



State of Nevada
Governor's Finance Office
Division of Internal Audits

Audit Report

**Department of Health and Human Services
Division of Health Care Financing and Policy
Behavioral Health Outpatient Treatment
Services**

Report No. 18-02
October 11, 2017

EXECUTIVE SUMMARY
Department of Health and Human Services
Division of Health Care Financing and Policy
Medicaid Fee-For-Service, Behavioral Health
Outpatient Treatment Services

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Objective: Ensure Medicaid Fee-For-Service, Behavioral Health Outpatient Treatment Clients Receive the Appropriate Level of Care

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Holding Medicaid fee-for-service, behavioral health outpatient treatment providers accountable for not following the Medicaid Service Manual (MSM) requirements will help ensure clients receive the appropriate level of care. A sample of client files revealed 43 percent did not have a current mental health plan. Of the 57 percent of client files that did have a mental health plan, 47 percent were missing information required by the MSM and 39 percent showed no participation by the client. A lack of provider documentation currently prevents the Division of Health Care Financing and Policy (HCFP) from determining if clients are receiving the appropriate level of care as outlined in their mental health plan.

Perform More In-Depth Reviews of Client Files.....page 6

Performing more in-depth reviews of client files will help ensure billing documentation is correct and includes the information required by the MSM. Client file documentation was insufficient: 15 percent of billings sampled did not have any documentation to support the services billed and 11 percent of billings sampled did not agree with the service documentation either due to a different service code, more units billed than documented, or documenting services not reimbursable as case management. HCFP reviews providers based on complaints and irregularities identified by their data analytics tool; however, these reviews are often focused and do not include reviewing the entire client file. More in-depth reviews may result in additional recoupments of up to \$7.4 million annually.

Objective: Better Assist Providers to Understand Medicaid Service Manual Requirements and Standardize Documentation to Enhance HCFP Reviews and Auditing of Client Files

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Increasing trainings for Medicaid fee-for-service, behavioral health treatment providers will assist them in understanding the MSM, which will help ensure client files have complete documentation. HCFP currently offers trainings to providers for updates to the MSM; however, providers are often confused by which MSM requirements apply to them.

Offering templates for Medicaid fee-for-service, behavioral health treatment providers will assist them in understanding the MSM and could help standardize client files throughout the state, making HCFP reviews and audits more efficient. Provider documentation for mental health plans and services provided did not include the information the MSM requires to be included and each provider had a different method of documenting mental health plans and services provided.

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INTRODUCTION

At the direction of the Executive Branch Audit Committee, the Division of Internal Audits conducted an audit of the Department of Health and Human Services (department), Division of Health Care Financing and Policy (HCFP).

Our audit focused on Medicaid fee-for-service, behavioral health outpatient treatment services. The audit's scope and methodology, background, and acknowledgements are included in Appendix A.

Our audit objectives were to develop recommendations to:

- ✓ Ensure Medicaid fee-for-service, behavioral health outpatient treatment clients receive the appropriate level of care.
- ✓ Better assist providers to understand Medicaid Service Manual requirements and standardize documentation to enhance HCFP reviews and auditing of client files.

Division of Health Care Financing and Policy Response and Implementation Plan

We provided draft copies of this report to the department and HCFP officials for their review and comments. Their comments have been considered in the preparation of this report and are included in Appendix B. In its response, HCFP accepted our recommendations. Appendix C includes a timetable to implement our recommendations.

NRS 353A.090 requires within six months after the final report is issued to the Executive Branch Audit Committee, the Administrator of the Division of Internal Audits shall evaluate the steps HCFP has taken to implement the recommendations and shall determine whether the steps are achieving the desired results. The administrator shall report the six month follow-up results to the committee, department, and HCFP officials.

The following report contains our findings, conclusions, and recommendations.

Ensure Medicaid Fee-For-Service, Behavioral Health Outpatient Treatment Clients Receive The Appropriate Level Of Care

HCFP can ensure Medicaid fee-for-service, behavioral health outpatient treatment clients receive the appropriate level of care by holding providers accountable for not following Medicaid Service Manual (MSM) requirements. Ensuring clients receive the appropriate level of care will help improve or sustain their level of behavioral health. In addition, more in-depth reviews of client files may result in additional recoupments of up to \$7.4 million annually.

Hold Providers Accountable

HCFP should hold Medicaid fee-for-service, behavioral health outpatient treatment providers accountable for not following MSM requirements. This will help ensure client files contain all documentation required to determine if clients are receiving the appropriate level of care. Receiving the appropriate level of care will help clients improve or sustain their level of behavioral health.

Clients May Not Be Receiving Appropriate Level of Care

It is unknown if Medicaid fee-for-service, behavioral health outpatient treatment clients are receiving the appropriate level of care due to a lack of documentation in client files. We sampled 72 client files at four billing providers statewide and found required documentation is missing or incomplete: 43 percent of client files had no mental health plan, 47 percent were missing required information in their mental health plan, and 26 percent of client files had missing or incorrect service documentation. Consequently, there is not enough information to determine if clients are receiving the appropriate level of care to improve or sustain their level of behavioral health.

Mental Health Plan and Level of Intensity Documentation Incomplete or Missing

Behavioral health outpatient treatment clients are required to receive a mental health plan to guide their treatment. To prepare the mental health plan, clients must first undergo a comprehensive assessment, which includes determining the level of intensity (LOI) of services the client requires. A LOI worksheet is prepared by a Qualified Mental Health Professional and the results are required to be included in the mental health plan.

MSM Mental Health Plan Requirements

The MSM encompasses requirements providers must follow for client care, service documentation, and receiving payment. MSM Section 403 (Mental Health and Alcohol/Substance Abuse Services) requires documentation of care, including a mental health plan.

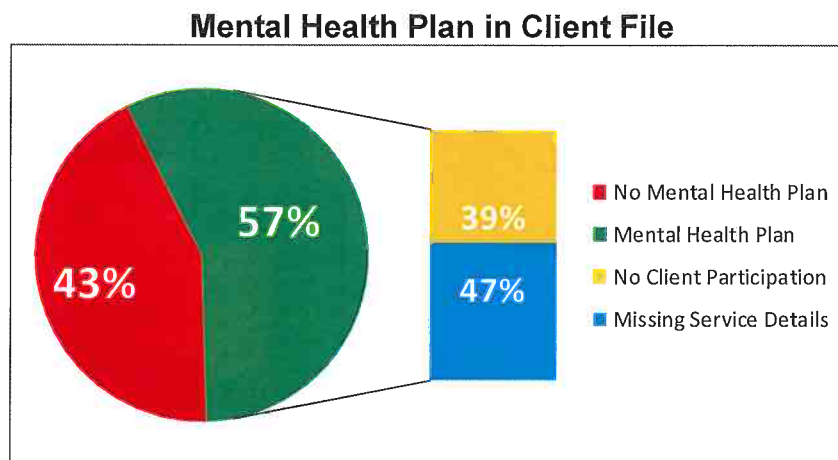
Mental health plans are either a treatment plan or a Rehabilitative Mental Health (RMH) plan. Treatment and RMH plans are written individualized plans developed jointly with the client or legal representative based on the comprehensive assessment. Both types of plans must include: the LOI; specific, measurable, achievable, realistic, and time-limited goals and objectives; as well as specific treatment services and/or interventions, including the amount, scope, duration, and anticipated providers of the services.

The client or legal representative must be fully involved in the treatment planning process, choice of providers, and indicate an understanding of the need for services and the elements of the plans. Both plans must also document the client or legal representative who participated in the treatment planning.

Mental Health Plan

Review of client files found almost half had missing or incomplete documentation. See Exhibit I.

Exhibit I



Our sample showed 43 percent of clients did not have a current mental health plan in their file. Without a mental health plan there is no documentation to support the client is receiving the appropriate services or if the services billed match the services prescribed. Additionally, without a mental health plan there are no goals documented to assess treatment progress.

Of the 57 percent of clients who did have a mental health plan, 39 percent showed no participation by the client or legal representative. Without documentation of client or legal representative participation, it is unknown if clients know the goals in their plans or agree they are receiving services needed to achieve their behavioral health goals.

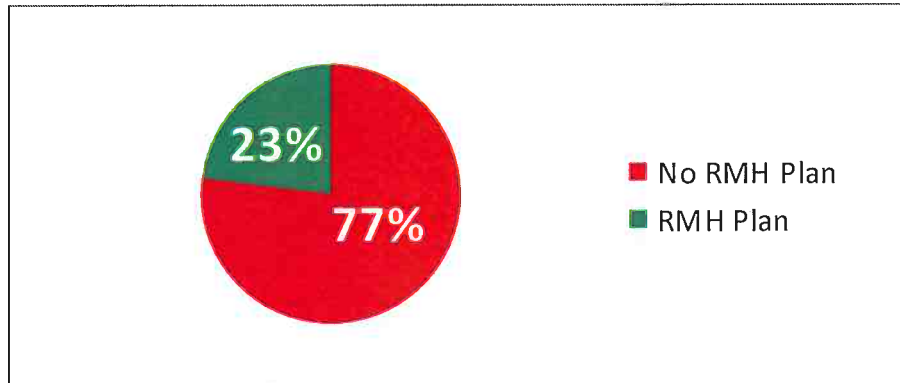
Additionally, detailed information required by the MSM, such as specific services, duration of services, and anticipated service providers, was missing from 47 percent of the mental health plans found in client files. Without complete mental health plans, HCFP cannot determine if the provider is following the plan in order to ensure the client is receiving the appropriate level of care.

RMH Plan

RMH plans are required if the client is prescribed RMH services. RMH services include basic skills training, program for assertive community treatment, day treatment, peer-to-peer support, psychosocial rehabilitation, and crisis intervention. A majority of clients who were prescribed RMH services received a treatment plan but not a RMH plan. A treatment plan is not as comprehensive as a RMH plan. Over three-quarters of client files reviewed did not contain a RMH plan when required. See Exhibit II.

Exhibit II

RMH Plan for Clients Prescribed RMH Services

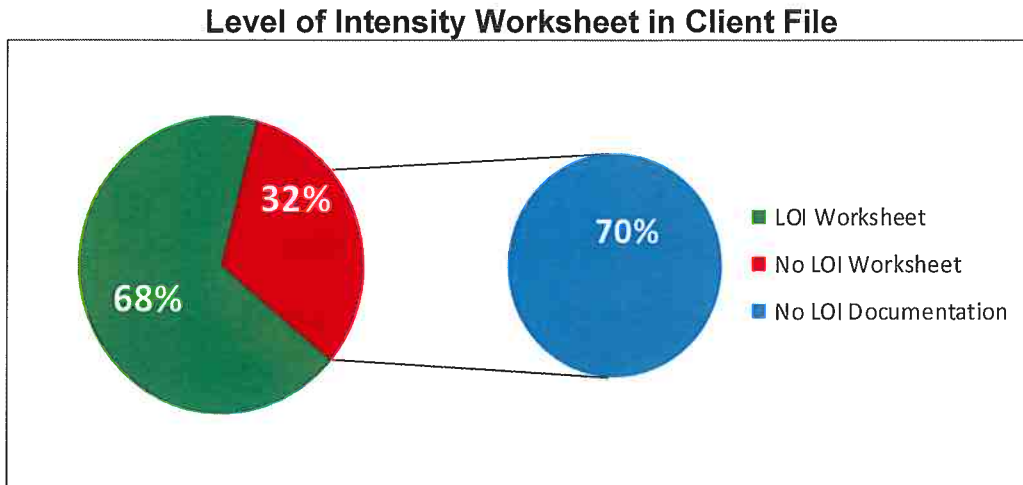


Our sample showed 77 percent of clients prescribed RMH services did not have a RMH plan. There was a treatment plan for 68 percent of clients prescribed RMH services in lieu of the comprehensive RMH plan. Consequently, clients who have functional impairment in daily living due to a mental and/or behavioral health disorder that require more comprehensive services may not be receiving the appropriate level of care.

Level of Intensity

Review of client files found one-third had missing or incomplete LOI documentation. See Exhibit III.

Exhibit III



Our sample showed 32 percent of client files did not contain the LOI worksheet. In addition, 70 percent of client files with no worksheet had no documentation showing the LOI, even though it is required to be included in the mental health plan. An example of documentation showing the client's LOI would be a prior authorization form. Without knowing the LOI, a provider cannot determine the amount or type of therapy to prescribe to achieve the client's behavioral health goals.

HCFP Reviews Hold Some Providers Accountable

The HCFP Surveillance and Utilization Review (SUR) unit performs focused and some random reviews of provider documentation. Providers are selected for review based on complaints and information from HCFP's data analytics tool that points to irregularities in billing practices, including data analysis, reports of improper billing received from various sources, and known areas where providers have been found to improperly bill Medicaid.

During reviews the SUR unit samples client files. Reviews include comparing mental health plan information to MSM requirements as well as to service and billing documentation to ensure it matches. The SUR unit will recoup payments for services billed with no supporting documentation or incorrect supporting documentation. In addition, the SUR unit will recoup amounts when documentation shows services are not reimbursable under the specified service code or the service provider has copied and pasted notes from prior services or services provided to other clients.

As a matter of HCFP policy, the SUR unit does not recoup payments when: a client does not have a current mental health plan; the mental health plan does not follow all MSM requirements; billings are for services not specifically included in the plan; or there is a treatment plan in lieu of a RMH plan. These deficiencies result in notification letters, which include specific education relating to each deficiency identified. However, only entities reviewed receive HCFP education/guidance. There is no mechanism in place to educate all providers on noted deficiencies to ensure clients receive the appropriate level of care. Holding providers who do not follow the MSM requirements accountable will help ensure clients are receiving the appropriate level of care.

Perform More In-Depth Reviews of Client Files

HCFP should perform more in-depth reviews of client files to ensure billing documentation is correct. This may increase recoupments of improper payments by up to \$7.4 million annually.

Client File Documentation Deficient

Our sample of client files revealed the following documentation deficiencies:

- A lack of documentation for services billed and paid;
- Documentation that did not match the code or number of units billed and paid;
- Documentation for services not reimbursable billed and paid as case management services; and
- Service notes lacking substance or copied.¹

These deficiencies represent up to \$8.8 million in improper payments for fiscal year 2016.

MSM Progress Note and Case Management Documentation Requirements

MSM Section 403 (Mental Health and Alcohol/Substance Abuse Services) requires progress note documentation. Progress notes are defined as written documentation of the treatment or services provided that reflect the progress or lack of progress toward the goals and objectives of the treatment or RMH plan. All progress notes reflecting a billable Medicaid mental health service must be sufficient to support the services provided and must document the amount, scope, duration, and provider of the service, according to the manual.

¹ The MSM requires services notes to include substantive items, such as what service was provided, including the amount, scope, duration, and provider of the service. In addition the notes must reflect the progress or lack of progress toward goals.

MSM Section 2502 (Case Management) requires providers to keep documentation relating to case management. Case management services are services which assist an individual in gaining access to needed medical, social, educational, and other supportive services. Case management documentation must include the nature, content, and units of the case management services provided.

No Documentation

Our sample showed 15 percent of billings did not have any documentation to support the services billed. This represents up to \$5.1 million in potentially improper payments for fiscal year 2016.

Documentation Did Not Match Billings

Our sample showed five percent of billings did not agree with documentation. This represents up to \$1.7 million in improper payments for fiscal year 2016.

Two percent of billings were for a different service code than documented, representing up to \$600,000 in improper payments for fiscal year 2016. Three percent of billings were for more units than documented, representing up to \$1.1 million in improper payments for fiscal year 2016.

Services Not Reimbursable Being Paid

Our sampled showed six percent of billings for case management were for services not reimbursable under the MSM. These services included, but were not limited to: training in daily living skills; grooming and other personal services; training in housekeeping, laundry, and cooking; transportation services; individual, group or family therapy services; and completing application forms, paper work, evaluations, and reports, including applying for Medicaid eligibility. This represents up to \$2 million in improper payments for services that are not reimbursable being paid as case management services for fiscal year 2016.

Documentation Lacks Substance and is Copied

Our sample revealed progress notes and case management documentation lacked the substance required by the MSM. Documentation for case management did not include what services or actions were provided for the client or the number of units. Progress notes for treatment services did not document discussions, activities, or include whether the client was progressing toward goals. In addition, progress notes were copied and pasted from session to session and across various clients. Some progress notes documented the same discussion word for word as several previous sessions and for other client's sessions. In other instances the progress notes referred to the client by the wrong pronoun, such as boys being called she, girls being called he, and in one

instance a boy being called by a girl's name. There were no notes to indicate the client wished to be referred to by a different name or sexual identity.

SUR Unit Reviews Often Focused

SUR unit reviews are often based on complaints or billing data irregularities; therefore, the scope of the reviews are often focused on particular billings instead of the full client file. Based on information provided by HCFP, in fiscal year 2016 the SUR unit recouped \$1.4 million from behavioral health outpatient treatment providers. The average recoupment per client was about \$800. Our sample review of full client files revealed an average of over \$2,000 in improper payments per client. If the SUR unit did a more in-depth review of full client files when they review behavioral health outpatient treatment providers for complaints or billing data irregularities, they may be able to recoup up to an additional \$7.4 million annually.²

The SUR unit should do more in-depth reviews of client files to ensure notes are individualized for the client, address the requirements in the MSM, and are for services reimbursable under the service specified. By doing a more in-depth review of client files instead of focused reviews, the SUR unit may be able to recoup up to an additional \$7.4 million in improper payments annually.

Conclusion

Holding Medicaid fee-for-service, behavioral health outpatient treatment providers accountable for not following MSM requirements will help ensure clients receive the appropriate level of care. In addition, more in-depth reviews of client files may result in additional recoupments of up to \$7.4 million annually.

Recommendations

1. Hold Medicaid fee-for-service, behavioral health outpatient providers who do not follow MSM requirements accountable.
2. Perform more in-depth reviews of client files.

² \$8.8 million improper payments identified by our sample less \$1.4 million recouped by the SUR unit for fiscal year 2016.

Better Assist Providers to Understand Medicaid Service Manual Requirements and Standardize Documentation to Enhance HCFP Reviews and Auditing of Client Files

HCFP can better assist Medicaid fee-for-service, behavioral health outpatient treatment providers by increasing trainings and offering templates for managing client files. Better assisting providers will enhance understanding of the MSM requirements and help standardize client files throughout the state, making HCFP's review and auditing of individual files more efficient.

Increase Trainings and Offer Templates

HCFP should increase provider trainings and offer templates for managing client files for Medicaid fee-for-service, behavioral health outpatient services. Discussions with providers indicated they need and want increased trainings and templates. Moreover, templates would help standardize files for HCFP reviews and audits.

Providers Need and Want Increased Training Opportunities

During our sampling of client files, providers represented the only training opportunities offered to them were for billing requirements and a limited number of workshops and conference calls outlining the updates to the MSM. Providers represented they are often confused by the MSM requirements and do not know which requirements apply to them or why prior authorization requests are being denied for not being medically necessary. During our discussions we learned providers want more guidance regarding the MSM requirements, best practices for managing client files, and documenting mental health plans and services provided. Additional trainings for providers will ensure they understand the MSM requirements for mental health plans and services, which should help ensure more complete documentation in client files.

Templates Will Help Standardize Files and Enhance Review and Audit Efficiency and Effectiveness

Each provider we sampled had a different method of keeping client files. In addition, each provider used a different form to document mental health plans and services provided to clients. Most of the forms used by providers do not document all the items required by the MSM, such as service code, number of units or hours, and start/end times. Offering trainings and templates for mental health plans and services, such as therapy and case management, will help

ensure documentation follows MSM requirements and help standardize client files throughout the state. Standardizing documentation will increase the number of files HCFP can efficiently and effectively review and audit.

Conclusion

Increasing trainings and offering templates for Medicaid fee-for-service, behavioral health outpatient treatment services will help providers understand the MSM requirements and standardize client files throughout the state. These improvements will help make HCFP audits and reviews more efficient and effective.

Recommendations

3. Increase provider trainings for Medicaid fee-for-service, behavioral health outpatient treatment services.
4. Offer templates for providers.

Exhibit IV

Estimated Benefits

Recommendation	Annual Benefit
2. Perform in-depth reviews of client files.	\$7,400,000

Appendix A

Scope and Methodology, Background, Acknowledgements

Scope and Methodology

We began the audit in February 2017. In the course of our work, we interviewed HCFP staff and discussed processes inherent to their responsibilities. We reviewed HCFP records, applicable Nevada Revised Statutes, and other state guidelines. We reviewed applicable sections of the Medicaid Services Manual as well as a sample of client files who received Medicaid benefits for fee-for-service, behavioral health outpatient treatments. We concluded field work and testing in August 2017.

We conducted our audit in conformance with the *International Standards for the Professional Practice of Internal Auditing*.

Background

HCFP is one of six divisions in the Department of Health and Human Services and is funded by the state general fund and federal revenues.³ HCFP's budget for fiscal year 2016 was approximately \$3.4 billion. Exhibit V summarizes HCFP's funding sources for fiscal year (FY) 2016.

Exhibit V

**Division of Health Care Financing and Policy
Funding Sources FY 2016**

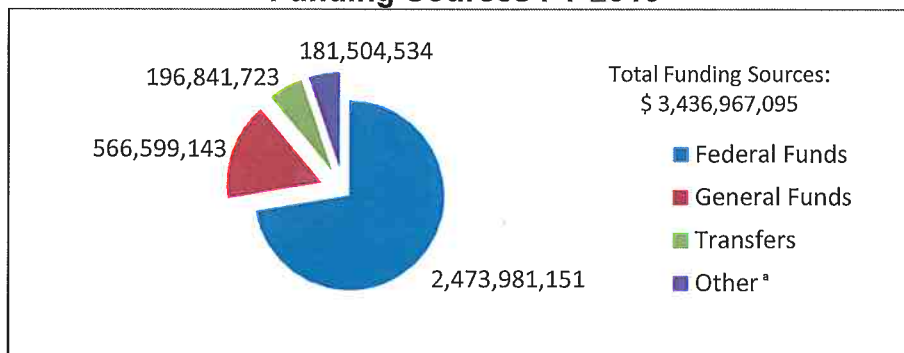


Table note:

^aOther includes adjustment to reserves.

³ Department of Health and Human Services' divisions: Aging and Disability Services, Child and Family Services, Health Care Financing and Policy, Public and Behavioral Health, Welfare and Supportive Services, and Public Defender.

HCFP’s mission is to purchase and provide quality health care services to low-income Nevadans in the most efficient manner; promote equal access to health care at an affordable cost to the taxpayers of Nevada; restrain the growth of health care costs; and review Medicaid and other state health care programs to maximize potential federal revenue.

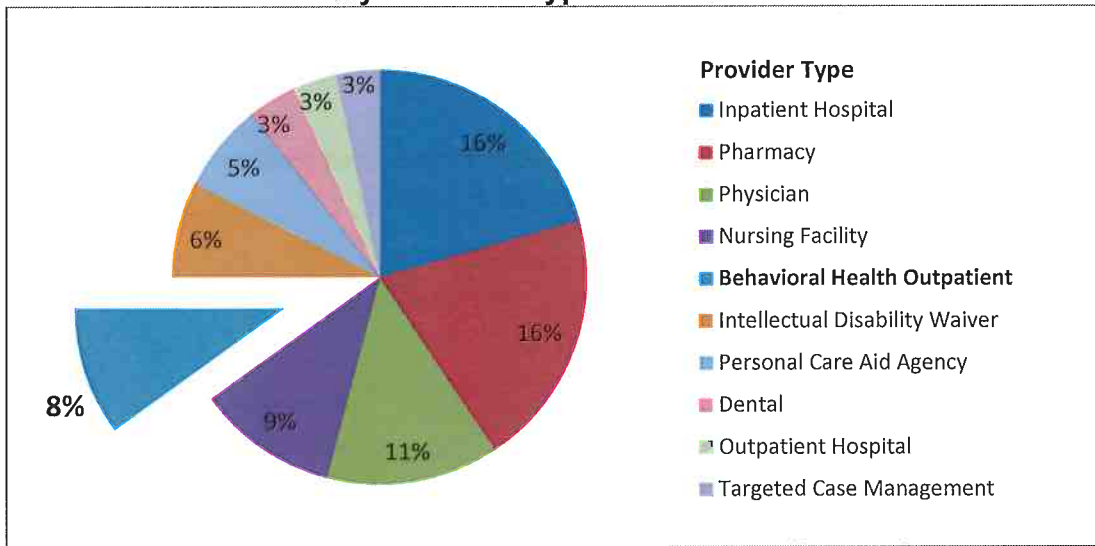
HCFP achieves its mission by working in partnership with the Centers for Medicare and Medicaid Services to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources. Services are provided through a combination of managed care organizations and traditional fee-for-service provider networks.

A managed care organization (MCO) is an entity that must provide its Medicaid enrollees inpatient hospital, outpatient hospital, laboratory, x-ray, family planning, physician, home health services, emergency services, and additional contracted State Plan benefits. The MCO provides these services for a premium or capitation fee, regardless of whether the individual enrollee receives services.

A fee-for-service is a method of reimbursement whereby the State of Nevada may reimburse Medicaid providers for a service rendered to a recipient. Exhibit VI summarizes the top ten fee-for-service expenditures by provider type for fiscal year 2016.

Exhibit VI

**Top Ten Fee-for-Services Expenditures
By Provider Type for FY 2016**



HCFP spent \$128 million on fee-for-service, behavioral health outpatient treatments. Behavioral health outpatient treatment services include assessment and diagnosis, testing, basic medical and therapeutic service, crisis intervention, therapy, partial and intensive outpatient hospitalization, medication management, and case management.

Acknowledgments

We express appreciation to the department director, HCFP administrator, deputy administrators, staff, and providers for their cooperation and assistance throughout the audit.

Contributors to this report included:

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Appendix B

Division of Health Care Financing and Policy Response and Implementation Plan



STATE OF NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF HEALTH CARE FINANCING AND POLICY

RESPONSE AND IMPLEMENTATION PLAN

DIVISION OF INTERNAL AUDITS PERFORMANCE AUDIT

SEPTEMBER 2017 - REVISED

The Division of Health Care Financing and Policy's (DHCFF) Surveillance and Utilization Review (SUR) Unit, and Policy Development & Program Management (PDPM) Unit have developed this response and implementation plan to address the four recommendations made by the Division of Internal Audits in their audit of Medicaid fee-for-service, behavioral health outpatient treatment services.

Background

According to government estimates between 7 and 14 percent of all health-care expenditures are improperly made, therefore, it is imperative to have an effective way to protect the integrity of the Nevada Medicaid Program. The program that protects the integrity of Nevada Medicaid from fraud and abuse is known as the Surveillance and Utilization Review (SUR) Unit. The SUR Unit, which is within the Division of Health Care Financing and Policy (DHCFF) guards against fraud and abuse by providers by identifying aberrant billing practices and investigating referrals from other governmental entities, providers, provider employees and from the public. SUR staff can initiate sanctions against those who have abused the Medicaid program, provide education on policy, recover overpayments, and assist in criminal investigations when appropriate.

SUR staff perform a variety of other functions, such as detecting areas where Medicaid regulations can be improved, finding contradictions in policy, administering the provisions of the Federal and Nevada False Claims Acts, conducting provider training on fraud and abuse, and preventing fraud and abuse from occurring.

SUR staff also conducts both random reviews and focused reviews. Providers are selected for review based on information that points to an irregularity in billing practices including data analysis, reports of improper billing received from various sources and known areas where providers have been found to improperly bill the Nevada Medicaid Program. A data mining program is used by SUR to identify outliers among various provider types including providers that bill high numbers of services, have high costs per patient, bill for seeing high numbers of patients per day and other algorithms that are used for fraud and abuse detection on a national level. When these providers are identified they are targeted for investigation.

The SUR Unit within comprised of seventeen positions. Of the seventeen positions, fourteen full-time employees are dedicated to performing case reviews. The SUR Unit is tasked with reviewing complaints pertaining to all provider types enrolled in Nevada Medicaid fee-for-service, however, the Centers for Medicare and Medicaid Services (CMS) has issued guidance advising states that they must utilize their resources to look at the variety of provider types, rather than focusing on select groups.

When potential improper payments are identified, a determination is made as to the nature of the error. For instance, if the provider appears to have been providing services appropriately, but failed to meet all documentation requirements, the caseworker will review whether that provider had previously been educated on those requirements. If they have not, the caseworker will send an education letter which requires them to sign and return an acknowledgment of their understanding of the requirements. If, in a future case, it is found that they are still not adhering to the requirements, the SUR Unit may recoup the improper payments.

In instances where a provider has a demonstrated pattern of disregarding the Medicaid policies, and/or in situations where a provider is unable to demonstrate that they provided the services billed, Nevada Medicaid typically seeks to recoup rather than educate. If patterns are identified reflecting wanton disregard of Medicaid policies, or in other situations in which a potential credible allegation of fraud is identified by the SUR Unit, a consultation and/or referral is made to the Attorney General's Medicaid Fraud Control Unit (MFCU).

Additionally, when there is an adverse finding against a provider, the provider has the right to an Administrative Fair Hearing in front of a Hearings Officer in the Department of Administration. The SUR Unit must build a case that our Deputy Attorney General (DAG) is able defend, and evidence of prior education by SUR oftentimes proves to be valuable. If the DHCFP has determined that an improper payment was made, the Centers for Medicare and Medicaid Services (CMS) requires that Nevada pay back the federal share (roughly 65%) of the improper payment regardless of the hearing outcome. In addition, SUR must give consideration to access to care issues, and work with providers to correct behaviors rather than recoup, when warranted.

Program Facts

- Over 1 million claims are processed on a monthly basis in the Medicaid Fee-for-Service (FFS) program.
- As of August 20, 2017, there were 5,198 active Behavioral Health Outpatient Services, Provider Type 14 (PT14) providers representing 18% of the total active providers.
- Of the total cases closed by the SUR Unit in SFY 2016, 12% were for PT 14 providers. In SFY 2017, 22% were for PT14 providers.
- The total dollar amount recouped from PT14 providers increased from \$1,420,622 in SFY16 to \$2,497,864 in SFY17.
- In SFY2016, PT14 providers represented approximately 9% of FFS expenditures.

Recommendation #1: Hold Medicaid fee-for-service, behavioral health outpatient providers who do not follow MSM requirements accountable.

The DHCFP agrees with this recommendation and believes we have processes in place that begin to address these issues. We acknowledge that this process could be strengthened by the additional of a more robust clinical aspect to the assessments.

The first audit objective was to develop recommendations to ensure Medicaid fee-for-service, behavioral health outpatient treatment clients receive the appropriate level of care. To determine the appropriateness of level of care and behavioral health care plans are appropriate, SUR would need to conduct clinical reviews. DHCFP including SUR does not currently include clinical staff qualified to accomplish these types of reviews. SUR will develop and present a plan for the staffing that would be needed to conduct this level of review.

The Division of Internal Audits identified instances where provider records were not in compliance with Medicaid policies, for example, files did not contain all required documentation. DHCFP expects providers to abide by all Nevada Medicaid policies however, we acknowledge that this can be challenging for providers and we assume that a first time finding may indicate a failure to understand the policy fully, as opposed to a willful violation of the policy. In instances such as these, the SUR Unit generally seeks to educate the behavioral health providers and allow them an opportunity to come into compliance with the policy. It has proven challenging to make a direct and sustainable link between a missing document, such as a behavioral health plan, the finding that no service was provided thus the payment should be canceled. There challenges come to light in the process of Administrative Hearings and appeals. We find that our recoupments are more likely to be upheld when we demonstrate that we have documented efforts to educate the providers on compliance with the policy.

The DHCFP will analyze how many additional clinical staff would be needed to enhance the SUR review process by April 2018. If the Division is able to submit a request for additional staff in the upcoming budget request and the positions are approved in the 2019 session, the Division will initiate the hiring process in October 2019.

Recommendation #2: Perform more in-depth reviews of client files.

The DHCFP agrees with the intent of this recommendation however, cases that require a full record review are extremely time consuming and while additional improper payments for that provider may be identified, the extra time invested in that case may delay or prevent a review of other providers. To assist in conducting additional and more in-depth reviews, the Division will explore requesting additional staff for the SUR unit in future legislative sessions.

The DHCFP will analyze how many additional staff would be needed to enhance the SUR review process by April 2018. If the Division is able to submit a request for additional staff in the upcoming budget request and the positions are approved in the 2019 session, the Division will initiate the hiring process in October 2019.

Recommendation #3: Increase provider trainings for Medicaid fee-for-services, behavioral health outpatient treatment services.

The DHCFP agrees with this recommendation. The performance audit identified issues with both Behavioral Health, Outpatient Treatment (PT14) and Behavioral Health Rehabilitative Treatment (PT82) services. Currently the DHCFP offers a provider webinar training on the second Wednesday of every month at 10am on a variety of topics related to behavioral health policy and procedures with an average attendance of 40 providers per training. Beginning in January 2018, the Behavioral Health Unit will add a training in the afternoon to increase provider engagement.

In addition, to enhance the provider's training experience, the Behavioral Health Unit has developed a provider survey on the relevance and applicability of current training and solicited ideas for future training. This survey was sent to providers on September 15, 2017, and the results be released in October. The Division will begin implementation of suggested trainings in January of 2018.

Recommendation #4: Offer templates for providers.

The DHCFP agrees with this recommendation and will work with its sister agency, the Division of Public and Behavioral Health, to create documentation templates and guidance for client file management that will assist providers in better organizing their files and being prepared for audits. Templates and guidance will be suggested and staff support will be offered in helping providers adapt for use in their organization. The Division will begin the creation of these templates and guidance in conjunction with the revised trainings in January 2018 with full implementation of the templates completed by April 2018.

Appendix C

Timetable for Implementing Audit Recommendations

In consultation with the Division of Health Care Financing and Policy (HCFP), the Division of Internal Audits categorized the recommendations contained within this report into one of two separate implementation time frames (i.e., *Category 1* – less than six months; *Category 2* – more than six months). HCFP should begin taking steps to implement all recommendations as soon as possible. HCFP's target completion dates are incorporated from Appendix B.

Category 1: Recommendations with an anticipated implementation period of less than six months.

<u>Recommendations</u>	<u>Time Frame</u>
3. Increase provider trainings for Medicaid fee-for-service, behavioral health outpatient treatment services. (page 10)	Jan 2018
4. Offer templates for providers. (page 10)	Apr 2018

Category 2: Recommendations with an anticipated implementation period exceeding six months.

<u>Recommendations</u>	<u>Time Frame</u>
1. Hold Medicaid fee-for-service, behavioral health outpatient providers who do not follow MSM requirements accountable. (page 8)	Oct 2019
2. Perform more in-depth reviews of client files. (page 8)	Oct 2019

The Division of Internal Audits shall evaluate the action taken by HCFP concerning the report recommendations within six months from the issuance of this report. The Division of Internal Audits must report the results of its evaluation to the Executive Branch Audit Committee, the Department of Health and Human Services, and HCFP.