DEPARTMENT OF HEALTH AND HOSPITALS
BATON ROUGE MAIN OFFICE OPERATIONS
STATE OF LOUISIANA

MANAGEMENT LETTER
ISSUED MAY 2, 2007

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

Under the provisions of state law, this report is a public document. A copy of this report has been submitted to the Governor, to the Attorney General, and to other public officials as required by state law. A copy of this report has been made available for public inspection at the Baton Rouge office of the Legislative Auditor.

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In compliance with the Americans With Disabilities Act, if you need special assistance relative to this document, or any documents of the Legislative Auditor, please contact Wayne "Skip" Irwin, Director of Administration, at 225-339-3800.

OFFICE OF
LEGISLATIVE AUDITOR
STATE OF LOUISIANA
BATON ROUGE, LOUISIANA 70804-9397

STEVE J. THERIOT, CPA
LEGISLATIVE AUDITOR

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March 29, 2007

DEPARTMENT OF HEALTH AND HOSPTIALS
BATON ROUGE MAIN OFFICE OPERATIONS
STATE OF LOUISIANA
Baton Rouge, Louisiana

As part of our audit of the State of Louisiana's financial statements for the year ended June 30, 2006, we considered the Department of Health and Hospitals' (Baton Rouge Main Office Operations) internal control over financial reporting and over compliance with requirements that could have a direct and material effect on a major federal program; we examined evidence supporting certain accounts and balances material to the State of Louisiana's financial statements; and we tested the department's compliance with laws and regulations that could have a direct and material effect on the State of Louisiana's financial statements and major federal programs as required by *Government Auditing Standards* and U.S. Office of Management and Budget Circular A-133.

The Annual Fiscal Report of the Department of Health and Hospitals (Baton Rouge Main Office Operations) is not audited or reviewed by us, and, accordingly, we do not express an opinion on that report. The department's accounts are an integral part of the State of Louisiana's financial statements, upon which the Louisiana Legislative Auditor expresses opinions.

In our prior management letter on the Department of Health and Hospitals (Baton Rouge Main Office Operations) for the year ended June 30, 2005, we reported findings relating to noncompliance with state movable property regulations and improper claims by waiver services providers. The finding relating to noncompliance with state movable property regulations has been substantially resolved by management. The waiver services finding is addressed again in this letter.

Based on the application of the procedures referred to previously, all significant findings are included in this letter for management's consideration. The findings included in this management letter that are required to be reported by *Government Auditing Standards* will also be included in the State of Louisiana's Single Audit Report for the year ended June 30, 2006.

Improper Claims by Waiver Services Providers

For the second consecutive year, providers of waiver services billed the Medical Assistance program (CFDA 93.778) for services that were not in accordance with policies established by the Department of Health and Hospitals (DHH). Waiver services are provided to eligible recipients under the New Opportunities Waiver and the Elderly and Disabled Adult Waiver. These services include individualized and family support,

personal care attendant, household support, and personal supervision. Regulations and requirements for the delivery of services and payment of claims for these waiver programs are established through administrative rules and policy manuals developed by DHH.

We reviewed 485 claims, totaling $348,471, filed by nine providers for 45 recipients during calendar year 2005. Errors were noted on 44 of the 485 claims tested (9.1%). The errors noted included the following:

- For 28 claims, the providers did not maintain time sheets and/or progress notes to support and describe the services provided and the units of service billed.

- For two claims, waiver services were billed when the recipient was hospitalized.

- For 16 claims, weekly hours of service were not delivered according to the plan of care approved by DHH. The plan of care specifies the units of service to be provided each week. The units of service provided were drastically less than the weekly units specified in the plan of care with no documentation in the recipient record explaining why the services were not provided.

- For 14 of 45 recipient records reviewed, the quarterly progress summary was not prepared.

These conditions occurred because the providers failed to follow established DHH policies and regulations for providing services according to the plan of care and adequately documenting those services. Questioned costs were $46,272, which included $32,293 of federal funds and $13,979 of state matching funds.

DHH should establish, implement, and enforce adequate controls to ensure that only appropriate claims for waiver services are paid to providers. Management concurred with the finding and outlined a corrective action plan (see Appendix A, pages 1-4).

Duplicate Claims Paid to Case Management Providers

Support coordination (case management) services providers billed the Medical Assistance program (CFDA 93.778) during calendar year 2005 for services that were not in accordance with the policies and procedures established by DHH. Case management services are provided to eligible recipients to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services. Regulations and requirements for the delivery of services and payment of claims for case management services are established through administrative rules and policy manuals developed by DHH. DHH case management policy states that the reimbursement rate is a monthly rate that is associated with intake, ongoing assessment,

planning, building/implementing supports, monitoring support strategies, and transition closure. Duplicate claims (same recipient, same or different provider, on the same date of service) will be denied. All claims will be billed after services have been rendered with date of service being the last day of the month that services were rendered. Documentation in the Case Management Information System (CMIS) must be current before billing for service.

During the calendar year 2005, DHH paid approximately $3.2 million to providers for infants and toddlers case management services to 4,181 recipients. Audit procedures determined that duplicate claims were submitted and paid for 166 recipients as follows:

- Forty instances were noted where duplicate claims were submitted by a different provider for the same recipient for the same month of service. Questioned costs were $4,804, which included $3,353 in federal financial participation (FFP).

- One-hundred thirty-three instances were noted where duplicate claims were submitted by the same provider for the same recipient for the same month of service. Questioned costs were $15,895, which included $11,093 in FFP.

These conditions occurred because the providers failed to follow established policies for showing the date of services on claims and use the CMIS. Questioned costs were $20,699, which included $14,446 of federal funds and $6,253 of state matching funds.

DHH should establish, implement, and enforce adequate controls to ensure that only appropriate claims are paid to the providers of case management services in accordance with established policies. Management concurred with the finding and outlined a corrective action plan (see Appendix A, page 5).

Improper Claims by Non-Emergency Transportation Service Providers

Providers of non-emergency medical transportation services billed the Medical Assistance program (CFDA 93.778) for services that were not provided in accordance with policies and procedures established by DHH, Bureau of Health Services Financing (BHSF). Non-Emergency Medical Transportation (NEMT) is defined as transportation provided for Medicaid recipients to and/or from a provider of Medicaid covered services. The NEMT program's provider manual requires that:

(1) providers maintain copies of all Recipient Verification of Medical Transportation Forms (Form MT-3) as documentation of trips provided;

(2) providers maintain copies of the Driver Identification Form (MT-8) for each driver and the form be completed when drivers are hired and annually thereafter for all current drivers;

(3) providers maintain copies of the Vehicle Inspection Form (MT-9) for each vehicle used and the form be completed on each vehicle before the vehicle can be used and annually thereafter; and

(4) providers maintain a daily schedule of transports.

We reviewed 108 claims totaling $25,492, paid to four providers during calendar year 2005. We noted that providers are allowed to bill for capitated (monthly) services at the beginning of the month before any services have been provided. This allows providers to be paid for services that may not be provided. Other errors noted for three providers representing 91 of the 108 claims (84%) tested included the following:

- For 34 of 91 claims (37%), the providers did not maintain adequate documentation of the trips provided. In particular, providers could not provide completed copies of MT-3's to substantiate all trips approved for capitated (monthly) rates.

- For 91 of 91 claims, the providers did not maintain a daily schedule of transports.

- For 91 of 91 claims, the providers did not maintain adequate documentation to support the driver's identification and vehicle certifications in their records.

One additional provider was no longer in business because of Hurricane Katrina. We were able to determine that three of 17 claims (18%) made by this provider were improper when we could not match claim services dates to any other claims paid for the recipient on the same day.

These conditions occurred because NEMT providers failed to follow established BHSF policies and procedures for providing services and adequately documenting those services. Questioned costs were $22,488, which included $15,674 of federal funds and $6,814 of state matching funds.

DHH management should enforce established controls to ensure that only appropriate claims for NEMT are paid to providers. Management concurred with the finding and outlined a corrective action plan (see Appendix A, pages 6-7).

Improper Claims by Long Term Personal Care Service Providers

Providers of Long Term Personal Care Services (LT-PCS) billed the Medical Assistance program (CFDA 93.778) for services that were not provided in accordance with policies and procedures established by DHH, Bureau of Health Services Financing (BHSF). DHH has established LT-PCS as an optional service under the Medicaid State Plan. DHH-BHSF policies and procedures require that a plan of care for each recipient be developed, approved, and followed by the LT-PCS providers. The plan of care specifies the units of service to be provided each week. Providers are to maintain time sheets and progress notes for all units of service provided.

We reviewed 168 claims totaling $104,070, paid to four providers during calendar year 2005. Errors were noted on 89 of the 168 claims tested (53%). The errors noted include the following:

- For 80 of 168 claims (48%), weekly units of service were not delivered according to the plan of care. In some instances, the units of service provided exceeded the weekly units specified in the plan of care by up to 127 units of service. In other instances, the units of service provided were less than the weekly units specified in the plan of care by up to 174 units of service.

- For 49 of 168 claims (29%), the provider did not maintain adequate documentation of the units of service provided. Some providers' time sheets and progress notes did not include matching times worked by employees; one provider's progress notes did not contain the times worked; and one provider used the same time sheets for both the LT-PCS and waiver services programs without distinguishing which units of services were for which program.

- For 41 of 168 claims (24%), providers billed for more units than worked. Providers were unable to provide time sheets to substantiate the units of service billed for the service dates on the claim.

- For two of 168 claims (1%), the provider billed units of service on days the recipient was hospitalized. LT-PCS services cannot be provided in a hospital, an institution for mental disease, a nursing facility, or an intermediate care facility for the mentally retarded.

These conditions occurred because LT-PCS providers failed to follow established BHSF policies and procedures for providing services according to the plan of care and adequately documenting those services. Questioned costs were $49,608, which included $34,621 of federal funds and $14,987 of state matching funds.

DHH management should establish, implement, and enforce adequate controls to ensure that only appropriate claims for LT-PCS services are paid to providers. Management concurred with the finding and outlined a corrective action plan (see Appendix A, pages 8-11).

Ineffective Medicaid Eligibility Quality Control System

DHH did not operate its Medicaid Eligibility Quality Control (MEQC) system in accordance with the guidelines approved by the Centers for Medicare and Medicaid Services (CMS). States are required to operate a MEQC system that re-determines eligibility for individual sampled cases of beneficiary eligibility made by state Medicaid agencies or their designees in accordance with the requirements in 42 CFR 431.800 through 431.865. DHH is operating a MEQC pilot project approved by CMS that allows them to perform targeted or focused reviews. The pilot project requires DHH to perform a total of 220 reviews per month.

The MEQC section did not perform any reviews for six months (November and December 2005; February, March, April, and June 2006). A test of 45 cases assigned for MEQC review in months where some reviews were performed disclosed that nine of the 45 cases (20%) were not reviewed. While hurricanes Katrina and Rita caused some disruption to the normal operation of the MEQC system, DHH did not obtain written approval from CMS to vary from the federal guidelines.

Failure to operate the MEQC system in accordance with the approved MEQC pilot project results in noncompliance with federal regulations and may allow incorrect eligibility determinations to go undetected. Therefore, payments may be made for recipients who are not Medicaid eligible.

DHH should ensure that reviews are performed in accordance with the approved pilot project for the MEQC system. Management concurred with the finding and outlined corrective action (see Appendix A, pages 12-13).

Failure to Maintain Adequate Third-Party Liability Documentation

DHH did not maintain adequate documentation to show that recipients had been informed that by accepting medical assistance, the assignment of third-party rights is automatic under state law. The Code of Federal Regulations [42 CFR 433.145(a)] requires that as a condition of eligibility, recipients must assign to the Medicaid agency his or her rights to medical support and to payment for medical care from any third party. Federal code 42 CFR 433.146(c) allows states to make the assignment of third-party rights to Medicaid automatic under state law, eliminating the need for individual assignment of these rights, provided that the recipient is informed of the terms and consequences of the state law. Louisiana Revised Statute 46:153(E) provides automatic assignment under state law. The DHH *Medicaid Eligibility Manual* states that the

recipient's signature on the application and renewal form acknowledges the automatic assignment of all third-party rights.

In a test of 60 case records, 23 records (38%) did not contain a signed application or renewal form that included the explanation of automatic assignment of third-party rights. Some of the applications and renewal forms were not available due to a change in how case records are maintained.

Applications containing the explanation of automatic assignment of third-party rights were not scanned into the case system when DHH converted from paper to electronic, and some case records were destroyed. Failure to include documentation, indicating that recipients have been informed that the assignment of third-party rights to Medicaid is required and automatic, results in noncompliance with federal and state regulations.

DHH should review all recipient case records to ensure that they contain evidence that recipients were informed of the automatic assignment of third-party rights. Management concurred with the finding and outlined corrective action (see Appendix A, pages 14-15).

Inadequate Conversion to Electronic Case Records for Medicaid Eligibility

During the conversion of Medicaid eligibility case records from a paper system to an electronic storage system, DHH failed to convert all needed documents. In addition, some paper eligibility case records were destroyed in violation of federal record retention regulations. Section S-200 of the *Medicaid Eligibility Manual* guides eligibility examiners to document all information required to make an eligibility decision or initiate a case change. The manual describes a properly documented case record as one that allows anyone who reviews the case record to make the same eligibility decision made by the agency representative. The required documentation may be forms designed to record specific information; original documents, photocopies, or signed statements; or statements recorded in the case record. Federal regulations require that all records be maintained for a period of six years.

Our review of Medicaid recipient eligibility noted the following:

- Adequate documentation of the verification of all eligibility factors was not present in 25 of 60 (42%) eligibility case records reviewed.
- The paper case record had been purged and/or destroyed for 21 case records for which the electronic case record did not contain adequate documentation.

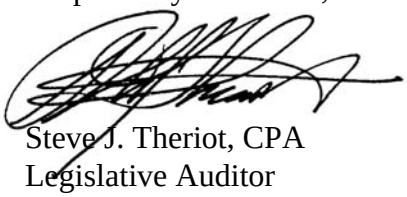
The examiners did not follow DHH's guidelines for converting paper records to electronic records. Since DHH case records do not contain all of the information needed to verify that the eligibility decisions made by the Medicaid eligibility examiners are correct, the department's decision on the eligibility of some recipients cannot be supported.

DHH should review all electronic case records to determine that all required information is present. Management concurred with the finding and outlined corrective action (see Appendix A, pages 16-17).

The recommendations in this letter represent, in our judgment, those most likely to bring about beneficial improvements to the operations of the department. The varying nature of the recommendations, their implementation cost, and their potential impact on the operations of the department should be considered in reaching decisions on courses of action. The findings relating to the department compliance with applicable laws and regulations should be addressed immediately by management.

This letter is intended for the information and use of the department and its management and is not intended to be, and should not be, used by anyone other than these specified parties. Under Louisiana Revised Statute 24:513, this letter is a public document, and it has been distributed to appropriate public officials.

Respectfully submitted,



Steve J. Theriot, CPA
Legislative Auditor

JES:WDG:PEP:ss

[DHH06]

Management's Corrective Action Plans and Responses to the Findings and Recommendations

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

December 15, 2006

Mr. Stephen J Theriot, C.P.A.
Legislative Auditor
1600 North Third Street
P.O. Box 94397
Baton Rouge, LA 70804-9397

Dear Mr. Theriot:

Re: Single Audit Finding—Improper Claims by Waiver Service Providers

Please accept this letter as a response to the Legislative Auditor finding regarding Improper Claims by Waiver Service Providers dated November 21, 2006. It is our understanding that the Legislative Auditor's position is that this finding occurred because New Opportunity Waiver (NOW) and Elderly and Disabled Adult (EDA) Waiver service providers failed to follow established Department of Health and Hospital (DHH) regulations and policies for providing services according to the plan of care and for inadequately documenting those services. DHH concurs with this finding.

Background Information
On November 1, 2005, as a result of Governor Blanco's Health Care Reform initiative, the Bureau of Community Supports and Services (BCSS) within DHH was restructured and renamed the Division of Long Term Supports and Services (DLTSS). DLTSS is responsible for the administration of the EDA Waiver, Adult Day Health Care (ADHC) Waiver, Long Term-Personal Care Services (LT-PCS), Support Coordination Services—HIV, and the development of a Medicaid Adult Residential Care Waiver and Program of All-Inclusive Care for the Elderly (PACE).[1] Responsibility for administering the NOW and Children's Choice (CC) Waivers transferred to (and currently resides with) the Office for Citizens with Developmental Disabilities (OCDD).

The Department of Social Services (DSS) previously conducted annual licensing surveys of waiver service providers and BCSS conducted semi-annual monitoring reviews. Act 483 of the 2005 Regular Session transferred licensing authority over waiver providers from DSS to the Health Standards Section (HSS) within DHH. To reduce fragmentation and consolidate functions, HSS is now responsible for conducting the monitoring function of all waiver providers (previously a responsibility of the former BCSS). Currently, during its annual licensing surveys, HSS reviews a minimum of 5% provider client record sample at the

[1] DLTSS has been transferred to the Office of Aging and Adult Services.

provider agency. HSS ensures that monitoring procedures are standardized and that samples are representative and non-duplicative. Corrective action is required by the provider agency where documentation deficiencies are noted. If a pattern of aberrant/irregular/improper provider documentation practices is suspected, HSS refers the matter to DHH's Surveillance Utilization Review System (SURS). SURS will, if appropriate, conduct a thorough review of a given provider's records and sanction accordingly as necessary (i.e., recoup monies, exclude from participating in the Medicaid program, etc.).

Additionally, in order to meet the objective of improving the efficiency and effectiveness of licensing waiver providers, the current licensing regulations are undergoing review. This review will ultimately serve to streamline standards and assure consistency with federal and state requirements and ensure that they support DHH's service delivery vision, values, and guiding principles.

Corrective Action Plan
Because there have been significant changes in departmental roles and responsibilities regarding the waiver service delivery system, corrective action requires a collaborative effort between the various offices within DHH. These offices will work jointly to ensure that the proposed corrective action will be implemented. Although we concur with the findings and will continue to monitor and take action when findings are identified, we want to acknowledge our corrective action will not ensure 100% compliance by providers.

Accordingly, DHH's official response is attached as requested. Rick Henley of the Office of Aging and Adult Services (OAAS) and Bonnie Callahan of the Office for Citizens with Developmental Disabilities (OCDD) are the contact persons responsible for corrective action. You may contact Mr. Henley at 225-219-0209 and Ms. Callahan at 225-342-8877. For any questions concerning the activities of HSS, you may contact Lisa Deaton at 342-4997.

Sincerely,

Jerry Phillips
Medicaid Director

JLP/HE:rh

Attachment

cc: Charles Castille
Kathy Kliebert
Hugh Eley
Kay Gaudet
Stan Mead
Lisa Deaton

Improper Claims by Waiver Service Providers

Error Noted: Failing to maintain timesheets and/or progress notes to support and describe the services provided and the units of services billed.

Summary: We concur with this finding. The "Home and Community Based Services (HCBS) Waiver Program Standards for Participation" require providers to maintain documentation of services rendered as per the approved comprehensive plan of care. Additionally, the provider is required to maintain documentation of the day-to-day activities of the recipient (progress notes). The requirements are also set forth in the respective NOW and EDA policy manuals.

DHH readily provides technical assistance and providers are encouraged to call DHH or its contractors if any questions concerning documentation requirements or billing issues arise.

Corrective Action: DHH will continue to reinforce provider compliance with proper documentation and correct billing practices through training and technical assistance. Additionally, memoranda will be issued by OCDD and OAAS to all service providers that will reiterate documentation requirements.

OCDD and OAAS will issue letters to providers with errors noted in this category requesting plans of correction and requesting that monies collected on invalid billings be returned. Failure of the provider(s) to submit an approvable plan of correction will result in a referral to HSS for sanctions. Failure to return monies owed will result in a referral to DHH's SURS unit. We anticipate that this corrective action will be complete in 120 days.

Error Noted: Billing while the recipient was hospitalized.

Summary: We concur with this finding. Payment for waiver services for participants who are inpatients in a nursing home, hospital, or ICF/MR is not allowable.

Corrective Action: DHH will continue to reinforce provider compliance with proper billing practices through training and technical assistance. Additionally, memoranda will be issued by OCDD and OAAS to all service providers that will reiterate that payment for waiver services for participants who are inpatients in a nursing home, hospital, or ICF/MR is not allowable.

OAAS will issue a letter to the provider noted in this category requesting a plan of correction and requesting that monies collected on invalid billings be returned. Failure of the provider to submit an approvable plan of correction will result in a referral to HSS for sanctions. Failure to return monies owed will result in a referral to DHH's SURS unit. We anticipate that this corrective action will be complete in 120 days.

Error Noted: Failing to deliver weekly hours of service according to the approved plan of care.

Summary: We concur with this finding. The "Home and Community Based Services (HCBS) Waiver Program Standards for Participation" requires providers to deliver services

as per the approved comprehensive plan of care. This requirement is also set forth in the respective NOW and EDA policy manuals.

It is expected that there may be some deviation from this policy. There may be circumstances that exist which make delivery of weekly service hours impermissible or otherwise impossible (*e.g.*, during intermittent periods of institutional stays, periods of natural disaster, inability to obtain support staff or recipient refuses services). However, DHH agrees that documentation should exist in the recipient record explaining why services were not provided.

Corrective Action: DHH will continue to reinforce provider compliance with service delivery and documentation requirements through training and technical assistance. Memoranda will be issued by OCDD and OADD to all service providers that will reiterate the requirement that services should be provided in accordance with the plan of care (and properly documented when services are not).

DHH will issue letters to providers with errors noted in this category requesting plans of correction. Failure of the provider to submit an approvable plan of correction will result in a referral to HSS for sanctions. We anticipate that this corrective action will be complete in 120 days.

Error Noted: Failing to prepare the quarterly progress summary.

Summary: We concur with this finding. The "Home and Community Based Services (HCBS) Waiver Program Standards for Participation" requires providers to prepare quarterly progress summaries. This requirement is set forth in the respective waiver NOW and EDA policy manuals.

Corrective Action: OCDD and OAAS will continue to reinforce provider compliance with documentation requirements through training and technical assistance. Memoranda will be issued by OCDD and OAAS to all service providers that will reiterate the quarterly progress summary requirement.

OCDD and OADD will issue letters to providers with errors noted in this category requesting plans of correction. Failure of the provider(s) to submit an approvable plan of correction will result in a referral to HSS for possible sanctions. We anticipate that this corrective action will be complete in 120 days.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Kathleen Babineaux Blanco
GOVERNOR

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

January 3, 2007

Mr. Steve J. Theriot, CPA
Legislative Auditor
P.O. Box 94397
Baton Rouge, Louisiana 70804-9397

Dear Mr. Theriot:

Below is the response from The Department of Health and Hospitals, Bureau of Health Services Financing related to the finding dated December 14, 2006 regarding **Duplicate Claims Paid to Case Management Providers:**

- DHH concurs with the finding. There were duplicate claims submitted for the same recipient for the same month of service.
- Corrective Action:
  - Contact: Janith Miller at 225/342-6248
  - Program Integrity is taking action for recoupment of the overpayments, Joe Kopsa (225)/342-4150) is the contact for Program Integrity.
    - A letter to be sent in early 2007 to the appropriate providers regarding the action to be taken.
    - This action is subject to due process which could delay the completion of this action.
  - Program Operations has requested a system change to place electronic edits in the payment system that is consistent with the policy outlined in the Case Management Program Manual. As a result, providers must bill with a monthly span date and will not be able to bill for the same procedure code for the same recipient regardless of the provider. This action shall have a retroactive effective date of January 2006 so after recoupment, any additional attempts to bill will be denied. Completion date is expected early 2007.

You may contact Janith Miller at 342-6248 regarding the action to be taken related to this finding.

Sincerely,

Jerry Phillips
Medicaid Director

JLP:JM

CC: Charles Castille
Stan Mead
Kay Gaudet
Darla Ratcliff
Joe Kopsa

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

January 8, 2007

Mr. Steve J. Theriot, CPA
Legislative Auditor
P.O. Box 94397
Baton Rouge, LA 70804-9397

Dear Mr. Theriot:

Below is the response from The Department of Health and Hospitals (DHH), Bureau of Health Services Financing related to the finding dated December 14, 2006 regarding **Improper Claims by Non-Emergency Transportation Service Providers:**

- DHH concurs with the findings. We agree that the providers and claims reviewed were not in accordance with Medicaid policies and procedures. Providers must maintain all MT-3's, MT-8's and MT-9's for all trips reimbursed by Louisiana Medicaid. Failure to do so is not acceptable. The issue regarding the provider that is no longer in business due to Hurricane Katrina is a unique situation due to the severe impact of the storm.
- Corrective Action:
  - Contact: Randy Davidson at 225/342-4818
  - Program Integrity is taking action for recoupment of the inappropriately paid claims. Joe Kopsa (225/342-4150) is the contact for Program Integrity.
    - A letter will be sent in early 2007 to the appropriate providers regarding the action to be taken.
    - This action is subject to due process which could delay the completion of this action.
  - Program Operations is implementing procedural and systematic changes to capitated trip methodology to prevent payment until all scheduled services have been provided. Medical Dispatch, the contractor that prior authorizes and schedules all NEMT trips has been authorized to set the date of service for all capitated trips as the last day of the month instead of the current methodology of using the first day of the month. This will ensure that no payment is made until the month in which all trips are scheduled to take place is completed.

- Completion date is expected to be by January 31, 2007.

DHH has controls in place to ensure that only appropriate claims are paid. All NEMT trips must be prior authorized and are issued a prior authorization number. Without this prior authorization number, the MMIS system will not pay the claim. However, DHH recognizes that just because a trip is prior authorized and billed, that does not guarantee the service was provided. DHH systematically performs post pay review to ensure services billed were actually provided. Mechanisms are in place to collect money paid to providers for inappropriately paid claims.

You may contact Randy Davidson at 342-4818 regarding the action to be taken related to this finding.

Sincerely,

Jerry Phillips
Medicaid Director

JLP:RD

CC: Charles Castille
Stan Mead
Kay Gaudet
Darla Ratcliff
Joe Kopsa

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

January 26, 2007

Mr. Stephen J Theriot, C.P.A.
Legislative Auditor
1600 North Third Street
P.O. Box 94397
Baton Rouge, LA 70804-9397

Dear Mr. Theriot:

Re: Single Audit Finding—Improper Claims by Long Term Personal Care Service Providers

Please accept this letter as a response to the Legislative Auditor finding regarding Improper Claims by Long Term Personal Care Service Providers dated January 4, 2007. It is our understanding that the Legislative Auditor's position is that this finding occurred because providers of Long Term Personal Care Service (LT-PCS) failed to follow established Department of Health and Hospital (DHH) regulations and policies for providing services according to the plan of care and for inadequately documenting those services. DHH concurs with this finding.

Background Information
On November 1, 2005, as a result of Governor Blanco's Health Care Reform initiative, the Bureau of Community Supports and Services (BCSS) within DHH was restructured and renamed the Division of Long Term Supports and Services (DLTSS). DLTSS is responsible for the administration of the EDA Waiver, Adult Day Health Care (ADHC) Waiver, Long Term-Personal Care Services (LT-PCS), Support Coordination Services—HIV, and the development of a Medicaid Adult Residential Care Waiver and Program of All-Inclusive Care for the Elderly (PACE).[1]

The Health Standards Section (HSS) within DHH is responsible for conducting the monitoring function of LT-PCS providers. Currently, during its annual licensing surveys, HSS reviews a minimum of 5% provider client record sample at the provider agency. HSS ensures that monitoring procedures are standardized and that samples are representative and non-duplicative. Corrective action is required by the provider agency where documentation deficiencies are noted. If a pattern of aberrant/irregular/improper provider documentation practices is suspected, HSS refers the matter to DHH's

[1]Oversight of the LT-PCS program previously resided in the Bureau of Health Services Financing. DLTSS has been transferred to the Office of Aging and Adult Services.

Surveillance Utilization Review System (SURS). SURS will, if appropriate, conduct a thorough review of a given provider's records and impose sanctions as warranted (i.e., recoup monies, exclude from participating in the Medicaid program, etc.).

Additionally, in order to meet the objective of improving the efficiency and effectiveness of licensing direct care service providers, the current licensing regulations are undergoing review. This review will ultimately serve to streamline standards and assure compliance with federal and state requirements and ensure that they support DHH's service delivery vision, values, and guiding principles.

Corrective Action Plan
Where appropriate, providers will be referred to Medicaid SURS for review, and if required, referral to the Medicaid Fraud Control Unit within the Attorney General's office. Medicaid SURS will also do pre-payment review on select providers to determine compliance with program requirements before payments are released to the selected provider.

DHH's official response is attached as requested. Rick Henley of the Office of Aging and Adult Services (OAAS) is the contact person responsible for corrective action. You may contact Mr. Henley at 225-219-0209.

Sincerely,

Jerry Phillips
Medicaid Director

JLP/HE:rh

Attachment

cc: Charles Castille
Hugh Eley
Kay Gaudet
Stan Mead
Lisa Deaton

Improper Claims by Long Term Personal Care Service Providers

Error Noted: Failing to deliver weekly units of service according to the plan of care (service plan).

Corrective Action: Where appropriate, providers will be referred to Medicaid SURS for review, and if required, referral to the Medicaid Fraud Control Unit within the Attorney General's office. Medicaid SURS will also do pre-payment review on select providers to determine compliance with program requirements before payments are released to the selected provider.

DHH will continue to reinforce provider compliance with service delivery and documentation requirements through training and technical assistance. Memoranda will be issued by OASS to all service providers that will reiterate the requirement that services should be provided in accordance with the service plan (and properly documented when services are not).

DHH will issue letters to providers with errors noted in this category requesting plans of correction. Failure of the provider to submit an approvable plan of correction will result in a referral to HSS for sanctions. We anticipate that this corrective action will be complete in 120 days.

Error Noted: Failing to maintain adequate documentation of the units of service provided.

Corrective Action: Where appropriate, providers will be referred to Medicaid SURS for review, and if required, referral to the Medicaid Fraud Control Unit within the Attorney General's office. Medicaid SURS will also do pre-payment review on select providers to determine compliance with program requirements before payments are released to the selected provider.

DHH will continue to reinforce provider compliance with proper documentation and correct billing practices through training and technical assistance. Additionally, memoranda will be issued by OAAS to all service providers that will reiterate documentation requirements.

OAAS will issue letters to providers with errors noted in this category requesting plans of correction. Failure of the provider(s) to submit an approvable plan of correction will result in a referral to HSS for sanctions. We anticipate that this corrective action will be complete in 120 days.

Error Noted: Billing for more units than worked.

Corrective Action: Where appropriate, providers will be referred to Medicaid SURS for review, and if required, referral to the Medicaid Fraud Control Unit within the Attorney General's office. Medicaid SURS will also do pre-payment review on select providers to determine compliance with program requirements before payments are released to the selected provider.

DHH will continue to reinforce provider compliance with proper documentation and correct billing practices through training and technical assistance. Additionally, memoranda will be issued by OAAS to all service providers that will reiterate documentation requirements.

OAAS will issue letters to providers with errors noted in this category requesting plans of correction and requesting that monies collected on invalid billings be returned. Failure of the provider(s) to submit an approvable plan of correction will result in a referral to HSS for sanctions. We anticipate that this corrective action will be complete in 120 days.

Error Noted: Billing while the recipient was hospitalized.

Corrective Action: Where appropriate, providers will be referred to Medicaid SURS for review, and if required, referral to the Medicaid Fraud Control Unit within the Attorney General's office. Medicaid SURS will also do pre-payment review on select providers to determine compliance with program requirements before payments are released to the selected provider.

Prior to the receipt of the Legislative Auditor's findings, DHH authorized a project which identified all LT-PCS providers who billed for procedure codes T1019 or Z0200 during dates of inpatient admission. 148 providers were identified as a result and the following sanctions were imposed (note that these counts are duplicated, i.e., all sanctions/actions for one case or one provider are counted):
144 education sessions
7 internal referrals
68 voluntary payments totaling $45,408.57
5 referrals to Provider Enrollment
4 referrals to the Attorney General's Office

DHH will continue to reinforce provider compliance with proper billing practices through training and technical assistance. Additionally, memoranda will be issued by OAAS to all service providers that will reiterate that payment for LT-PCS for participants who are inpatients hospital is not allowable.

OAAS will issue a letter to the provider noted in this category requesting a plan of correction and requesting that monies collected on invalid billings be returned. Failure of the provider to submit an approvable plan of correction will result in a referral to HSS for sanctions. We anticipate that this corrective action will be complete in 120 days.

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
Frederick P. Cerise, M.D., M.P.H
SECRETARY

February 16, 2007

Mr. Steve J. Theriot, CPA, Legislative Auditor
Office of Legislative Auditor
P. O. Box 94397
Baton Rouge, LA 70804-9397

Dear Mr. Theriot:

RE: Ineffective Medicaid Eligibility Quality Control System

Please refer to your correspondence dated January 22, 2007 reporting a Department of Health & Hospitals audit finding of an Ineffective Medicaid Eligibility Quality Control System. The Department concurs with the finding that during some months the minimum number of Quality Control reviews was not met.

In the aftermath of Hurricane Katrina, some Quality Control staff were temporarily reassigned to a special project to determine the whereabouts of Medicaid enrollees in our home and community based waivers who were displaced. The Department discussed a waiver of adherence to our approved Quality Control Pilot but Louisiana's final approved Katrina 1115 Waiver did not contain this language.

Corrective Action Plan

- Effective May of 2006 DHH resumed adherence to our Medicaid Eligibility Quality Control approved plan and we have been in full compliance since that date.

- The following will be incorporated into the next annual Quality Control Pilot Plan submitted to CMS for approval. "In the event of a disaster such as a major hurricane we may suspend this plan and divert Quality Control staff to alternative tasks related to recipient eligibility integrity."

Person Responsible: Joe Kopsa, DHH Program Manager 4, Medicaid Program Integrity Section Chief, Lou Ann Owen DHH Program Manager 4, Medicaid Eligibility Policy, Doretha Davis, Medicaid Quality Control Program Supervisor

Completion Date: March 15, 2007.

If you have any questions or concerns regarding this finding, please contact Joe Kopsa of my staff at 225 219 4150

Sincerely,

Jerry Phillips
Medicaid Director

JLP:jk

cc: Charles Castille, Undersecretary
Stan Mead, Director, Fiscal Services

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H
SECRETARY

February 16, 2007

Mr. Steve J. Theriot, CPA, Legislative Auditor
Office of Legislative Auditor
P. O. Box 94397
Baton Rouge, LA 70804-9397

Dear Mr. Theriot:

RE: Failure to Maintain Adequate Third Party Liability Documentation

Please refer to your correspondence dated January 22, 207 reporting a Department of Health & Hospitals audit finding of Failure to Maintain Adequate Third Party Liability Documentation. DHH concurs with this finding.

Some of the cases which formed the basis of this finding are TANF cash assistance cases. The Office of Family Services (OFS) within the Department of Social Services (DSS) determines eligibility and maintains the physical case record. TANF recipients in Louisiana are automatically entitled to receive Medicaid, and eligibility is transmitted nightly through an electronic interface between the OFS eligibility system (L'AMI) and DHH Medicaid eligibility system (MEDS). For cash cases, DHH does not maintain in either physical or electronic form the case record which includes the application form and which previously included the TPL notification. The Department was unaware that OFS had inadvertently removed the Third Party Liability information from the joint application.

Corrective Action Plan

- The Department initiated discussions with the Department of Social Services, Office of Family Support to reinstate the Third Party Liability notification as part of the application process for cash assistance and Medicaid. Instead of including this notification in the Rights and Responsibilities section of the application, DSS will provide the notification by means of an application addendum "flyer" that the applicant will sign at application.

- In order to properly document that this information has been given to the enrollee, this addendum will be filed and kept as part of the permanent case record that is maintained by OFS. We have obtained written clearance from the Center for

Medicare & Medicaid Services (CMS) Regional Office in Dallas that this procedure fulfils the federal requirement relative to TPL notification.

- To reduce the likelihood of future changes to TANF policies, procedures, and forms having unintended consequences on Medicaid eligibility and vice versa, proposed changes to policies, procedures and forms will be circulated between the Departments to elicit feedback, prior to changes being made final.

Persons responsible: 1) Lou Ann Owen, DHH Program Manager 4, Medicaid Eligiblity Policy Section Chief and 2)Pam Rosette, Assistant Director, Program Policy Section, OFS.

Anticipated Completion Date: March 15, 2007.

If you have any questions or concerns regarding this finding, please contact Lou Ann Owen of my staff at 225-342-4094.

Sincerely,

Jerry Phillips
Medicaid Director

JLP:lao

cc: Charles Castille, Undersecretary
Stan Mead, Director, Fiscal Services

Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Frederick P. Cerise, M.D., M.P.H.
SECRETARY

February 16, 2007

Mr. Steve. J. Theriot, CPA, Legislative Auditor
Office of Legislative Auditor
P.O. Box 94397
Baton Rouge, LA 94397

Dear Mr. Theriot:

RE: Inadequate Conversion to Electronic Case Records for Medicaid Eligibility Finding

Please refer to your correspondence dated January 22, 2007 reporting a Department of Health & Hospitals audit finding Inadequate Conversion to Electronic Case Records for Medicaid Eligibility. In regard to this finding, we concur.

We acknowledge that the conversion from paper financial eligibility case records to an electronic storage system was a challenging undertaking. Louisiana Medicaid is one of the first states in the nation to engage in such a conversion. The initial conversion from paper records to the Electronic Case Record (ECR) occurred during a 12 month phase-in period starting in April 2004. New applications along with associated documents were scanned into the ECR and renewals were entered as they became due and were processed. Expectations were that sufficient documentation would be scanned into the ECR, which along with the information contained in the Medicaid Eligibility Data System (MEDS), and other ancillary systems, that eligibility for Medicaid services would be clearly established. It was recognized that over time all relevant paper records would be converted to the ECR, but that until that happened that eligibility records would continue to exist in both paper and electronic form. The record retention requirement of six years was not altered by conversion to the ECR.

We are concerned that the Legislative Auditor could not verify that all factors of eligibility were met on 25 cases that they reviewed. Our first concern was to determine definitively if this was an issue solely of adequate documentation of the complex eligibility determination process or if in fact any of these individuals were ineligible for Medicaid services during the review period of calendar year 2005. We are in the course of reviewing the 25 deficient cases to determine if in fact all eligibility factors were met for calendar year 2005. We have finished the review in 20 of the 25 cases and it has been determined that all factors of eligibility were met for these individual during the calendar year 2005. The other five records are still under review and will be reported later. We acknowledge assignment of rights documentation is missing on some of these records and some paper records were destroyed during Hurricane Katrina and are no longer available. In fact, without the ECR the impact of Hurricane Katrina on destruction of Medicaid paper eligibility records would have been devastating!

Corrective Action Plan
The issue to be addressed is adequate documentation in the ECR, MEDS and ancillary systems to

allow an independent reviewer to follow the eligibility determination process and arrive at the same eligibility decision. Don Gregory, DHH Program Manager 4, is responsive for corrective action. We have and/are taking the following steps to address this finding:

- Eligibility Field Operations state office and regional management staffs were reminded verbally and in writing of the six year record retention requirement. They were instructed that under no circumstances should record materials that have not been imaged be destroyed until six years has elapsed. COMPLETE

- Two regional management meetings were held in January and February 2007, the issue raised by this audit finding was discussed in detail along with ways to insure adequate documentation of eligibility decisions. COMPLETE

- Eligibility caseworkers and first line managers are being advised of the importance of adequate documentation of their actions and minutes documenting this will be maintained in the Field Operations Section. ANTICIPATED COMPLETION DATE: March 31, 2007

- Training along with guidance on adequate documentation is under development and will be conducted. ANTICIPATED COMPLETION DATE: April 30, 2007

- Standard case activity log statements for the ECR are under development to assist staff with documentation of actions taken to determine eligibility. ANTICIPATED COMPLETION DATE: March 31, 2007

- It was recommended that DHH review **all** electronic case records to determine that all required information is present. We will undertake to complete this task with the annual renewal of each eligibility case. The standard we will strive to achieve is that any independent reviewer should be able to follow behind the eligibility determination process and arrive at the same eligibility determination. ANTICIPATED COMPLETION DATE: March 31, 2008

If additional information is needed, please contact Don Gregory at 225-342-9119.

Sincerely

Jerry Phillips
Medicaid Director

JLP:dg

cc: Charles Castille, Undersecretary
Stan Mead, Director, Fiscal Services