DEPARTMENT OF HEALTH AND HOSPITALS PREVENTION, DETECTION, AND RECOVERY OF IMPROPER MEDICAID PAYMENTS IN HOME AND COMMUNITY BASED PROGRAMS

PERFORMANCE AUDIT
ISSUED SEPTEMBER 14, 2011

LOUISIANA LEGISLATIVE AUDITOR
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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

September 14, 2011

The Honorable Joel T. Chaisson, II,
President of the Senate
The Honorable Jim Tucker,
Speaker of the House of Representatives

Dear Senator Chaisson and Representative Tucker:

This report provides the results of our performance audit on the Department of Health and Hospitals' processes to prevent, detect, and recover improper Medicaid payments in home and community based care provided to the elderly and individuals with disabilities.

The report contains our findings, conclusions, and recommendations. Appendix A contains the Department of Health and Hospitals' response to this report. I hope this report will benefit you in your legislative decision-making process.

We would like to express our appreciation to the management and staff of the Department of Health and Hospitals for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/dl

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Objectives and Findings: (Cont.)

Appendices:

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE, Legislative Auditor

Department of Health and Hospitals
Prevention, Detection, and Recovery of Improper Medicaid Payments in Home and Community Based Programs

September 2011

Audit Control # 40100021

Objectives and Overall Results

This report provides the results of our performance audit of the Department of Health and Hospitals (DHH). The purpose of the audit was to determine if DHH has established sufficient processes to prevent, detect, and recover improper Medicaid payments in the Long-Term Personal Care Services program (LT-PCS), the Elderly and Disabled Adults waiver (EDA), and the New Opportunities waiver (NOW). We focused on these programs because the amount of improper payments for these providers has increased over the last five years. In addition, Louisiana legislative auditors have cited questioned costs in these programs over the last four years. DHH's secretary also requested we evaluate whether program costs could be reduced in the LT-PCS program.

Appendix A contains DHH's response and Appendix B contains our scope and methodology. The audit objectives and results of our work are as follows:

Objective 1: What enhancements could DHH make to prevent or deter improper payments in the LT-PCS, NOW, and EDA Programs?

Results: While DHH has established processes such as provider enrollment, prior authorization of services, and computer edits to prevent potentially improper payments, we identified the following seven improvements that DHH could make to enhance their current processes:

- DHH should develop an edit check that prevents direct care workers who work for two different companies from charging overlapping times. Because this edit check does not currently exist, we estimate that in CY2010, 1,563 direct care workers claimed from $700,000 to $1.3 million in potential improper payments for times that overlapped between different recipients on the same day.

- Since 2003, DHH's Surveillance and Utilization Review System (SURS) unit has conducted post-payment reviews and identified over $780,000 in improper payments to waiver and LT-PCS providers who claimed they provided services in the recipients' home while they were in the hospital, in a nursing home, or at an adult day health care center. We conducted a similar analysis on 2010 data and found $194,163 in potentially improper payments to LT-PCS providers who provided services while recipients were hospitalized. Because of the prevalence of

this problem, DHH should implement a pre-payment review of pending claims for recipients when they have claims for different services on the same day.

- DHH should make improvements to the authorization process to prevent providers from billing previous clients under old prior authorization numbers. We identified $19,845 in potentially improper claims during CY2010 for the same client on the same day.

- Provider quality would be enhanced if DHH complied with federal mandates and best practices performed in other states. Specifically, DHH is not currently performing certain activities, such as criminal background checks, periodic re-enrollment of providers, and site visits that are required by the Affordable Care Act that was enacted in March 2011. According to DHH, the new Medicaid Management Information System (MMIS) contractor will be required to implement these activities.

- DHH should periodically verify whether providers are performing required exclusion checks on their employees. Knowledge of these direct care workers is important because there were over 47,000 direct care workers who provided at least one day of service in CY2010.

- Requiring providers to use call-in systems may help decrease costs. Other states, such as Florida and South Carolina, have seen a reduction in improper payments after implementing a call-in system.

- DHH's current penalty structure and assessment of fines is not sufficient to deter noncompliance. Although DHH regulations allow discretion in imposing various sanctions, DHH has rarely imposed fines over the last five years. Of 677 SURS cases involving improper payments totaling $4.7 million from CY2005 to CY2010, only 5% of those cases were fined for a total of $96,000 in fines.

Objective 2: What enhancements could DHH make to identify and recover improper payments in the LT-PCS, NOW, and EDA Programs?

Results: Although DHH recovered 80% of the total Medicaid improper payments it identified, DHH ranks low compared to other states in its overall identification of improper payments. We identified the following three activities that could enhance DHH's processes to identify improper payments:

- DHH should expand its programmatic monitoring process to include LT-PCS providers and to include financial monitoring.

- DHH could increase the identification of improper payments by diversifying its staff and increasing its data mining efforts. According to DHH, it does not currently have any staff members devoted solely to data mining. Data mining in 2010 resulted in a total of $261,056 in improper payments, or an average of $1,061.20 per case.

- Analysis of claims denied due to provider errors could enhance DHH's current efforts to identify problem providers. DHH does not currently use exception or error reports to identify trends or patterns with certain errors or providers.

Objective 3: How can DHH reduce program costs in the LT-PCS program?

Results: In addition to reducing costs by improving its processes to prevent, detect, and recover improper payments, we identified two additional ways DHH could reduce program costs.

- DHH should allow one direct care worker to care for two individuals who live at the same address at the same time. This is currently allowed in the NOW and EDA waivers but not in the LT-PCS program. Allowing shared supports in this program would have potentially saved $3.5 million last year.

- DHH should reduce the length of time of the recipients' appeals process. The current appeals process averages five months. During this time, recipients are allowed to receive services at their previous level, up to the new program maximum of 32 hours. If DHH could reduce the length of time of the entire process, it could save at least $284,570 for every month that is reduced.

Background

The federal Department of Health and Human Services estimates that the federal share of improper payments in the Medicaid program in FY2010 was $22.5 billion. The General Accounting Office has also designated the Medicaid program as high risk due to the prevalence of improper payments.

Improper payments are defined by the Improper Payments Elimination and Recovery Act of 2010 as payments to ineligible recipients, payments for ineligible services, duplicative payments, and payments for services not received.

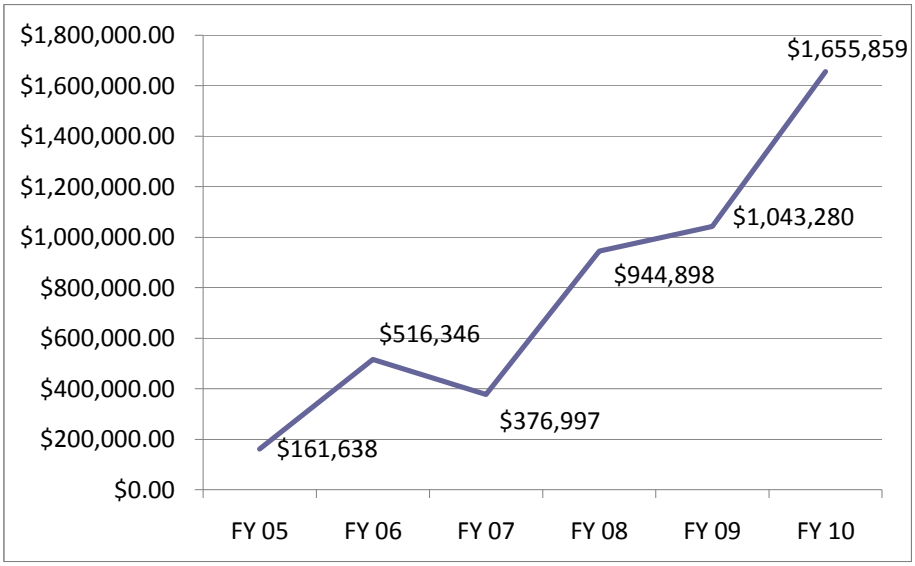
Locally, the Department of Health and Hospitals (DHH), through its Program Integrity Division, is responsible for administering and overseeing the Medicaid program to ensure that quality providers are enrolled and that improper payments are prevented, detected, and recovered. DHH and its current contractor, Molina Healthcare, conduct such integrity activities as provider enrollment, prior authorization of services, review of data for inappropriate utilization, and provider investigations. In FY2010, Medicaid expenditures totaled $6,287,331,540. Of that total, DHH identified less than 1% in improper payments. However, DHH did recover most of what it identified. In FY2010, DHH identified $5,632,691 in improper payments and recovered $4,466,303, or 80% of the total identified.

Although DHH recovers most of the improper payments it identifies, it ranks low compared to other states in the amount of improper payments identified. For example, it ranked 44th in the nation for the amount it recovered per full-time equivalent (FTE) in FY2008. It also ranked 44th in the nation regarding the percent of total Medicaid spending recovered through program integrity activities. Appendix C provides detail of Louisiana and how it compares to other states.

This report examines improper payments in home and community based programs. Home and community based programs are programs that provide services to various populations, such as the elderly and individuals with disabilities, that enable these individuals to remain in their homes and communities. These types of programs are particularly vulnerable to abuse because these services are generally provided in an individual's home and recipients often have cognitive impairments, such as Alzheimer's disease. In addition, DHH has seen a rise in the amount of improper payments to these providers over the years. In FY2010, DHH identified approximately $1.6 million in improper payments from these providers, or 37% of the total Medicaid funds identified for that year. Exhibit 1 on the following page summarizes the amount of improper payments recovered by DHH for personal care[1] providers.

[1] Personal care provider is defined as any agency that employs direct care workers who provide personal care services or attendant care services.

Exhibit 1: Improper Payments in Personal Care Providers FY2005 to FY2010



Source: Prepared by legislative auditor's staff using information from DHH.

Although DHH offers an array of home and community based programs, we reviewed three of its largest programs in this report. These programs include the Long-Term Personal Care Services program (LT-PCS), the New Opportunities waiver (NOW), and the Elderly and Disabled Adult waiver (EDA). Exhibit 2 summarizes the population served by each program as well as the programs' current number of approved slots, number of recipients, number of people on the waiting list, average cost per recipient, number of providers, and maximum service hours approved.

Exhibit 2
Program Summary
As of 5/24/2011

	LT-PCS	EDA	NOW
Eligible population	Elderly and adults with disabilities	Elderly and adults with disabilities	Individuals with developmental disabilities or mental retardation who qualify for institutional care
Slots approved	No maximum	4,603	8,682
Individuals receiving services	12,500*	4,300	7,533
Number on waiting list	N/A	18,920	9,190
Average cost per recipient	$16,623	$29,620	$62,246
FY2011 expenditure forecast	$184,589,989	$104,450,746	$383,166,489
Number of providers	657	603	1,513
Maximum service hours per week	32	No maximum service hours. $40,046 is the maximum annual amount per recipient	No cap for the total amount of all NOW services per recipient, but there are limits for individual NOW services

Source: Prepared by the legislative auditor's staff using information provided by DHH.
* Per DHH, this number is growing at a rate of 125 per month

Objective 1: What enhancements could DHH make to prevent or deter improper payments in the LT-PCS, NOW, and EDA programs?

Processes designed to prevent or deter improper payments are the most important activities for states to implement because they reduce costs in the long-run. While DHH has established processes such as provider enrollment, prior authorization of services, and computer edits to prevent potentially improper payments, we identified seven improvements that DHH could make to enhance its current processes. These improvements are discussed in detail in the sections below.

DHH's lack of preventative edits resulted in providers claiming from $700,000 to $1.3 million in potentially improper payments in 2010

Preventative edits do not allow Medicaid claims to move forward in the automated payment approval process without meeting certain predetermined criteria.

Providers track their service times in a system called the Louisiana Services Tracking System (LAST) which is maintained by Statistical Resources, Inc. (SRI). Providers are required to input the actual times that each of its direct care workers worked for each recipient into this system and then submit these times to the MMIS to receive payment. According to LAST data, there were approximately 47,990 direct care workers providing at least one day of service in CY2010. However, while there is an edit in the LAST database that prevents direct care workers from claiming overlapping times within the same provider, there is no edit that prevents direct care workers who work for two different providers to submit overlapping times for different recipients. In CY2010, there were approximately 7,220 direct care workers (15%) who worked for two or more providers.

We analyzed LAST data for CY2010 for LT-PCS, EDA, and NOW providers and estimated that improper payments[2] for these overlapping times ranged from $700,000 to $1.3 million for 1,563 direct care workers. This represents approximately 21% of all direct care workers who work for two different providers. Exhibit 3 provides an example of overlapping times in the data we analyzed.

[2] This amount is calculated based on the time recorded in the LAST system using an average rate of $3.00 per 15 minutes. The actual amount may be slightly higher or lower because the rate was different depending on the program and the rate changed several times during 2010. In addition, the $700,000 just includes the actual time overlapped. However, one entry must be incorrect in each of these instances; therefore, we calculated the total costs and took half of that to get the $1.3 million. We also use the word 'potential' because this data has integrity issues, such as the social security number issue described below.

Exhibit 3 Example of Overlapping Times for Different Recipients						
Provider Agency	**Direct Care Worker**	**Date of Service**	**Start Time**	**End Time**	**Client Last Name**	**Client First Name**
Provider 1	Worker 1	11-Mar-10	8:00 am	12:15 pm	Smith	John
Provider 2	Worker 1	11-Mar-10	8:00 am	11:45 pm	Doe	Jane
Source: Prepared by legislative auditor's staff using LAST data from SRI.						

Recommendation 1: DHH should develop an edit check that prevents direct care workers who work for two different agencies to submit overlapping claims.

Summary of Management's Response: DHH agrees with this recommendation and will issue a policy requiring the direct service providers to input the correct social security numbers and dates of birth for all direct care staff into the LAST system.

Increased use of prepayment reviews of certain pending claims would help DHH prevent improper payments

DHH, through Molina's SURS, conducts post-payment reviews based on the results of data analysis and complaint allegations. SURS will also open cases based on special projects such as reviewing claims to determine whether providers are billing for LT-PCS services while recipients are in nursing homes or hospitalized.

Since 2002, SURS has repeatedly found problems with providers billing for duplicative services. According to statistics on SURS cases, there have been 672 closed cases involving the provision of waiver or LT-PCS services while a recipient is hospitalized, in a nursing home, or in an adult day health care facility. These cases resulted in a total recoupment of $786,334. Exhibit 4 summarizes the results of SURS analysis.

Exhibit 4 SURS Cases and Results		
Case Type	**Number of Cases**	**Amount Recouped**
Billing for Waiver Services While Recipient is Hospitalized	199	$193,811.26
Billing for LT-PCS Services While Recipient is Hospitalized	318	283,243.87
Billing for LT-PCS Services While Recipient is in Nursing Home	61	90,804.56
Billing for LT-PCS Services While Recipient is in Adult Day Health Care	94	218,474.45
Total	**672**	**$786,334.14**
Source: Prepared by legislative auditor's staff using statistics from SURS.		

We performed a similar analysis on hospital and LT-PCS claims from CY2010 and identified $194,163 in potential improper payments. Because of the prevalence of this problem, DHH should try to develop measures to prevent this from occurring. However, according to DHH, preventative edit checks that deny such claims are difficult to implement because of the timing of these different types of claims. For example, LT-PCS providers submit claims daily while nursing home providers submit claims monthly.

Instead of edit checks that prevent claims from being accepted, DHH could develop a pending claims review that intercepts claims that meet certain criteria. According to DHH, they have this type of review to evaluate the appropriateness and necessity for certain procedures, such as sterilizations and hysterectomies, but have not developed this type of review for LT-PCS or waiver providers. Other states call this type of review pre-payment reviews and have developed review processes that have resulted in significant cost savings through cost avoidance as shown below.

- In New York, the Office of Medicaid Inspector General has a Pre-payment Review Unit that selects providers and builds edit criteria to review claim submissions. In CY2009, their staff reviewed nearly 1,000 providers. Claims are reviewed and adjudicated on a pre-payment basis allowing for more flexibility to react to issues. For 2009, cost savings for the Pre-payment Review Unit totaled $8,861,842.

- In FY2010 Florida initiated 263 pre-payment reviews in which providers' claims were pending. They closed 116 review cases where claims were denied, resulting in cost avoidance of $4.8 million. Sixty-six cases related to home and community based services were closed and resulted in a total of $1,950,842 in cost savings.

Recommendation 2: DHH should consider developing a review of pending claims to check for duplicative LT-PCS, nursing home, adult day health care, and hospital services.

Summary of Management's Response: DHH agrees with this recommendation and is currently working with its Fiscal Intermediary to develop a pre-payment review system.

Improvements to prior authorization process would help prevent providers from claiming the same recipient on the same day

SRI assigns prior authorization numbers to recipients for specific services and for different lengths of time. The prior authorization number must be submitted with the Medicaid claim to the MMIS to show that it is authorized. If an LT-PCS recipient wishes to change providers, he must notify Affiliated Computer Systems (ACS). ACS will notify the new provider, receive a signed agreement to provide services, and approve a new authorization. ACS then submits a revised ending date for services by the old provider and requests a new prior authorization number from SRI for the new provider.

We identified $19,845 in potential improper payments to providers who were using different prior authorization numbers for the same LT-PCS recipient on the same day. According to SRI, these errors generally occurred when recipients changed providers and revisions were made to the prior authorization number after the old provider had already provided services. According to SRI, to prevent this in the future, any after-the-fact revisions to prior authorization numbers will need to be checked by SRI to determine if services have already been provided.

Recommendation 3: DHH should require that any changes made to prior authorization numbers are reviewed by SRI to ensure services have not already been provided.

Summary of Management's Response: DHH agrees with this recommendation and will work with SRI to review prior authorization numbers to ensure services have not already been provided. In addition, DHH will call recipients monthly and perform quarterly in-home monitoring to ensure that the person is still eligible to receive services and that nothing has changed that would warrant a need to cancel the prior authorization.

Provider quality would be enhanced if DHH complied with federal mandates and best practices from other states

Compliance with newly enacted provider enrollment requirements would help improve the quality of providers. The Affordable Care Act (ACA) was enacted in March 2011 and requires states to conduct periodic re-enrollment, site visits, and criminal background checks for providers prior to enrolling them in Medicaid. However, the ACA does not specify how much time states are given to come into compliance with its requirements. Exhibit 5 summarizes the ACA requirements.

Exhibit 5
ACA Requirements

Title	Description and Benefits
Re-enrollment	The State Medicaid agency must screen all providers, regardless of provider type, at least every five years. This helps ensure that providers remain eligible
Site Visits	The State Medicaid agency must conduct pre-enrollment and post-enrollment site visits of providers. This helps confirm application information and ensures that providers actually have a business
Criminal Background Checks	The State Medicaid agency must require providers to consent to criminal background checks, including fingerprinting, as a condition of enrollment. This helps detect criminal and other offenses that would prohibit enrollment

Source: Prepared by legislative auditor's staff using information from the ACA.

According to DHH, the contractor selected for the new MMIS will be responsible for implementing the mandates of the ACA. As of June 15, 2011, DHH has selected a contractor, but no contract is yet in place.

DHH could also improve provider quality by implementing additional provider enrollment practices. We identified two additional activities that DHH could implement that would improve its provider enrollment process. These activities were recommended by the Centers for Medicare and Medicaid Services (CMS) and Louisiana's Medicaid Fraud Control Unit (MCFU) within the Attorney General's Office. Exhibit 6 summarizes these activities and the benefit of these activities.

Exhibit 6
Recommended Provider Enrollment Practices

Title	Description/Benefit
Surety Bonds	A bond which provides the agency with monetary compensation for providers who fail to repay inappropriate Medicaid payments. This helps guarantee that agencies have sufficient funds and allows states to recoup improper payments easier
Provider Training	Providing pre-enrollment provider training helps ensure that providers are aware of billing policies, covered and non-covered services, accountability and responsibilities, documentation requirements, etc.

Source: Prepared by legislative auditor's staff from interview with MFCU and review of CMS Program Integrity reports.

Recommendation 4: DHH should ensure that they are in compliance with the ACA, which requires the states to conduct provider re-enrollment, pre- and post-enrollment site visits, and criminal background checks.

Summary of Management's Response: DHH agrees with this recommendation and intends to comply with the provider screening provisions of the ACA.

Recommendation 5: DHH should consider requiring certain providers to purchase surety bonds upon enrollment.

Summary of Management's Response: DHH agrees with this recommendation and will determine if requiring high-risk providers to purchase a surety bond upon enrollment is beneficial.

Recommendation 6: DHH should consider providing pre-enrollment training to providers it deems high risk and use information from monitoring, licensing, SURS cases, and error codes to determine what kinds of training would be most valuable to providers.

Summary of Management's Response: DHH agrees with this recommendation and will determine how to incorporate pre-enrollment training into training currently held for all providers and newly licensed personal care assistance agencies.

DHH verification of provider compliance with exclusion requirements would enhance provider quality

According to DHH policy, providers have the responsibility to ensure that they do not employ individuals that have been suspended or excluded from Medicaid or any other health care program from any state. DHH does not currently have a method to verify that enrolled providers are conducting required exclusion checks on their employees. LT-PCS, EDA, and NOW providers are mostly business entities that employ workers to provide direct care services to recipients. Although DHH does provide training in this area on an as-needed basis, they do not have a formal system to ensure that providers fulfill this responsibility. Consequently, providers who do not perform exclusion checks may receive improper payments for services provided by excluded or suspended employees.

Knowledge of these direct care workers is important because there are approximately 47,990 direct care workers who provided at least one day of service in CY2010. The LAST system, maintained by SRI, does contain identity information on direct care workers. However, direct care workers are not required by DHH to submit valid and accurate social security numbers to this database. Currently, providers only enter the last 4 digits of their employees' social security numbers. However, many of these social security numbers are not valid. For example, 1,158 direct care workers listed the last four digits of their social security number as '9999' in this database. In addition, we found multiple cases of the same name having multiple social security numbers. If LAST data contained valid identification information, DHH could use this data to periodically check exclusion databases to confirm that agencies are actually complying with this requirement.

Recommendation 7: DHH should require that provider agencies submit accurate and complete employee social security numbers to the LAST system so that DHH can use this database to periodically check employees against exclusion data.

Summary of Management's Response: DHH agrees with this recommendation and will issue a policy requiring the direct service providers to input the correct social security numbers and dates of birth for all direct care staff into the LAST system.

Use of call-in systems may help reduce improper payments

Other states, such as Florida and South Carolina have implemented call-in systems which have reduced overall program costs by decreasing improper payments. A call-in system requires direct service workers to check-in and check-out by calling from a recipient's home to verify their arrival and departure times. Providers are only paid for time recorded via the call-in system which interfaces with the state's payment system. According to South Carolina, they annually save between $7.67 million and $8.85 million in reduced provider payments using a call-in system. It is likely that these cost savings result from a reduction in improper claims. Florida recently implemented a call-in system and realized a similar cost reduction. Exhibit 7 summarizes the cost to implement these systems and the associated cost savings in these two states.

Exhibit 7 Examples of Cost Savings of Implementing a Call-in System		
	South Carolina	**Florida**
Costs	$1.1 million in initial development costs; Operating costs are based upon claims generated in the system. The costs are $0.32 per claim with two calls and $0.19 per claim with one call	Approximately $1.1 million in initial development cost; The average annual cost to use this system is approximately $1,420,000 at a rate of $0.32 per claim.
Savings	Annual savings to be between $7.67 million and $8.85 million.	The program began July 1, 2010. Expenditures decreased from $10 million during the fourth quarter of FY2010 to approximately $6 million during the first quarter of FY2011.
Source: Prepared by legislative auditor's staff using information from South Carolina and Florida.		

Louisiana's Department of Children and Family Services (DCFS) currently has a contract with ACS to operate its finger imaging and call-in system for childcare providers who receive childcare assistance for low-income parents. This assistance program has been cited frequently by auditors for having improper payments. In the past, DCFS relied on sign-in sheets as proof of children's attendance. However, this system automates this process and decreases the risk of improper payments.

Recommendation 8: DHH should consider systems used in other states for implementing a call-in system for all home and community based services. The call-in system should be linked to the Medicaid payment system to ensure that providers are only paid for the period of time recorded by the system. This system would eliminate some of the problems with overlapping services outlined in the report.

Summary of Management's Response: DHH agrees with this recommendation and will implement an electronic visit verifications system within eight months of the start of the new MMIS contract.

DHH's penalty structure and assessment of fines may not be sufficient to deter provider noncompliance

DHH's current fine schedule may not be sufficient to deter subsequent noncompliance. DHH's current provider sanction rule states that DHH may impose monetary penalties, not to exceed $10,000 per violation, for prohibited conduct. In 2010, DHH also established an informal penalty schedule that includes minimum fines that range from $250 to $500 per offense.

However, DHH does not impose fines for first offense no matter how large the amount of the improper payment. This practice is compounded by the fact that DHH considers offenses by provider number rather than provider agency, which means that one provider with multiple provider numbers could have multiple offenses and would not be fined. We found that 46% of

providers who had closed cases with sanctions from CY2005 to CY2010 had multiple provider numbers.

Florida has recently developed a penalty structure that fines providers up to a percentage of the total improper payment amount identified and recouped based on the number of offenses. This allows the penalty amount to be commensurate with the amount of the offense. In addition, Florida's penalties are applied on a per-claim basis whereas Louisiana may consider multiple instances of misconduct as a single violation. According to DHH regulations, one violation can encompass multiple offenses. Exhibit 8 below compares DHH's sanction rule to Florida's rule.

Exhibit 8
Fines for Prohibited Conduct

	Florida	Louisiana
Fines begin at what offense?	First Offense	Second Offense
Minimum Fine	$1000 per claim	$250 per violation
Maximum Fine	Up to 50% of overpayment with no limit	$10,000 per violation

Source: Prepared by legislative auditor's staff using information from Florida and Louisiana law.

In addition to having insufficient fine amounts, DHH has not imposed fines for SURS cases that identified improper payments and could result in fines. DHH regulations allow a variety of sanctions for prohibited conduct, although regulations allow DHH discretion in determining the appropriate sanction. Exhibit 9 summarizes the 1,090 closed cases with sanctions from FY2005 to FY2010.

Exhibit 9
Summary of Sanctions for Closed Cases
FY2005 to FY2010

Actions	Number of Cases with Given Action	Percent of Cases with Given Action
Education Letter	611	56.06%
Recoupment	466	42.75%
Referral to Attorney General	385	35.32%
Voluntary Payment	221	20.28%
Internal Referral	155	14.22%
Other Referral	148	13.58%
Fines	36	3.30%
Monitoring	27	2.48%
Referral to DHH Legal for Collection	17	1.56%
Exclusion	6	0.55%
Pre-payment Reviews	4	0.37%
Voluntary Withdrawal	2	0.18%

Source: Prepared by legislative auditor's staff using data from SURS.
Note: One case may have multiple, unique actions.

As the exhibit shows, fines were imposed for 3% of all closed cases with sanctions from 2005 to 2010. According to DHH, they did not issue fines on a regular basis before 2010 because they did not have a penalty schedule prior to this time.[3] From 2005 to 2008, DHH imposed only $20,000 in fines. In 2010, when the penalty schedule was implemented, DHH increased the number of fines and imposed fines totaling $76,155, or 5% of total overpayment identifications that year. Exhibit 10 below shows the number and dollar amounts of fines imposed on personal care attendant providers between 2005 and 2010.

Exhibit 10
Number and Dollar Amount of Fines Imposed by Year
2005 to 2010

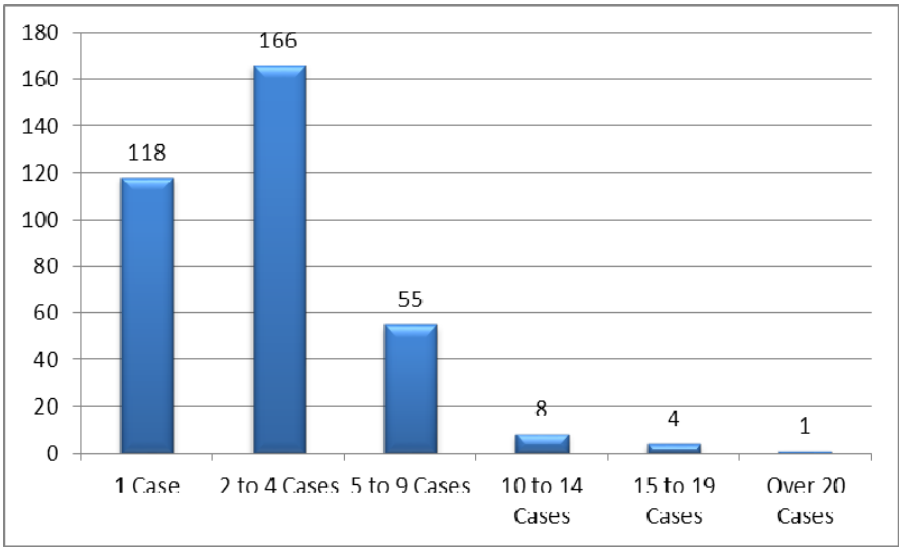
Year	Amount of Improper Payments Identified	Amount of Improper Payments Recouped	Sum of Fines Imposed	Percent of Fines	Number of Cases Involving Improper Payments	Number of Cases Fined	Percent
2005	$161,637.65	$161,637.65	$0	0%	9	0	0%
2006	516,345.71	516,345.71	0	0%	215	0	0%
2007	376,996.81	376,996.81	0	0%	49	0	0%
2008	944,897.77	944,897.77	20,000.00	2%	61	2	3.3%
2009	1,043,279.95	852,119.70	0	0%	102	0	0%
2010	1,655,858.97	1,411,570.96	76,154.45	5%	241	34	14%
Grand Total	**$4,699,016.86**	**$4,263,568.60**	**$96,154.45**	**2%**	**677**	**36**	**5.3%**

Source: Prepared by the legislative auditor's staff using information provided by DHH.

The consistent imposition of fines is an important tool for deterring providers from subsequent noncompliance. Because DHH has not consistently issued fines to providers, we found that approximately 65% of providers between CY2005 and CY2010 had multiple SURS cases closed against them with some sanction imposed. Exhibit 11 illustrates the number of closed cases involving these providers.

[3] However, even without a penalty schedule DHH had the authority to issue fines up to $10,000 for any violation or prohibited act.

Exhibit 11
SURS Case Counts
CY2005 to CY2010



Source: Prepared by legislative auditor's office using SURS data from CY2005 to CY2010.

As the exhibit shows, the majority of providers had multiple closed cases with some type of sanction imposed. Most of these cases also resulted in the provider having multiple and increasing improper payments. Exhibit 12 summarizes one example of a provider with multiple cases in date order of cases being closed.

Exhibit 12
Example of Provider with Multiple Offenses

Provider Name	Provider Number	Date Closed	Sanction(s)	Amount Recovered	Fines Imposed
New Horizons	19896	4/6/2006	Education Letter		
New Horizons	53448	4/18/2006	Education Letter		
New Horizons	17338	5/22/2006	Education Letter and Voluntary Payment	$408.00	$0.00
New Horizons	19663	6/29/2006	Education Letter and Voluntary Payment	84.00	0.00
New Horizons	53448	8/14/2006	Recoupment	36,587.12	0.00
New Horizons	19896	2/8/2007	Recoupment	6,393.00	0.00
New Horizons	19663	2/8/2007	Recoupment and AG Referral	3,192.00	0.00
New Horizons	17338	7/16/2007	Recoupment, AG Referral and Education Letter	24,663.00	0.00
New Horizons	30073	4/16/2008	Recoupment, AG Referral, Education Letter, Internal Referral and Other Referral	26,458.00	0.00
New Horizons	19662	4/16/2008	Recoupment, AG Referral, Education Letter, Internal Referral and Other Referral	37,141.50	0.00

Exhibit 12
Example of Provider with Multiple Offenses

Provider Name	Provider Number	Date Closed	Sanction(s)	Amount Recovered	Fines Imposed
New Horizons	19663	9/15/2008	Other Referral		
New Horizons	19896	9/23/2008	Other Referral		
New Horizons	19663	9/23/2008	Other Referral		
New Horizons	17338	7/13/2010	Recoupment, Fine, and AG Referral	$1,511.00	$1,000.00
New Horizons	19662	12/28/2010	Recoupment	1,691.74	0.00
			Total	**$138,129.36**	**$1,000.00**

Overall, DHH's penalty structure and imposition of consistent fines, especially in cases involving multiple offenses, could be improved. As the exhibit shows, this provider had multiple cases involving over $138,000 in improper payments. However, DHH only fined this provider $1,000, or less than 1% of the provider's total improper payments. This situation is not unique to this provider. Appendix D provides a complete list of providers, their number of cases/offenses, the amount DHH recouped, and the amount DHH fined for closed SURS cases from CY2005 to CY2010.

Recommendation 9: DHH should consider strengthening its sanction rule to impose higher fines based on the provider's identified overpayment.

Summary of Management's Response: DHH agrees with this recommendation and is reviewing the current sanctioning rules to determine if any additional changes are warranted.

Recommendation 10: DHH should consider imposing fines for first offenses.

Summary of Management's Response: DHH agrees with this recommendation and is determining if changes to its fine processes are warranted.

Recommendation 11: DHH should ensure that all fines are assessed consistently and appropriately.

Summary of Management's Response: DHH agrees with this recommendation and is reviewing all departments' fines to make sure the same fine structure applies equally to all provider types.

Objective 2: What enhancements could DHH make to identify and recover improper payments in the LT-PCS, NOW, and EDA programs?

As mentioned earlier, DHH recovered 80% of the total Medicaid improper payments it identified. However, DHH ranks low compared to other states in its overall identification of improper payments. We identified three activities that could enhance DHH's processes to identify improper payments. These activities are summarized in more detail in the sections below.

DHH should expand its programmatic monitoring process to include LT-PCS providers and to include financial monitoring

Provider monitoring is one of the most important activities to both identify and deter improper payments. DHH currently monitors a random sample 5% of waiver recipients each year, which equates to approximately 840 recipients per year. The purpose of this review is to determine whether services were provided in accordance with the recipient's comprehensive plan of care. However, DHH only conducts this monitoring for the waiver programs, so LT-PCS providers are not routinely monitored. According to DHH, once an LT-PCS provider is initially licensed, it is possible that they may never receive another monitoring visit by DHH unless DHH is investigating a complaint. Including LT-PCS providers in their current programmatic monitoring process would result in better coverage of providers.

DHH's current monitoring process could also be enhanced by conducting financial monitoring during its programmatic monitoring visits. Financial monitoring, which would include comparing actual paid claims to supporting documentation, would provide DHH the opportunity to identify more improper payments.

To determine whether other states conduct financial monitoring, we surveyed 10 states that have historically identified large amounts of improper payments to determine if they conduct financial monitoring. We found that of the six states that responded to our survey, five conduct some type of financial monitoring on its home and community based providers. Exhibit 13 provides a summary of the financial monitoring conducted in these five states.

Exhibit 13
States Conducting Financial Accountability Monitoring of Home Community Based Programs

State	Description
Florida	• Systematically conducts a number of focused field projects on home care providers. Most efforts are concentrated in Miami-Dade County where the largest concentration of home providers is based. Approximately 5 to 10 of the "larger" billing entities are chosen for each project. For approximately one week, records are evaluated and interviews are conducted with recipients and primary prescribers of services.

Exhibit 13 States Conducting Financial Accountability Monitoring of Home Community Based Programs	
State	**Description**
Connecticut	• Contracts with three access agencies who manage the home care program. These agencies then contract with providers. The agencies conduct audits of their providers which include comparisons of billing records to documentation.
Kentucky	• Conducts annual, first line billing audits of all home and community based services providers and 50% of home health providers (resulting in an audit for each provider every other year).
Missouri	• Conducts unannounced visits in which MMIS billing records are compared to documentation. • The State Plan requires that all providers be visited in a three year period.
Tennessee	• Financial Accountability Reviews (FARs) are conducted annually for 100% of providers who receive greater than or equal to $300,000 in Medicaid reimbursement. • Reviews waiver claims of approximately 20-30% of providers annually. These reviews are a result of a random sample of waiver recipients during the audit time period. The recipients' providers are identified and audited. These audits may also result from outcomes of quality assurance surveys.
Source: Prepared by the legislative auditor's staff with survey information and telephone contact.	

According to DHH, they have issued a Request for Proposal for a contractor to assume the monitoring functions. However, the proposal does not include financial monitoring nor does it include LT-PCS providers in the monitoring process.

Recommendation 12: DHH should expand its programmatic monitoring process to include LT-PCS providers.

Summary of Management's Response: DHH agrees with this recommendation and will include monthly calls and quarterly in-home visits for LT-PCS providers to ensure that the recipients are actually getting the services they have been authorized to receive.

Recommendation 13: DHH should expand its programmatic monitoring process to include financial monitoring to ensure that services billed by providers are actually provided to recipients.

Summary of Management's Response: DHH agrees with this recommendation and is developing rules and procedures to require home and community based service providers to prepare and submit annual cost reports.

Increased use of data mining could increase the identification of improper payments

As Medicaid billing is highly complex and services are delivered by a wide range of providers, it is important for DHH to use an array of computerized detection tools to identify billing error, abuse, and potential fraud. DHH currently uses a detection tool called J-SURS to analyze Medicaid claim data to detect improper payments. Although J-SURS is used by other states, other states also use various detection tools to enhance its capabilities. A list of detection systems and analysis techniques used by Florida and New York is presented in Exhibit 14.

Data mining and advanced detection tools help states identify outlier providers who exhibit general patterns of abnormal behavior including over-utilization, upcoding, un-bundling, overlapping services and double billing.

Exhibit 14
Detection Tools Used by Other States

	Function
Florida	
Decision Support System	Stores seven years of providers' claim history and determines possible over-utilization and other deviations from expected values and norms associated with reimbursement for Medicaid goods and services.
Chi Square Upcoding Reports	Applies when a provider bills for services using procedure codes in a series of codes paying different amounts, so that upcoding, or using a higher-paying code than warranted, is possible.
Early Warning System	Determines the rates of increase in payments to providers. Very rapid increases in payments may be due to the fact that providers are new or to other legitimate reasons. Or, they may be due to unwarranted billings by providers.
New York	
Data Warehouse	Stores five years of Medicaid claims with payments exceeding $200 billion; includes a graphical user interface which assists users in the compilation of queries. More sophisticated users have access to the data through the use of Structured Query Language (SQL) which allows for more complicated queries.
Desktop Graphical User Interface Tool	Provides ease-of-use through a graphical user interface; allows the user to make complex queries and effortlessly drill down into increasing levels of detail; displays results graphically or geographically.
Link Analysis Software	Specializes in resolving entity relationships (e.g. identity attributes) from disparate data sources; alerts staff on a number of entity relationships which include: duplicate recipient identification numbers, deceased recipients, duplicate providers, providers/associates with sanctions, deceased providers, providers who are recipients and relationships between current providers and those with a history of sanctions.

Source: Prepared by legislative auditor's staff using information from Florida and New York.

While DHH has the ability with J-SURS to conduct many of the above activities, DHH could enhance its data mining capabilities by expanding and diversifying its staff. Currently, DHH does not have any full-time staff devoted solely to data mining. In addition, DHH's staff consists of registered nurses. Since data mining is not wholly a computer-related process, devoting staff with diverse backgrounds to this activity is critical in providing input into the algorithms as well as interpreting the results. According to New York's Office of Medicaid Inspector General, their data mining team consists of eight individuals who possess experience auditing the Medicaid program and have backgrounds in accounting, business, fraud detection, nursing, and computer programming.

Despite having limited staff, DHH has found data mining to be an effective method to detect Medicaid improper payments. Of the 423 cases closed by SURS in CY2010, 246 (58.16%) originated from data mining. These cases resulted in the second largest amount of improper payments. On average, $1,061.20 was recouped per case originated by data mining.

Exhibit 15
Sources of Closed Cases in CY2010
Involving Waiver and LT-PCS Providers

Case Type	Number	Percentage	Total Recoupment	Average Recoupment per Case
Data Mining/Detection Tools	246	58.16%	$261,056.18	$1,061.20
Complaints	161	38.06%	83,750.72	520.19
Provider Reviews	8	1.89%	0	0
Explanation of Benefits	5	1.18%	0	0
Self-Audits	3	0.71%	6,004.26	2,001.42
Total	**423**	**100.00%**	**$350,811.16**	**$829.34**

Source: Prepared by legislative auditor's staff using data from SURS.

Recommendation 14: DHH should evaluate the cost-benefit of hiring additional and diversified staff to maximize their capabilities of identifying Medicaid improper payments.

Summary of Management's Response: DHH agrees with this recommendation and is determining the possibility of hiring additional contractors to enhance its data mining capabilities related to identifying improper Medicaid claims.

Analysis of claims denied due to errors could enhance current efforts to identify problem providers

DHH's MMIS has hundreds of edit checks that deny claims with certain characteristics. However, DHH does not currently use the error (or exception) code data to help determine the most prevalent errors or providers with the largest number of errors. For example, one of the most common errors in the LT-PCS program is providers trying to bill for more than what is

authorized, which could indicate that providers are intentionally trying to overbill. Other states, such as New York, conduct reviews based on error codes. For example, in FY2009, New York initiated 170 audits based on error codes resulting in over $2 million in potential improper payments.

Exhibit 16 summarizes the top denials for LT-PCS, EDA, and NOW programs for the month of January 2011.

Exhibit 16
Claim Errors Ranking
1/1/2011 - 1/31/2011

Ranking	Error Code	Number	Percentage	Description
LT-PCS				
1	813	**11,439**	**38.4%**	Exact duplicate error - identical provider claims
2	194	**5,896**	**19.8%**	Claim exceeds Prior Authorization limits
3	433	**1,437**	**4.8%**	Missing/invalid diagnosis code
4	272	**1,250**	**4.2%**	Claim exceeds 1 year filing limit
5	215	**1,096**	**3.7%**	Recipient not on file
EDA				
1	813	**8,830**	**17.2%**	Exact duplicate error - identical provider claims
2	972	**8,342**	**16.3%**	Allowable amount paid in full by Medicare
3	942	**3,508**	**6.8%**	Denied by Medicare, not covered by Medicaid
4	275	**2,800**	**5.5%**	Recipient is Medicare eligible
5	535	**2,712**	**5.3%**	Bill Medicare Part D
NOW				
1	813	**6,374**	**19.5%**	Exact duplicate error - identical provider claims
2	194	**2,390**	**7.3%**	Claim exceeds Prior Authorization limits
3	972	**1,669**	**5.1%**	Allowable amount paid in full by Medicare
4	299	**1,405**	**4.3%**	The procedure or drug not covered by Medicaid
5	190	**1,358**	**4.1%**	The Prior Authorization number not on file

Source: Prepared by legislative auditor's staff using error codes from MMIS.

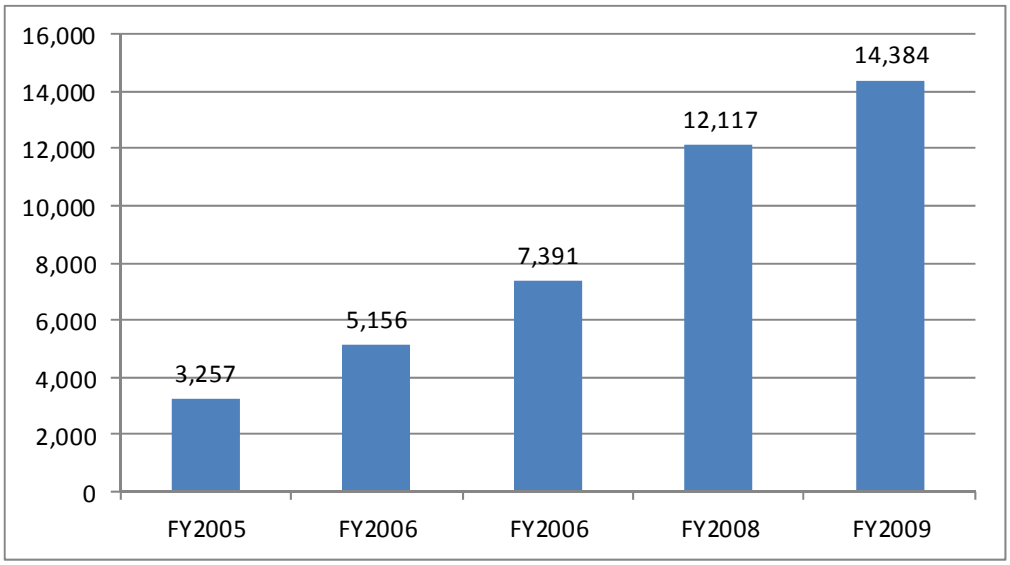
Recommendation 15: DHH should consider periodically reviewing denied claims to assess the prevalence of certain errors and to determine if providers repeatedly have the same error code. This information could be used to potentially open program integrity cases or to recommend additional training to providers.

Summary of Management's Response: DHH agrees with this recommendation and will start reviewing denied claims of problem providers to determine if the information gathered could be used to open a case or if the provider needs further training on proper billing.

Objective 3: How can DHH reduce costs in the LT-PCS program?

Expenditures in the LT-PCS program have increased significantly due to the large number of new enrollees each year. For example, in FY2005 there were only 3,257 recipients. In FY2009, this number rose to over 14,000 recipients. Exhibit 17 summarizes the number of LT-PCS recipients over the last five years.

Exhibit 17
LT-PCS Recipients FY2005 to FY2010



Source: Prepared by legislative auditor's staff using data from DHH.

DHH has implemented some cost-savings measures, such as reducing the number of hours an individual can receive each week. The program began at 56 hours a week and is currently limited to 32 hours a week. As a result of DHH's cost-saving measures, the per-person annual cost has been reduced from $24,934 in 2008 to $16,606 in 2011. We identified two additional ways DHH could save money in this program. These are summarized below.

Using shared supports in the LT-PCS program would have saved approximately $3.5 million in CY2010

In our review of cases that overlapped summarized on page 8, we noticed that some of the overlapping cases identified involved individuals who were caring for two family members in the same home at the same time. The NOW and EDA waivers allow shared supports, meaning that one direct care worker can work for two individuals that live at the same address and charge a reduced hourly fee for each one. However, the LT-PCS program currently does not allow shared supports.

We calculated the cost savings if shared supports were used at the EDA rate for all individuals residing at duplicate addresses identified in MMIS data from calendar year 2010. We identified approximately 1,053 individuals currently in LT-PCS that resided at addresses that were duplicative of other recipients. If these individuals had used shared supports instead of two direct care workers, the state could have saved approximately $3.5 million over the last year. Exhibit 18 summarizes the potential cost savings.

Exhibit 18
Cost Savings of Using Shared Supports with LT-PCS

Number Residing at Same Address	1,053
Current Total Per Week*	$353,808
Proposed Total Per Week**	$286,079
Savings Per Week	**$67,729**
Savings Per Year	**$3,521,908**

Source: Prepared by legislative auditor's staff using data from MMIS.
*For the current rate, we used $3.50 per 15 minutes, or $14.00 per hour.
**For the proposed rate, we used the EDA rate of $2.83 per fifteen minutes, or $11.32 per hour.

Recommendation 16: In order to decrease program costs, DHH should consider allowing shared supports in the LT-PCS program.

Summary of Management's Response: DHH agrees with this recommendation and has begun developing a policy allowing LT-PCS workers to assist up to three LT-PCS participants who live in the same residence.

The LT-PCS eligibility appeal process averages five months resulting in increased program costs

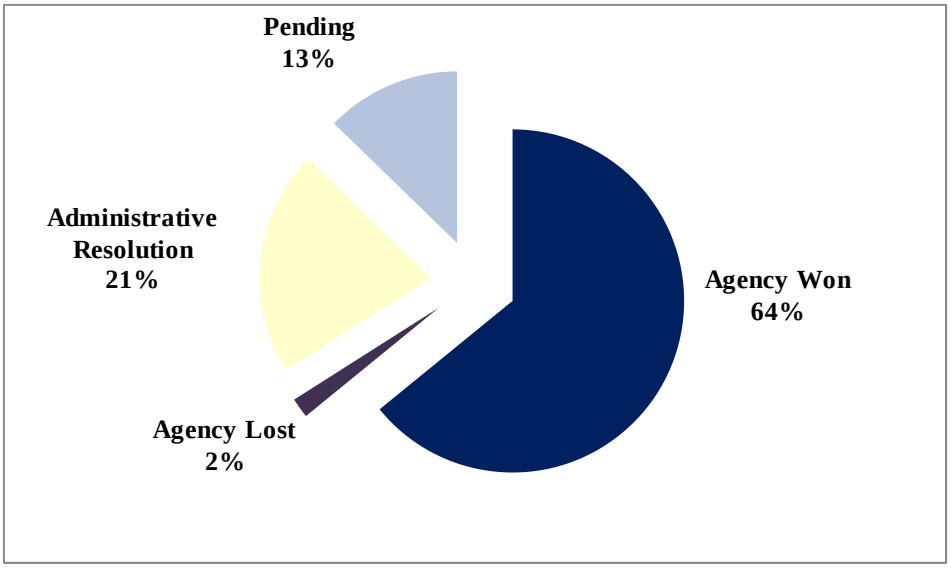
Although DHH is using a nationally recognized assessment tool to determine LT-PCS recipients' eligibility and number of approved service hours, multiple and lengthy appeals have resulted in excess services to recipients while they wait for the appeal to be resolved. DHH re-assesses LT-PCS recipients' medical needs annually. If DHH's re-assessment of a recipient reduces their weekly hours of care, the recipient has the right to appeal the reduction through the Division of Administrative Law (DAL).[4] After an appeal is filed, DHH is required to submit a summary of evidence to the DAL to justify the reduction within seven days from the time they are notified of the case. DHH currently only has one staff devoted to this function.

During the appeal process, which takes an average of five months,[5] DHH policy allows recipients to have services continue at their previous level, up to the new LT-PCS program maximum of 32 hours per week. Recipients are encouraged by their providers to appeal all reductions; however, only a small percentage of appeals are decided in the recipients' favor. We found that at least 64% of appeals were found in favor of DHH, meaning that the service hour

[4] The Division of Administrative Law is Louisiana's centralized state administrative hearings panel within the Louisiana Department of State Civil Service.
[5] This is an average of five months from the date that DAL notifies DHH of the appeal to the date that DAL makes a decision.

reductions in these cases were justified. Exhibit 19 below shows the results of LT-PCS appeal cases filed from January 2009 to March 2011.

Exhibit 19
Resolution of LT-PCS Appeals Cases
January 2009 to March 2011



Note: Administrative Resolutions include appeals closed due to one of several reasons including: death of recipient, the Agency rescinded its decision, the recipient received another assessment, the recipient started services on a waiver program, etc.
Source: Prepared by legislative auditor's staff using appeals data from DHH.

DHH does not keep track of the dates when extended service hours are actually discontinued for recipients who lose their appeal case or the number of extended hours given to each recipient during the appeal process. Therefore, the exact cost of offering extended service hours during the appeal process could not be determined. However, if an average of 10 extended hours were given to each LT-PCS appellant during the appeal process between January 2009 and March 2011, DHH would have spent at least $1.5 million on excess services to those recipients who ultimately lost their appeal. If DHH had been able to reduce the amount of time required to process appeals in this scenario, cost savings of at least $284,570 could have been realized for every month that was reduced.

Recommendation 17: DHH should evaluate the cost benefit of hiring additional staff to streamline the LT-PCS appeal process and decrease the cost of allowing extended services hours during the process.

Summary of Management's Response: DHH agrees with this recommendation and has implemented a paperless appeal system to streamline the appeal process.

APPENDIX A: MANAGEMENT'S RESPONSE

Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Management and Finance

August 25, 2011

Daryl G. Purpera, CPA, CFE
Legislative Auditor
P.O. Box 94397
Baton Rouge, LA 70804-9397

Dear Legislative Auditor Purpera:

The Department of Health and Hospitals (DHH) would like to take this opportunity to thank you and your staff for their hard work related to the preparation of the "**Prevention, Detection, and Recovery of Improper Medicaid Payments in Home and Community Based Programs**" report. This report will help DHH management make necessary changes to this program and will assist us in providing better support to the citizens we serve.

Per your offices request, the Department has reviewed this report and each of your offices recommendations. For each recommendation we will indicate if we agree or disagree with each of the recommendation and identify the corresponding corrective action we are taking as a result of this review.

The following is each of your offices recommendations and the corresponding corrective action:

Recommendation 1: DHH should develop an edit check that prevents direct care workers who work for two different agencies from submitting overlapping claims.

- DHH agrees with this recommendation. In the short term, we will issue a policy requiring the direct service providers to input the correct Social Security Numbers and dates of birth for all direct care staff into the Louisiana Services Tracking System (LAST). For the long term, DHH is in the process of implementing a new Medicaid Management Information System (MMIS) and part of this implementation will include a direct care staff electronic visit verifications system.

Recommendation 2: DHH should consider developing a review of pending claims to check for duplicative LT-PCS, nursing home, ADHC, and hospital services.

- DHH agrees with this recommendation and we are currently working with our Fiscal Intermediary contractor to develop a pre-payment review system. The review system will allow the Program Integrity section to review claims for up to two weeks before the payments are released to the providers.

Recommendation 3: DHH should require that any changes made to prior authorization numbers are reviewed by SRI to ensure services have not already been provided.

- DHH agrees with this recommendation and will work with SRI to implement. In addition, our contractor Affiliated Computer Services (ACS) which prepares the plans of care on which prior authorizations are based, has been charged with calling recipients monthly and performing quarterly in the home monitoring. This process is effective for July 1, 2011. These calls and visits will help to ensure that the person is still eligible to receive services and that nothing has changed that would warrant a need to cancel the prior authorization (such as death, loss of Medicaid eligibility, moved out of state, institutionalization, etc.). As a result, ACS will be able to notify SRI to cancel prior authorizations more quickly where they are not needed. Second, this should be much less of an issue as since July 1, 2010 EDA waiver recipients receive personal care through the waiver and can no longer access LT-PCS. Fail safes have been implemented to ensure that any existing LT-PCS prior authorizations for waiver recipients are canceled as soon as they are approved for the waiver.

Recommendation 4: DHH should ensure that they are in compliance with the Affordable Care Act which requires the states to conduct provider re-enrollment, pre and post enrollment site visits, and criminal background checks.

- DHH agrees with this recommendation. A new Home and Community Based Services (HCBS) Licensing rule was promulgated June 20, 2011 mandates a copy of a statewide criminal background check, including sex offender registry status, be provided on all owners and administrators of HCBS providers. This will be applicable to all future and current providers. DHH also intends to comply with the provider screening provisions of the Affordable Care Act (ACA) and these provisions will be implemented during the first 13 months of the new fiscal intermediary contract.

Recommendation 5: DHH should consider requiring certain providers to purchase surety bonds upon enrollment.

- DHH agrees with this recommendation and we are in the process of reviewing this recommendation and making the determination if it will be beneficial to start requiring high risk providers to purchase a surety bond upon enrollment.

Recommendation 6: DHH should consider providing pre-enrollment training to providers it deems high risk and use information from monitoring, licensing, SURS cases, and error codes to determine what kinds of training would be most valuable to providers.

- DHH agrees with this recommendation. Currently, DHH's Program Integrity section participates in the training held by Health Standards for all newly licensed personal care assistance agencies and our Fiscal Intermediary Provider Relations staff holds annual trainings for all providers on the contents of all the manuals and addresses areas of concern. DHH is currently determining how we will incorporate this recommendation into the training previously mentioned.

Recommendation 7: DHH should require that provider agencies submit accurate and complete employee social security numbers to the LAST system so that DHH can use this database to periodically check employees against exclusion data.

- DHH agrees with this recommendation and we are in the process of issuing a policy requiring the direct service providers to input correct Social Security Numbers and dates of birth for all direct care staff into the Louisiana Services Tracking System (LAST). The Program Integrity section is currently checking provider employees who are part of a SURS audit against the Federal exclusion list.

Recommendation 8: DHH should consider systems used in other states for implementing a call-in system for all home and community based services. The call-in system should be linked to the Medicaid payment system to ensure that providers are only paid for the period of time recorded by the system. This system would eliminate some of the problems with overlapping services outlined in the report.

- DHH agrees with this recommendation and implementation of an electronic visit verifications system is a deliverable in the recently awarded Medicaid Management Information Systems (MMIS) contract. DHH's solicitation for proposal calls for implementation of this system within eight (8) months of the start of the new MMIS contract.

Recommendation 9: DHH should consider strengthening its sanction rule to impose higher fines based on the provider's identified overpayment.

- DHH agrees with this recommendation. We currently have the authority under the Surveillance Utilization Review Section (SURS) rule to sanction a provider up to $10,000 per occurrence and we are reviewing our sanctioning rules to determine if any additional changes are warranted.

Recommendation 10: DHH should consider imposing fines for first offenses.

- DHH agrees with this recommendation and we are reviewing this to determine if changes to our processes are warranted. We want to make sure we give providers sufficient time to correct mistakes/errors and that we are not giving the providers a disincentive to self-report overpayments and/or errors before fines are imposed.

Recommendation 11: DHH should ensure that all fines are assessed consistently and appropriately.

- DHH agrees with this recommendation and we are currently reviewing the department's standard fine chart to make sure the same fine structure applies equally to all provider types.

Recommendation 12: DHH should expand its programmatic monitoring process to include LT-PCS providers.

- DHH agrees with this recommendation and our contractor Affiliated Computer Services (ACS) is currently being tasked to expand their duties starting July 1, 2011 to include monthly calls and quarterly in-home visits for LT-PCS providers. These calls and visits will help to ensure that the recipients are actually getting the services they have been authorized and confirm that the clients are satisfied with these services. We have issued the Request for Proposal (RFP) that will ultimately produce a contract for increased monitoring of the Home and Community Based Service (HCBS) providers.

Recommendation 13: DHH should expand its programmatic monitoring process to include financial monitoring to ensure that services billed by providers are actually provided to recipients.

- DHH agrees with this recommendation and as part of the plan required by Act 299 of the 2011 Regular session, DHH is developing rules and procedures to require HCBS providers to prepare and submit annual cost reports. A plan cost reports will be developed by January 15, 2011.

Recommendation 14: DHH should evaluate the cost-benefit of hiring additional and diversified staff to maximize their capabilities of identifying Medicaid improper payments.

- DHH agrees with this recommendation and is reviewing this recommendation to determine the possibility of hiring additional contractors to boost our data mining capabilities related to identifying improper Medicaid claims.

Recommendation 15: DHH should consider periodically reviewing denied claims to assess the prevalence of certain errors and to determine if providers repeatedly have the same error code. This information could be used to potentially open program integrity cases or to recommend additional training to providers.

- DHH agrees with this recommendation and our Program Integrity section will start the process of reviewing the denied claims of problem providers and determine if the information gathered could be used to open a case or if the provider should be referred to provider relations for further training on proper billing.

Recommendation 16: In order to decrease program costs, DHH should consider allowing shared supports in the LT-PCS program.

- DHH agrees with this recommendation and our Office for Aging and Adult Services (OAAS) has begun the process of developing a policy to allow LT-PCS workers to assist up to three (3) LT-PCS participants who live in the same residence. OAAS anticipates having this policy finalized by October 1, 2011 and they are currently identifying the recipients which are candidates for this new service delivery method.

Recommendation 17: DHH should evaluate the cost benefit of hiring additional staff to streamline the LT-PCS appeal process and decrease the cost of allowing extended services hours during the process.

- DHH agrees with this recommendation and our Office for Aging and Adult Services (OAAS) has been working hard to alleviate the backlog of appeals related to the LT-PCS program. They have implemented a paperless appeal system to streamline the appeal process and as of August 1, 2011, there is no longer any backlog associated with OAAS's part of the appeal process. The Division of Administrative Law performs the Departments appeal process and we are currently working with them to schedule these hearings and clear the current backlog.

DHH looks forward to working with your office in the future and if you have any questions or need any additional information, please contact W. Jeff Reynolds, Deputy Medicaid Director at 225-342-6043 or by e-mail at Jeff.Reynolds@la.gov.

Sincerely,

Jerry Phillips, Undersecretary
Department of Health and Hospitals

JP/jr

APPENDIX B: SCOPE AND METHODOLOGY

We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. Louisiana Revised Statute (R.S.) 24:522 directs the Legislative Auditor to establish a schedule of performance audits to ensure that at least one performance audit is completed and published for each executive department agency within a seven-year period, beginning with the 1998 fiscal year. In accordance with this legislative mandate, we scheduled a performance audit of the Department of Health and Hospitals (DHH) for FY2011. Our audit focused on the prevention, detection, and recovery of improper payments to Medicaid providers for the Long-Term Personal Care Services (LT-PCS) program, the Elderly and Disabled Adult waiver (EDA) program, and the New Opportunities waiver (NOW) program. We also evaluated ways to reduce costs in the LT-PCS program. Our audit period generally covered CY2010, but in some cases we reviewed data over the last five years to evaluate patterns and trends. This audit does not include Medicaid fraud activities conducted by the Louisiana Attorney General's Medicaid Fraud Control Unit.

The audit objectives were to answer the following questions:

1. What enhancements could DHH make to prevent or deter improper payments in the LT-PCS, NOW, and EDA programs?

2. What enhancements could DHH make to identify and recover improper payments in the LT-PCS, NOW, and EDA programs?

3. How can DHH reduce costs in the LT-PCS program?

We conducted this performance audit in accordance with generally accepted government auditing standards promulgated by the Comptroller General. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. To answer the audit objectives, we reviewed internal controls relevant to the audit objectives and performed the following audit steps:

- Researched and reviewed federal and state laws and DHH's internal policies and procedures

- Identified prevention and detection best practices by reviewing the following sources:

  - Other states' Medicaid program integrity audit reports
  - Other state's annual program integrity reports

  - Centers for Medicare and Medicaid Services' (CMS) 2009 and 2010 Program Integrity review reports

- Throughout this report, we primarily used Florida, New York, and Texas as best practice states in detecting Medicaid improper payments because we found that these three states identified significant amounts of improper payments in a cost-effective manner

- Obtained and analyzed CMS's 2008 State Program Integrity Assessment data as well as states' 2008 Medicaid expenditures data to identify states with high percentages of improper payment identification and compare Louisiana to other states

- Contacted other states who identify a high percentage of improper Medicaid payments to determine their programmatic monitoring activities related to Medicaid services within our scope

- Contacted Florida and South Carolina to obtain cost-savings data related to the implementation of a call-in system

- Interviewed various DHH staff and contractors to develop an understanding of program operations

- Conducted site visits to observe DHH's 5% monitoring process and Provider Enrollment process

- Conducted file reviews of improper payment cases investigated by Molina's Surveillance and Utilization Review System unit

- Obtained and analyzed error data detected by Medicaid Management Information System (MMIS) edit checks from Medicaid claims submitted during January 2011

- Analyzed 2009-2011 LT-PCS and EDA appeal case data obtained from DHH

- Obtained and analyzed 2005-2010 case and fine data from DHH's Medicaid fiscal intermediary - Molina

- Obtained and analyzed CY2010 Medicaid claims data from the MMIS

- Obtained and analyzed CY2010 service tracking data from the Louisiana Service Tracking System

- Evaluated controls and reliability of data sets used in analysis

APPENDIX C: STATE MEDICAID PROGRAM INTEGRITY EFFECTIVENESS COMPARISON

State	Medicaid Improper Payments Recovered	Amount Recovered per FTE	National Ranking	Dollar Amount Recovered per Dollar Amount on Medicaid Program Integrity Activities	National Ranking	Percent of Total Medicaid Spending Recovered through Program Integrity Activities	National Ranking
Alabama	$7,503,776.95	$267,992.03	27	4.21	20	0.1840%	33
Alaska	712,759.00	101,822.71	39	0.37	41	0.0801%	39
Arizona	6,780,000.00	125,555.56	38	2.72	30	0.0903%	37
Arkansas	No Data	No Data	N/A	No Data	N/A	No Data	N/A
California	87,806,150.58	82,781.32	42	1.26	35	0.2266%	28
Colorado	7,132,619.45	713,261.95	16	No Data	N/A	0.2250%	29
Connecticut	35,000,000.00	1,458,333.33	3	5.93	14	0.7703%	9
Delaware	852,092.66	34,083.71	45	0.81	37	0.0773%	40
District of Columbia	9,561,091.86	562,417.17	21	4.11	21	0.6613%	12
Florida	No Data	No Data	N/A	No Data	N/A	No Data	N/A
Georgia	5,300,000	160,606.06	33	59.55	1	0.0722%	42
Hawaii	50,000.00	8,333.33	47	0.06	42	0.0041%	47
Idaho	1,058,245.27	132,280.66	37	1.81	33	0.0877%	38
Illinois	21,525,178.10	140,687.44	35	3.90	23	0.1855%	32
Indiana	2,435,322.56	26,761.79	46	0.39	40	0.0396%	45
Iowa	2,911,489.00	83,185.40	41	0.91	36	0.1024%	36
Kansas	28,356,819.00	395,768.58	26	3.46	25	1.2468%	5
Kentucky	31,268,516	781,712.90	13	2.75	29	0.6503%	13
Louisiana	3,853,819.72	**44,811.86**	**44**	**0.58**	**39**	**0.0635%**	**44**

State	Medicaid Improper Payments Recovered	Amount Recovered per FTE	National Ranking	Dollar Amount Recovered per Dollar Amount on Medicaid Program Integrity Activities	National Ranking	Percent of Total Medicaid Spending Recovered through Program Integrity Activities	National Ranking
Maine	$12,262,347.44	$167,977.36	32	3.29	26	0.5442%	15
Maryland	22,771,707.00	591,472.91	19	4.39	19	0.3995%	22
Massachusetts	53,693,415.00	1,342,335.38	6	6.32	13	0.4962%	16
Michigan	3,331,900.80	151,450.04	34	No Data	N/A	0.0338%	46
Minnesota	4,718,000.00	94,360.00	40	0.72	38	0.0676%	43
Mississippi	2,793,886.67	133,042.22	36	3.24	27	0.0733%	41
Missouri	51,020,140.00	773,032.42	14	10.90	5	0.7196%	10
Montana	No Data	No Data	N/A	No Data	N/A	No Data	N/A
Nebraska	5,346,436.97	1,069,287.39	8	5.19	17	0.3366%	23
Nevada	5,841,165.00	253,963.70	29	2.54	32	0.4435%	19
New Hampshire	No Data	No Data	N/A	No Data	N/A	No Data	N/A
New Jersey	17,169,447.55	686,777.90	17	9.25	7	0.1822%	34
New Mexico	6,389,670.13	912,810.02	9	15.03	3	0.2098%	31
New York	476,355,675.00	892,051.83	10	8.37	10	1.0004%	6
North Carolina	93,593,561.82	667,333.77	18	No Data	N/A	0.9210%	8
North Dakota	3,782,224.68	1,146,128.69	7	No Data	N/A	0.7077%	11
Ohio	58,860,930.48	878,521.35	12	5.07	18	0.4509%	18
Oklahoma	15,240,619.52	578,830.97	20	5.29	16	0.4307%	20
Oregon	18,691,876.00	743,215.75	15	6.80	12	0.5804%	14
Pennsylvania	43,466,618.38	536,624.92	22	14.40	4	0.2667%	26
Rhode Island	33,290,451.00	1,560,733.76	2	18.76	2	1.8150%	1
South Carolina	18,468,810.00	879,467.14	11	9.04	8	0.4163%	21
South Dakota	11,091,683.00	482,247.09	24	6.88	11	1.6920%	2
Tennessee	66,216,000.00	1,891,885.71	1	5.82	15	0.9227%	7
Texas	286,167,120.26	1,438,025.73	4	8.53	9	1.3334%	3
Utah	3,976,451.16	265,096.74	28	3.92	22	0.2621%	27
Vermont	2,129,314.40	532,328.60	23	1.46	34	0.2188%	30

State	Medicaid Improper Payments Recovered	Amount Recovered per FTE	National Ranking	Dollar Amount Recovered per Dollar Amount on Medicaid Program Integrity Activities	National Ranking	Percent of Total Medicaid Spending Recovered through Program Integrity Activities	National Ranking
Virginia	$69,968,063.37	$1,427,919.66	5	2.60	31	1.2996%	4
Washington	29,093,183.00	451,057.10	25	3.63	24	0.4623%	17
West Virginia	6,408,192.02	206,715.87	30	10.63	6	0.2813%	24
Wisconsin	13,533,892.00	189,285.20	31	No Data	N/A	0.2713%	25
Wyoming	505,180.00	57,734.86	43	3.05	28	0.1025%	35
National Average	**$35,920,975.38**	**$555,789.57**		**$6.38**		**0.461883%**	

Source: This analysis is based on each states' self-reported data to CMS's FY2008 State Program Integrity Assessment Survey and states' 2008 Medicaid Budgets.

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APPENDIX D: SUMMARY OF PROVIDERS, NUMBER OF CASES, RECOUPMENTS AND FINES CY2005 TO CY2010

Provider Name	Cases	Total Recoupments	Number of Fines	Total Fines
Helping Hands	21	$27,470.50	1	$5,000.00
Care Inc.	17	37,890.22	2	2,000.00
Association For Retarded Citizens	16	135,255.22		
Gulf Coast Teach Fam.Serv-L.C	16	59,979.64		
New Horizons Ind Living Ctr	15	138,129.36	1	1,000.00
Family Care Services	13	12,451.80		
Southwest La Indepence Ctr	13	77,799.00		
Community Connection Programs	13	117,291.10		
Home Assistance Services Inc.	13	35,573.96	1	3,483.96
L & D Community Care Inc.	12	75,740.71	2	3,410.89
First Thessalonians Comm Programs	12	90,291.04	1	5,000.00
Leading Health Care Of La	10	489.36		
We Care Homes Inc.	10	33,177.71	1	1,000.00
Bethesda Community Programs	9	44,031.65		
Heavenly Haven Inc.	8	57,707.11	1	1,000.00
Maxima Group Behavioral Svcs	8	8,908.35		
Marie's Family Healthcare	8	5,188.58	1	1,000.00
P & L Medical Services	8	14,820.84	1	1,250.00
Certicare Inc.	8	15,522.00		
Metropolitan Circles LLC	8	14,924.13		
Angels Of Mercy	8	9,401.50	1	110.88
Agape Care Provider	8	71,781.93		
Kellies Sitting Services Inc.	8	5,693.66		
We Care Home Care Inc.	8	55,157.44		
Rejuvenating Concepts Inc.	7	2,262.96		
Alms Resource Center	7	14,914.50		
Community Support Specialists	7	1,352.00		
Volunteers Of America	7	66,378.86		
Red River Health Care	7	11,303.83		
Immaculate Heart Of Mary	7	7,875.70		

Provider Name	Cases	Total Recoupments	Number of Fines	Total Fines
Rms Care Providers Inc.	7	$69,362.82		
Community Angels Of Hope LLC	7	41,987.77	2	$10,408.54
Tcp Inc.	7	98,146.12		
An Angels Touch Of The River	7	83,267.50		
Parishes Supportive Living	7	12,820.14	1	1,000.00
House Of Mercy Inc.	7	20,593.50	1	1,000.00
Home-Care Pca LLC	7	26,337.25		
Tender Loving Care Prof Adult	6	2,742.10		
Seniors Club	6	52,123.88		
Paynes Home Care Services Inc.	6	58,237.79		
Guardian Angels Care Services	6	24,501.09		
Tarc	6	2,766.82		
Hearts Desire	6	8,564.36		
All About Care Inc.	6	6,019.82		
Families First Choice Inc.	6	23,673.67	1	1,000.00
Professional Personal Care Svcs	5	101,544.94		
Family Resources Unlimited	5	27,597.50	1	1,000.00
Tender Heart Plus Enterprises	5	95,756.80	1	10,000.00
Heaven On Earth Network Inc.	5	86,900.93	2	14,787.43
American Pride Caregivers LLC	5	1,109.06		
Angel Lovin Care Inc.	5	75,132.60		
Someone Cares Inc.	5	7,088.00		
Holistic Concepts Inc.	5	9,718.00		
The Right Way Inc.	5	5,169.36		
Angels Healthcare Sitter Srvc	5	642.30		
Alpha Supported Living Serv	5	142,699.00	1	10,000.00
First A Southeast Inc. LLC	5	120.00		
Pdi Of The South	5	14,255.00		
Authentic Community Living	5	8,692.56	1	500.00
Qbc Home Medical	5	1,562.00		
Lafourche Arc	5	11,986.97		
Sylvias Caring Companions	5	670.72		
Bayou Home Bureau	5	55,495.28		
We Care Ministries Outreach	5	41,270.44		
Louisiana Health & Rehab Opts	5	4,023.00		
Theophilus Community Programs	5	15,398.20		
Acadiana Circle Of Friends I	5	6,236.64		

Provider Name	Cases	Total Recoupments	Number of Fines	Total Fines
Options Inc.	5	$77,781.75		
Empowering Care Services LLC	4	9,475.32		
Exceptional Client Care Service	4	36,042.42		
Evergreen Community Services	4	2,317.00		
Independent Living Inc.	4	3,270.18		
Care Solutions Inc.	4			
Northwest La Incs LLC	4	14,801.64		
Serenity Homes Of New Orleans	4	811.92		
Indo-Ameri Soft LLC	4			
Independent Care Services	4	10,228.42		
Institute For Networking Comm	4	15,489.46		
All About You Support Service	4	5,984.50		
Jubilee Respite Services Inc.	4	10,684.26		
Thomas Place Recovery House	4	36,723.06		
Angel Care Agencies LLC	4	8,002.40	1	$1,000.00
Global Personal Care Services	4	5,041.68		
Assurance Care Services	4	3,371.59		
Angel Manor LLC	4	5,369.50		
People Centered Support Services	4	11,830.76		
Superior Options Of La Inc.	4	4,716.00		
Pointe Coupee Community Care	4	89,217.20		
Family Personal Care Attendan	4	8,829.24	1	8,829.24
Angelic Touch Care Services	4			
Malicorp	4	9,477.00		
Promise Quality Care	4	3,506.90		
The Potter's House Comm Prog	4	917.20		
Higher Dimension Inc.	4	5,449.46	1	1,000.00
Extended Family Healthcare Seervices	4	38,782.00		
Delta American Healthcare Inc.	4	3,685.59		
Agape Total Care LLC	4	32,091.58		
Delta Medical Services Inc.	4	3,710.68	1	1,000.00
Medical Advantage Care LLC	4	18,993.22	2	5,000.00
Alliance Healthcare Specialist	4	18,385.32		
We Care Nursing & Family Svc	4	40,073.10		
Northshore Incs LLC	3	72.00		
True Home Care LLC	3	7,176.36		
St John Day Developmental Ctr	3	851.92		

Provider Name	Cases	Total Recoupments	Number of Fines	Total Fines
A Plus Home Care Services LLC	3	$3,996.40		
Millennium Pca Services	3	5,319.76		
Community Care Bossier Inc.	3			
Reliable Community Alternative	3	2,884.92	1	$1,000.00
Community Independent Living	3	3,010.56		
Catholic Charities Archdiocese	3	37,313.65		
Contin-U-Care Outreach Svc	3	13,698.54		
Accessible Care Services	3	84,436.08		
D & M Personal Care Attendant	3	5,343.10		
Natural Touch	3	70,620.18		
A Small World In The River	3	1,793.14		
Positive Care LLC	3	6,830.26		
Dream Team Of La Inc.	3	588.00		
Round The Clock Personal Care	3	273.00		
All Kare Alternative Inc.	3	25,114.66		
Caring Concepts For Life LLC	3	18,948.58		
Extraordinary Care Inc.	3	4,068.36	1	1,000.00
The Will Of God Min Outreach	3	5,980.70		
A1 Absolute Best Care	3	64,590.75		
United Cerebral Palsy Of G No	3	3,227.44		
Gifted Heart Services LLC	3	573.00		
Accessible Healthcare Solutions	3	4,327.36		
Good Shepherd Personal Care	3	4,221.00		
N.O.Resources-Indepen. Living	3			
Greater New Orleans-Arc	3	234.50		
New Beginning Independent Living	3	3,836.72		
Heavenly Hands Pcs	3	3,129.30		
Berrys Reliable Resources	3	8,310.18		
Able Life Care Services	3			
Quality Personal Care Att Ser	3	19,569.00		
Absolute Care Providers	3			
Reliable Pca Agency LLC	3	4,391.50		
Ibc Nursing Services Inc.	3	35,775.84		
St Genevive Health Care Services	3	1,697.72		
Acadiana Personal Care Services	3	2,457.66		
Supportive Living Skills Inc.	3	1,011.00		
Inspiration House Care Providers	3	10,497.15		

Provider Name	Cases	Total Recoupments	Number of Fines	Total Fines
Caring Hearts Medical Service	3	$5,356.33	1	$1,000.00
Anointed Angels Homecare LLC	3	3,570.00		
Cathy E Moore Respite Care	3			
Keys Of Life Professional Care	3	0.00		
Trinity Independent Living Services	3	3,896.64	1	1,000.00
La Human Care Connection Inc.	3	1,487.74		
Tunson Pca Agency	3			
Magnolia Home Care LLC	3	3,148.68		
A 1 Nursing Registry Inc.	3	852.80		
Jane Lockett Hartman Outreach	3			
Greater Fellowship Outreach	2	1,778.18		
Gentiva Health Services	2	50,000.00		
Vision Seekers LLC	2			
D & D Pca/Respite Services	2			
St John The Bapt Human Servs	2	1,748.10		
Higher Heights Managing Servi	2	39,857.78		
Holistic Educational Rehab Center	2	24,921.86		
Community Care Services Inc.	2	18,404.75		
Premier Community Services	2	4,545.16		
Home Health Care 2000	2			
Comprehensive Independent	2			
Home Instead Homecare Svcs Inc.	2	1,274.00		
Supreme Home Health Services	2	3,779.82		
Angelic Services LLC	2			
Advanced Sitting Solutions Inc.	2	402.96		
Hood Management Group Inc.	2	2,020.24		
United Home Care	2	2,226.00		
Human Svs Management And Inve	2	2,045.50		
Activities Of Daily Living Sr	2	20,725.00		
D And D Community Connections	2	14,507.26	1	373.51
Future Expectations Community	2	126.00		
Angels Care LLC	2			
Reliable Pca And Respite Care	2	2,862.86		
Independent Living Center Inc.	2	112.00		
Glory Divine Home Care Inc.	2	1,694.00		
Dear Hearts Respite & Pca Services	2	276.08		
Strive Incorporated	2	44,650.78		

Provider Name	Cases	Total Recoupments	Number of Fines	Total Fines
Comforcare Senior Services	2	$13,505.00		
Caring Hands Homemaker Services	2	325.00		
Island Enterprises	2			
Continuous Health Care Services	2	240.00		
Christian Foundation Inc.	2	849.50		
Cheries Tender Care Inc.	2	1,513.00		
All About U Personal Care Services	2	8,784.00		
Able Community Services LLC	2	6,929.00		
Anointed Care Services	2	17,408.38		
Unlimited Healthcare Services	2	900.00		
Desoto Council On Aging	2	1,054.96		
Vonnieabs Personal Care Svcs	2	5,484.36		
Community Living Alternatives	2			
Friends And Family Adhc LLC	2	2,751.00		
Assistance Just For You LLC	2	4,443.30		
Body & Soul Services Inc.	2	1,426.94		
Life At Home LLC	2	191.56		
Reaching Seniors Inc.	2	1,889.50		
Lil Lus Booming Enterprise Inc.	2			
Gentle Touch Services Inc.	2	4,817.72		
Living Stones Employment Services	2	8,680.68		
Rest Adult Day Health Care	2	896.00		
Loving Hearts Respite & Pca Services	2	1,079.69		
Seasons Health Care Services	2	1,733.94		
Lucis Troop	2	5,439.86	1	$1,000.00
Golden Rule Care Provider LLC	2	1,274.30		
Easy Care Inc.	2	4,205.00		
St Mary Council On Aging Inc.	2			
A+ People Services LLC	2	659.10		
Comfort's Intervention Services	2	919.03		
Eternal Blessing	2	6,909.00		
Grace For Grace Pcs	2	3,159.03		
Assured Health Care Providers	2			
Gracious Care Inc.	2	1,668.00		
Exceeds Their Needs Inc.	2	2,380.56		
Tender Love Pca Services	2	4,218.24		
Alexandria Community Care LLC	2	1,116.50		

Provider Name	Cases	Total Recoupments	Number of Fines	Total Fines
The Center For Better Living	2	$33,274.05		
Community Wide Conn Provi LLC	2			
Guiding Light Services Inc.	2			
Faith And Hope Independent Living	2	5,335.96		
Tlc Health Care Services LLC	2	749.00		
Nca Medsource Personal Care Services	2			
Healthy Choices LLC	2	2,126.74		
Compassion Comm Services LLC	2	53,388.00		
Amian Health Services	2	3,627.00		
Family Helpers Of Greater New Orleans	2	2,003.00		
Unity Family Service	2	264.00		
Optimum Personal Care Service	2	2,461.12		
Unlimited Home Care Of La Inc.	2			
Berachah Valley Corporation	2			
Visiting Care Association LLC	2			
Alternative Concept Care Serv	2			
Cookies Helping Hands	2	1,788.00		
Best Care Providers Inc.	2	19,070.00		
Lbh Unlimited Resources Inc.	2	194.88		
Care And Development Center Inc.	1			
Chase Health Care	1	1,092.00		
Advanced Personal Care Service	1			
Magnolia Med Resources Inc.	1	413.00		
1st Home Health Kare	1			
He Restored Us LLC	1	1,375.66		
Dsd Community Connections	1			
Assumption Arc-Pca	1			
Jamis Enterprises Inc.	1	534.04		
Martin Family Support Service	1			
Family Circle Inc.	1	182.00		
Matters Of The Heart Inc.	1	90.00		
Calcasieu Assoc/Retarded Cits	1	336.00		
Healing Hands Staffing LLC	1	74.36		
Southern Ingenuity Inc.	1			
Health Care Options Pcs	1	624.00		
St. Tammany Assoc-Retard Citzs	1			
Able Care Providers LLC	1	6,920.00		

Provider Name	Cases	Total Recoupments	Number of Fines	Total Fines
Tailored Care Inc.	1			
Ficm Inc. Care Services	1	$539.61		
Employment Assistance Services	1	814.20		
Comm Opportunities-E. Ascension	1	959.00		
Arms Of An Angel LLC	1			
First Chance Independent Living	1	19,315.50		
Louisiana Community Care Inc.	1			
Alternative Home Care Special	1	42.00		
A-1 Northwest La Incs LLC	1			
Heavens Blessings Inc.	1	920.26		
Seasons Care Services Inc.	1	944.00		
B & L Personal Care Services	1			
Shalom Home Care Services LLC	1	6,661.78		
New Life Care Services LLC	1	686.76		
Special Needs Unlimited LLC	1	2,595.84		
New Life Christian Healthcare	1	1,040.20		
St Landry Council On Aging	1	156.00		
Normal Life Family Services I	1			
Gods Gift Professional Care S	1			
North Central La Community Se	1			
Gods Way Inc.	1	3,423.00		
Northeast La Home Care	1			
Jadan Inc.	1	104.52		
A Good Home Care Services LLC	1			
Exxodus Foundation Inc.	1			
Basic Home Care Services Inc.	1			
Graceful Care Service LLC	1			
Nursing Prn	1			
La Comm Care Inc-Personal Care	1	1,239.00		
Above And Beyond Providers	1	736.28		
Ldj Childrens Residential Pal	1			
Action Resources Total Care Inc.	1	1,422.98		
Amazing Care Services LLC	1			
Bayou Industrial Maint Servs	1			
Assoc Retarded Citizens-Ouachita	1			
Bell Oaks Inc.	1	1,285.00		
American Health Inc.	1			

Provider Name	Cases	Total Recoupments	Number of Fines	Total Fines
Pathways Of La	1			
All Family Attendant Care LLC	1	$210.00		
Florida Parishes Resources	1			
Ibl Special Care Management	1			
Evangeline Council On Aging	1			
Alternatives Living Inc.	1	88,114.25		
Peltier-Lawless Developmental	1			
A Caring Place Inc.	1			
Holistic Healthcare Svs Inc.	1	6,079.64		
Care Management Alliance Inc.	1			
Phoenix Personal Care Inc.	1			
Care Services Of Nw Louisiana	1	568.82		
Pinecrest Developmental Ctr	1	1,470.00		
Angels Family Care Services	1	34,596.00		
A New Horizon Of No Inc.	1			
Gloss Enterprise LLC	1			
Pointe Coupee Outreach Center	1	1,218.26		
Acadiana Support Services LLC	1	74.36		
All American Personal Care Inc.	1	11,331.83		
Strides Of Acadiana LLC	1	3,073.00		
Precious Gems Inc.	1	132.00		
Sunset Personal Care	1	3,176.36		
Precious Life Care LLC	1	6.00		
Angels On Assignment Health C	1	307.58		
Precision Caregivers	1			
Iv Plus Alexandria	1			
Preferred Caregivers And Sitters	1	955.50		
Jaba Enterprises Inc.	1	101.50		
Preferred Living Inc.	1	406.00		
Teche Home Health Agency Inc.	1			
G M Business Services Inc.	1	29.00		
A Plus Personal Home Care Inc.	1	2,538.30		
Blessed Care Incorporated	1	1,624.38		
The Arc Of Iberia Pca Service	1	1,130.50		
Promise Pride Community Service	1			
Center For Personal Development	1	780.50		
Galvez Personal Care Services	1	1,551.28		

Provider Name	Cases	Total Recoupments	Number of Fines	Total Fines
Another Chance Enterprise Per	1	$1,946.94		
Brown & Associates Independent	1	27.04		
L & D Family Support Services	1			
Quality Care Pca/Pss Inc.	1			
Diversified Rehab Services	1	5,306.00		
Evergreen Presbyterian Minist	1	3,150.00		
Colettes Nursing & Healthcare	1	0.00		
R C Moore Inc.	1			
Allied Medicine Inc.	1	30,720.00		
Rapides Association For Retar	1			
Universal Care LLC	1	709.00		
Horizon Management Inc.	1	1,554.02		
Enhanced Health Treatment Ctr	1			
Real Care Inc.	1			
Visions Of Tomorrow Inc.	1	2,282.00		
Bumgarner Client Care Service	1			
Choice And Change Ministries	1	2,928.40		
Caddo-Bossier Assoc/Retarded	1	4,985.98		
Washington Parish Activity Ct	1			
House Of Choice Inc.	1			
Cognitive Development Ctr	1	1,104.54		
Acadiana Comm Based Servs Inc.	1	560.00		
Dreamcatchers Total Care Inc.	1			
Hammond Developmental Center	1			
A New Beginning Of New Orleans	1	1,932.00		
Hansberry Personal Care Service	1	746.98		
Grand Total	**1,090**	**$4,263,568.60**	**36**	**$96,154.45**

Note: Provider names were taken directly from SURS electronic case data and the end of some names in that data were truncated.
Source: Prepared by legislative auditor's office using data from SURS.