

# STATE OF LOUISIANA LEGISLATIVE AUDITOR

Department of Health and Hospitals  
Baton Rouge Main Office Operations  
State of Louisiana  
Baton Rouge, Louisiana

January 22, 2003



***Financial and Compliance Audit Division***

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**Albert J. Robinson, Jr., CPA**

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

Management Letter  
Dated January 9, 2003

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

January 22, 2003



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

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January 9, 2003

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

Baton Rouge, Louisiana

As part of our audit of the State of Louisiana's financial statements for the year ended June 30, 2002, we considered the Department of Health and Hospitals' (Baton Rouge Main Office Operations) internal control over financial reporting and over compliance with requirements that could have a direct and material effect on a major federal program; we examined evidence supporting certain accounts and balances material to the State of Louisiana's financial statements; and we tested the department's compliance with laws and regulations that could have a direct and material effect on the State of Louisiana's financial statements and major federal programs as required by *Government Auditing Standards* and U.S. Office of Management and Budget Circular A-133.

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

In our prior management letter on the Department of Health and Hospitals (Baton Rouge Main Office Operations) for the year ended June 30, 2001, we reported findings relating to improper claims by waiver services providers, improper claims by case management providers, ineffective controls over Medicaid cash management transactions, and an ineffective internal audit function. The findings relating to ineffective controls over Medicaid cash management transactions and an ineffective internal audit function have been resolved by the department. The findings relating to improper claims by waiver services providers and improper claims by case management providers are addressed again in this letter.

Based on the application of the procedures referred to previously, all significant findings are included in this letter for management's consideration. All findings included in this management letter that are required to be reported by *Government Auditing Standards* will also be included in the State of Louisiana's Single Audit Report for the year ended June 30, 2002.

**Improper Disproportionate Share Payments**

The Department of Health and Hospitals (DHH) paid amounts to the Louisiana State University Health Sciences Center, Health Care Services Division (HCSD) that exceeded the maximum allowed by federal regulations for the disproportionate share hospital (DSH) program. The DSH program allows DHH, through the Medical Assistance Program (Medicaid) (CFDA 93.778), to reimburse the uncompensated care costs (UCC) to facilities that treat a disproportionate share of indigent patients. The

LEGISLATIVE AUDITOR

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

Management Letter, Dated January 9, 2003

Page 2

Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) mandates that payments to public hospitals under the DSH program are limited to 100% of uncompensated care costs. In addition, the Louisiana Medicaid State Plan, Attachment 4.19-A, Item 1, Page 10e states that DSH payments to a hospital shall not exceed the hospital's uncompensated care costs for the state fiscal year to which the payment is applicable.

For fiscal years 1996 through 2002, DSH payments to HCSD exceeded the supported uncompensated care costs by \$257,222,818, including federal financial participation (FFP) of \$185,605,936, which represents questioned cost. Annually, HCSD provided an estimate of uncompensated care costs and requested the DSH payments for each of the nine HCSD facilities. However, the estimated costs upon which DHH made the DSH payments far exceeded the actual uncompensated care costs that HCSD can support. Despite the variances between the actual and estimated costs, HCSD estimation methodology was not adjusted.

DHH did not require HCSD to provide adequate documentation to support its estimates of uncompensated care costs before making initial and subsequent DSH payments. As a result, HCSD continued to submit unsupported estimates for payment purposes causing overpayments averaging approximately 7% per year. The Centers for Medicare and Medicaid Services may require DHH to refund the FFP for these overpayments.

DHH management should develop and implement additional controls over DSH payments to HCSD that would ensure that all estimates of uncompensated care costs could be supported by actual, allowable costs. Furthermore, DHH should facilitate the completion of all outstanding cost report audits and negotiate the return of any overpayments. Management concurred that internal controls over DSH payments to HCSD should be strengthened noting that new internal controls are being finalized. However, management did not concur with the reported questioned cost amount (see Appendix A, page 1).

**Additional Comments:** In a letter December 2, 2002, the Department of Health and Human Services, Centers for Medicare and Medicaid Services, recognized DSH overpayments to HCSD of \$290,154,502. As a result, the federal participation amount of \$210,603,335 is due to the federal government.

**Improper Payments for TANF  
Initiative Recipients**

DHH, Office for Addictive Disorders (OAD), failed to document and/or verify the eligibility of certain recipients of the Temporary Assistance for Needy Families Program (TANF), (CFDA 93.558), Women and Children's Residential Prevention and Treatment Program. A Memorandum of Understanding (MOU) between DHH/OAD and the Department of

LEGISLATIVE AUDITOR

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

Management Letter, Dated January 9, 2003

Page 3

Social Services, Office of Family Support, establishes regulations and requirements for the delivery of services and payment of invoices. According to the MOU, recipients are program eligible if any family member receives services from certain federal programs. DHH/OAD is required to verify program eligibility and maintain supporting documentation. DHH/OAD contracts with seven residential providers to provide the program's services. During fiscal year 2002, the program expended \$1,654,818 on 529 recipients (193 women and 336 children).

In our review of 118 recipients, 63 recipients (53%) did not have proper documentation establishing eligibility. The exceptions noted included the following:

- For 23 recipients, four providers could not provide documentation of eligibility.
- For 27 recipients, three providers did not have documentation sufficient to determine what date eligibility was verified.
- For 13 recipients, two providers did not verify the recipients' eligibility before billing for the services provided.

Additional audit procedures were performed to determine if the 63 recipients noted above were eligible for the program. Of the 63 recipients, four recipients (6%) were determined to be ineligible at the time the recipients were admitted for services.

The residential providers either failed to follow or did not understand controls established to ensure proper eligibility determination. In addition, DHH/OAD did not properly monitor the providers to ensure compliance with requirements for verifying and documenting recipient eligibility. As a result, DHH paid providers for services on four ineligible recipients who did not meet the requirements established for the Residential Prevention and Treatment Program. Accordingly, questioned costs are \$12,804.

The department should ensure providers understand the program's eligibility requirements, ensure providers know what documentation is necessary to ensure eligibility is properly verified, increase monitoring over the provider's eligibility determinations to ensure only eligible recipients are reimbursed, and review all fiscal year 2002 eligibility determinations to ensure only eligible recipients were reimbursed. Management concurred with the finding and recommendation and outlined a plan of corrective action (see Appendix A, pages 2-3).

LEGISLATIVE AUDITOR

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

Management Letter, Dated January 9, 2003

Page 4

**Improper Claims by Waiver  
Services Providers**

For the third consecutive year, providers of waiver services billed the Medical Assistance Program (CFDA 93.778) for services that were not in accordance with policies established by the DHH, Medicaid Waiver Services. Waiver services are provided to eligible recipients under the Mentally Retarded/Developmentally Disabled (MR/DD) Waiver Program, the Patient Care Attendant (PCA) Waiver, the Elderly and Disabled Adult (EDA) Waiver Program, and the Children's Choice Waiver Program. These services include PCA services, respite care services, supervised independent living (SIL) services, and companion services. Regulations and requirements for the delivery of services and payment of claims for these waiver programs are established through administrative rules and policy manuals developed by DHH Waiver Services.

We reviewed claims filed by three providers for 30 recipients during calendar year 2001. For 29 of the 30 recipients, DHH made payments of \$167,283 for 341 services where the services delivered failed to meet department policies. Specific deficiencies noted in the review of waiver services include the following:

- For 28 recipients, the waiver services were not delivered according to the plan of care established by the case manager and approved by DHH regional office staff. Deviations from the plan of care included services not following the schedule designed to meet the needs of the recipient and the recipient's family and inconsistent services that did not meet the amount or type of services approved. By not following the plan of care, the provider may not be meeting the medical needs of the recipient and may be providing services based on its own scheduling convenience.
- For 22 recipients, the providers did not maintain adequate documentation to distinguish among PCA, respite care, and SIL services. According to policies established for waiver programs, PCA, respite care, and SIL services are separate services with separate hours approved and scheduled in the plan of care. Our review of recipient files revealed that the providers made no distinction among these services, supporting all with the same general progress note and giving no consideration as to whether or not the primary caregiver was available.
- For eight recipients, two providers did not maintain any progress notes to describe the services provided and support the claims filed. Without adequate progress notes, the quality and sufficiency of the care cannot be determined.

## LEGISLATIVE AUDITOR

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

Management Letter, Dated January 9, 2003

Page 5

- For three recipients, hours of service were billed that exceeded the amount that could be adequately supported by the provider's documentation.
- For two recipients, no plan of care was present in the recipient's file to support the claims filed. Without an approved plan of care, the provider had no description or schedule of services to provide.
- For one recipient, the service provided was not available for the days billed since the recipient was in the hospital at the time.
- In two instances, one provider employee provided care for two waiver recipients in the same household. For the hours of service provided by the employee, the provider billed hours as if providing separate services to each recipient, resulting in being paid for two hours for every hour worked.

These conditions occurred because waiver services providers failed to follow established agency regulations for providing services according to the plan of care and adequately documenting those services. As a result of the exceptions noted above, providers were paid for erroneous claims, and waiver recipients did not receive needed services. Accordingly, questioned costs were \$167,283, which include \$117,600 of federal funds and \$49,683 of state matching funds.

DHH should (1) increase monitoring by department personnel and case managers to ensure that plans of care are followed and needed services are provided; (2) educate providers on how to distinguish between services and maintain adequate documentation through improved progress notes; and (3) establish adequate control to ensure that only appropriate claims for waiver services are paid to providers. Management concurred with the finding and recommendation and outlined a plan of corrective action (see Appendix A, pages 4-7).

#### **Improper Claims by Case Management Providers**

For the second consecutive year, providers of case management services billed the Medical Assistance Program (CFDA 93.778) during calendar year 2001 for services that were not in accordance with policies established by the DHH, Medicaid Waiver Services. Case management services are provided to qualified recipients participating in DHH waiver services programs. Regulations and requirements for the delivery of services and payment of claims for waiver services and case management are established through administrative rules and policy manuals developed by DHH Waiver Services.

## LEGISLATIVE AUDITOR

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

Management Letter, Dated January 9, 2003

Page 6

Generally, case managers are required to (1) develop a plan of care; (2) assist the waiver recipient in accessing needed services; and (3) monitor the providers of the waiver services to determine that the plan of care is followed. The requirements for monitoring include monthly or quarterly monitoring of the providers and quarterly face-to-face visits with the recipient that must be documented by the case manager.

In a review of claims filed by three case managers for eight of 30 recipients, claims were filed and payments of \$5,526 were made for 37 claims where the services delivered failed to meet department requirements for monitoring. The errors noted included the following:

- For six recipients, the case manager's documentation of the monthly or quarterly monitoring of providers was incomplete.
- For one recipient, the quarterly face-to-face visits with the recipient were not conducted.
- For one recipient, both the monitoring of providers and the quarterly face-to-face visits with the recipient were not conducted.

The department failed to establish and implement necessary internal controls over the payments for case management services. As a result, case managers were paid for erroneous claims when the required monitoring services were not performed. Accordingly, questioned costs were \$5,526, which include \$3,885 of federal funds and \$1,641 of state matching funds.

DHH should establish adequate controls to ensure that only appropriate claims for case management services are paid to providers and that required monitoring of providers and face-to-face visits with recipients are performed and documented. Management concurred with the finding and recommendation and outlined a plan of corrective action (see Appendix A, pages 8-10).

#### **Medicaid Provider Overpayment Errors**

DHH understated the balance of provider overpayments in the Medical Assistance Program (CFDA 93.778, Medicaid) by \$532,011 and did not return an estimated \$374,003 in federal financial participation (FFP) for this overpayment to the Centers for Medicare and Medicaid Services. The Code of Federal Regulations (42 CFR 433.300-433.320 and 433.40) requires that in most cases states are to refund the federal share of identified provider overpayments to the federal government within 60 days of identification of the overpayment, regardless of whether the overpayment was collected from the provider.

LEGISLATIVE AUDITOR

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

Management Letter, Dated January 9, 2003

Page 7

Some provider overpayments are identified by the Medicaid Fraud Control Unit (MFCU) operated by the Louisiana Attorney General (AG) who prosecutes Medicaid providers suspected of committing fraud in the program. When the court enters a judgment against a provider, the AG maintains the account and monitors the collection of the outstanding balance. Once the judgment is entered and the balance owed by the provider is determined, DHH is responsible for reporting the balance and returning the FFP. Audit procedures performed on identified provider overpayments disclosed four accounts maintained by the AG that had not been reported by the department. The judgment for one of these accounts was entered in July 2000 and the judgments for the other three accounts were entered in July 2001. The total of these account balances at June 30, 2002 is \$532,011, and the FFP that should have been returned is \$374,003.

This condition occurred because the MFCU did not report all accounts for which judgments had been rendered to DHH. Because the MFCU did not accurately report provider overpayments, DHH could not comply with federal regulations that require a refund to the federal government within 60 days. This results in questioned costs of \$374,003. In addition, the federal government may impose penalties because of noncompliance with cash management regulations.

DHH should strengthen controls to ensure that accounts maintained by the AG are reported to DHH and that the federal share of these payments is returned in accordance with federal regulations. Also, the MFCU should ensure that all accounts for which judgments have been rendered are reported to DHH. Management concurred with the finding and recommendation and outlined a plan of corrective action (see Appendix A, pages 11-12).

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

LEGISLATIVE AUDITOR

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

Management Letter, Dated January 9, 2003

Page 8

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

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Grover C Austin". The signature is written in a cursive style with a large, prominent initial "G".

Grover C Austin, CPA  
First Assistant Legislative Auditor

WDG:EFS:RCL:ss

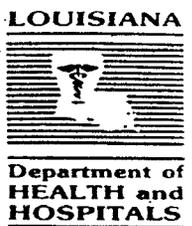
[DHH02]

## Appendix A

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



STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS



David W. Hood  
SECRETARY

M. J. "Mike" Foster, Jr.  
GOVERNOR

December 6, 2002

Dr. Daniel G. Kyle, CPA, CFE  
Legislative Auditor  
1600 North Third Street  
P.O. Box 94397  
Baton Rouge, LA 70804-9397

Dear Dr. Kyle:

We are in receipt of your audit finding "**Improper Disproportionate Share Payments**". The Department of Health and Hospitals (DHH) concurs with the finding and recommendations made as they relate to a lack of internal controls over Disproportionate Share (DSH) payments to LSU Health Care Services Division (LSUHCS). However, we cannot concur with the reported questioned cost of \$185,605,963 in federal funds. DHH recognizes receivables and payables based upon audited cost reports and we have not received any audited cost reports as it relates to these costs.

We are in the process of strengthening our internal controls as they relate to HCSD's estimates of uncompensated care costs and their request for DSH payments. The new internal controls related to these payments will be furnished to your office as soon as they are finalized. No additional DSH payments will be made to HCSD prior to the implementation of these new internal controls.

The person responsible for the implementation of our Corrective Action Plan is Mr. Jerry Phillips, Medicaid Deputy Director. He can be reached at (225) 342-9767.

Should you have any questions regarding this matter, please feel free to contact me at (225) 342-6726.

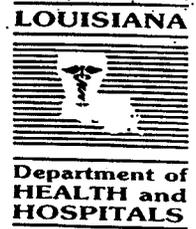
Very truly yours,

Charles F. Castille  
Undersecretary

CFC/CSM/jbm



STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS



M.J. "Mike" Foster, Jr.  
GOVERNOR

David W. Hood  
SECRETARY

December 18, 2002

Dr. Daniel G. Kyle, CPA, CFE  
Legislative Auditor  
1600 North Third Street  
Baton Rouge, Louisiana 70804-9397

Dear Dr. Kyle:

This letter is in response to your finding regarding the Office for Addictive Disorders Improper Payment for TANF Initiative Recipients.

We do concur with the findings that were submitted to us on December 11, 2002.

The Office for Addictive Disorders has already taken steps to correct some of the deficiencies that were found. Our TANF Project Coordinator, Quinetta Rowley, is responsible for the corrective action. We anticipate that the corrective action plan will be in place by January 6, 2003. Steps taken are as follows:

1. We have hired a monitor to conduct on-site monitoring which includes a review of verification of documentation of client eligibility. This monitor will also provide technical assistance and information to programs regarding eligibility requirements and their responsibility to determine eligibility prior to billing for services.
2. Following the audit visit, OAD sent inquiries and letters (copies attached) to the providers to clarify TANF eligibility and appropriate documentation required to meet eligibility.
3. We are also instituting a procedure which will require providers to submit a copy of the documentation verifying eligibility when the invoice is submitted for payment to the regional office. Before submission to the DSS for reimbursement, our state office TANF Program Coordinator will confirm with the regional staff that they have received the proper back up documents verifying eligibility.
4. We are instituting monthly telephone conferences with the Residential Providers and Regional Administrators. This will facilitate communication and our ability to provide information on any questions, updates, and monitoring results.

Please inform us if this corrective action plan meets with your approval, or if we can provide you with any additional information.

Sincerely,

A handwritten signature in black ink that reads "Michael Duffy". The signature is written in a cursive style with a large, stylized "D" at the end.

Michael Duffy  
Acting Assistant Secretary

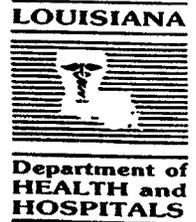
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Attachments

c Ernest F. Summerville, Jr., CPA  
Stan Mead



STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS



David W. Hood  
SECRETARY

M. J. "Mike" Foster, Jr.  
GOVERNOR

September 30, 2002

Dr. Daniel G. Kyle, CPA, CFE  
Legislative Auditor  
1600 North Third Street  
P.O. Box 943967  
Baton Rouge, LA 70804-9397

RE: Department of Health and Hospitals  
Legislative Audit Finding, Calendar Year 2001  
Improper Claims by Waiver Service Providers

Dear Dr. Kyle:

This is in response to your reportable audit findings of "Improper Claims by Waiver Service Providers" for the calendar year 2001. We appreciate the thoroughness, professionalism and care with which your office reviewed the activities of waiver service providers. Our office is in the process of using the data in your report to complete a quality review of the waiver system, as well as visiting recipients identified in the audit to insure that their health and welfare is appropriately addressed. Through this process we will validate the accuracy of provider billing with program requirements and initiate recovery of inappropriately paid claims.

Your findings focus on areas which the Department recognizes as needs and is currently working diligently to address. We concur that there remain areas of concern in the coordinated provision of services, and in the billing for waiver services by providers in Louisiana.

Since 1998 DHH has taken an active stance in addressing the requirements to balance the needs of recipients, their suggestions as to how services should be provided and the need for service accountability. Quality assurance activities have been implemented using increased monitoring. Case management agencies have specific responsibility for monitoring the services delivered by the direct service providers.

With the growing number of direct service providers and the number of recipients continuing to increase each month, it is necessary for DHH to continue to actively address quality issues in waiver services. Therefore, in addition to specially assigned staff in the Bureau of Community Supports and Services and increased monitoring by contracted case management agencies, DHH has directed our Surveillance and Utilization Review Section (SURS) to address the ongoing needs in this program.

Dr. Daniel G. Kyle, CPA, CFE

September 30, 2002

Page 2

The audit for the fiscal year ending June 30, 2002 revealed similar findings as the calendar year 2001 review. However, we were pleased to learn from the auditors that there was not one single exception for billing over the amount of services authorized. This lets us know that the prior authorization is succeeding in addressing this concern. We are continuing to work on systems development, standards for participation and policy development to demonstrate similar results in your audit findings.

The attached Corrective Action Plan provides more specific information concerning measures that have been taken by BCSS to address areas of concern resulting from the audit findings of your staff. If you have any questions or need further clarification about this plan, please feel free to contact me or any of the contact persons identified in the plan at telephone number (225) 219-0223.

Sincerely,



Barbara C. Dodge  
Director

BCD/DJ/JDW

Attachment

c: David W. Hood  
Charles Castille  
Ben Bearden  
Stan Mead

**Corrective Action Plan**  
**Legislative Audit Finding, Calendar Year 2001**  
**Improper Claims by Waiver Service Providers**

Systems Development

The prior authorization system has been operational since February 2001 and has given us a positive finding for this year. In addition, the Department has implemented prior authorization for the Children's Choice and the Elderly and Disabled Adult waivers. Prior authorization allows DHH to prior authorize supports and services, thus increasing the integrity of the services billing system and assuring service delivery as prescribed in the approved plan of care. The Department will implement prior authorization for the remaining waivers and each new waiver that is developed, as we believe this system will allow us to use limited resources more efficiently and effectively in service provision as well as addressing the concerns noted in your audit. The current prior authorization program is being enhanced to assist with other concerns found in your audit, and also improve reporting and planning systems. The Department's target date for training direct service providers on the enhanced prior authorization program is January and February 2003, with implementation scheduled for March 2003.

Contact person: Janith Miller

Standards for Participation of Current and Future Service Providers

The Department is developing standards for participation and criteria for all current and future service providers to ensure that they have the experience and training necessary to provide quality supports and services. Enrollment in the Medicaid program for providers of waiver services will be limited to designated enrollment periods. Provider orientation and training will be provided to assure that DHH expectations of quality are clearly communicated. DHH has a task force that has met with provider representatives and other stakeholders in a collaborative effort to develop these standards. The Department plans to implement rulemaking necessary to begin this process in January 2003.

Contact persons: Judy Moore and Sue Merrill

Policy Development

Service definitions for the existing Mentally Retarded/Developmentally Disabled (MR/DD) waiver were rewritten in an attempt to clarify them and make clear service definitions. A Notice of Intent clarifying the MR/DD service definitions was published in the October 20, 2001 *Louisiana Register*. Providers, advocates and recipients were dissatisfied with the proposal. Therefore, DHH in conjunction with the Department of Social Services, the Department that licenses these agencies, began a collaborative effort to address these concerns and to develop a new waiver which will define services based on a new set of definitions and expectation of providers. The new waiver is ready to be sent to the Centers for Medicare and Medicaid Services (CMS) for approval. Training will occur this fall and implementation is expected in March 2003.

Contact person: Claudette Hill

Service Documentation and Progress Notes

Documentation is a key component of quality service provision. It is the indicator that services actually occurred, that services were consistent with the plan of care and that the expected outcomes were obtained. DHH developed a clarification of the required components of documentation necessary to monitor recipient services and progress. Case management agencies and direct service providers were provided specific written information on this system. Education on this process is ongoing. Training on this activity is being planned as a result of this most recent finding. Documentation training will also be included in provider orientation for existing and new providers as part of the implementation of the new standards for payment. The target date for this initiative is ongoing.

Contact persons: Judy Moore, Judy Baker and Sue Merrill

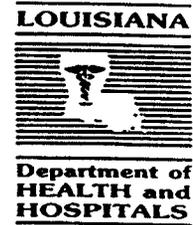
Monitoring Services

As systems described in this letter are being implemented, monitoring activities by DHH and contract case management agencies are being implemented to insure that services planned are provided and remain appropriate for the recipients. Monitoring changes are being implemented and will continue through systems development and implementation of systems outlined in this letter. Monitoring is a part of the DHH strategic plan with objectives to enhance the quality of the services and to include more of the service providers in the bi-annual monitoring. The Department intends for efforts related to system enhancements to improve accountability, and thus enable waiver services to operate more efficiently and effectively and avoid future systemic findings as identified by your staff during this review. The target date for this is ongoing.

Contact persons: Sue Merrill and Delphine Jackson



**STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS**



M. J. "Mike" Foster, Jr.  
GOVERNOR

David W. Hood  
SECRETARY

September 30, 2002

Dr. Daniel G. Kyle, CPA, CFE  
Legislative Auditor  
1600 North Third Street  
P. O. Box 943967  
Baton Rouge, LA 70804-9397

**RE: Department of Health and Hospitals  
Legislative Audit Finding, FYE 6/30/02  
Improper Claims by Case Management Providers**

Dear Dr. Kyle:

This correspondence is in response to your reportable audit finding of "Improper Claims by Case Management Providers" for FYE 6/30/02. We appreciate the care and attention with which your office reviewed the actions of case management agencies. Our office is in the process of using the information in your report to continue a quality review of the case management system and the specific agencies cited in your report. Through this process we will validate the accuracy of provider billing with program requirements and initiate recovery of inappropriately paid claims.

Your findings focus on areas which the Department continues to recognize as areas of concern. The Department is working diligently to address these concerns. We recognize that there remain areas of concern in the coordinated provision of the required case management services and billing for these services by case management providers in Louisiana. We have been working on improving case management services in Louisiana since 1998. There is an ongoing need to balance the needs of recipients, their requests as to how case management services should be provided and the need for case management agency accountability.

An RFP for case management services was released in October 2001. Contracts were awarded in the nine DHH administrative regions based on the responses to the RFP. Additional quality assurance measures were placed into the RFP and incorporated into the case management contracts. Quarterly meetings are being held with the case management providers to facilitate direct discussion of areas of concern.

The Department will continue to periodically review the case management providers to assure that they meet all requirements. When problems are identified during the monitoring, corrective action plans are required to be implemented. Departmental staff review the results of the corrective action plans to determine if additional training and/or technical assistance is required.

Dr. Daniel G. Kyle, CPA, CFE  
September 30, 2002  
Page 2

Direct quality assurance activities for case management and other home and community-based services are accomplished in DHH by 10 regional office employees. One employee is assigned in each of eight DHH administrative regions, and two employees are assigned in one region, to directly monitor case management and other home and community-based waiver services. DHH added an additional employee to oversee case management contract compliance.

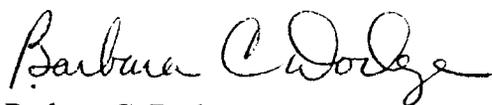
With over 7,500 current recipients and this number continuing to increase each month, it is necessary for DHH to continue to actively address quality issues in case management services. Therefore, in addition to the specially assigned statewide and regional staff in the Bureau of Community Supports and Services (BCSS), DHH has directed the Surveillance and Utilization Review Section (SURS) to continue to monitor the ongoing needs in this program.

We have already addressed some of the issues outlined in this report by taking these actions: revising the case management manual to clearly detail all documentation requirements; implementing a policy to review all instances in which the quarterly requirements specific to the case management population being served will be reviewed by personnel in the BCSS Case Management Section to determine if recoupment should take place; and placing additional requirements for training capacity on the case management agencies in the new case management contracts.

The Department of Health and Hospitals intends for these system enhancements to improve accountability, and thus enable us to operate more efficiently and effectively and avoid future systemic findings as identified by your staff during this review.

The attached Corrective Action Plan provides more specific information concerning measures that have been taken by BCSS to address areas of concern resulting from the audit findings of your staff. If you have any questions or need further clarification about this plan, please feel free to contact me or any of the contact persons identified in the plan at telephone number (225) 219-0223.

Sincerely,



Barbara C. Dodge  
Director

BCD/JB/JDW

Attachment

c: David W. Hood  
Charles Castille  
Ben Bearden  
Stan Mead

**Corrective Action Plan**  
**Legislative Audit Finding, FYE 6/30/02**  
**Improper Claims by Case Management Providers**

The BCSS Case Management Section requested information on the recipients noted from the three agencies that were audited. It is important to note that the different case management populations have different requirements regarding the site of the face-to-face visits. Not all populations require a visit in the home. Based on a review of the material received from the case management agencies, there were some findings with which we agree. We will be taking steps to recoup payments made to these agencies in the instances where the documentation was inadequate to support the reimbursement made to these organizations, or if there was a failure to meet the minimum requirements for the population being served. We will continue to review the material to determine if penalties should be applied.

**Audit Findings:** Quarterly or Monthly Notes Not Available; Required Face-to-Face Visits Did Not Occur

Based on a review of the documentation submitted by the case management provider organizations, it has been determined that a retraining on proper and required documentation will be presented. The training will be mandatory; all case management providers will be required to attend this training. BCSS is moving toward competency-based training. Personnel from the BCSS Case Management Section, in collaboration with personnel from the BCSS Consumer Services and Development Section, will plan together for a competency-based training.

The new case management manual requires that each case management agency has a staff person who is responsible for their agency's training. These individuals will be required to be a part of the planning process to determine how training on case management documentation will take place.

The provider organizations cited in the Legislative Audit findings will be required to submit a corrective action plan regarding their agency's oversight of documentation in each recipient's record.

In addition, numbered memoranda will be sent to the case management agencies clarifying policy regarding the requirements for each population the agency serves and the documentation requirements specific to that population. The case management manual will be reviewed to determine if additional information or clarification should be incorporated into a revision of the manual.

In the instance of the two persons who were noted not to have the required face-to-face visits, a review of the material submitted indicates that inadequate documentation may have been the cause.

A policy has been put in place to insure that agencies failing to meet the quarterly requirements for the population being served must submit documentation for the quarter to the BCSS Case Management Section for a determination as to whether payment made for the first two months of the quarter will be recouped.

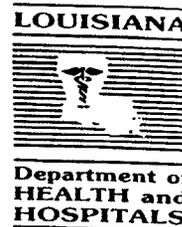
Target Date: January 15, 2003

Contact Persons: Judy Baker, Jean Melancon, Sue Merrill and Judy Moore



M. J. "Mike" Foster, Jr.  
GOVERNOR

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS



David W. Hood  
SECRETARY

November 18, 2002

Daniel G. Kyle, PH.D., CPA, CFE  
Legislative Auditor  
State of Louisiana  
1600 North Third Street  
Post Office Box 94397  
Baton Rouge, Louisiana 70804-9397

Dear Dr. Kyle:

This letter is in response to your office's audit finding contained in Mr. Ernest F. Summerville, Jr.'s letter dated October 28, 2002. The finding is captioned "Medicaid Provider Overpayment Errors" and relates to the Medicaid Fraud Control Unit (MFCU) operated by the Louisiana Attorney General not reporting all accounts for which judgments had been rendered to the Department of Health and Hospitals. Consequently, DHH did not refund \$374,003 of federal financial participation (FFP) to the federal government within 60 days, as required by federal regulations.

The department concurs with the finding that the judgment accounts totaling \$532,011 of which \$374,003 was FFP should have been reported to DHH and that DHH is obligated under federal regulations to return the FFP within 60 days. The department concurs with the recommendation that the MFCU should ensure that all accounts for which judgments have been rendered are reported to DHH.

The department concurs with the recommendation that controls should be strengthened to ensure that accounts maintained by the AG are reported to DHH and that FFP is returned to the federal government in accordance with federal regulations. The department will request that the procedures for the reporting of judgment accounts by the MFCU to DHH be incorporated into the memorandum of understanding (MOU) between the MFCU and DHH. Absent a provision in the MOU, DHH has no way of requiring that the MFCU report the judgment accounts to DHH. Federal regulations at 42 C.F.R. §1007.9 specifically require that the MFCU be a separate and distinct unit from DHH (Medicaid) and that no DHH (Medicaid) official can have authority to review the activities of the unit. These regulations do require the MFCU to enter into a MOU with DHH (Medicaid).

Daniel G. Kyle, PH.D., CPA, CFE  
November 18, 2002  
Page 2

If you have questions or need additional information, please contact Don Gregory at  
(225)219-4149.

Sincerely,

A handwritten signature in cursive script, appearing to read "Ben A. Bearden".

Ben A. Bearden  
Director

BAB/JP/DG

cc: David W. Hood  
Charles F. Castille  
Stan Mead  
Don Gregory  
Fred Duhy