LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA

December 28, 2009

Interim Communication Required for the
2009 Office of Management and Budget (OMB)
Pilot Project

Ms. Angele Davis, Commissioner
Division of Administration
Post Office Box 94095
Baton Rouge, Louisiana 70804-9095

Dear Commissioner Davis:

This communication is provided pursuant to the parameters of the 2009 Office of Management and Budget (OMB) pilot project. Such project requires auditors of entities that volunteer for the project to issue, in writing, an early communication of significant deficiencies and material weaknesses in internal control over compliance for certain federal programs having expenditures of American Recovery and Reinvestment Act of 2009 (ARRA) funding at an interim date, prior to the completion of the compliance audit. Accordingly, this communication is based on our audit procedures performed through November 30, 2009, an interim period. Because we have not completed our compliance audit, additional significant deficiencies and material weaknesses may be identified and communicated in our final report on compliance and internal control over compliance issued to meet the reporting requirements of OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations.*

In planning and performing our audit through November 30, 2009, of Unemployment Insurance (UI, CFDA 17.225) and the Medical Assistance Program (Medicaid, CFDA 93.778), we are considering the State of Louisiana's compliance with activities allowed or unallowed, allowable costs, cash management, eligibility, reporting, and special tests and provisions as described in the *OMB Circular A-133 Compliance Supplement* for the year ended June 30, 2009. We are also considering the State of Louisiana's internal control over compliance with the requirements previously described that could have a direct and material effect on UI and Medicaid programs in order to determine our auditing procedures for the purpose of expressing our opinion on compliance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the State of Louisiana's internal control over compliance.

Our consideration of internal control over compliance is for the limited purpose described in the preceding paragraph and would not necessarily identify all deficiencies in the State of Louisiana's internal control that might be significant deficiencies or material weaknesses as defined in the following paragraph. However, as discussed subsequently, based on the audit procedures performed through November 30, 2009, we identified certain deficiencies in internal control over compliance that we consider to be significant deficiencies and another deficiency that we consider to be a material weakness.

A control deficiency in an entity's internal control over compliance exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect noncompliance with a type of compliance requirement of a federal program on a timely basis. A significant deficiency is a control deficiency or combination of control deficiencies that adversely affect the entity's ability to administer a federal program such that there is more than a remote likelihood that noncompliance with a type of compliance requirement of a federal program that is more than inconsequential will not be prevented or detected by the entity's internal control. We consider the following deficiencies in internal control over compliance to be significant deficiencies.

DEPARTMENT OF HEALTH AND HOSPITALS
CFDA 93.778 - MEDICAL ASSISTANCE PROGRAM

Improper Payments to Non-Emergency Medical Transportation Service Providers

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

- Copies of all Recipient Verification of Medical Transportation Forms (Form MT-3) as documentation of all trips provided
- Copies of the Driver Identification Form (MT-8) for each driver and the form be completed when drivers are hired and annually thereafter for all current drivers
- Copies of the Vehicle Inspection Form (MT-9) for each vehicle used and the form be completed on each vehicle before the vehicle can be used and annually thereafter
- A daily schedule of transports

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

- For 79 of the 153 (52%) claims tested, the providers did not maintain adequate documentation of the trips provided. In particular, providers could not provide completed copies of MT-3's to substantiate all trips approved under capitated (monthly) rates. Questioned costs totaled $26,169.

- Five of the six providers tested did not maintain an adequate daily schedule of transports in their records.

- Five of the six providers tested did not maintain adequate documentation to support vehicle certifications (MT-9) in their records.

- Five of the six providers tested did not maintain adequate documentation to support the driver's identification (MT-8) in their records.

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

DHH management should establish, implement, and enforce adequate controls to ensure that only appropriate claims for NEMT are paid to providers. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, pages 1-2).

Ineligible Medicaid Payments for State Transportation Services

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

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

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

DHH should establish procedures to ensure that claims for the state NEMT program are paid only from state funds. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, pages 3-4).

Improper Claims by Long Term Personal Care Services Providers

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

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

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

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

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

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

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

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

Inappropriate Access to the Medicaid Eligibility Data System

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

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

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

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

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

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

DHH management should establish controls to ensure that access to MEDS is appropriate and given only for a valid business need and that system programmers are restricted from incompatible duties, including migrating program changes to production without authorization and review. Management concurred with the finding and outlined a corrective action plan (see Appendix A, pages 8-9).

Improper Payments to Waiver Services Providers

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

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

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

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

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

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

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

DHH should establish, implement, and enforce adequate controls to ensure that only appropriate claims for waiver services are paid to providers in accordance with departmental policies and federal regulations. Management concurred with the finding and outlined a plan of corrective action (see Appendix A, pages 10-13).

LOUISIANA WORKFORCE COMMISSION
CFDA 17.225 - UNEMPLOYMENT INSURANCE

Improper Charging of Administrative Expenditures to Federal Awards

The Louisiana Workforce Commission (LWC) incorrectly charged expenditures of the Disaster Unemployment Assistance (DUA) Program (CFDA 97.034) to the Unemployment Insurance (UI) Program (CFDA 17.225). The Office of Management and Budget (OMB) Circular A-87 states that costs are allowable if they are reasonable and necessary for the proper and efficient performance and administration of the program, are allocated to a particular program to the extent of the relative benefits received, and are appropriately documented.

Based on our audit procedures, we identified expenditures totaling $1,586,176, which represent fees paid to contractors to process UI and DUA unemployment claims after Hurricane Gustav. Of this amount, $536,304 should have been allocated to DUA but was incorrectly charged to UI and is therefore considered questioned costs.

LWC procedures require the program personnel to approve costs charged to their programs. The program personnel did not verify the correct federal coding based on the description of work provided on the invoice. This increases the risk that expenditures could be improperly charged to the wrong federal program when more than one federal program is involved.

Management should ensure that costs charged to a program are properly reviewed and approved by program personnel. Management concurred with the finding and recommendation and outlined a plan of corrective action (see Appendix A, page 14).

Noncompliance With Record Retention Policy

For the third consecutive year, LWC did not retain employer wage records for the UI program (CFDA 17.225). Employer wage records are the basis for determining whether applicants for UI benefits have earned sufficient wages in a base period to qualify for those benefits. Louisiana Revised Statute (R.S.) 44:411.A(1) requires that the head of each state agency submit a record retention schedule to the state archivist. LWC's current record retention schedule was approved by the state archivist on June 6, 2006, and it requires that employer tax records be maintained for 11 years. In addition, OMB Circular A-133, Subpart C, Section 300(b) requires states to establish internal control over federally funded programs to provide reasonable assurance that the states are administering federal awards in compliance with grant provisions, and OMB Circular A-87 requires that costs be adequately documented.

Our tests of 60 claimants' eligibility of UI benefits disclosed that employer wage records for 22 claimants (37%) were not retained by LWC. Employers provided these records to LWC on electronic media, and LWC returned the records to the employers after the information was input into LWC's UI benefit master files. LWC was able to later provide support for payments to these claimants by contacting individual employers and requesting resubmission of the wage records.

In addition, our tests disclosed that LWC did not retain employer wage records that supported tax payments to LWC for 14 of 30 (47%) employees tested. Paper copies of the electronic media were made but were discarded. These wage records will be needed in the future to verify wages for UI claimants.

Failure to retain records to support employee wages and eligibility may result in improper benefit payments and/or questioned costs, and failure to maintain records of employer tax payments increases the risk that LWC's records may not accurately reflect employer UI tax payments. LWC management should strengthen its controls to ensure that records are retained in accordance with state and federal laws and regulations. Management

concurred with the finding and recommendation and outlined a plan of corrective action (see Appendix A, page 15).

A material weakness is a significant deficiency or combination of significant deficiencies that result in more than a remote likelihood that material noncompliance with a type of compliance requirement of a federal program will not be prevented or detected by the State of Louisiana's internal control. We consider the following deficiency in internal control over compliance to be a material weakness.

LOUISIANA WORKFORCE COMMISSION
CFDA 17.225 - UNEMPLOYMENT INSURANCE

Noncompliance With Administrative Rules for Interstate Unemployment Compensation Benefit Payments

For the second consecutive year, the Louisiana Workforce Commission (LWC) paid $21,075,286 in Unemployment Insurance (UI, CFDA 17.225) benefits to other states during fiscal year 2009 without recouping the cost of these claims from Louisiana employers. Additional benefits of $6,832,003 that were paid to claimants by Pennsylvania and billed to LWC have not been reimbursed by LWC. Furthermore, LWC has not implemented procedures to determine if claimants filing in other states are working in Louisiana at the time they file the claim and during the duration of the claim.

The State of Louisiana participates in the Interstate Benefit Payment Plan which is an interstate agreement that allows claimants to file for unemployment in a different state from where wages are primarily earned. The states where wages are earned are charged for the unemployment paid by the filing state. The Code of Federal Regulations [20 CFR 616.6] states that, effective January 6, 2009, the claimant must have wages and employment in the filing state's base period. Administrative Rule 341 of the Louisiana Employment Security Law provides the methods by which LWC is to recoup the cost of interstate claims from employers, requires notification to the employers of the potential liability, and allows 10 days for the employer to protest the charges. In addition, good internal controls would ensure that LWC notify employers of interstate claims and verify work status of claimants to reduce the risk of payments on fraudulent claims.

Of 40 UI interstate claimants reviewed, we found the following:

- Forty (100%) of the claims had no notification to the employer of the claim in efforts to recoup the cost of benefits paid. LWC personnel verified that there are no procedures in place to notify the employers of these claims and recoup the costs of claims paid.

- Twenty-four (60%) of the claimants appear to have been employed while receiving unemployment benefits totaling $59,497, which violates program eligibility requirements and is an indication of potentially fraudulent claims. Wage records for nine of the 24 claimants indicate the claimants received wages from their employer continuously over several quarters, and wage records for the remaining 15 indicated that the claimants received wages for the same period for which they received unemployment benefits.

- Thirty-six (90%) of the claimants appear to have received unemployment insurance compensation after January 6, 2009, from states where wages have not been earned.

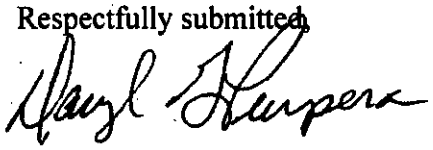
LWC has not placed sufficient emphasis on implementing controls to ensure compliance with Administrative Rule 341 and 20 CFR 616.6 or to ensure the validity of the claims being paid. Failure to notify employers of the UI claims filed increases the risk that benefits will be incorrectly paid to individuals who are employed, which results in questioned costs. In addition, failure to recoup the cost of interstate claims from employers results in the loss of state funds. Benefits charged to LWC for interstate claims total $21,075,286 and are considered questioned costs.

LWC should establish procedures to ensure that interstate benefit claims are charged to employers and that employers are timely notified of any claims against them. Additional procedures should include a review of interstate bills to ensure that claimants are not working in Louisiana and have worked in the filing state at the time UI claims are paid. Management concurred with the finding and recommendation and outlined a plan of corrective action (see Appendix A, page 16).

The State of Louisiana's responses to our findings are attached in Appendix A. We did not audit State of Louisiana's responses and, accordingly, we express no opinion on them.

This interim communication is intended solely for the information and use of management, others within the entity, the Louisiana Legislature, federal awarding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

Respectfully submitted,



Daryl G. Purpera, CPA
Temporary Legislative Auditor

BQD:THC:dl

ARRA PILOT PROJECT LETTER 2009

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
Waiver Assistance and Compliance Section

November 3, 2009

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

Dear Mr. Theriot:

Below is the response from The Department of Health and Hospitals, Bureau of Health Services Financing related to the finding dated October 23, 2009 regarding **Improper Payments to Non-Emergency Transportation Service Providers:**

- DHH concurs with the findings. We agree that the providers and claims reviewed were not in accordance with Medicaid policies and procedures. Providers must maintain daily schedules as well as all MT-3's, MT-8's, and MT-9's for all trips reimbursed by Louisiana Medicaid. Failure to do so is not acceptable.
- Corrective Action:
  - Contact: Darrell Curtis at (225) 342-6220.
  - Program Integrity is taking action for recoupment of the inappropriately paid claims. Joe Kopsa (225-342-4150) is the contact for Program Integrity.
    - A letter will be sent in February 2010 to the appropriate providers regarding the action to be taken.
    - This action is subject to due process which could delay the completion of this action.
  - Completion date is expected to be by February 2010.

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

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

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

Sincerely,

Jerry Phillips
Medicaid Director

JP:RD:wdc

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

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

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

November 3, 2009

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

Dear Mr. Theriot:

Below is the response from The Department of Health and Hospitals, Bureau of Health Services Financing related to the findings dated October 23, 2009 regarding **Ineligible Medicaid Payments for State Transportation Services:**

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

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

Sincerely,

Jerry Phillips
Medicaid Director

JP:RD:wdc

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

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

December 2 2009

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

Dear Mr. Theriot:

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

Please accept this as the Louisiana Department of Health and Hospitals' (DHH) response to the November 3, 2009 Legislative Auditor finding regarding Improper Claims by Long Term Personal Care Service Providers. It is our understanding that the Legislative Auditor's position is that this finding occurred because providers of Long Term Personal Care Service (LT-PCS) submitted claims that were not in accordance with established policies and procedures.

DHH's official response is attached as requested. Rick Henley of the Office of Aging and Adult Services (OAAS) is the contact person responsible for corrective action. Mr. Henley can be reached by telephone at 225-219-0209 and by e-mail at Rick.Henley@LA.GOV.

Sincerely,

Jerry Phillips
Medicaid Director

JLP/HE:rh

Attachment

cc: Charles Castille
Hugh Eley
Kay Gaudet
Jeff Reynolds

Improper Claims by Long Term Personal Care Service Providers

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

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

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

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

Error Noted: Failure to maintain standardized weekly service logs.

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

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

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Bureau of Health Services Financing

November 23, 2009

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

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

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

Finding:

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

Response:

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

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

Finding:

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

Response:

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

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

Sincerely,

Jerry Phillips
Medicaid Director

JP:KV

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

December 10, 2009

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

Dear Mr. Theriot:

RE: Improper Payments to Waiver Service Providers

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

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

Sincerely,

Jerry Phillips
Medicaid Director

JLP/TD

Attachment

cc: Charles Castille
Kathy Kliebert
Kay Gaudet
Jeff Reynolds

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

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

DHH Response: DHH concurs with this finding.

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

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

Corrective action Plan:

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

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

Anticipated completion date is March 15, 2010.

Contacts:

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

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

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

Corrective Action Plan:

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

Anticipated completion date is February 15, 2010.

Contacts:

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

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

DHH Response: DHH concurs with this finding.

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

Corrective action plan:

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

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

In addition, OCDD will:

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

Anticipated completion date is March 15, 2010.

Contacts:

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

LOUISIANA WORKFORCE COMMISSION

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Bobby Jindal, Governor
Curt Eysink, Executive Director

December 17, 2009

Mr. Daryl Purpera, CPA
Temporary Legislative Auditor
Post Office Box 94397
Baton Rouge, LA 70804-9397

RE: Improper Charging of Administrative Expenditures to Federal Awards

Dear Mr. Pupera:

We concur with the finding that the LWC incorrectly charged expenditures of the Disaster Unemployment Insurance to the Unemployment Insurance Program. When a natural disaster occurs, the state is required to issue DUA (disaster unemployment benefits) payments and is subsequently reimbursed by FEMA for all administrative costs incurred. A formal request for reimbursement that includes the $536,304 questioned costs in this finding is being submitted to FEMA. Receipt of this reimbursement will resolve this finding.

We concur with the finding that program personnel did not verify the correct federal coding based on the description of work provided on the invoice. For future disasters, we will implement a review process that ensures proper review and approval of federal coding.

The contact person for implementation of these corrective actions will be Marianne Sullivan, Director of Unemployment Insurance.

Please feel free to contact my office should you have any further questions.

Sincerely,

C. Eysink

Curt Eysink
Executive Director

CE:rer:mdp

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Temporary Legislative Auditor
Post Office Box 94397
Baton Rouge, LA 70804-9397

RE: Noncompliance with Record Retention Policy

Dear Mr. Purpera:

We concur with the finding that LWC did not retain all wage records for the Unemployment Insurance Program.

In July 2009, LWC successfully implemented a state-of-the-art imaging system that provides the appropriate documentation for reconciliation to the main frame. As part of this system, all employer wage records are scanned in and are readily retrievable for reconciliation purposes.

The contact person for implementation of these corrective actions will be Marianne Sullivan, Director of Unemployment Insurance.

Please feel free to contact my office should you have any further questions.

Sincerely,

C. Eysink

Curt Eysink
Executive Director

CE:rer:mdp

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Post Office Box 94397
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RE: Noncompliance with Administrative Rules for Interstate Unemployment Compensation Benefit Payments

Dear Mr. Pupera:

We concur with the finding regarding noncompliance with administrative rules for Interstate Unemployment Compensation Benefit Payments.

We have completed the programming necessary to begin charging employers for interstate unemployment compensation benefit payments. We have incorporated the procedures with a unit that has similar procedures for another process. We are planning to notify all base period employers for interstate claims filed as of October 1, 2009 in a single mailing. Beginning in January 2010 we will issue these notices as claims are filed.

The contact person for implementation of these corrective actions will be Marianne Sullivan, Director of Unemployment Insurance.

Please feel free to contact my office should you have any further questions.

Sincerely,

Curt Eysink
Executive Director

C. Eysink

CE:rer:mdp