the analysis on the assumption that lack of preventive care is a risk factor for people with SMI resulting in higher ER and inpatient treatment and thereby higher risk for nursing home placement, a relationship supported by research[29] and feedback from key informants.

As shown in Exhibit 21, a greater proportion of individuals transitioned and diverted are receiving services such as ACT, CPST, and PSR compared to the larger population of adults with SMI. These services are highly appropriate if not essential services for the transition population, as they provide the high level of support that is required to ensure successful post-transition stabilization. It is appropriate, therefore, that a greater proportion of these groups is receiving these services compared to adults with SMI as a whole. Whether the intensity of these behavioral health services is sufficient is the question, given the number of post-transition individuals with behavioral health ER visits and inpatient admissions. It also begs the question of what services and supports are needed to address high physical health ER visits and inpatient admissions.

For the target population residing in nursing facilities (shown in the first column of Exhibit 21), penetration of ACT, CPST, PSR, and psychotherapy are slightly lower compared to the broader population of adults with SMI (shown in the last column). PASRR Level II data for a sample of 90 individuals approved for nursing facility care (shown previously in Exhibit 14) suggest the need for these services may be higher. For example, MCOs recommended ACT for 13.3% of individuals, CPST for 26.7%, PSR for 20.0%, and outpatient therapy (individual) for 14.4%. The penetration rates for these services among the target population residing in nursing facilities is: ACT 1.9%, CPST

[29] Fullerton CA, Witt WP, Chow CM, Gokhale M, et al. 2018. Impact of a Usual Source of Care on Health Care Use, Spending, and Quality Among Adults With Mental Health Conditions, Administration and Policy in Mental Health and Mental Health Services Research, Vol.45 (3), p.462-471

7.2%, PSR (individual) 7.4%, and psychotherapy 7.4%. We cannot make a direct comparison between the service needs identified from our PASRR sample and service utilization because they are drawn from different samples, but the difference between the identified service needs and actual services received by individuals in the target population not transitioned is something for OBH to monitor moving forward.

Exhibit 21. Service penetration rates for the target population and at-risk compared to Medicaid-enrolled adults with SMI, CY2019

	Target Pop: Residing in NFs		Target Pop: Transitioned		Target Pop: Diverted		At-Risk		Adult SMI	
	N	%	N	%	N	%	N	%	N	%
Total Served	3,566	100%	92	100%	170	100%	3,643	100%	195,102	100%
Mental Health										
ACT	69	1.9%	24	26.1%	29	17.1%	180	4.9%	4,713	2.4%
CPST	257	7.2%	21	22.8%	10	5.9%	366	10.0%	18,261	9.4%
PSR – Individual	263	7.4%	29	31.5%	12	7.1%	392	10.8%	18,550	9.5%
PSR – Group	2	0.1%	1	1.1%	2	1.2%	6	0.2%	273	0.1%
Psychotherapy	265	7.4%	13	14.1%	40	23.5%	788	21.6%	41,666	21.4%
Psych Eval/Testing	721	20.2%	33	35.9%	79	46.5%	1,025	28.1%	50,484	25.9%
E&M for BH	692	19.4%	25	27.2%	50	29.4%	764	21.0%	39,455	20.2%
Crisis Intervention	3	0.1%	1	1.1%	1	0.6%	36	1.0%	1,693	0.9%
Crisis Follow-up	3	0.1%	1	1.1%	1	0.6%	19	0.5%	1,483	0.8%
ER for MH	290	8.1%	12	13.0%	79	46.5%	691	19.0%	22,356	11.5%
Inpatient for MH	576	16.2%	11	12.0%	96	56.5%	575	15.8%	22,594	11.6%
SUD Services										
Screening/Asses	3	0.1%	0	0.0%	1	0.6%	81	2.2%	4,162	2.1%
Counseling	1	0.0%	0	0.0%	1	0.6%	40	1.1%	2,093	1.1%
IOP (2.1)	3	0.1%	0	0.0%	1	0.6%	93	2.6%	5,017	2.6%
Sub.Detox (3.2)	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Acute Detox (3.7)	2	0.1%	0	0.0%	1	0.6%	25	0.7%	2,086	1.1%
Residential (3.3)	0	0.0%	0	0.0%	0	0.0%	2	0.1%	162	0.1%
Tx Program (3.5/7)	8	0.2%	0	0.0%	6	3.5%	180	4.9%	8,107	4.2%
Halfway House	1	0.0%	0	0.0%	0	0.0%	23	0.6%	756	0.4%
ER for SUD	23	0.6%	2	2.2%	6	3.5%	293	8.0%	7,933	4.1%
Inpatient for SUD	13	0.4%	0	0.0%	5	2.9%	176	4.8%	6,059	3.1%
Physical Health										
Preventive Care	30	0.8%	5	5.4%	10	5.9%	859	23.6%	38,826	19.9%
ER for PH	1,659	46.5%	50	54.3%	100	58.8%	3,509	96.3%	117,400	60.2%
Inpatient for PH	1,276	35.8%	37	40.2%	55	32.4%	1,601	43.9%	34,072	17.5%

Source: Medicaid claims data. Penetration rates are calculated as the number who received the service divided by the total number served multiplied by 100.

The data displayed in Exhibit 21 suggest several other important gaps. First, the limited number of individuals in both the target population and the Adult SMI groups receiving crisis services compared to the much larger number with behavioral health ER visits and inpatient admissions is a clear endorsement of the Agreement's emphasis on the need for expanded crisis services in the state. For example, only about 1% of any of the evaluation groups received the state's Medicaid-funded crisis intervention service in 2019. During the same timeframe, the rates who presented to the emergency room for a mental health crisis were much higher: 8.1% of the target population

residing in nursing facilities, 13% among individuals transitioned, 46.5% of individuals diverted, 19% of the at-risk group, and 11.5% of the population of adults with SMI.

Second, rates of SUD service use for all population groups are notably low. Among the 92 individuals transitioned, in the year following transition none received Medicaid-funded SUD screening/assessment or outpatient SUD services, although two individuals visited the ER for SUD, as indicated by the primary diagnosis on the ER claim record. Although our analysis could not determine the number among the 92 people transitioned with a SUD diagnosis, the lack of SUD service utilization post-transition should be considered in light of the result shown previously in Exhibit 17 that 12.7% of transition assessment respondents said SUD treatment in the community was somewhat or very important to them. On a broader level, the extremely limited number of individuals in Louisiana's adult SMI population who are receiving SUD services, even screening and assessment (2.1%), is an indication of a likely unmet need. SAMHSA estimates that nearly 30% of individuals with SMI have a co-occurring substance use disorder.[30]

Finally, the extremely high utilization of intensive physical health services (ER and inpatient) across all population groups and the low utilization of preventive care indicates this is an area for priority attention. With regard to preventive care services, we acknowledge that individuals residing in nursing facilities likely receive some preventive care through the nursing home and that these services for individuals over age 65+ may be covered by Medicare for dual-eligibles, resulting in the low rates shown in Exhibit 21 for the target population (residing in nursing facilities and transitioned). However, less than one quarter of the at-risk group and only one in five Medicaid-enrolled adults with SMI—both groups that are primarily under age 65—received preventive care services, indicating an unmet need in the broader behavioral health population.

In addition to the service categories shown above, we examined the proportion of the target population and at-risk group who received any of the Medicaid-funded specialized behavioral health services tracked in this analysis. As shown in Exhibit 22, 39.1% of the transitioned group, 29.4% of the diverted group, and 46.5% of the at-risk group received none of the specialized services tracked in our analysis (for the transitioned and diverted the timeframe is post-transition or diversion; for the at-risk the timeframe is 2019). This highlights a gap where lack of behavioral health services is likely to result in high rates of ER and inpatient use, which are pathways to nursing home placement. The table also shows the proportion that received both mental health and SUD services (bottom row) vs. mental health services without any SUD services and SUD services without any mental health services. As shown below, 1.1% of the transitioned, 7.6% of the diverted, and 10.5% of the at-risk received services for both mental health and SUD.

[30] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, Mental Health, Detailed Tables available at: https://www.samhsa.gov/data/population-data-nsduh

Exhibit 22. Number and percentage of the transitioned, diverted, and at-risk who received any Medicaid-funded behavioral health services, CY2019

	Target Population - Transitioned		Target Population - Diverted		At-Risk	
	N	%	N	%	N	%
TOTAL PERSONS	**92**	**100.0%**	**170**	**100.0%**	**3,643**	**100.0%**
No specialized BH services	36	39.1%	50	29.4%	1,693	46.5%
MH services, no SUD services	54	58.7%	107	62.9%	1,461	40.1%
SUD services, no MH services	1	1.1%	0	0.0%	106	2.9%
MH & SUD services	1	1.1%	13	7.6%	383	10.5%

Source: Medicaid claims data. Mental health services include: ACT, CPST, PSR, psychotherapy, psychological evaluation or testing, crisis intervention, and ER or inpatient for mental health; SUD services include: SUD screening/assessment, SUD counseling, IOP, subacute and acute detox, residential, SUD treatment program, halfway house, and ER or inpatient for SUD.

We were also interested in understanding whether service penetration for individuals in the transitioned and diverted groups changed in the year post-transition/diversion compared to the prior year. For those who transitioned to the community, we would expect services and service utilization to be at least equal to, but preferably greater than, rates for the services while residing in nursing facilities—given that nursing facilities provide additional supports that are not available in the community.

Exhibits 23-25 present transition and diverted group penetration rates for services one year before and one year after transition/diversion. Because the numbers in Exhibit 23 are small, it is not possible to draw definitive conclusions, but we see some encouraging trends and some that will be important to monitor. Of the positive trends for the transitioned group, the proportion that received ACT increased to nearly one in three (29.3%) in the year following transition. Penetration of PSR also increased post-transition, though less dramatically. Rates among the transitioned of ER and inpatient use for mental health dropped very slightly. However, penetration of ER for physical health among the transitioned increased from 52.2% in the year prior to transition to 63.0% in the year post-transition. To probe deeper into this finding, we looked at how many of the 58 people transitioned with an ER visit for physical health also received waiver services: 40 of the 58 (69%) had received at least some waiver services post-transition (data not shown). Within the scope of this analysis we could not look further into the type or intensity of these services, but this is an area OBH should investigate, perhaps through chart reviews, to better understand the factors that precede ER visits for the transitioned to address them prior to rising to the level of needing ER care.

For the diverted group, penetration rates for behavioral health services did not increase post-diversion and in some cases even show a slight dip, as with CPST which was 8.2% in the year prior to diversion and 6.5% in the year following. Notably, rates for intensive services such as ACT, PSR, and CPST are much lower post-diversion compared to post-transition; for example, individual-level PSR was received by 33.7% of those transitioned compared to only 5.9% of those who were diverted. This suggests individuals who are diverted are not receiving intensive services for mental health at the same rates as those who are transitioned, an area of likely unmet need. This is an

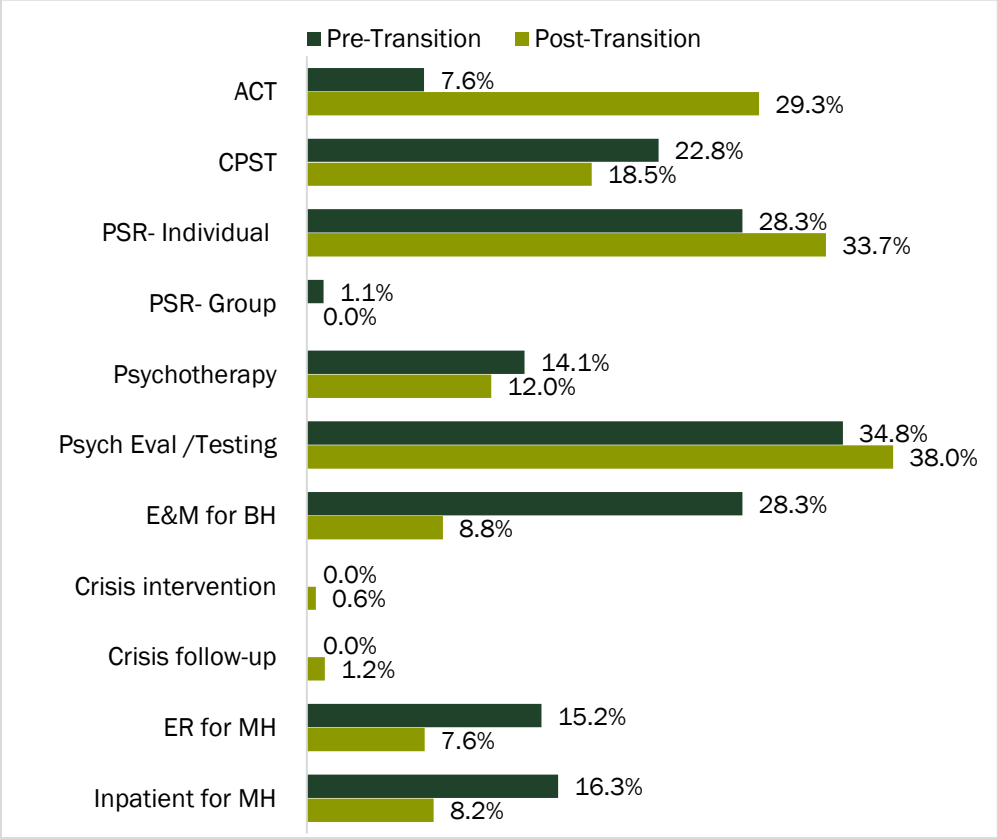
area to monitor moving forward to prevent those diverted from again being referred to nursing home care. It is interesting, however, that despite no increases in penetration of behavioral health services there is a decrease in use of the ER for mental health—from 52.9% in the year pre-diversion to 35.9% in the year post-diversion. However, the rate of ER for mental health post-diversion (35.9%) is still more than double the rate post-transition (14.1%); again suggesting a possible unmet need for more intensive services such ACT, PSR, or CPST for individuals who are diverted. There is also a decrease in ER utilization for physical health in the year post-diversion, though the difference is smaller.

Exhibit 23. Service penetration one year pre- and post- transition or diversion

	TRANSITIONED				DIVERTED			
	Pre-		Post-		Pre-		Post-	
	N	%	N	%	N	%	N	%
Total	92	100.0%	92	100.0%	170	100.0%	170	100.0%
Mental Health Services								
ACT	7	7.6%	27	29.3%	26	15.3%	26	15.3%
CPST	21	22.8%	17	18.5%	14	8.2%	11	6.5%
PSR – Individual	26	28.3%	31	33.7%	13	7.6%	10	5.9%
PSR – Group	1	1.1%	0	0.0%	2	1.2%	1	0.6%
Psychotherapy	13	14.1%	11	12.0%	42	24.7%	38	22.4%
Psych Eval/Testing	32	34.8%	35	38.0%	74	43.5%	71	41.8%
E&M for BH	26	28.3%	15	16.3%	49	28.8%	47	27.6%
Crisis Intervention	0	0.0%	1	1.1%	2	1.2%	1	0.6%
Crisis Follow-up	0	0.0%	2	2.2%	1	0.6%	1	0.6%
ER for MH	14	15.2%	13	14.1%	90	52.9%	61	35.9%
Inpatient for MH	15	16.3%	14	15.2%	109	64.1%	76	44.7%
SUD Services								
Screening/Asses	0	0.0%	0	0.0%	0	0.0%	1	0.6%
Counseling	0	0.0%	0	0.0%	0	0.0%	1	0.6%
IOP (2.1)	0	0.0%	0	0.0%	1	0.6%	1	0.6%
Subacute.Detox (3.2)	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Acute Detox (3.7)	0	0.0%	0	0.0%	1	0.6%	1	0.6%
Residential (3.3)	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Tx Program (3.5, 3.7)	0	0.0%	0	0.0%	5	2.9%	5	2.9%
Halfway House (3.1)	0	0.0%	0	0.0%	0	0.0%	0	0.0%
ER for SUD	2	2.2%	4	4.3%	7	4.1%	4	2.4%
Inpatient for SUD	0	0.0%	0	0.0%	2	1.2%	4	2.4%
Physical Health Services								
Preventive Care	2	2.2%	5	5.4%	13	7.6%	10	5.9%
ER for PH	48	52.2%	58	63.0%	104	61.2%	91	53.5%
Inpatient for PH	43	46.7%	36	39.1%	47	27.6%	62	36.5%

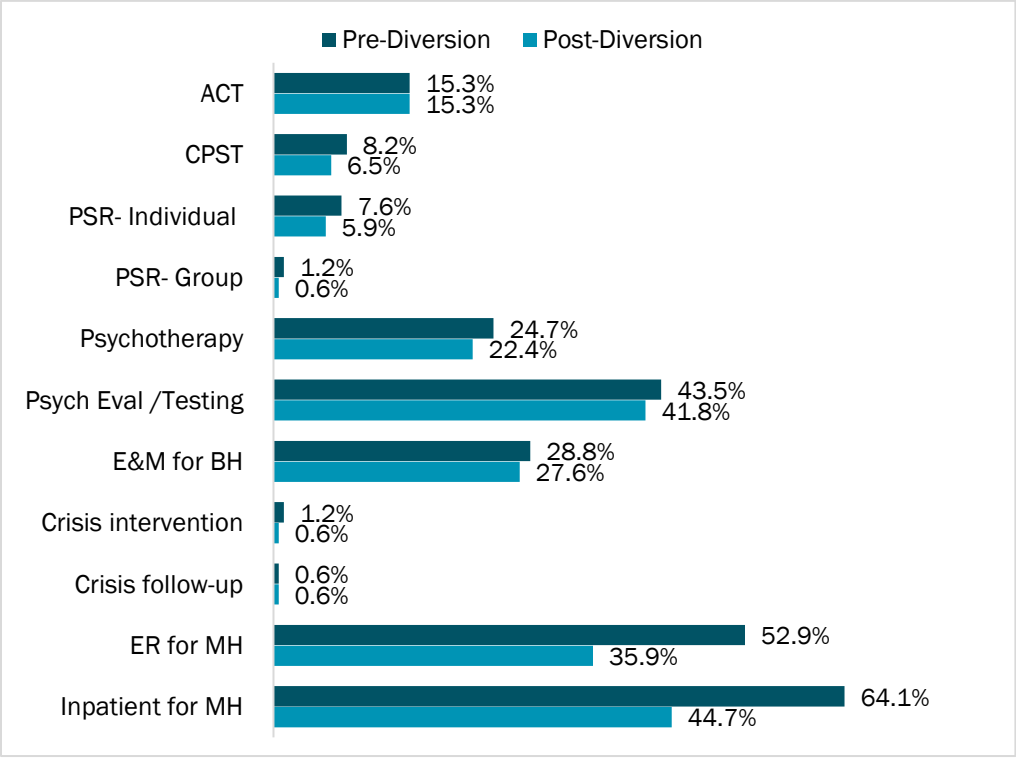
Source: Medicaid claims data

Exhibit 24. Pre-post change in mental health service utilization among the transitioned



Source: Medicaid claims data

Exhibit 25. Pre-post change in mental health service utilization among the diverted



Source: Medicaid claims data

Exhibit 26 shows pre-post trends for waiver services. We were not expecting to see waiver service use pre-transition since most waiver services cannot be provided while in a nursing facility; however, we performed the same pre-post comparison as with the behavioral health services shown above.

Nearly 60% of individuals received CCW support coordination and personal assistance services post-transition, and the percentage among those age 65+ is much higher, as shown in Exhibit 27. Only 2.4% of the 170 diverted individuals received support coordination through the ADHC waiver, and none received any services under the Community Choice waiver (CCW). According to LDH, the 1915 c waiver application has priority groups for access to waiver services. Individuals in the diverted group residing in the community likely have requested services; however, they are currently on the registry waiting for a waiver offer. Offers for the priority group that would include this group are made on a first come, first serve basis. For those in the diverted group needing personal care type services are encouraged to access long term personal care services, which are state plan services that are readily available without having to wait.

Although we did not have data specifically addressing the service needs of the diverted population, we expect there would be a need for personal care services given that three quarters of transition assessment respondents indicated a need for such services. The data shown in Exhibit 26, therefore, indicate a likely unmet need for personal care services for diverted individuals who are not participating in the CCW Program.

Exhibit 26. OAAS waiver services penetration one year pre- and post- transition/diversion

	TRANSITIONED				DIVERTED			
	Pre-		Post-		Pre-		Post-	
	N	%	N	%	N	%	N	%
Total	92	100.0%	92	100.0%	170	100.0%	170	100.0%
ADHC	0	0.0%	1	1.1%	2	1.2%	2	1.2%
ADHC Support Coord.	0	0.0%	1	1.1%	3	1.8%	4	2.4%
ADHC Transition Intensive Support Coordination	0	0.0%	0	0.0%	0	0.0%	0	0.0%
CCW Transition Service	9	9.8%	13	14.1%	0	0.0%	0	0.0%
Home Delivered Meals	0	0.0%	2	2.2%	0	0.0%	0	0.0%
PERS	0	0.0%	0	0.0%	0	0.0%	0	0.0%
CCW Transition Intensive Support Coordination	42	45.7%	4	4.3%	0	0.0%	0	0.0%
CCW Support Coord.	4	4.3%	54	58.7%	0	0.0%	0	0.0%
CCW Personal Assis.	2	2.2%	52	56.5%	0	0.0%	0	0.0%
Environ. Accessibility Adaptation	2	2.2%	8	8.7%	0	0.0%	0	0.0%
Perm. Supp. Housing	0	0.0%	2	2.2%	0	0.0%	0	0.0%
PSH/ Crisis Intervention	0	0.0%	1	1.1%	0	0.0%	0	0.0%
Nursing Services	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Skilled Main. Therapy	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Assistive Devices/Sup.	1	1.1%	12	13.0%	0	0.0%	0	0.0%

Source: Medicaid claims data

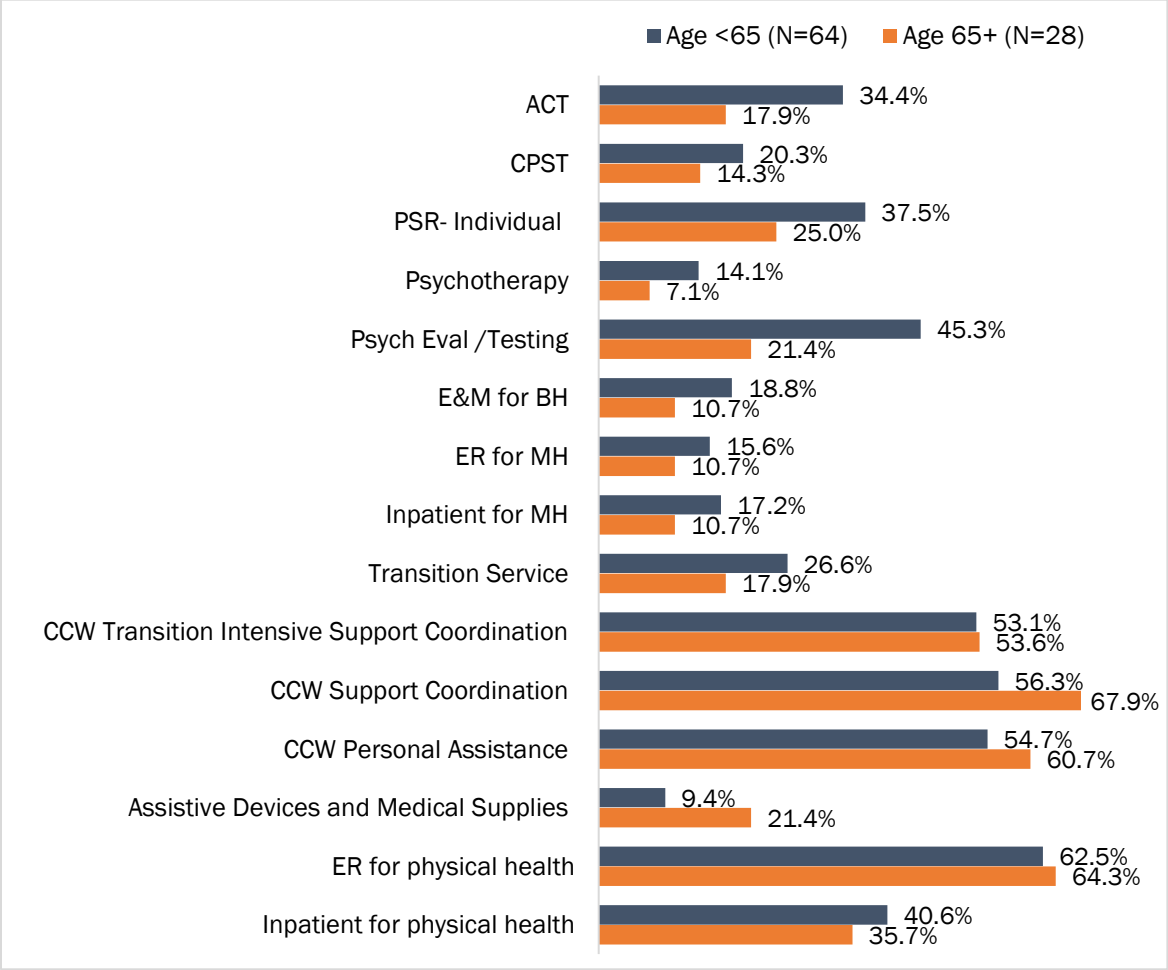
The evaluation also reviewed whether service penetration rates for individuals who transitioned to the community differ by age group—under age 65 vs. age 65+. It is important to note that at the time of our analysis (through CY2019) only 28 individuals age 65+ had transitioned to the community, so the numbers for this age group should

be interpreted with caution. As Exhibit 27 shows, a greater proportion of individuals under age 65 received behavioral health services compared to those ages 65 and older; this is true for intensive services such as ACT and CPST as well as psychotherapy, psychological evaluation/testing, and evaluation and management (E&M) with a behavioral health provider. The largest difference is in psychological testing/evaluation where 45% of individuals under age 65 received the service post-transition compared to 21% of individuals age 65+. Although a greater proportion of the under age 65 group received specialty behavioral health services, a slightly higher proportion had ER or inpatient visits for mental health compared to those age 65+.

The high rate of ER use for physical health post-transition among both age groups—over 60% in both groups—is notable for the challenge it presents. As mentioned previously, 40 of the 58 people with an ER visit for physical health post-transition also received waiver services, though we did not look at the frequency or intensity of waiver services leading up to the ER visit. This is an area for further investigation and monitoring.

Compared to those under age 65, a greater proportion of those age 65+ received support coordination (68% vs. 56%) and personal care services (61% vs. 55%) under the CCW waiver. The percentage that received Transition Intensive Support Coordination is the same in both age groups (53%). Again, these figures should be interpreted with caution given the small number of people in the age 65+ group (N=28) and monitored moving forward as the number transitioned increases. OAAS noted that all those eligible for CCW services (meeting nursing facility level of care) and who wanted the services post-transition received them.

Exhibit 27. Service penetration one-year post-transition by age group (<65 and 65+)



Source: Medicaid claims data.

4. Medicaid-Enrolled Adults with SMI

Whereas the preceding section focused on the target population subgroups and the at-risk group, this section addresses the second purpose of the needs assessment: to analyze current prevalence rates and utilization patterns for the broader population of Medicaid-enrolled adults with serious mental illness (SMI) in order to identify potential service gaps. In our analysis of Medicaid claims data, SMI was defined as the presence of any claim/encounter record with an SMI diagnosis code in 2019. We note that this definition is based on diagnosis alone; SAMHSA—as well as many states, including Louisiana—uses a more restrictive definition that includes certain functional impairments to determine service eligibility, but those impairments are not identifiable from Medicaid claims.

4.1. Demographic Characteristics

Exhibit 28 shows the demographic characteristics of Medicaid-enrolled adults with SMI in Louisiana. Over two thirds (67.5%) are female, consistent with the higher prevalence of SMI among women nationally.[31] Nearly half of Medicaid-enrolled adults with SMI (49.3%) are ages 26-49 and only 10.6% are age 65+, likewise consistent with the age distribution of SMI nationally. This contrasts with the target population, of which over half are age 65+. As discussed previously, data on race and ethnicity are missing for a large proportion of individuals (43.8%); this important gap in data availability hinders an analysis of racial equity and disparities in service utilization.

Exhibit 28. Demographic characteristics of Medicaid-enrolled adults with SMI, 2019

	N	%
Total	**195,102**	**100.0%**
Gender		
Female	131,697	67.5%
Male	63,405	32.5%
Age		
18-25	25,500	13.1%
26-49	96,274	49.3%
50-64	52,694	27.0%
65+	20,633	10.6%
Race/Ethnicity		
Hispanic/Latino	6,779	3.5%
Asian	355	0.2%
American Indian	805	0.4%
Black	46,481	23.8%
White	55,134	28.3%
Race unknown	85,541	43.8%

Source: Medicaid claims data.

[31] National Institute of Mental Health, data courtesy of SAMHSA, https://www.nimh.nih.gov/health/statistics/mental-illness#part_154788

Exhibit 29 shows the number of Medicaid-enrolled adults with SMI across LGE regions. The purpose of this table is to examine the distribution of adults with SMI across the state for the purpose of resource allocation and location of service providers. Variation in the rate of Medicaid-enrolled adults with SMI per 1,000 population across regions is undoubtedly related to social determinants of health; for example, the Central Louisiana region has less than half the population size of the Capital region, but a higher number of Medicaid-enrolled adults with SMI per 1,000 population (51 per 1,000 vs. 34 per 1,000).

Exhibit 29. Number and rate of Medicaid-enrolled adults with SMI by region, 2019

	Population size ages 12 and older*	Number of Medicaid-enrolled adults with SMI	Rate of Medicaid-enrolled adults with SMI per 1,000 population
Acadiana	608,763	29,557	49
Capital	685,568	23,499	34
Central Louisiana	304,675	15,537	51
Florida Parishes	584,048	23,064	39
Imperial Calcasieu	303,383	14,034	46
Jefferson Parish	439,036	13,286	30
Northeast	352,335	16,140	46
Metropolitan	462,842	18,745	40
Northwest	542,115	22,751	42
South Central	401,568	17,785	44

*Population size by region taken from FY20-21 Block Grant Application based on Census data, p. 23. The source for the number of Medicaid-enrolled adults with SMI is Medicaid claims data.

4.2. Penetration of Medicaid-Funded Behavioral Health Services Among Adults with SMI

Exhibit 30 presents data on utilization of Medicaid-funded behavioral health services for adults with SMI. We intended to obtain three years of data in order to identify possible trends, but within the scope of the study we were able to obtain data only for 2018 and 2019. Overall, approximately one in five adults with SMI received psychotherapy, approximately one in four received psychological evaluation or testing, and around 10% received CPST or individual-based PSR in 2019. Penetration of CPST and PSR decreased slightly between 2018 and 2019. One in five (20.2%) of adults with SMI received evaluation and management (E&M) from a mental health practitioner in 2019 (data not shown).[32] Roughly 12% of adults with SMI had at least one emergency room visit for mental health compared to only 1% who received the state's crisis intervention service, a finding that is discussed in more detail in Section 5: Crisis Services.

Penetration of SUD services—particularly SUD screening/assessment—among adults with SMI appears low given the known co-occurrence of mental illness and SUD; only 2% of adults with SMI received SUD screening or assessment—a rate that did not

[32] Evaluation & management was not among the initial set of behavioral health services examined in this analysis but was conducted later for 2019 data.

increase between 2018 and 2019—and 4.2% participated in a treatment program in 2019, up slightly from 3.9% in 2018. As discussed in Section 7, it is possible that rates for SUD screening/assessment are low due to coding on claims data and that some screening/assessment services were coded under E&M or other codes.

Exhibit 30. Service penetration for Medicaid-enrolled adults with SMI, 2018 & 2019

	2018		2019	
	N	%	N	%
Total with SMI	188,068	100.0%	195,102	100.0%
Mental Health Services				
ACT	3,678	2.0%	4,713	2.4%
CPST	21,834	11.6%	18,261	9.4%
PSR- Individual	20,673	11.0%	18,550	9.5%
PSR- Group	265	0.1%	273	0.1%
Psychotherapy	39,203	20.8%	41,666	21.4%
Psych Eval/Testing	51,084	27.2%	50,484	25.9%
Crisis Intervention	1,790	1.0%	1,693	0.9%
Crisis Follow-up	1,356	0.7%	1,483	0.8%
ER for mental health	22,471	11.9%	22,356	11.5%
Inpatient for mental health	22,225	11.8%	22,594	11.6%
SUD Services				
Screening/Assessment	4,202	2.2%	4,162	2.1%
Counseling	2,056	1.1%	2,093	1.1%
IOP (2.1)	4,206	2.2%	5,017	2.6%
Subacute Detox (3.2)	0	0.0%	0	0.0%
Acute Detox (3.7)	1,899	1.0%	2,086	1.1%
Residential (3.3)	329	0.2%	162	0.1%
Treatment Program (3.5, 3.7)	7,411	3.9%	8,107	4.2%
Halfway House (3.1)	759	0.4%	756	0.4%
ER for SUD	7,921	4.2%	7,933	4.1%
Inpatient for SUD	5,836	3.1%	6,059	3.1%

Source: Medicaid claims data. Penetration rates are calculated as the number who received the service divided by the total with SMI multiplied by 100.

Exhibit 31 shows the proportion of Medicaid-enrolled adults with SMI who received any Medicaid-funded behavioral health services in 2019, including outpatient services as well as ER or inpatient for mental health or substance use disorder. Of 195,102 Medicaid-enrolled adults with SMI in 2019, half (50.1%) did not receive any of the specialty behavioral health services tracked in this report (those services listed above, in Exhibit 30); however, all 195,102 individuals received some type of Medicaid-funded service for which an SMI diagnosis was listed on the claim/encounter record in order to meet inclusion criteria for this analysis. Within the scope of this study, we could not further investigate services received beyond those tracked in this study.

Some national data provide a comparison for the proportion of adults with SMI who receive treatment services annually. According to the latest (2019) NSDUH data, 65.5% of adults with SMI nationally received mental health services in the past year.[33] Although the NSDUH uses a broader definition of mental health services that includes

[33] SAMHSA, *Behavioral Health Barometer*; Indicators as measured through the 2019 NSDUH. Accessed at: https://www.samhsa.gov/data/sites/default/files/reports/rpt32815/National-BH-Barometer_Volume6.pdf

having used prescription medications for mental health, the lower service penetration rate for adults with SMI in Louisiana indicates more can be done to engage adults with SMI in treatment, which in turn should reduce crises and reliance on emergency care. A Kaiser Family Foundation analysis of 2015 NSDUH data found that 49% of adults under age 65 with SMI and Medicaid insurance received outpatient mental health treatment in the past year and 10% received inpatient treatment in 2015.[34] As shown previously in Exhibit 30, close to 12% of Medicaid-enrolled adults with SMI in Louisiana received inpatient treatment for mental health, a figure we expect would be reduced with increased penetration of community-based services and the introduction of services and supports such as case management and employment supports.

Exhibit 31 also shows that of the half of Medicaid-enrolled adults with SMI who did receive services, 39.5% received mental health services and no SUD services, 2.6% received SUD services and no mental health services, and 7.7% received both mental health and SUD services. For Louisiana, increasing the penetration of behavioral health services for individuals with SMI would likely reduce reliance on high-cost emergency and inpatient care, as discussed in the following section.

Exhibit 31. Number and percentage of Medicaid-enrolled adults with SMI receiving any Medicaid-funded community-based behavioral health services, 2019

	N	%
Total Medicaid-Enrolled Adults with SMI	195,102	100.0%
No specialized BH services	97,825	50.1%
MH services, no SUD services	77,089	39.5%
SUD services, no MH services	5,123	2.6%
MH & SUD services	15,065	7.7%

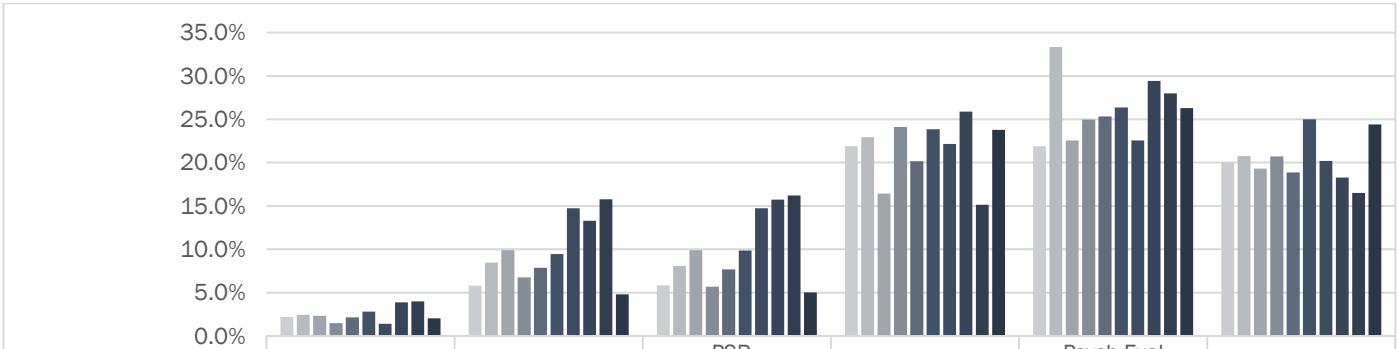
Source: Medicaid claims data. Services include outpatient, emergency room, and inpatient.

Exhibit 32 compares Human Service Districts on the basis of the proportion of the Medicaid-enrolled adult SMI population that received mental health services in 2019. This table analyzes whether there are regional differences in mental health service penetration. This is important because the presence of regional variation could indicate one of two things: regional differences in policies or practices related to service access, or regional differences in service needs that would likely be tied to variation in social determinants of health. In either case, understanding if there are regional differences in service use will help OBH in its plans for resource allocation, in particular the development of crisis services that is underway. As Exhibit 32 shows, variation in service penetration is limited, with the exception of CPST and PSR, both of which range from 5% to 16%; for both services, South Central marks the low end of the range and Northwest the high end. The Northwest region also has the highest penetration of ACT at 4%, more than double the rate in the Northeast and Florida

[34] Kaiser Family Foundation. Facilitating Access to Mental Health Services: A Look at Medicaid, Private Insurance, and the Uninsured, 2017. Figure 6. Accessed at: https://www.kff.org/medicaid/fact-sheet/facilitating-access-to-mental-health-services-a-look-at-medicaid-private-insurance-and-the-uninsured/

Parishes. Due to such low penetration rates for SUD services in general, we did not present SUD service penetration by region.

Exhibit 32. Medicaid-funded mental health service penetration among Medicaid-enrolled adults with SMI, by region, 2019



	ACT	CPST	PSR-Individual	Psychotherapy	Psych Eval /Testing	E&M for BH
Acadiana	2.2%	5.8%	5.8%	21.9%	21.9%	20.1%
Capital	2.4%	8.5%	8.1%	22.9%	33.4%	20.7%
Central Louisiana	2.3%	9.9%	9.9%	16.4%	22.5%	19.3%
Florida Parishes	1.5%	6.8%	5.7%	24.1%	24.9%	20.7%
Imperial Calcasieu	2.1%	7.9%	7.7%	20.2%	25.3%	18.9%
Jefferson Parish	2.8%	9.5%	9.9%	23.8%	26.4%	25.0%
Northeast	1.4%	14.7%	14.7%	22.2%	22.6%	20.2%
Metropolitan	3.9%	13.3%	15.7%	25.9%	29.4%	18.3%
Northwest	4.0%	15.8%	16.2%	15.2%	28.0%	16.5%
South Central	2.0%	4.8%	5.0%	23.8%	26.3%	24.4%

Source: Medicaid claims data. Penetration rates are calculated as the number of adults with SMI who received the service out of the total number of Medicaid-enrolled adults with SMI in the region multiplied by 100. The total number of Medicaid-enrolled adults with SMI (the denominator) for each region is as follows: Acadiana N=29,557; Capital N=23,499; Central Louisiana N=15,537; Florida Parishes N=23,064; Imperial Calcasieu N=14,034; Jefferson Parish N=13,286; Northeast N=16,140; Metropolitan N=18,745; Northwest N=22,751; South Central N=17,785.

While Medicaid plays a primary role in funding services for individuals with SMI, we also reviewed available data from Local Governing Entities (LGEs), Louisiana's main public payer aside from Medicaid. Louisiana's FY2020-2021 Combined Behavioral Health Block Grant Plan provides data on the numbers served by LGEs and the proportion of those served who have SMI. These data were submitted by LGEs for the purpose of fulfilling SAMHSA's reporting requirements. It is important to note these data do not reflect individuals served in private clinics or by providers not receiving SAMHSA Block Grant funds, therefore they do not provide a complete picture of service penetration across the LGEs. However, we reviewed the data to see the number of individuals with SMI being served by LGEs that receive Block Grant funds and whether the proportion of individuals with SMI served varies by LGE.

Exhibit 33 shows data on adults served by LGE based on Electronic Health Record (EHR) data provided to OBH by the LGEs. LGEs receiving Block Grant funds served a total of 14,862 adults with SMI in FY2018, about 8% of the total Medicaid-enrolled adults with SMI in 2018 (N=188,068 Medicaid-enrolled adults with SMI in 2018).

There is considerable variability across LGEs in the proportion of adults with SMI out of the total served, ranging from 16% in Imperial Calcasieu to 90% in the Northeast region. This may suggest that some LGEs are less successful in reaching their target population and could benefit from technical assistance and guidance from OBH in this area. For most LGEs, individuals with SMI constitute a smaller proportion of the total served than would be expected given that individuals with SMI are the target population for Block Grant funding allocated to the LGEs.

Exhibit 33. Number of persons with SMI served by LGE-contracted providers that receive SAMHSA Block Grant funding, by LGE, FY2018

LGE	Total Served	Adults with SMI Served	% with SMI out of Total Served
Metropolitan	4,462	2,391	54%
Capital	5,871	1,550	26%
South Central	7,731	4,894	63%
Acadiana	1,665	1,161	70%
Imperial Calcasieu	1,560	250	16%
Central Louisiana	3,148	789	25%
Northwest	1,616	608	38%
Northeast	1,556	1,399	90%
Florida Parishes	4,057	1,125	28%
Jefferson	2,369	695	29%
Total	**34,035**	**14,862**	**44%**

Source: Louisiana Department of Health Office of Behavioral Health. FY 2020-2021 Combined Behavioral Health Assessment and Plan: Community Mental Health Services and Substance Abuse Prevention and Treatment Block Grants. https://ldh.la.gov/assets/csoc/block_grant/FY20-21BGApplicationFinal-revision.request.updates.pdf

5. Crisis Services

Crisis services are an essential component of a good and modern behavioral health system. The need to improve and expand Louisiana's crisis service system is a prominent feature of the Agreement, and addressing that need will have significant benefit for the population as a whole. The crisis service system was also identified as a critical need by a number of the key informants interviewed for this study. Crisis services mediate between routine community-based services and admission to intensive short-term emergency and inpatient treatment by providing needed supports to divert individuals from avoidable ER and inpatient admissions and to ensure a smooth, non-coercive transition when these more intensive services are appropriate, thus addressing one of the most important risk factors for inappropriate nursing home placement.

As not all behavioral health crises are alike, crisis service systems should incorporate multiple components to address diversity of needs; these include warm lines and call centers, 24-hour mobile crisis teams, 23-hour respite centers, peer supports, and robust data systems for tracking. Crisis service systems will need to be able to accommodate all members of the general population regardless of payer source; therefore, they must be capable of managing multiple funding streams.

Crisis service systems should maintain partnerships with a wide range of community stakeholders, most critically law enforcement. Crisis services systems should function to relieve law enforcement from the burden of addressing behavioral health crisis and to prevent the traumatic effects of law enforcement involvement for individuals in crisis. Crisis service providers should also maintain close collaborative relationships with both community providers and hospitals in order to ensure early interventions and smooth transitions.

At present in Louisiana, MCO contracts require provision of crisis services (crisis intervention), but the description of requirements is quite general, utilization is extremely low as shown in the analysis of claims data in the prior sections, and key informants report that while some crisis intervention does exist it is extremely limited and varies by region and provider. LDH has developed a detailed plan for a comprehensive crisis service system that will fill this gap in accordance with the Agreement.[35] The system will be operational in FY 2022 and will provide four new crisis services to adults enrolled in the Medicaid program: mobile crisis, community-based crisis services, behavioral health urgent care, and crisis stabilization units. The Recommendations section of this report provides a more detailed discussion of what will be required for an effective and comprehensive crisis service system for Louisiana.

In Sections 3 and 4 of this report we presented penetration rates for crisis services—which we defined as crisis intervention and follow-up services as well as emergency

[35] The Louisiana Department of Health Office of Behavioral Health - Coordinated Crisis System Plan https://ldh.la.gov/assets/docs/MyChoice/CrisisFramework.pdf

room and inpatient where the primary diagnosis on the claim was a mental health or substance use disorder—for the target and at-risk populations and for Medicaid-enrolled adults with SMI. In addition, HSRI was asked to look at penetration rates for crisis services among all Medicaid enrollees to help inform OBH in its efforts to develop a comprehensive statewide crisis service system that serves the entire population.

The following analysis shows the penetration rates for crisis services among Medicaid enrollees overall, and by region. As shown in Exhibit 34, penetration of the state's two Medicaid-billable crisis codes for adults—crisis intervention and crisis follow-up—is practically nonexistent. Just over 2,000 (0.2%) adult Medicaid enrollees received the crisis intervention service in 2019; in contrast, over 38,000 (3.3%) visited emergency rooms for a mental health or SUD issue. As indicated in Exhibit 30 in Section 4.2, 22,356 Medicaid-enrolled adults with SMI presented to the ER for mental health; Exhibit 34, below, shows that 29,267 adult Medicaid enrollees presented at the ER for mental health—a difference of nearly 7,000 adults not diagnosed with SMI but still using the ER for a mental health-related crisis.

Exhibit 34. Number and percent of adult Medicaid enrollees who used crisis services, 2019

	N	%
Total Medicaid-enrolled adults	1,141,370	100.0%
Crisis intervention	2,200	0.2%
Crisis follow-up	1,955	0.2%
ER for MH	29,267	2.6%
ER for SUD	12,754	1.1%
ER for MH or SUD	38,177	3.3%
Inpatient for MH	22,997	2.0%
Inpatient for SUD	7,573	0.7%
Inpatient for MH or SUD	28,597	2.5%

Source: Medicaid claims data.

The need for behavioral health crisis services clearly extends beyond adults with a diagnosis of SMI. We did not find a comparable national average for ER use for behavioral health among Medicaid enrollees with which to put Louisiana's rates in context. The CDC reported during 2016-2018, the annual rate of ER visits related to mental health disorders was 43.9 visits per 1,000 persons with a mental health disorder (not restricted to Medicaid).[36] However, we could not compare our analysis results to this figure because of methodological differences (we identified ER visits where the *primary diagnosis* on the claim was a mental health disorder; the CDC data include visits with any listed diagnosis of a mental health disorder, not only in the primary diagnosis position).

[36] QuickStats: Emergency Department Visit Rates Related to Mental Health Disorders, by Age Group and Sex—National Hospital Ambulatory Medical Care Survey, US 2016-2018. MMWR 2020, accessed at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6948a13.htm

Exhibit 35 shows penetration rates for crisis services among Medicaid enrollees across regions in Louisiana. The purpose of this analysis is to identify any regional variation in use of the ER and inpatient for behavioral health, which can help inform OBH of how best to allocate funding for crisis services across the state. Exhibit 35 shows no extreme outliers, but the Acadiana region, which has the most Medicaid enrollees, has the highest rate of ER use at 3%, followed closely by Imperial Calcasieu and South Central at 2.9%. As shown previously in Exhibit 32, the South Central region has the lowest penetration rates of CPST and PSR among Medicaid-enrolled adults with SMI.

It is also noteworthy that Jefferson Parish, which has one of the state's only mobile crisis programs, has among the lowest rates of ER use for behavioral health at 1.9%, tied with the Capital region also at 1.9%. As the new crisis service system becomes operational, we would expect to see decreases in penetration rates for ER for behavioral health statewide, and especially in regions where crisis services are currently most lacking.

Exhibit 35. Penetration rates for crisis services, emergency room, and inpatient among Medicaid enrollees of all ages, by region, 2019

		Penetration Rates			
	Number of Medicaid Enrollees	Crisis Intervention	Crisis Follow-up	ER for MH or SUD	Inpatient for MH or SUD
Acadiana	250,925	0.2%	0.1%	3.0%	2.1%
Capital	242,038	0.2%	0.2%	1.9%	1.9%
Central Louisiana	130,182	0.1%	0.1%	2.6%	2.0%
Florida Parishes	211,973	0.1%	0.0%	2.2%	2.0%
Imperial Calcasieu	117,352	0.1%	0.1%	2.9%	2.4%
Jefferson Parish	173,688	0.2%	0.1%	1.9%	1.6%
Northeast	167,586	0.5%	0.5%	2.3%	1.5%
Metropolitan	205,424	0.3%	0.2%	2.3%	1.7%
Northwest	221,063	1.2%	1.1%	2.1%	1.6%
South Central	159,205	0.0%	0.1%	2.9%	1.8%
Out of state/unknown	12,534	0.0%	0.0%	1.0%	1.0%

Source: Medicaid claims data

6. Summary & Recommendations

6.1. Summary of Key System Strengths and Gaps

6.1.1. Assets and Strengths

To be useful as a guide for system change, a needs assessment should identify the assets and strengths of a system as well as needs, and it should base recommendations on how these assets and strengths can be used to advantage in addressing limitations and shortcomings.

Perhaps the most critical asset for any system is effective and committed leadership, and the state is fortunate in having this in the Louisiana Department of Health (LDH). A prime example is the Agreement wherein LDH has committed to an ambitious program of system improvement that will have a positive impact not only for the target population but the entire population of individuals with behavioral health needs. To support this broader purpose, OBH has asked that the focus this needs assessment be expanded to consider not only the target population but also an at-risk group and the entire population of adults who require behavioral health services and supports.

Other assets are additional initiatives and programs, some a part of the Agreement and others preceding it, that provide the foundation for performance improvement throughout the system—such as expansion of community-based supports, a vigorous program of community outreach and education, significant post-Katrina expansion of permanent supportive housing (with an additional 1,000 units committed by the Agreement), and the implementation of some initial value-based payment methods.

The development of innovative models of integrated care in Louisiana was prompted by the 2007 federal Primary Care Access and Stabilization Grant (PCASG) designed to address the damage to the region's health care system caused by Hurricane Katrina, which resulted in a number of safety-net clinics in the New Orleans area becoming early adopters of the patient-centered medical home (PCMH) model. PCMHs are established on the basis of certification from the NCQA and 28 sites that received PCASG funding obtained NCQA certification.

In 2016 LDH conducted an analysis of medical comorbidity for people with SMI that identified 52,321 adults diagnosed with a mental illness and a co-occurring physical health condition including asthma, diabetes, cancer, and heart disease. To better serve this group, in 2018 LDH obtained a five-year, $200,000-per-year grant, Promoting Integration of Primary and Behavioral Health Care (PIPBHC), to develop integrated care programs in Morehouse, Terrebonne, Orleans, and East Baton Rouge Parishes. The overall goal of the program is "to provide a coordinated, comprehensive

approach to improve the overall wellness and status of adults with co-occurring mental illness and physical health conditions or chronic diseases, and individuals with a substance use disorder through improved health care delivery." The grant is supporting the development of policy changes that would facilitate integrated care and the implementation of evidence-based practices in four FQHCs or community health centers.

Louisiana received approval of an 1115 Demonstration Waiver, effective February 1, 2018 through December 31, 2022, allowing for services to be provided in Institutions for Mental Disease (IMDs) for stays with durations longer than 15 days. As a result of waiver approval, Louisiana is able to receive federal financial participation (FFP; i.e., the Medicaid match) for the continuum of services to treat addictions to opioids and other substances.

In addition, much progress has been made through initiatives under the Agreement. Many of the activities and initiatives identified in the Implementation Plan are consistent with the model of a good and modern behavioral health system as represented in the above sections, while others have been in development prior to the DOJ suit. In particular, we endorse the following, which are part of the Implementation Plan:

- HUD approval to prioritize the target population for Section 8 vouchers
- A comprehensive process to monitor and provide oversight specific to the case management process
- Draft Personal Care Attendant PCA service definition and develop PCA providers
- Quality matrix with the My Choice Advisory Group, identify modifications needed, and revise the measures as appropriate
- OBH-internal workgroup evaluating data elements, identifying additional elements to incorporate in reporting moving forward
- OAAS-internal workgroup evaluating data elements, identifying additional elements to incorporate in reporting moving forward
- Self-advocates or individuals with personal lived experience to participate in committees and recruit them to attend meetings, and/or conduct targeted outreach
- Quality assurance reporting to monitor outcomes for persons that will be or are in the process of transitioning, mortalities, critical incidents, and other key performance data to inform continuous quality improvement
- A long-term quality assurance, mortality and critical incident management process that will allow LDH to assess and oversee provider and MCO services; measure the success of reform; identify trends, patterns, strengths, and areas of concern that will drive quality enhancement activities focused on performance improvement and planning

6.1.2. Limitations and Challenges

The central limitations/challenges to the current behavioral health system were discussed in Section 2.4.2. Below is a summary of these primary limitations, with some additional detail that emerged from the analysis of claims and other data sources.

Funding/resource constraints: The most critical challenge, which drives most of the others, is scarcity of resources and limited funding for behavioral health. Louisiana is a relatively poor state, ranking 35th in per capita GDP among the states and the District of Columbia. Moreover, as discussed in Section 2.4.2, Louisiana commits a smaller proportion of public funds to behavioral health when compared to other states, and as a result ranks 45th on this measure.

Low service penetration for adults with SMI: An important limitation identified in our analysis of claims data is the relatively low service penetration rates given the prevalence of SMI in the state. As shown in Exhibit 30, less than 10% of Medicaid-enrolled adults with SMI received CPST or PSR in 2019, and only about 20% received the least intensive services, psychotherapy and evaluation and management.

Quality and care coordination: Louisiana's below average performance in four out of the five behavioral health-related HEDIS measures tracked on LDH's Medicaid Managed Care Quality Dashboard[37]—most notably follow-up after hospitalization for mental health—was discussed in Section 2.4.2. In addition to being below the 50th percentile in all but one measure, performance on all but one measure has decreased between 2016/2017 and 2020. Lack of care coordination was cited by multiple key informants as a challenge contributing to inappropriate nursing home placement.

Limited integrated care: Excess morbidity and mortality for people with SMI is a well-documented problem.[38] People with SMI die about 10 to 20 years earlier than the general population, mostly from preventable physical diseases.[39] Although the causes of excess morbidity and mortality are complex and not fully understood, one clearly identified factor is access to health care. As a result of increasing recognition of this issue in recent years, initiatives to promote various models for integration of primary care with behavioral health services are now increasingly common. As noted above, despite some promising examples, integrated care models are not widely developed in Louisiana.

The Combined Behavioral Health Block Grant application asks state mental health authorities whether providers screen and refer for prevention and wellness education and health risks such as heart disease, hypertension, high cholesterol, and diabetes.

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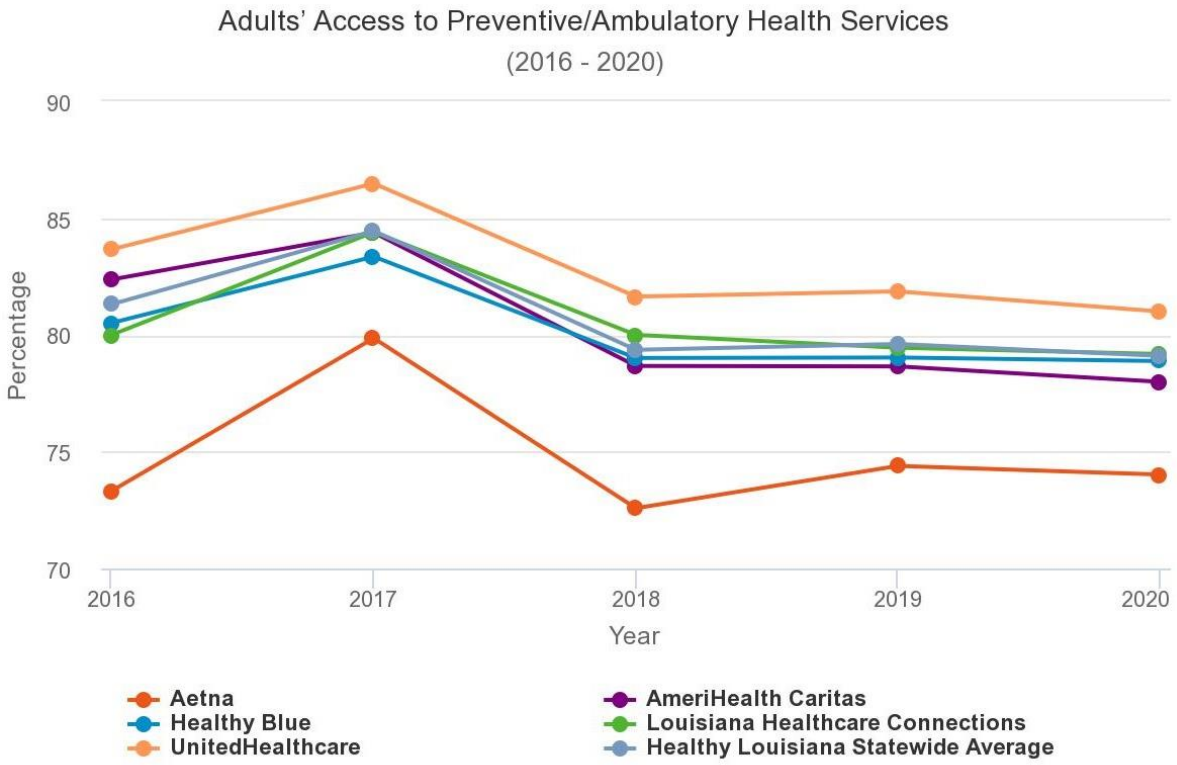
[37] https://qualitydashboard.ldh.la.gov/

[38] Liu NH, Daumit GL, Dua T, et al. Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. World Psychiatry. 2017;16(1):30-40. doi:10.1002/wps.20384

[39] https://www.who.int/mental_health/evidence/excess_mortality_meeting_report.pdf?ua=1

OBH responded in the negative to all, and we have been told that OBH does not receive data on preventive care for the SMI population.

Performance measures for MCOs include the HEDIS measure Adult Access to Primary Care/Preventive Services. Healthy Choice MCOs have reached the NCQA 50th percentile rate only once in the past four years. Rates for all five MCOs on this measure have declined since 2017, as shown in the image below from the LDH Quality Dashboard. Given the importance of access to preventive services for avoiding ER and hospital admissions, this measure is highly relevant for avoiding unnecessary referrals to nursing facilities.



Source: LDH Medicaid Managed Care Quality Dashboard. Accessed 5/25/2021 at: https://qualitydashboard.ldh.la.gov/

Case management: Key informants observed that there are many case managers but their activities primarily consisted of administrative functions for the MCOs. Key informants also identified a need for more training especially in case managers' ability to anticipate and forestall behavioral health crises.

Peer support services: Compared to other locales, peer services are relatively undeveloped in the Louisiana behavioral health system, one of the needs recognized by OBH in the 2018/2019 Block Grant application and confirmed by key informants.

Social determinants of health: An additional challenge, related to the state's economy, is the prevalence of social determinants of health (SDOH) that are risk factors for poor behavioral health. SDOH represent factors with which policymakers must contend, despite having limited capacity to influence—what researchers refer to

as "outer settings."[40] Louisiana has the second highest poverty rate of the states, with 18.6% of its population below the Federal Poverty Level; poverty correlates with many other SDOH such as housing, transportation, access to care, etc., and places additional strain on the behavioral health and health care system. In a 2019 interview with Centers for Health Care Strategies, Jen Steele, then-director of Louisiana Medicaid, discussed these challenges. Noting that the state was 50th in overall health rankings, she stated "When you start from the base of poverty and add the challenges in education and employment opportunities that exist in Louisiana, combined with social inequalities that overburden certain and/or historically vulnerable populations with health inequities, it is hard to overcome where we stand. The good news is we have tremendous opportunity for improvement, but to get the momentum needed to improve these rankings is a real challenge.[41]

6.2. Recommendations

The shortcomings and limitations of Louisiana's behavioral health system are long-standing. More than a decade ago, the Public Affairs Research Council of Louisiana produced a document titled Public Mental Health Care in Louisiana: An Analysis of Louisiana's Fragmented System of Care and Options for Reform. The document opens with this statement:

> Louisiana's system of public mental health care is biased toward expensive institutional care, thereby reducing the adequacy of funding for tens of thousands of persons, both adults and children, who suffer from mental, addictive or other behavioral health disorders. The state ranks poorly (50th in the U.S.) in per-capita funding of community-based treatment services and poorly (46th) in access to services for the population in need of treatment. Solutions will not be easy or simple.[42]

Demonstrating that these shortcomings persist today, the LDH identified the following needs in its 2020-2021 Combined Block Grant application:

- Accessible housing for individuals with behavioral health diagnoses
- More peer services in crisis services, case management, supported employment
- Integrated services for patients with intellectual disabilities and mental health issues, particularly at residential level of care (inpatient settings, PRTFs, and therapeutic group home settings)
- Education on how to navigate the behavioral health system and access services

[40] Bruns, E., E. Parker, et al. (2019). "The role of the outer setting in implementation: associations between state demographic, fiscal, and policy factors and use of evidence-based treatments in mental healthcare." *Implementation Science* 14.

[41] https://www.chcs.org/using-medicaid-levers-to-improve-health-outcomes-and-reduce-disparities-qa-with-louisianas-medicaid-director-jen-steele/

[42] Public Affairs Research Council of Louisiana. December, 2009. Public Mental Health Care in Louisiana: An Analysis of Louisiana's Fragmented System of Care and Options for Reform

- Data system updates, training, and utilization
- Increased professional and work development trainings
- Increased integrated primary care and behavioral health care

All of these needs are confirmed by this needs assessment, as discussed throughout this report, and are addressed in the following recommendations.

The following recommendations cover five topic areas: 1) service gaps and what is required to address them, 2) integration of primary care and behavioral health, 3) quality, 4) value-based payment methodologies, and 5) health information technology.

6.2.1. Address critical gaps in the service continuum

In Louisiana, as in most jurisdictions, gaps in a system's continuum of care are primarily the result of resource constraints. As noted previously, Louisiana ranks 45th among the states in spending on behavioral health as a percent of gross domestic product (GDP), which inevitably constrains opportunities to implement the full continuum of the "good and modern" behavioral health services. The critical service gaps identified in this needs assessment in comparison to a "good and modern" system are:

- Crisis services
- Case management
- Peer services
- Personal care and in-home supports
- Housing for adults with SMI
- Evidence-based practices, including supported employment

6.2.1.1. DEVELOP A MULTI-LEVEL CRISIS SERVICE SYSTEM

Development of a comprehensive crisis service system is a central feature of the Agreement and the highest priority to prevent unnecessary nursing facility admission. Key informants likewise identified this as the most critical gap in the system, emphasizing that the lack of effective crisis services that would divert individuals from emergency rooms and inpatient treatment are a contributing factor to nursing home referral. As shown in Exhibit 21, 12 people of the 92 in the transitioned group (13%) had an ER visit for mental health and 11 people (12%) were admitted to psychiatric inpatient facilities; these figures clearly indicate a need for crisis and diversion services for this population. The situation is similar for the at-risk group, of which 691 (19%) had an ER visit for mental health in 2019 and 575 (16%) had inpatient treatment for mental health. LGEs and MCOs are providing some level of crisis services; yet, as shown in the utilization analysis in this report, the number receiving these services is small.

LDH has developed a detailed plan for a comprehensive crisis service system that will fill this gap in accordance with the Agreement.[43] The long-term goal is a crisis system that will be managed through a contract with a single statewide crisis management entity (CME), that will coordinate with LGEs and MCOs to ensure continuity of care. For this system to be effective, numerous factors related to coordination must be considered. It will be important that this service be coordinated with law enforcement and coroners' offices if it is to reduce the use of petitions. Also, if the LGEs and MCOs are to be providers as part of the crisis service system, it will be important that their practices and procedures are aligned with those of the system as a whole. Financing of crisis services will need to take into account that not everyone using the service will be enrolled in Medicaid; therefore, provisions for billing other third-party payors will need to be included. Adequate coding and data collection, including the use of petitions, will be necessary for coordination and quality monitoring of the crisis service system.

In accordance with the established principle that crisis services are for "anyone, anywhere and anytime," funding the system will be challenging, requiring a braided funding approach that will require new Medicaid services, allocation from general revenues and other sources, as described in the SAMHSA Crisis Services Toolkit. As noted in the Crisis System Plan, "funding for additional services and administration of those services is dependent on budget allocation by the Louisiana State Legislature. The fiscal climate for new and expanded services will largely affect a successful implementation." (p.8).[44]

Recommendation: Development of an adequate crisis service system is the single most important measure for preventing unnecessary institutional care, including hospitals and nursing facilities. Allocation of funding for the crisis service system, therefore, should be the highest priority for addressing gaps in the Louisiana public behavioral health system.

***Recommendation*:** Coordination with LGEs and MCOs will be critical for ensuring transition between levels of care, but more challenging given Louisiana's decentralized behavioral health system. It will be important for LDH to adopt an "air traffic control" approach to tracking transitions of individuals through the system and to have detailed protocols for how transitions are managed.

***Recommendation*:** Coordination with law enforcement is essential for an adequate crisis service system. The SAMHSA Crisis Toolkit provides a set of recommendations for how this coordination should be operationalized, which should be considered early in the planning process.

The primary function of crisis services is diversion from emergency departments and inpatient facilities. In the "good and modern" system, however, diversion takes place at every level along the continuum of care, with efforts at each level to avoid transition

[43] The Louisiana Department of Health Office of Behavioral Health - Coordinated Crisis System Plan https://ldh.la.gov/assets/docs/MyChoice/CrisisFramework.pdf
[44] SAMHSA Crisis Services Toolkit

to the next more restrictive and costly level—including diversion from crisis services. Thus, although increasing accessibility to crisis services is a goal, reducing utilization is also a goal along with reducing utilization of emergency departments, inpatient facilities, and nursing facilities. This is achieved by effective prevention—that is, by community providers being alert to the potential for a crisis and intervening to divert individuals even from the crisis system.

The Medicaid Behavioral Health Services Provider Manual specifies that ACT programs are to provide "assertive outreach" defined as "knowing what is going on with a member and acting quickly and decisively when action is called for."[45] According to key informants, however, there is considerable variability among ACT workers in their responsiveness to potential crises and engagement early in the response to a crisis. The same is true of MCO case managers according to key informants. MCO contracts have been revised to include the target population and at-risk group as Medicaid beneficiaries with Special Health Care Needs (SHCN), which requires MCOs to offer case management to these individuals.

Recommendation: LDH has provided Transition Coordinators with training focused on improving their capability in planning for crisis and engagement and intervention techniques to reduce the need for higher level of care intervention. This type of training should be incorporated into the training curriculum for ACT teams, MCO case managers and the future community case managers as described in the Implementation Plan.

Recommendation: It will be important for case managers to be closely coordinated with the crisis teams, by means such as protocols and cross-training.

6.2.1.2. STRENGTHEN AND EXPAND CASE MANAGEMENT

Case management is an essential function for ensuring coordination and continuity of care, and for targeting resources effectively. Although case management takes many different forms and degrees of intensity, it is important in any case to have well-developed program requirements, protocols, job descriptions, and training. The Agreement provides guidelines for case management for the target population that specify that it should provide "consistency, and continuity, both pre- and post-transition" and "be of sufficient intensity to ensure case managers are able to identify and coordinate services and supports to help prevent reinstitutionalization and assist the individual to maintain community placement" (p. 11), although without specifying some measure for intensity such as number of visits.

Louisiana's case management services provided by the MCOs consist of a broker model, where the case manager conducts assessments and refers to services as needed. Key informants observed that there appears to be an adequate supply of MCO case managers, but their functions are not optimized, and a culture of person-

[45] Behavioral Health Services Provider Manual Chapter Two of the Medicaid Services Manual https://www.lamedicaid.com/provweb1/providermanuals/manuals/bhs/bhs.pdf

centered care is not well established. Aside from the contractually required MCO case managers, Louisiana does not have a Medicaid case management benefit, other than ACT. Based on projections discussed previously in this report, the number in the target population needing case management in FY2022 is projected to be 400, and this number will continue to grow as individuals are transitioned out of nursing facilities. The MCOs' poor performance on NCQA measures of follow-up after inpatient hospitalization suggests shortcomings in the functions of MCO case managers and the need for increased capacity and improvement of case management services for adults with SMI.

Recommendation: Implement Medicaid case management benefit for the target population; explore enhanced care coordination models for the broader population of adults with SMI.

Recommendation: Case manager functions and performance should be reviewed in the context of the MCOs' poor performance on NCQA measures for follow-up from inpatient care. This may be a candidate for an MCO PIP.

6.2.1.3. EXPAND PEER SUPPORTS TO THE BROADER POPULATION OF INDIVIDUALS WITH BEHAVIORAL HEALTH CONDITIONS

Peer services have been lacking, as indicated in the 2018/2019 Block Grant application and confirmed by key informants; however, as a condition of the Agreement, LDH is currently in the process of developing an extensive peer support program, including credentialing and training. The State also implemented Medicaid Peer Support Services as of March 2021.

Recommendation: Expand opportunities for Medicaid peer supports for the target population and the broader adult behavioral health population beyond the current LGE network.

6.2.1.4. MAXIMIZE AVAILABILITY OF PERSONAL CARE SERVICES AND IN-HOME SUPPORTS

In our interviews with key informants, we asked: "What do you think is the primary reason that people get referred for nursing homes when they might otherwise remain in the community?" and the responses, especially from those associated with OAAS programs, cited lack of personal assistance services, medication monitoring, and adult day health services, with adult day health as a mechanism for addressing the first two, a perception that is supported by the research literature.[46,47]

Personal Assistance is generally identified as the service that is most critical in supporting adults with SMI to remain in the community. As shown in Exhibit 26, over half (57%) of the post-transition group, and most of those over 65 (77%), are receiving Personal Assistance services; however, this service, which is provided under the

46 Gaugler, J. E., S. Duval, et al. (2007). "Predicting nursing home admission in the U.S: a meta-analysis." BMC geriatrics 7: 13-13.
47 Segelman, M., O. Intrator, et al. (2017). "HCBS Spending and Nursing Home Admissions for 1915(c) Waiver Enrollees." Journal of Aging & Social Policy 29(5): 395-412.

Community Choice Waiver, is available only for adults over age 64 and adults under age 65 with a physical disability who meet need for nursing facility level of care. As data from the transition assessment showed (Exhibit 16), over two-thirds (77%) of respondents indicated the need for support with at least one ADL, highlighting the strong need for personal assistance in the target population, as well as for the at-risk population that has a similar profile to the target population in terms of physical health comorbidities and frequent ER use.

As evidence for further justification, a meta-analysis of research on predictors of nursing home placement[48] identified dependencies for activities of daily living as one of the strongest predictors, demonstrating the importance of these support services in maintaining people in the community.

Medication non-adherence among the elderly is a major problem with negative clinical and cost implications, including factors that contribute to nursing home placement, such as increased hospital admissions and emergency department visits.[49] Although the reasons for non-adherence are complex and not fully understood, it is evident that a number of the services in OAAS and waiver programs provide means for enhancing adherence, both for elderly and younger adults. These include the adult day health care waiver program, which provides medication supervision and administration, the Community Choices waiver program, which provides personal assistance services and nursing care, and the State Personal Assistance Services Program, which provides a similar range of support services vital to supporting community living.

Recommendation: There are several strategies the State may consider to improve medication adherence. LDH should provide additional training to PCAs regarding psychotropic medications and strategies for assisting individuals to take their medication, especially as the new personal care service is implemented for individuals in the target population. The State can also develop educational materials for consumers on the importance of taking medications as directed, and training for providers on monitoring adherence and responding to non-adherence.

6.2.1.5. DEVELOP EVIDENCE-BASED SUPPORTED EMPLOYMENT PROGRAMS

Research has shown that EBPs such as supported employment result in fewer ED and inpatient admissions, consistent with the goals of the My Choice Louisiana program. As shown in Exhibit 18, 12% of transition assessment respondents rated “finding somewhere to work/having a job” as somewhat or very important, although we believe this to be a vast underestimate for the reasons described in Section 3.2; we estimate that around 27% of the target population would be interested in employment support, or up to 50% of individuals under age 65, both in the target population and

[48] Gaugler, J. E., S. Duval, et al. (2007). "Predicting nursing home admission in the U.S: a meta-analysis." BMC geriatrics 7: 13-13.

[49] Hughes, C. M. (2004). "Medication non-adherence in the elderly: how big is the problem?" Drugs Aging 21(12): 793-811.

in the broader population of adults with SMI. Although ACT teams include an employment specialist, this reaches a small proportion of the population. We discussed these results with a subject matter expert on supported employment who suggested, based on experience in other states, that up to 50% of individuals under age 65 would be interested in employment once settled in the community and with transition coordinators or case managers promoting the service. Therefore, as discussed previously, we project 27% of the overall target population would use employment support.

Recommendation: Expand MCO and LGE capacity to provide employment support and make the service available to the broader population of adults with SMI. Implement training for MCO and LGE service providers on providing employment services.

6.2.1.6. WIDELY EXPAND USE OF EVIDENCE-BASED PRACTICES

Key informants report that current MHR services are not evidence based for the most part (with the exception of ACT) and have perceived generally poor outcomes. ACT is the only mental health rehabilitation EBP reimbursed by Medicaid, and as shown in Exhibit 30, ACT is received by only 2.4% of Medicaid-enrolled adults with SMI. Otherwise, widely endorsed EBPs—illness management and recovery, medication management, family psychoeducation, supported employment, and integrated dual diagnosis treatment—are lacking in Louisiana's behavioral health system; all are EBPs that impact risk factors for inappropriate nursing home placement by reducing crises and hospital and ED use. Problems with medication adherence and "family burnout" were cited by key informants as contributing factors to nursing home placement and these would be addressed by medication management and family psychoeducation. Illness management and recovery and Integrated Dual Diagnosis Treatment are EBPs that have been shown to reduce use of hospitalization and other high-cost services. Key informants state that providers may be reimbursed using more general codes but lack incentives and high-fidelity EBPs are more costly than routine care that is reimbursed at the same rate.

In 2018, the Medicaid program initiated a process of reviewing benefits that included consultation with the Oregon Health & Science University Center for Evidence-based Policy. The Oregon consultants recommended that LDH "consider developing a core list of high-quality evidence, clinical practice guideline, and policy sources to standardize and maintain consistency in the coverage decision-making process and development of policies."

Recommendation: We recommend this process of reviewing benefits as recommended by the Oregon consultants for consideration of behavioral health EBPs for Medicaid coverage, with supported employment a priority. Other EBPs that have been shown to reduce relapse and rehospitalization and thereby reduce the risk of inappropriate nursing home placement—such as illness management and recovery, medication management, and family psychoeducation—may be considered as well.

6.2.1.7. IMPROVE CARE COORDINATION AMONG SERVICE PROVIDERS

One aspect of quality in the "good and modern" behavioral health system is coordination. The National Quality Forum identifies care coordination as: "a multidimensional concept that encompasses—among many other facets of healthcare organization and delivery—the effective communication between patients and their families, caregivers, and healthcare providers; safe care transitions; a longitudinal view of care that considers the past, while monitoring delivery of care in the present and anticipating the needs of the future; and the facilitation of linkages between communities and the healthcare system to address medical, social, educational, and other support needs, in alignment with patient goals"[50]

Key informants identified lack of coordination and several types of disconnection among service providers as a major shortcoming of the LA behavioral health system and a primary cause of inappropriate nursing home placement of individuals with behavioral health conditions. As discussed previously, the HEDIS measure for follow-up after hospitalization for behavioral health highlights this shortcoming of the system.

Key informants provided several other examples of problems related to coordination:

- Lack of coordination between behavioral health and social support care plans, and lack of communication between behavioral health and social support direct service providers
- Lack of communication and coordination in care transitions, especially between hospital discharge planners and community service providers
- Lack of coordination and communication among MCOs to collaborate in addressing high level system issues

Recommendation: Develop shared protocols and training to improve care coordination among Transition Coordinators, MCO case managers, and HCBS direct service providers.

6.2.1.8. INCREASE SUD SCREENING AMONG ADULTS WITH SMI

In 2012, with the Louisiana Behavioral Health Partnership, LDH established a continuum of services consistent with American Society of Addiction Medicine (ASAM) Levels of Care. The system was further enhanced through a CMS 1115 Demonstration. A review by the SME indicated that there were no network adequacy issues for the various SUD levels of care. As shown in Exhibit 30, however, penetration rates for SUD services among Medicaid-enrolled adults with SMI are extremely low, with only slightly more than 2% even receiving screening. Given known high prevalence of co-occurring SUD among this population, more frequent screening should be expected.

[50] National Quality Forum (December 2, 2014). NQF-Endorsed Measures for Care Coordination: Phase 3, 2014.

Recommendation: Consider developing a target for screening for SUD among Medicaid-enrolled adults with SMI as a quality improvement initiative.

6.2.1.9. ADDRESS HOUSING NEEDS FOR THE BROADER POPULATION OF ADULTS WITH SMI

Housing is a critical need for the target population and for the adult SMI population generally. Following hurricanes Katrina and Rita in 2005, Louisiana developed the nation's first cross-disability PSH program, establishing 3,000 units, which was as a critical component of the state's hurricane recovery plan and served as a model for subsequent federal policy. This experience is a valuable foundation for the housing-related activities described in the 2021 Implementation Plan. As noted in the 2018/2019 Block Grant application and by numerous key informants, housing is a critical need for adults with SMI in Louisiana. The 2021 Implementation Plan describes a variety of activities to develop housing and tenancy supports for the target population. Assuming the required funding and approvals are received, these measures should do much to alleviate need among the target population. It will be important in this case that prioritization for the target population does not crowd out availability for other individuals with SMI, thereby merely increasing the size of the at-risk population.

Recommendation: Continue efforts to expand the supply of appropriate housing (especially accessible housing) for the target population while ensuring that these do not occur at the expense of also addressing housing needs of the broader population of adults with SMI.

6.2.2. Promote integration of primary care and behavioral health

As discussed previously, integration of health care and behavioral health is especially important for addressing the needs of the target and at-risk populations: Poorly managed chronic health conditions combined with mental illness are likely risk factors for nursing home placement. The claims data analysis presents stark evidence for a lack of integrated care for persons with SMI generally but especially for the transition and at-risk groups. As shown in Exhibit 23, only 5 people out of the 92 in the transition group received any of the preventive care service codes examined in this study; however, more than half were seen in the ER for physical health and 40% were hospitalized for medical reasons. Given that ER and inpatient utilization are risk factors for nursing home placement, this is obviously a concern. Additionally, on a broader level, the HEDIS measure for Adult Access to Primary Care/Preventive Services shows Health Choice MCOs have reached the NCQA 50th percentile rate only once in the past four years.

Recommendation: Conduct a QI analysis to identify the causes of ER and inpatient admissions, with a focus on the extent to which these adverse events are the result of barriers to primary care preventive services; based on this analysis, identify strategies for reducing the frequency of these events.

Recommendation: Support scaling up integrated care models throughout the state. Below are some examples for consideration.

- FQHCs—of which there are more than 200 in Louisiana—represent an underdeveloped and underutilized resource for providing integrated care for individuals with SMI. Key informants indicated that FQHCs vary in their commitment to developing integrated care models. We learned of one that began as a behavioral health provider organization and obtained certification as an FQHC, for which integrated care was a primary function, which could serve as a model for replication. A number of key informants also noted that a major gap in the Louisiana behavioral health system was the lack of services in rural parts of the state. FQHCs offer a resource to address this shortage. The PIBHC program can provide performance benchmarks and cost projections that will serve to integrate FQHCs more fully into the managed care system.
- Patient-centered medical homes (PCMH)[51] (or patient-centered behavioral health homes) is a model for integrated behavioral health/primary care that has been widely promoted by numerous organizations, especially the Agency for Healthcare Research and Quality (AHRQ) and it is one of the focus areas of the Louisiana Health Care Quality Forum. A PCMH is characterized by five attributes all of which would provide clear benefit for adults with SMI and co-morbid conditions:
    - Comprehensive Care
    - Patient-Centered
    - Coordinated Care
    - Accessible Services
    - Quality and Safety

Although a number of LGE and FQHC providers offer both behavioral health services and primary care, information from key informants and our inventory of the service system indicate that care integration in the state, with a few exceptions, is generally limited. One knowledgeable informant characterized the general status as being the third level of SAMHSA's five-level degrees of integration, which is defined as "Basic Collaboration Onsite: Mental health and other healthcare professionals have separate systems but share facilities. Proximity supports at least occasional face-to-face meetings and communication improves and is more regular."[52]

Recommendation: In addition to promoting the development of integrated care models, with regard to the target and at-risk populations it will be important for case managers (e.g., proposed community case managers and MCO case managers) to ensure that physical health care needs, including preventive care, are addressed. Communication with physical health care providers should be a part of care coordination including care plan development and team meeting case reviews.

[51] https://pcmh.ahrq.gov/page/defining-pcmh
[52] https://www.pcpcc.org/resource/standard-framework-levels-integrated-healthcare

Recommendation: If not already done, review MCO compliance with the required and recommended activities to promote integrated care. One provider organization that originated as a behavioral health agency received certification as an FQHC in order to integrate primary care with the behavioral health services it was providing. This is a model that might be considered for replication elsewhere in the state.

6.2.3. Maximize quality initiatives for behavioral health

In 2006, the Institute of Medicine published an exhaustive report in the Quality Chasm series on the quality of behavioral health care today. The report identified the importance of behavioral health quality as being broadly personal and societal: "Together, mental and substance-use illnesses are the leading cause of death and disability for women, the highest for men ages 15-44, and the second highest for all men. Effective treatments exist, but services are frequently fragmented and, as with general health care, there are barriers that prevent many from receiving these treatments as designed or at all. The consequences of this are serious—for these individuals and their families; their employers and the workforce; for the nation's economy; as well as the education, welfare, and justice systems."[53]

LDH's attention to quality in Medicaid behavioral health services has been increasing in the past decade, prompted by federal promotion of integrated care and performance measurement—an effort that has been intensified in the past three years by the DOJ Agreement. In a 2019 publication LDH presented its quality strategy for MCO services within the conceptual framework of the Triple Aim, partnering with "enrollees, providers, and health plans to continue building a Medicaid managed care delivery system that improves the health of populations (better health), enhances the experience of care for individuals (better care) and effectively manages costs of care (lower costs)".

CMS requires that Medicaid MCOs conduct at least two PIPs per year, in coordination with the EQRO, with the incentive of a 75% FMAP. For 2019-2020, the five Healthy Louisiana MCOs collaborated on a PIP focusing on the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measure, with the aim of identifying and addressing barriers, especially to improve follow-up care after members have been diagnosed with an SUD.[54] The HEDIS measures listed in Exhibit 9 are comparable candidates for a PIP.

Recommendation: Draw upon the 2019-2020 combined MCO PIP as a model for further collaboration to address MCO performance issues related to behavioral health indicated by HEDIS measures. Consider ways of incorporating LGEs in these efforts.

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[53] Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series

[54] IPRO. March 2020. Quality Companion Guide for Healthy Louisiana Managed Care Organizations. Prepared on Behalf of State of Louisiana Department of Health https://ldh.la.gov/assets/docs/BayouHealth/CompanionGuides/LA_QCG_MCO.pdf

Recommendation: Given the relevance of several other measures for quality issues pertaining to nursing facility placement, LDH should consider adding to the NCQA measures for which incentive payments are provided two additional measures: access to preventive care and adherence to medication for individuals with behavioral health conditions.

6.2.4. Consider value-based payment and alternative payment methodologies

Alternative payment methodologies (APM) aim to increase provider accountability for care by attributing patients to providers and linking payment to outcomes. LDH utilizes several APMs. The broadest, which provides the foundation for others that currently exist or might be implemented in the future, is enrollment of the Medicaid population in managed care with capitated payment to MCOs.

LDH was an early adopter (2018) of the CMS Primary Care First, a payment redesign initiative for Healthy Louisiana MCOs. PCF is a multi-payer model designed to provide primary care practices with tools and incentives to reduce patients' complications and overutilization of higher cost settings, leading to improved outcomes and reduced spending.[55]

In 2016, LDH revised the set of quality measures to standardize across the MCO plans and selected a subset to be linked to payment incentives, which went into effect in 2018 with the Medicaid Managed Care Incentive Payment Program, which provides incentive payments known as Approved Incentive Arrangements (AIAs) to MCOs.[56] Incentive payments may be up to 5%, in total, above the approved capitation payments. Current AIAs focus on increasing members' access to primary health care; improving health outcomes for pregnant women, babies, and members diagnosed with chronic conditions; and reducing inefficiencies and costs in the Medicaid delivery system by reducing avoidable health care service utilization, promoting evidence-based practices, and reducing low-value care.[57] Medicaid has also introduced incentive payments to encourage MCOs to establish VBPs with their network providers.[58]

Recommendation: LDH should conduct an analysis of utilization and outcomes data for service recipients with SMI in these various integrated models (and research on Health Homes) to determine which should receive priority support for that population, and what adaptations would improve effectiveness and efficiency.

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[55] https://innovation.cms.gov/files/x/primary-cares-initiative-onepager.pdf

[56] Louisiana Department of Health Bureau of Health Services Financing. December 1, 2018. Medicaid Managed Care Quality Incentive Program Response to HR 252 of the 2018 Regular Legislative Session Version 1.0

[57] https://ldh.la.gov/assets/docs/LegisReports/HR252RS201812.pdf

[58] Louisiana Medicaid Bureau of Health Services Financing (2019). Louisiana's Medicaid. Managed Care Quality Strategy.

7. Data Limitations and Future Directions

The following data limitations impacted this study and are important to acknowledge.

Our analysis of service penetration relied on Medicaid claim/encounter data. These administrative claims data are for billing purposes and are not designed specifically for research. Our examination of service use relied on CPT codes, which are service codes entered by providers for billing purposes. It is possible that different provider types use different coding conventions for some services. In addition, we could not capture services funded by other sources, such as Medicare. This is particularly relevant for the target population—many of whom are dual-eligible. Dual-eligible individuals might have received some additional behavioral health services covered by Medicare, such as Intensive Outpatient (IOP), that are not reflected in our analysis. The physical health preventive medicine services codes we included in our analysis are likely underestimated for the target population because Medicare may cover these services, and for all population groups if providers bill for these services under evaluation & management or other service codes. SUD screening is another service that might be underestimated due to providers' coding conventions for this service.

In addition:

- The sample sizes for the transitioned and diverted populations were relatively small as of 2019, so penetration rates for these groups should be interpreted with caution.
- Within the scope of the analysis, we were unable to explore reasons or barriers that explain shortcomings in the quality of care that were indicated by various measures—notably the low rate of follow-up after psychiatric hospitalization, access to preventive care, adherence to psychiatric medications, and SUD screening. Accordingly, we recommend these be considered as topics for future QI initiatives that can examine processes of care to identify and address these system performance shortcomings.
- Within the scope of our analysis, we were not able to examine service intensity or frequency. Future efforts should examine the frequency of services such as personal care services to determine if more frequent service use is associated with reduced ER use and reductions in hospitalizations.
- We were not able to examine where in the community geographically individuals in the target population want to live after transition, which will have important implications for the location of services and supports. This information is now being collected on the transition assessment and should be analyzed to inform decisions about provider/service locations and accessible housing availability.

- Due to the large amount of missing data on race and ethnicity, we could not examine equity or disparities in service use by race or ethnicity. We recommend that data collected on service and support needs from the transition assessment be analyzed by race and ethnicity to identify and address any barriers to access for certain groups.
- We used data from a sample of PASRR Level II evaluations and from Transition Assessments to estimate service needs in the target and at-risk populations. However, we did not have measures of service need specifically for the various groups examined in this report (transitioned, diverted, at-risk, adults with SMI).