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

MANAGEMENT LETTER
ISSUED MARCH 10, 2010

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

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA

January 27, 2010

DEPARTMENT OF HEALTH AND HOSPITALS
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, 2009, 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 Reports of the Department of Health and Hospitals (Baton Rouge Main Office Operations) are not audited or reviewed by us, and, accordingly, we do not express an opinion on these reports. 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, 2008, we reported findings related to ineffective Medicaid eligibility quality control system, improper payments to waiver services providers, noncompliance with state movable property regulations, improper claims by long term personal care services providers, improper payments to non-emergency medical transportation service providers, inappropriate access to the Medicaid eligibility data system, and inadequate internal control over cooperative endeavor agreements. The findings related to ineffective Medicaid eligibility quality control system, noncompliance with state movable property regulations, and inadequate internal control over cooperative endeavor agreements have been resolved by management. The findings related to improper payments to waiver services providers, improper claims by long term personal care services providers, improper payments to non-emergency medical transportation services providers, and inappropriate access to the Medicaid eligibility data system have not been resolved by management and are addressed again in this letter.

Based on the application of procedures referred to previously, all significant findings are included in this letter for management's consideration. All 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, 2009.

Improper Payments to Waiver Services Providers

For the third consecutive year, the Department of Health and Hospitals (DHH) paid Medical Assistance Program (CFDA 93.778) claims for waiver services that were not in accordance with established policies. Waiver services are provided to eligible recipients under the New Opportunities Waiver. These services include individualized and family supports. Regulations and requirements for the delivery of services and payment of claims for this waiver program are established through administrative rules and policy manuals developed by DHH. These regulations include providing services consistent with the approved comprehensive plan of care and maintaining adequate documentation to support services billed.

In a test of 2,405 claims, totaling $1,028,046, paid to six providers for 45 recipients during calendar year 2008, 603 errors (25%) were noted. The errors noted included the following:

- For 499 claims (21%), appropriate units 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 daily. The recipient record did not contain documentation as to why the services were not provided according to the plan of care.

- For 102 claims (4%), auditors were unable to determine if services provided were consistent with the plan of care because the provider could not provide the recipient's plan of care.

- For 252 claims (10%), the providers did not maintain adequate time sheets and/or progress notes to support the units of service billed.

- One (17%) of six providers did not maintain required quarterly progress notes.

These conditions occurred because DHH paid waiver services claims even though providers failed to follow established DHH policies and federal regulations for providing services. Questioned costs are $33,764, which include $24,469 in federal funds and $9,295 in state matching funds.

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

Improper Claims by Long Term Personal Care Services Providers

For the second consecutive year, DHH paid Medical Assistance Program (Medicaid, CFDA 93.778) claims for Long Term Personal Care Services (LT-PCS) that were not in accordance with established policies and procedures. DHH has established LT-PCS as an optional service under the Medicaid State Plan. DHH 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.

Audit procedures performed on claims totaling $299,992 that were paid to six LT-PCS providers during calendar year 2008 identified the following errors:

- For 221 of 3,241 (7%) claims tested, the provider did not maintain adequate documentation of the units of service provided. This error was noted for all six providers tested.

- For 229 of 3,241 (7%) claims, the provider did not maintain standardized weekly LT-PCS service logs. This error was noted for three of the six providers tested.

- For 205 of 3,059 (7%) claims, the provider did not document deviations from the plan of care. This error was noted for five of the six providers tested.

These conditions occurred because DHH paid LT-PCS claims even though the providers failed to follow established DHH policies and regulations for providing services according to the plan of care and did not adequately document those services. Known questioned costs are $26,180, which include $18,973 of federal funds and $7,207 of state matching funds.

DHH management should establish, implement, and enforce adequate controls to ensure that only appropriate claims for LT-PCS are paid to providers. Management concurred in part with the finding, noting that deviations from the plan of care are allowed if reason for the deviation is adequately documented. Management outlined a plan of corrective action (see Appendix A, pages 5-7).

Additional Comment: Management noted that deviations from the plan of care are allowed if adequately documented. The finding only included exceptions for deviation from the plan of care when adequate documentation was not provided.

Improper Payments to Non-Emergency Medical Transportation Service Providers

For the second consecutive year, DHH paid claims to providers of Non-Emergency Medical Transportation (NEMT) for services billed to the Medical Assistance Program (CDFA 93.778) that were not provided in accordance with established policies. NEMT is defined as transportation for Medicaid recipients to and/or from a provider of Medicaid covered services. The NEMT program's *Provider Manual* requires that providers maintain the following:

- Copies of all Recipient Verification of Medical Transportation Forms (Form MT-3) as documentation of all trips provided
- 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
- 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
- A daily schedule of transports

A review of 153 claims totaling $39,091 paid to six providers during calendar year 2008 identified errors for all six providers. The errors noted include the following:

- For 79 of the 153 (52%) claims tested, 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 under capitated (monthly) rates. Questioned costs totaled $26,169.
- Five of the six providers tested did not maintain an adequate daily schedule of transports in their records.
- Five of the six providers tested did not maintain adequate documentation to support vehicle certifications (MT-9) in their records.
- Five of the six providers tested did not maintain adequate documentation to support the driver's identification (MT-8) in their records.

These conditions occurred because NEMT providers failed to follow established DHH Bureau of Health Services Financing policies and regulations for providing services and adequately documenting those services, and DHH controls were inadequate in detecting these exceptions. Questioned costs were $26,169, which includes $18,965 of federal funds and $7,204 of state matching funds.

DHH management should establish, implement, and enforce adequate controls to ensure that only appropriate claims for NEMT are paid to providers. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, pages 8-9).

Inappropriate Access to the Medicaid Eligibility Data System

For the second consecutive year, DHH failed to develop and implement adequate internal control over access to the Medicaid Eligibility Data System (MEDS). MEDS is an integral component for processing claims and payments for the Medical Assistance Program (Medicaid, CFDA 93.778). Good internal control over information technology requires a segregation of duties that restricts programmers from performing incompatible duties including performing end user functions, migrating program changes directly to production, or having access to the security application for the production files.

Since DHH does not have a mainframe computer, the MEDS application resides on a mainframe computer that is owned and maintained by another state agency, the Department of Social Services (DSS). The security software program on the DSS mainframe, RACF, is maintained and controlled by DSS personnel, not DHH personnel.

A review of the MEDS security and access revealed the following concerns:

- Forty-eight users with access to the RACF security application possessed rights to alter MEDS production data files, including files that interface daily with the Medicaid Management Information System, which are incompatible functions. These RACF users included 22 MEDS contractors, 14 DHH programmers, 2 DHH database administrators, 1 DSS database administrator, and 9 DSS production control employees.

- Fourteen users had access to perform security administrator functions in MEDS. Of these, only five were charged with security administrator functions. The remaining nine users were either Medicaid Program supervisors and monitors or no longer needed the access. These nine users were also assigned to transaction groups that are normally granted to functional users of MEDS. This incompatible access would allow the programmers to make changes to production data through transactions in MEDS.

Unauthorized or inappropriate system access could adversely affect the integrity and confidentiality of MEDS data. The ability of programmers to migrate changes into production without approval or independent review could allow unauthorized changes to the production environment, and misappropriations and/or errors may not be readily detected.

DHH management should establish controls to ensure that access to MEDS is appropriate and given only for a valid business need and that system programmers are restricted from incompatible duties, including migrating program changes to production without authorization and review. Management concurred with the finding and outlined a corrective action plan (see Appendix A, pages 10-11).

Ineligible Medicaid Payments for State Transportation Services

DHH used funds from the Medical Assistance Program (Medicaid, CFDA 93.778) to pay for a state-funded Non-Emergency Medical Transportation (NEMT) program. Act 16 of the 2006 Regular Session included an appropriation of $100,000 to make payments to private providers for a state-funded NEMT program for dialysis and cancer patients in Orleans Parish who did not qualify for such services under Medicaid eligibility guidelines. To track these claims, DHH set up a separate procedure code in the accounting system. The claims charged to this procedure code should have been paid only with state funds.

In a review of 499 claims for the state program NEMT services paid in calendar years 2006, 2007, and 2008, all claims were identified as charged to the Medicaid program. Audit procedures disclosed that 494 claims, totaling $70,149, were paid for recipients who were not eligible for Medicaid.

These errors occurred because DHH improperly classified state NEMT program transactions to the Medicaid program. As a result, DHH used $50,837 in federal funds to pay for a state-funded program. Since $19,312 of the total $70,149 was paid with state matching funds, questioned costs total $50,837.

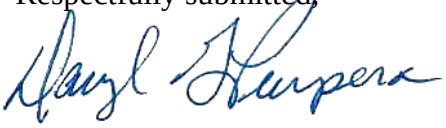
DHH should establish procedures to ensure that claims for the state NEMT program are paid only from state funds. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, pages 12-13).

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 costs, 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's compliance with applicable laws and regulations should be addressed immediately by management.

In addition, we have included Budgetary Comparison Schedules, which were prepared from the Annual Fiscal Reports of the Department of Health and Hospitals and from additional data in the Integrated Statewide Information System (ISIS), the state's accounting system. These schedules are presented as additional information but have not been subjected to auditing procedures.

This letter is intended for the information and use of the department and its management, others within the entity, and the Louisiana Legislature 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,



Daryl G. Purpera, CPA, CFE
Temporary Legislative Auditor

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DEPARTMENT OF HEALTH AND HOSPITALS
AGENCY 303 -- DEVELOPMENTAL DISABILITIES COUNCIL

Budgetary Comparison Schedule
For the Fiscal Year Ended June 30, 2009

APPROPRIATED REVENUES:

	TOTAL BEFORE ADJUSTMENTS	AGENCY ADJUSTMENTS	ADJUSTED TOTAL	REVISED BUDGET	VARIANCE FAVORABLE (UNFAVORABLE)
State general revenue	$713,482		$713,482	$713,482	
Federal aid	1,436,353	($20,492)	1,415,861	1,562,730	($146,869)
Total Appropriated Revenues	$2,149,835	($20,492)	$2,129,343	$2,276,212	($146,869)

APPROPRIATED EXPENDITURES:

	DEVELOPMENTAL DISABILITIES COUNCIL
Salaries	$412,048
Other compensation	13,817
Related benefits	138,709
Travel and training	38,957
Operating services	69,200
Supplies	6,717
Other charges	1,423,148
Interagency transfers	26,633
Total appropriated expenditures before adjustments	2,129,229
System adjustments	(9,166)
Total Appropriated Expenditures	2,120,063
Revised Budget	2,276,212
Variance Favorable (Unfavorable)	$156,149

NOTE: This schedule was prepared using information from the Budgetary Comparison Schedule (Schedule 1) in the agency's Annual Fiscal Report and the ISIS 2G15 report (Appropriation Report by Agency).

Additional detail is available on request.

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DEPARTMENT OF HEALTH AND HOSPITALS
AGENCY 305 -- MEDICAL VENDOR ADMINISTRATION

Budgetary Comparison Schedule
For the Fiscal Year Ended June 30, 2009

APPROPRIATED REVENUES:

	TOTAL BEFORE ADJUSTMENTS	AGENCY ADJUSTMENTS	ADJUSTED TOTAL	REVISED BUDGET	VARIANCE FAVORABLE (UNFAVORABLE)
State general revenue	$72,283,726		$72,283,726	$72,468,999	($185,273)
Federal aid	117,864,598	($7,517,339)	110,347,259	135,975,153	(25,627,894)
General Fnd-SGR	2,087,402		2,087,402	2,190,339	(102,937)
General Fund- IAT	774,780		774,780	3,519,155	(2,744,375)
Nursing Home Residents Trust	203,342		203,342	203,342	
Health Trust Fund	1,949		1,949	2,056	(107)
New Opportunities Waiver Fund	1,885,465		1,885,465	1,885,465	
Overcollection Fund	573,650		573,650	573,650	
Total Appropriated Revenues	$195,674,912	($7,517,339)	$188,157,573	$216,818,159	($28,660,586)

APPROPRIATED EXPENDITURES:

	MEDICAL VENDOR ADMINISTRATION	ACT 672 AND HIRING FREEZE	TOTAL
Salaries	$60,025,726		$60,025,726
Other compensation	1,140,624		1,140,624
Related benefits	20,468,141		20,468,141
Travel and training	643,135		643,135
Operating services	8,538,838		8,538,838
Supplies	957,717		957,717
Professional services	72,109,236		72,109,236
Other charges	2,718,790		2,718,790
Capital outlay	2,195,726		2,195,726
Interagency transfers	17,477,890		17,477,890
Total appropriated expenditures before adjustments	186,275,823	NONE	186,275,823
System adjustments	(142,885)		(142,885)
Total Appropriated Expenditures	186,132,938	NONE	186,132,938
Revised Budget	216,609,485	$208,674	216,818,159
Variance Favorable (Unfavorable)	$30,476,547	$208,674	$30,685,221

NOTE: This schedule was prepared using information from the Budgetary Comparison Schedule (Schedule 1) in the agency's Annual Fiscal Report and the ISIS 2G15 report (Appropriation Report by Agency).

Additional detail is available on request.

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DEPARTMENT OF HEALTH AND HOSPITALS
AGENCY 306 -- MEDICAL VENDOR PAYMENTS

Budgetary Comparison Schedule
For the Fiscal Year Ended June 30, 2009

APPROPRIATED REVENUES:

	TOTAL BEFORE ADJUSTMENTS	AGENCY ADJUSTMENTS	ADJUSTED TOTAL	REVISED BUDGET	VARIANCE FAVORABLE (UNFAVORABLE)
State general revenue	$1,158,230,748		$1,158,230,748	$1,164,869,889	($6,639,141)
Federal aid	5,012,610,433	$34,495,302	5,047,105,735	5,287,339,594	(240,233,859)
General Fund-SGR	16,889,732	4,764,072	21,653,804	5,766,082	15,887,722
General Fund- IAT	52,880,703	4,476,123	57,356,826	11,491,469	45,865,357
Louisiana Medical Assistance Trust Fund	198,385,591		198,385,591	198,385,591	
Medical Assistance Program Fraud Detection Fund	2,677,967		2,677,967	3,131,547	(453,580)
Medicaid Trust Fund for the Elderly	46,137,618		46,137,618	46,137,618	
Health Trust Fund	15,308,853		15,308,853	16,150,476	(841,623)
New Opportunities Waiver Fund	17,723,055		17,723,055	17,723,055	
Louisiana Fund	6,696,071		6,696,071	6,696,071	
Health Excellence Fund	20,532,059		20,532,059	20,532,059	
Total Appropriated Revenues	$6,548,072,830	$43,735,497	$6,591,808,327	$6,778,223,451	($186,415,124)

APPROPRIATED EXPENDITURES:

	PAYMENTS TO PRIVATE PROVIDERS	PAYMENTS TO PUBLIC PROVIDERS	MEDICARE BUY-INS AND SUPPLEMENTS	UNCOMPENSTATED CARE COSTS	RECOVERY FUNDS	TOTAL
Other charges	$4,418,117,819	$225,218,671	$293,153,462	$158,707,855	$41,449,676	$5,136,647,483
IAT	236,509	568,207,983	150,000	686,576,799	1,582,401	1,256,753,692
Total appropriated expenditures before adjustments	4,418,354,328	793,426,654	293,303,462	845,284,654	43,032,077	6,393,401,175
System adjustments			(2,635)			(2,635)
Total Appropriated Expenditures	4,418,354,328	793,426,654	293,300,827	845,284,654	43,032,077	6,393,398,540
Revised Budget	4,638,392,654	810,031,302	316,255,963	966,209,656	47,333,876	6,778,223,451
Variance Favorable (Unfavorable)	$220,038,326	$16,604,648	$22,955,136	$120,925,002	$4,301,799	$384,824,911

NOTE: This schedule was prepared using information from the Budgetary Comparison Schedule (Schedule 1) in the agency's Annual Fiscal Report and the ISIS 2G15 report (Appropriation Report by Agency).

Additional detail is available on request.

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DEPARTMENT OF HEALTH AND HOSPITALS
AGENCY 307 -- OFFICE OF THE SECRETARY

Budgetary Comparison Schedule
For the Fiscal Year Ended June 30, 2009

APPROPRIATED REVENUES:

	TOTAL BEFORE ADJUSTMENTS	AGENCY ADJUSTMENTS	ADJUSTED TOTAL	REVISED BUDGET	VARIANCE FAVORABLE (UNFAVORABLE)
State general revenue	$59,008,045		$59,008,045	$59,067,978	($59,933)
Federal Aid	22,504,473	(10,114,430)	12,390,043	64,181,805	(51,791,762)
General Fund-SGR	5,792,631		5,792,631	6,733,250	(940,619)
General Fund- IAT	5,372,061		5,372,061	20,550,336	(15,178,275)
Louisiana Health Care Redesign Fund	875,334		875,334	875,334	
Overcollection Fund	11,388,965		11,388,965	11,388,965	
Louisiana Fund	474,415		474,415	474,415	
Total Appropriated Revenues	$105,415,924	($10,114,430)	$95,301,494	$163,272,083	($67,970,589)

APPROPRIATED EXPENDITURES:

	MANAGEMENT AND FINANCE PROGRAM	GRANTS PROGRAM	AUXILIARY PROGRAM	ACT 672 AND HIRING FREEZE	TOTAL
Salaries	$24,186,774		$132,978		$24,319,752
Other compensation	1,036,107				1,036,107
Related benefits	8,129,994		34,988		8,164,982
Travel and training	482,672		379		483,051
Operating services	4,229,142		3,912		4,233,054
Supplies	440,803		358		441,161
Professional services	6,409,547				6,409,547
Other charges	20,572,625	$18,899,766	78		39,472,469
Capital outlay	224,241				224,241
Interagency transfers	10,256,113		1,920		10,258,033
Total appropriated expenditures before adjustments	75,968,018	18,899,766	174,613	NONE	95,042,397
System adjustments		(1,446,974)			(1,446,974)
Agency adjustments	5,209,928				5,209,928
Total Appropriated Expenditures	81,177,946	17,452,792	174,613	NONE	98,805,351
Revised Budget	104,411,074	58,580,828	220,248	$59,933	163,272,083
Variance Favorable (Unfavorable)	$23,233,128	$41,128,036	$45,635	$59,933	$64,466,732

NOTE: This schedule was prepared using information from the Budgetary Comparison Schedule (Schedule 1) in the agency's Annual Fiscal Report and the ISIS 2G15 report (Appropriation Report by Agency).

Additional detail is available on request.

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DEPARTMENT OF HEALTH AND HOSPITALS
AGENCY 320 -- OFFICE OF AGING AND ADULT SERVICES

Budgetary Comparison Schedule
For the Fiscal Year Ended June 30, 2009

APPROPRIATED REVENUES:

	TOTAL BEFORE ADJUSTMENTS	AGENCY ADJUSTMENTS	ADJUSTED TOTAL	REVISED BUDGET	VARIANCE FAVORABLE (UNFAVORABLE)
State general revenue	$14,725,939		$14,725,939	$15,175,828	($449,889)
Federal aid	1,681,052	($296,010)	1,385,042	2,928,909	(1,543,867)
General Fund-SGR	2,365,814	(580,729)	1,785,085	1,733,332	51,753
General Fund- IAT	23,816,941		23,816,941	32,195,255	(8,378,314)
Health Trust Fund	417,503		417,503	440,456	(22,953)
Overcollection Fund	57,708		57,708	57,708	
Total Appropriated Revenues	$43,064,957	($876,739)	$42,188,218	$52,531,488	($10,343,270)

APPROPRIATED EXPENDITURES:

	ADMINISTRATION PROTECTION AND SUPPORT	JOHN J. HAINKEL, JR., HOME AND REHAB CENTER	VILLA FELICIANA MEDICAL COMPLEX	AUXILIARY ACCOUNT	TOTAL
Salaries	$8,235,128	$4,446,417	$10,866,159		$23,547,704
Other compensation	355,083	17,858	610,805		983,746
Related benefits	2,283,824	1,232,282	4,582,323		8,098,429
Travel & training	185,235	11,493	1,000		197,728
Operating services	396,562	544,320	783,094		1,723,976
Supplies	96,193	746,153	1,399,873		2,242,219
Professional services	297,332	135,129	386,422		818,883
Other charges	2,083,797	8,932	(38)	$18,681	2,111,372
Capital outlay	48,650	26,610	7,981		83,241
Interagency transfers	483,193	555,534	1,456,466		2,495,193
Total appropriated expenditures before adjustments	14,464,997	7,724,729	20,094,085	18,681	42,302,489
System adjustments			(6,956)		(6,956)
Total Appropriated Expenditures	14,464,997	7,724,729	20,087,129	18,681	42,295,536
Revised Budget	24,346,439	7,995,140	20,130,409	59,500	52,531,488
Variance Favorable (Unfavorable)	$9,881,442	$270,414	$43,280	$40,819	$10,235,952

NOTE: This schedule was prepared using information from the Budgetary Comparison Schedule (Schedule 1) in the agency's Annual Fiscal Report and the ISIS 2G15 report (Appropriation Report by Agency).

Additional detail is available on request.

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DEPARTMENT OF HEALTH AND HOSPITALS
AGENCY 324 -- LOUISIANA EMERGENCY RESPONSE NETWORK

Budgetary Comparison Schedule
For the Fiscal Year Ended June 30, 2009

APPROPRIATED REVENUES:

	TOTAL BEFORE ADJUSTMENTS	AGENCY ADJUSTMENTS	ADJUSTED TOTAL	REVISED BUDGET	VARIANCE FAVORABLE (UNFAVORABLE)
State General Revenue	$4,077,948		$4,077,948	$4,397,790	($319,842)
Total Appropriated Revenues	$4,077,948	NONE	$4,077,948	$4,397,790	($319,842)

APPROPRIATED EXPENDITURES:

	LOUISIANA EMERGENCY RESPONSE NETWORK
Salaries	$245,859
Related benefits	58,717
Travel & training	29,456
Operating services	59,298
Supplies	23,013
Professional services	1,958,308
Other charges	500
Capital outlay	1,492,960
Interagency transfers	18,147
Total appropriated expenditures before adjustments	3,886,258
Total Appropriated Expenditures	3,886,258
Revised Budget	4,397,790
Variance Favorable (Unfavorable)	$511,532

NOTE: This schedule was prepared using information from the Budgetary Comparison Schedule (Schedule 1) in the agency's Annual Fiscal Report and the ISIS 2G15 report (Appropriation Report by Agency).

Additional detail is available on request.

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UNAUDITED

DEPARTMENT OF HEALTH AND HOSPITALS
AGENCY 330 -- OFFICE OF MENTAL HEALTH

Budgetary Comparison Schedule
For the Fiscal Year Ended June 30, 2009

APPROPRIATED REVENUES:

	TOTAL BEFORE ADJUSTMENTS	AGENCY ADJUSTMENTS	ADJUSTED TOTAL	REVISED BUDGET	VARIANCE FAVORABLE (UNFAVORABLE)
State general revenue	$22,328,908		$22,328,908	$22,328,908	
Federal aid	25,276,469	($8,052,261)	17,224,208	27,398,580	($10,174,372)
General Fund- IAT	11,603,206		11,603,206	11,770,029	(166,823)
Total Appropriated Revenues	$59,208,583	($8,052,261)	$51,156,322	$61,497,517	($10,341,195)

APPROPRIATED EXPENDITURES:

	ADMINISTRATION AND SUPPORT	COMMUNITY MENTAL HEALTH PROGRAM	TOTAL
Salaries	$1,841,416	$3,385,699	$5,227,115
Other compensation	200,737	11,223,529	11,424,266
Related benefits	1,611,363	2,529,136	4,140,499
Travel & training	68,884	99,615	168,499
Operating services	38,123	387,647	425,770
Supplies	45,170	94,359	139,529
Professional services	350,616	735,067	1,085,683
Other charges	463,969	16,549,714	17,013,683
Interagency transfers	704,846	10,157,714	10,862,560
Total appropriated expenditures before adjustments	5,325,124	45,162,480	50,487,604
System adjustments	(8,901)	(57,960)	(66,861)
Total Appropriated Expenditures	5,316,222	45,104,520	50,420,742
Revised Budget	7,023,852	54,473,665	61,497,517
Variance Favorable (Unfavorable)	$1,707,630	$9,369,145	$11,076,775

NOTE: This schedule was prepared using information from the Budgetary Comparison Schedule (Schedule 1) in the agency's Annual Fiscal Report and the ISIS 2G15 report (Appropriation Report by Agency).

Additional detail is available on request.

DEPARTMENT OF HEALTH AND HOSPITALS
AGENCY 340 -- OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Budgetary Comparison Schedule
For the Fiscal Year Ended June 30, 2009

APPROPRIATED REVENUES:

	TOTAL BEFORE ADJUSTMENTS	AGENCY ADJUSTMENTS	ADJUSTED TOTAL	REVISED BUDGET	VARIANCE FAVORABLE (UNFAVORABLE)
State general revenue	$39,163,843		$39,163,843	$39,163,843	
Federal aid	8,591,103	($7,598,430)	992,673	6,847,201	($5,854,527)
General Fund-SGR	9,709,008	(3,725,906)	5,983,102	10,557,480	(4,574,377)
General Fund- IAT	236,163,983	(814,898)	235,349,085	235,349,085	
New Opportunities Waiver Fund	771,506		771,506	771,506	
Overcollection Fund	949,288		949,288	949,288	
Total Appropriated Revenues	$295,348,731	($12,139,234)	$283,209,497	$293,638,403	($10,428,904)

APPROPRIATED EXPENDITURES:

	ADMINISTRATION AND GENERAL SUPPORT	COMMUNITY BASED PROGRAMS	GREATER NEW ORLEANS	NORTH LAKE	SUPPORTS AND NORTHWEST
Salaries	$2,483,740	$9,744,077	$9,918,633	$29,199,441	$12,296,058
Other compensation	38,360	546,399	92,112	749,664	181,018
Related benefits	1,101,407	2,809,078	3,191,216	8,722,950	3,370,845
Travel and training	34,371	194,712	67,147	93,286	73,598
Operating services	33,239	758,173	1,280,742	2,124,160	1,658,537
Supplies	19,626	131,466	580,260	3,192,743	1,317,722
Professional services		4,091,640	657,576	1,598,921	939,978
Other charges	694,947	21,381,368	1,062,079	1,860,111	1,259,058
Capital outlay	21,315	123,246	138,393	1,041,292	168,724
Major repairs			109,959	214,637	
Interagency transfers	577,018	1,708,876	1,282,113	3,169,065	961,850
Total appropriated expenditures before adjustments	5,004,023	41,489,035	18,380,230	51,966,270	22,227,388
System adjustments	(76)	(199)	(1,550)	(21,057)	(1,886)
Total Appropriated Expenditures	5,003,947	41,488,837	18,378,681	51,945,213	22,225,503
Revised Budget	5,859,227	43,914,513	20,917,340	55,117,993	22,550,738
Variance Favorable (Unfavorable)	$855,280	$2,425,676	$2,538,659	$3,172,780	$325,235

NOTE: This schedule was prepared using information from the Budgetary Comparison Schedule (Schedule 1) in the agency's Annual Fiscal Report and the ISIS 2G15 report (Appropriation Report by Agency).

Additional detail is available on request.

SERVICES CENTER					
PINECREST	NORTHEAST	ACADIANA REGION	AUXILIARY ACCOUNT	ACT 672 AND HIRING FREEZE	TOTAL
$65,141,402	$8,204,428	$8,761,845	$90,668		$145,840,292
1,246,974	268,302	82,160			3,204,989
20,579,903	1,961,566	2,798,875	35,860		44,571,700
223,954	66,103	7,045			760,216
5,188,522	601,962	642,958			12,288,293
4,712,514	807,488	766,370			11,528,189
1,289,955	308,399	196,593			9,083,062
3,494,243	850,345	1,347,483	869,822		32,819,456
760,602	141,060	512,449			2,907,081
340,886		143,416			808,898
7,664,669	951,751	942,914			17,258,256
110,643,624	14,161,404	16,202,108	996,350	NONE	281,070,435
(61,045)		(18,605)	(48)		(104,465)
110,582,580	14,161,404	16,183,503	996,301	NONE	280,965,970
112,867,212	14,653,010	16,492,767	1,190,325	$75,278	293,638,403
$2,284,632	$491,605	$309,263	$194,024	$75,278	$12,672,433

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DEPARTMENT OF HEALTH AND HOSPITALS
AGENCY 351 -- OFFICE FOR ADDICTIVE DISORDERS

Budgetary Comparison Schedule
For the Fiscal Year Ended June 30, 2009

APPROPRIATED REVENUES:

	TOTAL BEFORE ADJUSTMENTS	AGENCY ADJUSTMENTS	ADJUSTED TOTAL	REVISED BUDGET	VARIANCE FAVORABLE (UNFAVORABLE)
State general revenue	$45,501,910		$45,501,910	$45,501,910	
Interim Emergency Board	152,832		152,832	684,000	($531,168)
Federal aid	35,098,956		35,098,956	44,273,693	(9,174,737)
General Fund-SGR	591,507		591,507	598,132	(6,625)
General Fund- IAT	12,508,504	($899,916)	11,608,588	11,608,588	
Tobacco Tax Health Care Fund	3,521,634		3,521,634	3,521,634	
Compulsive and problem gambling	2,500,000		2,500,000	2,500,000	
Addictive Disorders Professional Licensing and Certification Fund				68,379	(68,379)
Overcollection Fund	709,010		709,010	709,010	
Total Appropriated Revenues	$100,584,353	($899,916)	$99,684,437	$109,465,346	($9,780,909)

APPROPRIATED EXPENDITURES:

	ADMINISTRATION	PREVENTION AND TREATMENT	AUXILIARY ACCOUNT	TOTAL
Salaries	$1,595,897	$17,679,721		$19,275,618
Other compensation	(21,288)	5,062,678		5,041,390
Related benefits	411,141	6,652,579		7,063,720
Travel & training	57,977	488,358		546,335
Operating services	8,401	1,950,353		1,958,754
Supplies	42,212	1,695,801		1,738,013
Professional services		1,208,263		1,208,263
Other charges		37,301,874		37,301,874
Capital outlay	54,045	830,985		885,030
Major repairs		337,625		337,625
Interagency transfers	615,914	23,603,329		24,219,243
Auxiliary program			$7,224	7,224
Total appropriated expenditures before adjustments	2,764,299	96,811,566	7,224	99,583,090
System adjustment		(65,624)		(65,624)
Total Appropriated Expenditures	2,764,300	96,745,943	7,224	99,517,466
Revised Budget	3,418,470	105,910,876	136,000	109,465,346
Variance Favorable (Unfavorable)	$654,170	$9,164,933	$128,776	$9,947,880

NOTE: This schedule was prepared using information from the Budgetary Comparison Schedule (Schedule 1) in the agency's Annual Fiscal Report and the ISIS 2G15 report (Appropriation Report by Agency).

Additional detail is available on request.

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

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

December 10, 2009

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: Improper Payments to Waiver Service Providers

Please accept this letter as a response to the Legislative Auditor finding regarding Improper Payments to Waiver Services Providers dated November 17, 2009. It is our understanding that the Legislative Auditor's position is that this finding occurred because providers of waiver services submitted claims that were not in accordance with established policies and procedures.

DHH's official response is attached as requested. Jean Melanson of the Office for Citizens with Developmental Disabilities (OCDD) is the contact person responsible for corrective action relative to these claims under the New Opportunity Waiver (NOW). You may contact Mrs. Melanson at 225-342-887. For corrective action relative to claims under the NOW, you may contact either Ms. Jean Melanson at 225-342-8877, or Mr. Charles Ayles at 225-342-6822.

Sincerely,

Jerry Phillips
Medicaid Director

JLP/TD

Attachment

cc: Charles Castille
Kathy Kliebert
Kay Gaudet
Jeff Reynolds

FINDING: **Improper Payments to Waiver Services Providers**

Error Noted: Weekly hours of service were not delivered according to the plan of care approved by DHH.

DHH Response: DHH concurs with this finding.

Waiver participants must have flexibility built into the waiver service delivery process. Current policy allows flexibility through the development of an alternate schedule included in the CPOC. The prior authorization is issued by DHH for these services on a quarterly basis to allow for this flexibility. It is expected that there are circumstances that exist which make delivery of the weekly service hours impractical or impossible; however, OCDD agrees that if the flexibility is not in the alternate schedule, that appropriate documentation should exist in the recipient record explaining the deviation in the schedule.

A memorandum was issued on February 6, 2008 advising all direct service provider agencies of the requirement to clearly document and maintain this documentation supporting reasons for services not being delivered in accordance with the approved plan of care. This documentation should be maintained as part of the recipient records. OCDD reissued this policy statement on March 11, 2009 and posted it on the OCDD Waiver Supports and Services Publications website. OCDD also began the process of including the website information in all Medicaid Waiver Service Provider Enrollment Packets.

Corrective action Plan:

OCDD will continue to reinforce provider compliance with documentation requirements through electronic notifications, training and technical assistance. OCDD will conduct an on-site programmatic audit of the providers in question to review all of the documentation or lack thereof and make recommendations for any further administrative action based on the following criteria:

1. Review all policies to determine if revisions are needed.
2. Issue letters to providers with errors noted in this category requiring plans of correction.
3. Require the providers who were found to be out of compliance to attend training provided by the Program Office(s).
4. Re-issue the policy statement to all providers reiterating our policy and expectations on the documentation of schedule deviation.
5. Verify that documentation policy statements are included in or scheduled for inclusion in the Medicaid Waiver Service Provider enrollment packets to insure that all new providers are aware of the documentation requirements upon enrollment.
6. If there is suspected fraudulent activities or abuse, referral will be made to the Medicaid Waiver Compliance Section for notification to the appropriate entity.

Anticipated completion date is March 15, 2010.

Contacts:

1. NOW Provider Letters: Paul Rhorer at 225-342-8804
2. NOW Policy Activities: Jean Melanson at 225-342-8877
3. NOW Provider Auditing: Charles Ayles at 225-342-6822

Error Noted: Providers could not provide the recipient plan of care to support services provided were consistent with the plan of care.

DHH Response: DHH agrees that the plan of care must be maintained in the recipient record.

Corrective Action Plan:

1. OCDD will notify the direct service provider cited in the audit of this deficiency and the relevant policy requirements and require that appropriate action be taken.
2. If there is suspected fraudulent activities or abuse, OCDD will make referral to the Medicaid Waiver Compliance Section for notification to the appropriate entity.

Anticipated completion date is February 15, 2010.

Contacts:

1. NOW Provider Letters: Paul Rhorer at 225-342-8804

ERROR Noted: Providers did not maintain time sheets and/or progress notes to support the units of service billed.

DHH Response: DHH concurs with this finding.

A memorandum was issued August 31, 2007 to all direct waiver service providers and support coordination agencies advising and reminding them of the minimum requirements for case record documentation as previously advised through memorandum issued April 3, 2001; a memorandum issued August 27, 2007 advised all providers of mandatory training to be conducted by Unisys, the Medicaid Fiscal Intermediary, during the period September 11, 2007 and October 4, 2007; training was conducted by Unisys during the period September 11, 2007 and October 4, 2007 and included detailed information relative to documentation requirements; the September/October 2007 Medicaid Provider Update, Vol. 24, Issue 5, Page 6, advised all waiver service providers of general information concerning documentation requirements; a memorandum issued July 30, 2004 to all direct service provider agencies and support coordination agencies clarified documentation procedures. OCDD/DHH readily provides technical assistance and providers are encouraged to call OCDD/DHH or its contractors if any questions concerning documentation requirements or billing issues arise. OCDD reissued the February 6, 1008 policy statement relative to documenting services not being provided in accordance with the plan of care on March 11, 2009 and posted it on the OCDD Waiver Supports and Services Publications website. OCDD also began the process of including the website information in all Medicaid Waiver Service Provider Enrollment Packets.

Corrective action plan:

OCDD/DHH will continue to reinforce provider compliance with documentation requirements through training and technical assistance. OCDD will establish an audit schedule which will review a sample of providers for both programmatic and fiscal activities. We will specifically look for documentation which supports all activity and review for any inappropriate non-delivery of services.

Upon the establishment of this process, we will review provider records to check for deviations or violations and make recommendations for appropriate action.

In addition, OCDD will:

1. Review all policies to determine if revisions are needed.
2. Issue letters to providers with errors noted in this category requiring plans of correction.
3. Require the providers who were found to be out of compliance to attend training provided by the Program Office(s).
4. Revise if necessary and re-issue the policy statement to all providers reiterating our policy and expectations on the documentation of schedule deviation.
5. Insure all policy statements relative to documentation are placed on the OCDD Waiver Supports and Services Publications website.
6. OCDD will refer all providers to DHH Program Integrity to begin process to recoup all funds paid to providers who did not maintain the required supporting documentation for payment.

Anticipated completion date is March 15, 2010.

Contacts:

1. NOW Provider Letters: Paul Rhorer at 225-342-8804
2. NOW Policy Activities: Jean Melanson at 225-342-8877
3. NOW Provider Auditing: Charles Ayles at 225-342-6822
4. Program Integrity Recoupment: Joe Kopsa at 225-219-4150

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

December 2 2009

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 as the Louisiana Department of Health and Hospitals' (DHH) response to the November 3, 2009 Legislative Auditor finding regarding Improper Claims by Long Term Personal Care Service Providers. 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) submitted claims that were not in accordance with established policies and procedures.

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. Mr. Henley can be reached by telephone at 225-219-0209 and by e-mail at Rick.Henley@LA.GOV.

Sincerely,

Jerry Phillips
Medicaid Director

JLP/HE:rh

Attachment

cc: Charles Castille
Hugh Eley
Kay Gaudet
Jeff Reynolds

Improper Claims by Long Term Personal Care Service Providers

Background:
Before March 1, 2009, units of service for Long Term Personal Care Services were authorized using a very restrictive resource allocation guide, which allowed for very little flexibility of scheduling task performance. Providers complained about the rigid documentation process. Numerous legislative audit findings were noted, many times based on the providers' service logs or lack thereof.

To better address this, OAAS implemented a resource allocation method called Service Hour Allocation of Resources (SHARe) on March 1, 2009. SHARe allows recipients feeedom for flexibility of service delivery within each week, which allows for individual differences or preferences. The time allowed for each task is no longer restrictive, and can be adjusted from day to day within the prior authorized week to reflect changes in the recipients' needs. Assessors of LT-PCS have benefitted from these changes in the care planning process. They no longer have 15 minute increments of time to assign for specific tasks, and instead are able to take a more person-centered approach to care planning. Providers also have less complicated documentation requirements allowing them to respond to recipients' changes in needs throughout the week without the fear of violating rules or procedures.

Shortly after SHARe was implemented, OAAS conducted statewide training with providers. The training advised providers of the SHARe initiative and instructed them on use of the new mandatory service log issued for use effective July 1, 2009. The new service log allows providers to document the provision of both LT-PCS and companion services offered under the Elderly and Disabled Adult Waiver on a single form, though units between the two services are still divided. During this training, providers were also reminded about the need for service logs as well as other general documentation requirements. Additionally, DHH issued documentation memoranda and traning materials to direct service providers and posted same on its website.

Error Noted: Failing to maintain adequate documentation of the units of service provided.
Corrective Action: DHH concurs with this finding. All identified cases will be turned over to Program Integrity for investigation. DHH will continue to reinforce provider compliance with proper documentation and correct billing practices through training and technical assistance. As stated above, training during the spring of 2009 was conducted and memoranda was issued by OAAS that, among other things, reiterated documentation requirements. This information currently can be readily accessed by providers through accessing SHARe Information on the OAAS website at
http://www.oaas.dhh.louisiana.gov

Error Noted: Failure to maintain standardized weekly service logs.

Corrective Action: DHH concurs with this finding. All identified cases will be turned over to Program Integrity for investigation. DHH will continue to reinforce provider compliance with proper documentation and correct billing practices through training and technical assistance. As stated above, training during the Spring of 2009 was conducted and memoranda was issued by OAAS that, among other things, reiterated documentation requirements. This information currently can be readily accessed by providers through accessing SHARe Information on the OAAS website at http://www.oaas.dhh.louisiana.gov

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Error Noted: Failure to document deviations from the plan of care.
Corrective Action: DHH partially concurs with this finding. It is anticipated that there may be some deviation from the plan of care. This can occur due to a number of factors, such as worker not showing up, recipient refusing services, etc. However, while some deviation is expected, it is not acceptable for a provider to deviate from the plan of care without good cause. And when cause is present, it should be documented. As stated above, SHARe allows for feeedom for flexibility of service delivery within each week, which allows for individual differences or preferences. The time of day and amount of time allowed for each task are no longer restrictive, and can be adjusted from day to day to reflect changes in the recipients' needs. Thus, as DHH moves toward a more person-centered and outcome based approach, failure to note deviations from the plan of care should not be viewed as an auditable finding that warrants recoupment. Rather, as long as the deviation is consistent with the recipients needs and preferences, deviation is, and can be warranted. It is noted that the findings were for dates of claims that were before SHARe implementation on March 1, 2009. Delivery of services in accordance with plans of care set prior to implementation and without use of the SHARe methodology are subject to the more rigid adherence to approved time of day and/or amount of time assigned for each task.

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing
Waiver Assistance and Compliance Section

November 3, 2009

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 October 23, 2009 regarding **Improper Payments to 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 daily schedules as well as 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.
- Corrective Action:
  - Contact: Darrell Curtis at (225) 342-6220.
  - 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 February 2010 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.
  - Completion date is expected to be by February 2010.

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

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services billed were actually provided. Mechanisms are in place to collect money paid to providers for inappropriately paid claims.

You may contact Darrell Curtis at 342-6220 regarding the action to be taken related to this finding.

Sincerely,

Jerry Phillips
Medicaid Director

JP:RD:wdc

CC: Charles Castille
Ray Dawson
Randy Davidson
Joe Kopsa
Jeff Reynolds

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

November 23, 2009

Steve J. Theriot, CPA
Legislative Auditor
1600 North Third Street
Post Office Box 94397
Baton Rouge, Louisiana 70804-9397

RE: DHH Information Technology Audit
Inappropriate Access to MEDS Production Files

Below is the response from the Department of Health and Hospitals (DHH), Medical Vendor Administration (MVA), related to the finding regarding "Inappropriate access to the Medicaid Eligibility Data System (MEDS)".

Finding:

Forty-eight (48) users with access to the RACF security application possessed rights to alter MEDS production data files.

Response:

A request is being submitted to the Department of Social Services (DSS) security staff to remove all but four (4) of the RedMane Technology staff user IDs from RACF ALTER access. This means that only four (4) RedMane staff will have access to alter MMIS daily production files.

RACF alter access has already been deleted for six (6) DHH IT staff as requested by DHH IT management. A request has been submitted to DSS Production control supervisor to change alter access to "read only" for MMIS daily files for eight (8) DSS Production control staff. A request has also been submitted to DHH Database Administrator (DBA) supervisor to remove alter access to MMIS daily files for the two (2) MEDS DBA's.

Finding:

Fourteen (14) users had access to perform security administrator functions in MEDS.

Response:

Effective September, 2009, only five (5) users, all employees in the MEDS unit, have access to perform security administrator functions in MEDS production.

You may contact Diane Batts or Robynn Schifano at (225) 342-6398 if you need any additional information regarding this finding.

Sincerely,

Jerry Phillips
Medicaid Director

JP:KV

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing
Waiver Assistance and Compliance Section

November 3, 2009

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 findings dated October 23, 2009 regarding **Ineligible Medicaid Payments for State Transportation Services:**

- DHH concurs with the findings. We agree that the department improperly classified state NEMT program transactions to the Medicaid program.
- Corrective Action:
  - Contact: Darrell Curtis at (225) 342-6220.
  - We are working with Medicaid Financial Operations and DHH Financial Management to correct establish procedures to ensure that claims for the state NEMT program are paid with state funds only, as well as taking action to repay the inappropriately paid claims to CMS.
  - Completion date is expected to be by February 2010.

You may contact Darrell Curtis at 342-6220 regarding the action to be taken related to this finding.

Sincerely,

Jerry Phillips
Medicaid Director

Bienville Building • 628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone #: 225/342-6234 or #225/342-5774 • Fax #: 225/342-6148 • *WWW.DHH.LA.GOV*
"An Equal Opportunity Employer"

JP:RD:wdc

CC: Charles Castille
Ray Dawson
Randy Davidson
Joe Kopsa
Jeff Reynolds