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

MANAGEMENT LETTER
ISSUED DATED JUNE 3, 2009

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.

This document is produced by the Legislative Auditor, State of Louisiana, Post Office Box 94397, Baton Rouge, Louisiana 70804-9397 in accordance with Louisiana Revised Statute 24:513. Five copies of this public document were produced at an approximate cost of $19.20. This material was produced in accordance with the standards for state agencies established pursuant to R.S. 43:31. This report is available on the Legislative Auditor's Web site at www.lla.la.gov. When contacting the office, you may refer to Agency ID No. 3347 or Report ID No. 80080060 for additional information.

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.

LOUISIANA LEGISLATIVE AUDITOR
STEVE J. THERIOT, CPA

May 22, 2009

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, 2008, 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 those 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, 2007, we reported findings related to improper claims by waiver services providers, ineffective Medicaid eligibility quality control system, and noncompliance with state movable property regulations. None of these findings were resolved by management and they 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* have also been included in the State of Louisiana's Single Audit Report for the year ended June 30, 2008.

Ineffective Medicaid Eligibility Quality Control System

For the third consecutive year, the Department of Health and Hospitals (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 redetermines eligibility for individual

sampled cases of beneficiary eligibility made by the 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 the department to perform targeted or focused reviews. The pilot project requires DHH to perform a total of 220 reviews per month, including 80 negative reviews. A negative review is consideration of a case with negative case action--meaning action to deny, suspend, or terminate Medicaid eligibility. DHH policy for MEQC requires assignment of review samples within one to two months depending on case type. DHH policy for MEQC also requires that reviews be completed within 45 days after the review sample has been identified.

In a test of 60 cases assigned for MEQC review, the following was identified:

- Five (8%) cases were not reviewed by the MEQC within 45 days as required by DHH policy. The reviews were completed 13 to 74 days late.

- Twelve (20%) cases were not assigned for review within one to two months as required by DHH policy. The cases were assigned one to two months late.

- Three (5%) cases were not reviewed by MEQC.

Audit procedures also noted that DHH MEQC did not perform any of the monthly negative MEQC reviews for April 2008 through September 2008, resulting in an additional 477 cases not reviewed.

Although DHH is required to operate a MEQC system, the department failed to assign sufficient personnel to perform the reviews required by the system. Failure to operate the MEQC system in accordance with the guidelines approved by CMS 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 eligibility reviews are performed in accordance with the approved pilot project for the MEQC system and should assign sufficient personnel to perform all required reviews timely. Management concurred with the finding and outlined corrective action (see Appendix A, pages 1-2).

Improper Payments to Waiver Services Providers

For the second consecutive year, 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 and the Elderly and Disabled Adult Waiver. These services include individualized and family supports and companion services. 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. 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 615 claims totaling $574,688 filed by six providers for 40 recipients during calendar year 2007, 130 (21%) errors were noted. The errors noted included the following:

- For 129 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 recipient record did not contain documentation as to why the services were not provided according to the plan of care.

- For seven 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.

These conditions occurred because DHH paid waiver services claims even though providers failed to follow established DHH policies and regulations for providing services according to the plan of care and adequately documenting those services.

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 3-5).

Noncompliance With State Movable Property Regulations

For the second consecutive year, DHH did not maintain adequate control over movable property as prescribed by law. Louisiana Administrative Code Title 34 Part VII Section 307 (A) requires all acquisitions to be tagged and information reported to the Louisiana Property Assistance Agency (LPAA) within 60 days after receipt.

During the examination of the department's movable property items, the following deficiencies were noted:

- During the fiscal year ending June 30, 2008, 146 items costing $638,386 were not reported to LPAA within the required 60 days. These items were reported to the LPAA untimely, ranging from 61 and 532 days after receipt by the department.

- For 7 (12%) of 60 acquisitions tested, property was not tagged as required.

Although the department has policies and procedures that contain many elements of a good internal control system, these procedures are not followed uniformly. Failure to maintain an accurate movable property system increases the risk of loss arising from unauthorized use and subjects the department to noncompliance with state laws and regulations.

DHH should ensure that its movable property procedures are followed consistently and that all property is tagged and reported timely to LPAA. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, page 6).

Improper Claims by Long Term Personal Care Services Providers

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 438 claims totaling $133,067 that were paid to three LT-PCS providers during calendar year 2007 identified 47 (10.7%) errors. The errors included the following:

- For 33 (7.5%) of the 438 claims tested, appropriate units of service were not delivered according to the plan of care. This error was noted for two of three providers tested.

- For 31 (7.1%) of the 438 claims, the provider did not maintain adequate documentation of the units of service provided. Audit procedures identified time sheets without time shift(s) noted and time sheets with LT-PCS units mislabeled as waiver units and vice versa that made it difficult to determine LT-PCS hours. This error was noted for all three providers tested.

- For 31 (7.1%) of the 438 claims, the provider billed for more units than those worked. Providers were unable to provide time sheets to substantiate the units billed for the service dates on the claim. This error was noted for all three providers tested.

- For nine (7.7%) of the 117 claims, the provider did not maintain standardized weekly LT-PCS service logs. The logs are a requirement for all claims with service dates of November 1, 2007, and after.

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 $8,082, which include $5,632 of federal funds and $2,450 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 plan of corrective action (see Appendix A, pages 7-9).

Improper Payments to Non-Emergency Medical Transportation Service Providers

DHH paid claims to providers of Non-Emergency Medical Transportation (NEMT) for services billed to the Medical Assistance Program (CFDA 93.778) that were not provided in accordance with established policies. 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:

- Providers maintain copies of all Recipient Verification of Medical Transportation Forms (Form MT-3) as documentation of all trips provided.
- Providers maintain copies of the Driver Identification Form (MT-8) for each driver. The form is to be completed when drivers are hired and annually thereafter for all current drivers.
- Providers maintain copies of the Vehicle Inspection Form (MT-9) for each vehicle used. The form is to be completed on each vehicle before the vehicle can be used and annually thereafter.
- Providers maintain a daily schedule of transports.
- Effective July 1, 2007, providers bill for capitated (monthly) services at the end of the month. Before July 1, 2007, providers were allowed to bill for capitated (monthly) services at the beginning of the month before any services had been provided. This allowed providers to be paid for services that may not have been provided.

A review of 94 claims totaling $20,683 paid to four providers during calendar year 2007 identified errors for all four providers. The errors noted include the following:

- For 42 (45%) of the 94 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 $7,992.

- For 12 (13%) of the 94 claims, the providers were approved to transport recipients to and/or from a non-Medicaid provider. The total amount paid for these 12 claims was $5,150. Of this amount, $2,174 was already questioned above because of inadequate MT-3 documentation. Questioned cost totaled $2,976.

- For 38 (40%) of the 94 claims, the providers billed for capitated (monthly) trips before month end. Twelve (32%) of the 38 claims were for service dates after July 1, 2007.

- All four providers tested did not maintain a daily schedule of transports and adequate documentation to support vehicle certifications (MT-9) in their records.

- Three of the four providers 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 are $10,968, which includes $7,643 of federal funds and $3,325 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 10-11).

Inappropriate Access to the Medicaid Eligibility Data System

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. In addition, management should receive and periodically review security reports to determine that all access and related privileges are appropriate and driven by business need.

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, controlled, and understood by DSS personnel, not DHH personnel. Complete and comprehensive security reports for the MEDS application user IDs and associated rights have not been readily available to DHH management who are responsible for the transactions.

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

- Seventeen users with access to MEDS were not shown on the RACF security report, which means their actions would not be reflected in this report. Of these, nine user IDs were assigned to MEDS contract programmers, six were assigned to DHH programmers, and two were assigned to database administrators. Based on user groups attached to these user IDs, users could perform update functions for Medicaid production data.

- Forty 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 14 MEDS contractors, 14 DHH programmers, 2 DHH database administrators, 1 DSS administrator, and 9 DSS production control employees.

- Thirty-two users had access to perform security administrator functions in MEDS. Of these, only four were charged with security administrator functions. The remaining 28 users were either application programmers or Medicaid management personnel. These 28 users were also assigned to transaction groups that are normally granted to functional users of MEDS. This incompatible access would allow 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. In addition, DHH management should obtain access to reliable security reports and perform a periodic review of all user IDs. Management concurred and provided corrective action plans for each of the finding recommendations (see Appendix A, pages 12-14).

Inadequate Internal Control Over Cooperative Endeavor Agreements

DHH failed to establish and enforce adequate internal control over the cooperative endeavor agreements for payments to medical professionals under the Professional Workforce Supply Grant - GNO Health Service Corps Program (CFDA 93.779). The DHH undersecretary identified four agreements where the signature attributed to him was not his signature and appeared to be a forgery. Good internal control and Louisiana law require that adequate supervision and approval processes be established over cooperative endeavor agreements to ensure that agreements are legally enforceable, and payments are authorized only after both parties are obligated to perform under the agreement. If the party contracting with the state is not obligated to perform under the agreement, the payment may be considered gratuitous and would possibly violate Louisiana Constitution, Article VII, Section 14(A), which prohibits donation of state funds. Louisiana Revised Statute 14:72 prohibits forgery.

DHH management identified 10 cooperative endeavor agreements, totaling $335,000, in which the signature of one or both parties was questionable and did not match the signatures from the same individuals on other agreements located in the contract file. The DHH undersecretary identified four of those agreements in which the signature attributed to him was not his signature and appeared to be a forgery.

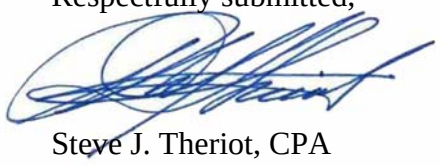
DHH failed to ensure that employees processing the cooperative endeavors were obtaining valid signatures on the agreement from both parties before payments were made under the agreement. Since these 10 identified cooperative endeavor agreements may not legally bind both parties to perform under the agreement, the payments made under these agreements may not be valid and represent questioned costs totaling $335,000. DHH is performing extensive reviews on cooperative endeavor agreements to identify those with questionable signatures and is taking corrective action on those agreements that are identified as questionable.

DHH management should establish and enforce adequate internal control over cooperative endeavor agreements to ensure that the agreements include valid signatures from the appropriate parties. DHH should seek the advice of the attorney general and the district attorney as to legal remedies to the possible forgery. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, page 15).

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.

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,



Steve J. Theriot, CPA
Legislative Auditor

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DHH08

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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

November 26, 2008

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

Dear Mr. Theriot:

Please refer to your correspondence dated October 16, 2008 reporting a Department of Health and Hospitals audit finding of an Ineffective Medicaid Eligibility Quality Control system. The Department concurs with the finding that some reviews were not assigned nor reviewed within 45 days and no negative QC reviews were conducted for April, 2008 through September, 2008.

The majority of the findings for this audit occurred when the agency was in the final stages of catching up on the backlogged reviews (cited in FY06/07 findings) and simultaneously working the current month's reviews. Please recall in the agency's response dated October 29, 2007 to Legislative Audit findings for FY 06/07, where we indicated that we would not clear out the all the backlog of cases until after the New Year (2008).

In response to this recent audit for FY07/08, steps were taken immediately to implement a correction action plan for compliance effective November 1, 2008.

Corrective Action Plan

Staff changes within the Eligibility Policy Section since April, 2008 have resulted in the Quality Control Section now being under complete new management from the direct supervisor, intermediate supervisor up to the Section Chief.

The case review process is highly reliant on client contact, cooperation and ability to secure documentation from clients to verify eligibility determinations. Despite staff's best efforts, some cases cannot be completed timely, irrespective of processing timeframes. The new management team implemented procedures in November, 2008 to ensure that reviews are assigned timely and cases are reviewed within 45 days. The the Quality Control manager now monitors assignments and reviews processing timeframes for each review month. Reports are required at the 30 day point in the review process to monitor the number of cases completed and identify issues with incomplete cases. These procedures provide 15 days for issues to be resolved before the processing deadline. This emphasis on assignment date, processing timeframes and

monitoring will place necessary attention to the importance of timeliness and deter future deficiencies. It will also serve as a check point to ensure that the quantity and the required monthly quota for reviews are regularly being met. Also, since the completion of the audit period, steps have been taken to automate many of the steps in the review process. All review forms and findings are scanned and maintained electronically, eliminating the need to retain hard copies of each case reviewed. These efficiencies will enable staff additional time to devote to processing of reviews timely.

The Qualify Control Unit has resumed conducting Quality Control negative action cases starting with the October, 2008 review month which were assigned in November, 2008. The current supervisor will monitor assignment dates of negative action cases and also require status reporting on the 30th day of the 45-day processing timeframe.

All of the above actions will be used to monitor workload activities and will assist in identifying throughout the process whether sufficient staff is assigned to conduct timely reviews required by the Quality Control system.

If you have any questions or concerns regarding this finding and corrective action plan, please contact Darlene Hughes at 225-342-7628.

Sincerely,

Jerry L. Phillips
Medicaid Director

JLP:DGDH

Cc: Charles Castille, Undersecretary
Jeff Reynolds, Director, Fiscal Services

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

February 23, 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 Waiver Services Providers

Please accept this letter as a response to the Legislative Auditor finding regarding Improper Claims by Waiver Services Providers dated February 11, 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. Rick Henley of the Office of Aging and Adult Services (OAAS) is the contact person responsible for corrective action relative to claims under the Elderly and Disabled Adult Waiver. You may contact Mr. Henley at 225-219-0209. For corrective action relative to claims under the New Opportunities Waiver (NOW), you may contact either Ms. Jean Melancon at 225-342-8877, or Mr. Charles Ayles at 225-342-6822. Both Ms. Melancon and Mr. Ayles are with the Office for Citizens with Developmental Disabilities (OCDD).

Sincerely,

Jerry Phillips
Medicaid Director

JLP/LAO

Attachment

cc: Charles Castille
Hugh Eley
Kathy Kliebert
Kay Gaudet
Jeff Reynolds

FINDING: Improper Claims by Waiver Services Providers

Error Noted: Weekly units of service were not delivered according to the plan of care.

DHH Response: DHH concurs with this finding.

Some deviation from the Plan of Care is to be expected due to factors such as the worker not showing up, the recipient refusing services, and the like, thus prohibiting delivery of the weekly service hours in strict accordance with the Plan of Care. However, while some deviation is expected, it is not acceptable for a provider to deviate from the Plan of Care without cause, and when cause is present, documentation should exist in the record explaining the reason for deviation in the schedule.

Corrective Action through OAAS:

OAAS has implemented a resource allocation method called Service Hour Allocation of Resources (SHARe) to allow recipients freedom for flexibility of service delivery. A task list will be developed with the recipient which will list individual needs and preferences, but the time allowed for each task will not be restrictive, and thus, allow for daily adjustment to reflect changes in the recipients' needs. This will allow for a more person-centered approach to care planning. Part of the SHARe initiative was also to establish acuity-based tiered caps for the total cost of EDA recipients' care plans. SHARe is scheduled for implementation on March 1, 2009.

DHH through OAAS will continue to reinforce provider compliance with service delivery and documentation requirements through training and technical assistance. Memoranda will be re-issued by OAAS 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). We anticipate this training to occur within the next 90 days.

Corrective Action through OCDD:

OCDD will continue to reinforce provider compliance with documentation requirements through electronic notifications, training and technical assistance. OCDD will conduct its own internal 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. Include documentation policy statements in the Medicaid Waiver Service Provider enrollment packets to insure that all new providers are aware of the documentation requirements.

6. Post the February 6, 2008 memorandum to direct service providers on the OCDD Waiver Supports and Services Publications website.
7. If there is suspicion of fraudulent activities or abuse, referral will be made to the Medicaid Waiver Compliance Section for Notification to the appropriate entity.

Anticipated completion date is June 15, 2009.

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

DHH Response: DHH concurs with this finding.

Corrective Action Plan:

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

In addition, OCDD will:

1. Issue letters to providers with errors noted in this category requiring plans of correction.
2. Require the providers who were found to be out of compliance to attend training provided by the Program Office(s).
3. Re-issue the policy statement to all providers reiterating our policy and expectations on the documentation of schedule deviation.
4. Include documentation policy statements in the Medicaid Waiver Service Provider enrollment packets to insure that all new providers are aware of the documentation requirements.
5. Post the August 31, 2007 memorandum to direct service providers on the OCDD Waiver Supports and Services Publications website
6. Review all records cited in the audit and take appropriate action.

Anticipated completion date is June 15, 2009.

OCDD will begin the process to recoup all funds paid to providers who did not maintain the required supporting documentation for payment. Providers who fail to return monies owed will be referred to DHH Program Integrity for recoupment.

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Management and Finance

February 27, 2009

Mr. Steve J. Theriot, CPA, Legislative Auditor
Office of the Legislative Auditor
1600 North Third Street
Baton Rouge, LA 70804-9397

RE: Noncompliance with State Movable Property Regulations

Dear Mr. Theriot:

In response to your offices letter dated February 16, 2009, the Department of Health and Hospitals concurs with your offices "Noncompliance with State Movable Property Regulations" finding.

It is DHH's opinion that we have sufficient movable property policies and procedures in place for a good internal control system but several of our offices did not follow our existing policies and procedures. Our corrective action plan involved notifying each of the non-compliant offices and requiring them to submit correspondence back to DHH. In this correspondence, they must identify their specific corrective action plan and the individual within their office responsible for ensuring compliance to these policies. It was also reiterated to each of the non-compliant offices the importance of ensuring compliance to the movable property policies and procedures.

The following DHH employees have been identified as being responsible for ensuring compliance to the movable property policies and procedures:

- Health Education Authority of Louisiana: Mr. Marshall J. Ryals
- Medical Vendor Administration: Mr. Darryl Johnson
- OMF/Division of Information Technology: Mr. John Ragsdale
- Office of Mental Health: Ms. Loretta Williams
- Office for Citizens with Developmental Disabilities: Ms. Kathy H. Kliebert
- Office for Addictive Disorders: Ms. Anita Herring

If you have any questions or need any additional information, please contact Jeff Reynolds at 225-342-8222 or by e-mail at jreynolds@dhh.la.gov.

Sincerely,

Charles F. Castille, Undersecretary

c: Alan Levine, Secretary
Sybil Richard, Deputy Secretary

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

February 16, 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 letter as a response to the Legislative Auditor finding regarding Improper Claims by Long Term Personal Care Service Providers dated February 6, 2009. 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. 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
Jeff Reynolds

FINDING: Improper Claims by Long Term Personal Care Service Providers

DEPARTMENT RESPONSE: The Department of Health and Hospitals concurs with the finding.

Error Noted: Appropriate units of service were not delivered according to the plan of care.

Corrective Action: It is anticipated that there may be some deviation from the plan of care. This may occur due to a number of factors such as the 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. When cause is present, it must be documented.

LTPCS services use a very restrictive resource allocation guide. In 2007, OAAS began its current resource allocation initiative to address problems with the existing system of allocation of LTPCS service hours. The current system allows 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.

OAAS has implemented a resource allocation method called Service Hour Allocation of Resources (SHARe) to allow recipients feeedom for flexibility of service delivery within each week, which allows for individual differences or preferences. The time allowed for each task would no longer be restrictive, and could be adjusted for daily changes in recipients' needs. The support coordinators would benefit from the changes in the care planning process. They would no longer have 15 minute increments of time to assign for specific tasks, and instead would be able to take a more person-centered approach to care planning. The providers would 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.

Over the past year OAAS has conducted research on the current approval and utilization of services for LTPCS. The goal of this research was to revise the existing, rigid level of service guide for LTPCS and to establish acuity based tiered caps for the total cost of EDA recipients' care plans. SHARe is scheduled for implementation on March 1, 2009.

DHH will continue to reinforce provider compliance with service delivery and documentation requirements through training and technical assistance. Correspondence will be re-issued by OAAS 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). We anticipate this training to occur within the next 90 days.

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

Corrective Action: As part of its SHARe initiative, OAAS has developed a service log that allows for documentation of both LT-PCS and companion services provided under the Elderly and Disabled Adult Waiver. Units between the two services will have to be divided and the requirement that separate timesheets must be maintained will remain.

DHH will continue to reinforce provider compliance with proper documentation and correct billing practices through training and technical assistance. Additionally, correspondence will be issued by OAAS to all service providers that will reiterate documentation requirements. We anticipate that this training will occur within the next 90 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 for criminal prosecution.

Additionally, effective March 1, 2009, all LT-PCS providers will be prior authorized through Statistical Resources Inc. (SRI). Units will be prior authorized on a weekly basis and though this will not ensure that providers bill with adequate documentation, it will ensure that prior authorization is not exceeded since any attempt to bill in excess of the weekly prior athorization will be denied.

DHH will continue to reinforce provider compliance with proper documentation and correct billing practices through training and technical assistance. Additionally, correspondence will be issued by OAAS to all service providers that will reiterate documentation requirements. We anticipate that this training will occur within the next 90 days.

Error Noted: Failure to use standardized weekly service logs.

Corrective Action:
DHH will continue to reinforce provider compliance with proper billing practices through training and technical assistance. Additionally, correspondence 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. We anticipate that this training will occur within the next 90 days. During this training, OAAS will train on the new standardized service log that allows for documentation of LT-PCS and companion care on the same form and will reiterate that this is a mandatory form.

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

March 2, 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 February 19, 2009 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. DHH will continue to re-educate providers of these requirements and issue sanctions when appropriate.

- The issue regarding transportation to non-enrolled providers is something that is allowed by CMS with certain qualifications, a copy of the guidance is attached. BHSF staff is reviewing these criteria to see if these claims apply.

- 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 March 2009 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.

Waiver Assistance and Compliance has implemented procedural and systematic changes to Capitated trip methodology to prevent payment until after all scheduled services are to have been provided. As a result of the finding that some claims paid incorrectly:

- BHSF staff will ask our contractors, Unisys and First Transit, to conduct testing to identify and correct lapses in programming.
- Completion date is expected to be by March 31, 2009.

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 225/342-4818 regarding the action to be taken related to this finding.

Sincerely,

Jerry Phillips
Medicaid Director

JP/rd

CC: Charles Castille
Jeff Reynolds
Joe Kopsa

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

December 17, 2008

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

Dear Mr. Theriot:

Below is the response from the Department of Health and Hospitals (DHH), Medical Vendor Administration (MVA), related to the finding number PF 17-D-4-a and PF 17-D-6-a regarding inappropriate access to the Medicaid Eligibility Data System (MEDS) production files.

Recommendation:

Access rights to production programs and files should be restricted to those individuals on a business need basis. We recommend that DHH management take the following actions to enhance the security over the MEDS application:

- Remove (where appropriate) or change to READ only access for the application programmers currently having RACF ALTER access to the MEDS production datasets.

Corrective Action:

Changes will be made to existing MEDS User Access Security to ensure that all user ID's other than MAU (DHH staff) and TIU (DSS/OCS staff) are set up for "inquiry only" access user group. Since contract staff and DHH IT staff have distinct user ID's, it will be easy to identify and change the access for these users.

A MEDS security training is being planned for January 2009 in order for contractor to train two MEDS unit staff members, along with MEDS Program Managers, on administration of security subsystem. These two staff members will take over full responsibility of security administration, which includes access to MEDS production data. Only these security administrators will have capability of providing access to production data and controlling who

has update vs inquiry access. The Legislative Auditors will be notified once training is held and security is handed over to MEDS unit staff.

- Restrict access to make changes through the MEDS application to the MEDS production data by application programmers and non-functional users to emergency situations only with additional mitigating controls.

  Corrective Action:
  Changes planned in #1 above will resolve some access issues. If contractor assistance is needed on an emergency basis (i.e. eligibility for individual must be transmitted to MMIS for immediate services but system edits are preventing transmittal of eligibility), MEDS unit security administrators would update security to allow production update access to contractor for resolution and immediately change access back to inquiry only. The MEDS audit trails would display any system changes. When this happens, this will also trigger a change request so that a new user group can be created to allow MEDS unit staff to make future changes, without the assistance of contractor staff. The user group would be controlled by MEDS unit security staff only. The Legislative Auditors will be notified when this procedure is implemented.

- Develop comprehensive reports over user accounts and related privileges and review the report on a periodic basis to ensure those user accounts and access rights remain current and reflect the appropriate business need for the MEDS application.

  Corrective Action:
  The MEDS unit contractor is currently working on a job specification document at the request of the MEDS unit Program Manager. Once the job specifications are complete and approved, the contractor will begin work on a set of comprehensive reports which will be available in our ViewDirect reporting system. The reports will be available as needed and will be monitored by MEDS unit security staff and MEDS Program Managers. The Legislative Auditors will be notified as soon as the reports are available in ViewDirect.

- Establish procedures and on-going communications with DSS and other related parties (such as the contractor) so that access changes related to the MEDS users within those entities can be notified to DHH and changed by DHH in a timely manner.

  Corrective Action:
  As described in #1 above, two staff members will take over full responsibility of security administration. These security administrators will have capability of providing access to production data and controlling who has update vs inquiry access. They will also have responsibility for maintaining

communication with DSS to ensure that changes are promptly reported and acted upon.

- Develop review procedures to examine the relevant MEDS application audit logs on a periodic basis.

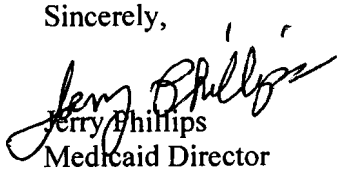
  Corrective Action:
  As described in #3 above, MEDS unit staff will be assigned to monitor all security reports and MEDS audit trails periodically.

- Develop procedures to prevent application programmers from migrating changes into production without documented managerial review and approval.

  Corrective Action:
  Currently, code is only migrated into MEDS production at the request of one of the MEDS unit Program Managers. The requests are made via e-mail and information regarding the move is entered into an Access database by MEDS unit Program Managers. A more formal process will be implemented in the near future, similar to what is used today for sign off and approval for contractor to begin work on a user request. MEDS unit staff will use this same process for changes to MEDSWeb (web-based reporting system) and Shadow Direct (middleware). The documents and procedures will be shared with the Legislative Auditors upon implementation.

Should you have additional questions or concerns regarding this finding, please feel free to contact Diane Batts or Robynn Schifano at (225) 342-6398.

Sincerely,



Jerry Phillips
Medicaid Director

JP:DSB

cc: Jeff Reynolds
J. Ruth Kennedy
Don Gregory
Robynn Schifano
Diane Batts

Bobby P. Jindal
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

LOUISIANA
Department of HEALTH and HOSPITALS
Alan Levine
SECRETARY

February 20, 2009

Mr. Steve J. Theriot, CPA
Legislative Auditor
1600 North Third Street
Baton Rouge, LA 70804

RE: Legislative Audit Finding
Inadequate Internal Control Over Cooperative Endeavor Agreements

Dear Mr. Theriot,

The Bureau of Primary Care and Rural Health concurs with the above named finding. The Bureau agrees that ten identified cooperative endeavor agreements were processed and paid with forged signatures and may not legally bind both parties to perform under the agreements. The Bureau does feel that internal controls were in place but failed due to the apparent collusion between employees involved in the approval process.

Since the problem was identified, the employees involved have been terminated. It is cost prohibitive for the Department to implement fail safe controls, but the Bureau has implemented an additional step in the approval process in an attempt to prevent this for occurring again. The Program Monitor verifies all information in the files before it is sent to the Secretary's office for signature. After the proper signatures are received, the agreements are sent to DHH Contracts and Procurement Support. All signatures are checked again. Once the agreements are submitted for the Office of Contractual Review approval, they are returned to the Bureau for payment authorization. Before payment is authorized, the signatures will again be verified by Mr. Don Parker, Program Manager.

Mr. Don Parker, Program Manager will be responsible for monitoring this process in the future. All involved staff members have been counseled on the importance of signature validation and we do not anticipate future issues. All of the implemented changes and checks are complete.

Our investigation into the matter found no evidence of criminal intent or fictitious persons receiving payments.

Thank you for your offices' efforts in this matter. If you have any further questions, please feel free to contact Don Parker at 225.342.9361.

Sincerely,

Gerrelda Davis, Director
Bureau of Primary Care and Rural Health