

MEDICAL ASSISTANCE PROGRAMS FRAUD
DETECTION FUND

LOUISIANA DEPARTMENT OF HEALTH
AND
OFFICE OF THE LOUISIANA ATTORNEY GENERAL



PERFORMANCE AUDIT SERVICES
JULY 25, 2018

**LOUISIANA LEGISLATIVE AUDITOR
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**FOR QUESTIONS RELATED TO THIS PERFORMANCE AUDIT, CONTACT
CHRIS MAGEE, PERFORMANCE AUDIT MANAGER,
AT 225-339-3800.**

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LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

July 25, 2018

The Honorable John A. Alario, Jr.,
President of the Senate
The Honorable Taylor F. Barras
Speaker of the House of Representatives

Dear Senator Alario and Representative Barras:

This report provides the results of our evaluation of the Medical Assistance Programs Fraud Detection Fund (Medicaid Fraud Fund). The purpose of this audit was to determine whether the Louisiana Department of Health (LDH) and the Office of the Louisiana Attorney General (AG) deposited and expended funds from the Medicaid Fraud Fund from fiscal years 2012 through 2017 in accordance with state law. The report contains our findings, conclusions, and recommendations. 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 AG and LDH for their assistance during this audit.

Respectfully submitted,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/aa

MEDICAID FRAUD FUND

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE



Medical Assistance Programs Fraud Detection Fund Louisiana Department of Health Office of the Louisiana Attorney General

July 2018

Audit Control # 40170026

Introduction

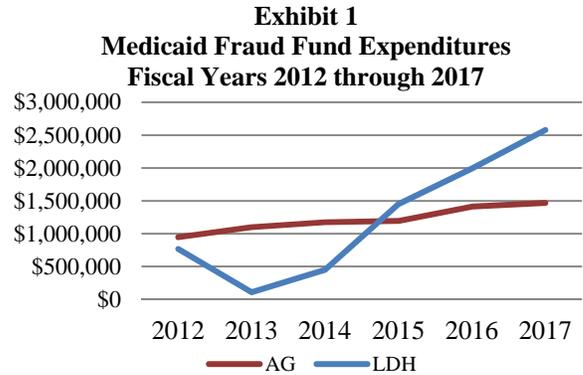
In 1997 the Louisiana Legislature enacted Revised Statute (R.S.) 46:440.1, which established the Medical Assistance Programs Fraud Detection Fund (Medicaid Fraud Fund). The purpose of this fund is to provide financial support to the Louisiana Department of Health (LDH) and the Office of the Louisiana Attorney General (AG) for their efforts related to Medicaid fraud and abuse. Any monies that result from settlements or civil awards related to Medicaid fraud and abuse recovery efforts are required to be deposited into this fund, except for that amount necessary to make Medicaid whole.¹

Prior to fiscal year 2009, there was no limit on the amount of funds LDH and the AG could each withdraw from the Medicaid Fraud Fund. Act 712 of the 2008 Regular Legislative Session amended the statute effective fiscal year 2009 to direct 50% to be allocated to LDH to be used solely for Medicaid fraud detection and prevention, and 50% of the monies collected and deposited into the Medicaid Fraud Fund to be allocated to the Medicaid Fraud Control Unit (MFCU) within the AG. Funds can only be expended for the following purposes:

- To pay costs or expenses incurred by LDH or the AG relative to a Medicaid fraud or abuse case
- To enhance fraud and abuse detection and prevention activities related to Medicaid
- To pay rewards for information concerning Medicaid fraud and abuse, and
- To provide a source of revenue for Medicaid in the event of a shortfall in state general fund.

¹ To make Medicaid whole is to fully recover overpayments or improper payments made to providers.

Between fiscal years 2012 and 2017, LDH contributed \$323,570 to the Medicaid Fraud Fund, while the AG contributed a total of approximately \$16.7 million. Together, both agencies expended a total of \$14,644,186 from the Medicaid Fraud Fund. Other expenditures were the result of fund sweeps due to budget deficits. Exhibit 1 illustrates the LDH’s and the AG’s expenditures from the Medicaid Fraud Fund for fiscal years 2012 through 2017, while Exhibit 2 shows contributions and expenditures, by category.



Source: Prepared by legislative auditor’s staff using information provided by LDH and the AG.

Exhibit 2 Medicaid Fraud Fund Contributions and Expenditures, by Category Fiscal Years 2012 through 2017		
Category	Contribution	Expenditure
LDH	\$323,570	\$7,347,986
AG	16,669,257	7,296,200
Interest	127,550	n/a
Fund Sweeps*	n/a	7,584,917
Total**	\$17,120,377	\$22,229,103
<p>* As a result of Act 420 of the 2013 Regular Session, \$7.02 million of this amount was transferred into the state general fund in fiscal year 2014. The remaining \$563,646 was swept during fiscal years 2015 through 2017.</p> <p>** The Medicaid Fraud Fund had a surplus from fiscal years 2010 through 2013. This allowed for the Medicaid Fraud Fund to absorb the deficits depicted in this chart for fiscal years 2012 through 2017.</p> <p>Source: Prepared by legislative auditor’s staff using information from the Department of Treasury.</p>		

The objective of this audit was:

To determine whether LDH and the AG deposited and expended funds from the Medicaid Fraud Fund from fiscal years 2012 through 2017 in accordance with state law.

Overall, we found that both LDH and the AG need to develop an effective process to identify and ensure that the appropriate monies are deposited into the Medicaid Fraud Fund. In addition, LDH needs to ensure that funds expended from the Medicaid Fraud Fund meet the requirements established in state law. The issues we identified are summarized on the following page and in more detail throughout the report. Appendix A provides management’s responses, and Appendix B details our scope and methodology. Appendix C shows both LDH and AG expenditures from the Medicaid Fraud Fund from fiscal years 2012 through 2017.

Objective: To determine whether LDH and the AG deposited and expended funds from the Medicaid Fraud Fund from fiscal years 2012 through 2017 in accordance with state law.

Our evaluation identified the following:

- **Both LDH and the AG lack an effective process to properly identify and deposit monies into the Medicaid Fraud Fund. As a result, LDH did not deposit approximately \$2.8 million, and the AG did not deposit \$712,713 into the Medicaid Fraud Fund in fiscal year 2016 in accordance with state law.** LDH did not deposit \$2,797,768 in fines and monetary penalties assessed between fiscal years 2012 and 2017 into the Medicaid Fraud Fund until February 2018. In fiscal year 2016, the AG deposited \$712,713 less than the amount indicated by agency memos and could not provide memos to support \$23,782 in deposits that were made into the Medicaid Fraud Fund between fiscal years 2013 and 2015.
- **LDH incorrectly deposited \$323,570 into the Medicaid Fraud Fund in fiscal year 2012 that should have been deposited into the Nursing Home Residents' Trust Fund.** According to LDH staff, deposits into the Medicaid Fraud Fund prior to fiscal year 2012 may have also been improper, because the memos directing the monies did not clearly specify where these monies were to be deposited.
- **LDH spent \$477,266 from the Medicaid Fraud Fund in fiscal year 2017 for salaries that do not appear to meet the intended purpose of contributing to the prevention and detection of Medicaid fraud and abuse. In addition, LDH spent \$642,593 from the Medicaid Fraud Fund in fiscal year 2012 on software that could not be implemented due to system compatibility issues.** LDH paid salaries for the internal audit section through the Medicaid Fraud Fund which do not fully contribute to the prevention and detection of Medicaid fraud and abuse as required by R.S. 46:440.1. The software, called Microsoft Dynamics 365, was purchased in June 2012 and was intended to track health care related events and identify fraud, waste, and abuse in the Medicaid program.
- **The AG expended \$7,062,076 from the Medicaid Fraud Fund during fiscal years 2012 through 2017 in accordance with the requirements of R.S. 46:440.1.** The Medicaid Fraud Fund is used to pay the state share of operations of the MFCU, which is responsible for investigating and prosecuting Medicaid provider fraud.

These issues are discussed in more detail on the following pages.

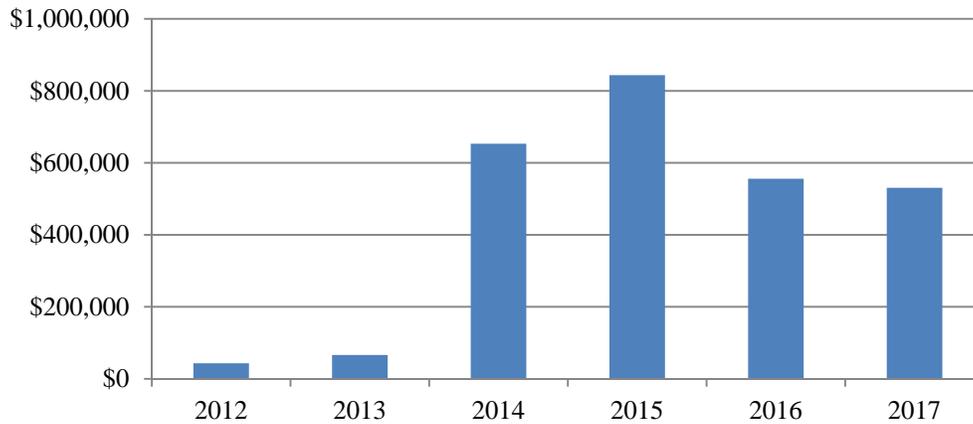
Both LDH and the AG lack an effective process to properly identify and deposit monies into the Medicaid Fraud Fund. As a result, LDH did not deposit approximately \$2.8 million, and the AG did not deposit \$712,713 into the Medicaid Fraud Fund in fiscal year 2016 in accordance with state law.

R.S. 46:440.1 requires that all monies received by the state pursuant to a civil award granted or settlement, except for the amount to make Medicaid whole, shall be deposited into the Medicaid Fraud Fund. If LDH or the AG levy and collect penalties or additional recoveries as part of settlement agreements between the state and violators of the state's Medical Assistance Program Integrity Law (MAPIL),² these penalties and any additional recoveries such as costs of investigation should be deposited into the Medicaid Fraud Fund. For example, if an overpayment or fraud of \$3,500 is identified by LDH or the AG and a \$500 penalty is assessed, then the \$3,500 overpayment is recovered from the provider to make Medicaid whole and the \$500 monetary penalty is deposited into the Medicaid Fraud Fund. Both LDH and the AG send memos to their respective financial departments instructing that monies beyond the amounts needed to make Medicaid whole, be put into the Medicaid Fraud Fund.

Between fiscal years 2012 and 2017, LDH collected \$2,797,768 in fines and monetary penalties but did not deposit any of these monies into the Medicaid Fraud Fund. LDH's Program Integrity section imposes penalties for violations such as improper billing or billing for services not rendered, as well as for providers not having general liability insurance, workers' compensation insurance, or being improperly licensed. While these fines and monetary penalties are required to be deposited into the Medicaid Fraud Fund, LDH did not deposit them prior to February 2018. We reviewed LDH's case tracking system and identified \$2,797,768 in fines and monetary penalties during fiscal years 2012 through 2017 that should have been deposited into the Medicaid Fraud Fund. Instead, LDH staff erroneously classified these fines and monetary penalties as self-generated revenue. Once we identified this issue, LDH staff confirmed the results and appropriately deposited these monies into the Medicaid Fraud Fund in February 2018. Exhibit 3 shows the penalties and fines collected by LDH in fiscal years 2012 through 2017.

² MAPIL was enacted to combat and prevent fraud and abuse in the Medicaid program. It grants authority to pursue penalties, damages, or other remedies to protect the fiscal and programmatic integrity of Medicaid from providers who engage in fraud, misrepresentation, abuse, or other ill practices to obtain payments to which these providers are not entitled.

Exhibit 3
LDH Program Integrity Fines and Monetary Penalties Collected
Fiscal Years 2012 through 2017



Source: Prepared by legislative auditor’s staff using information from LDH Program Integrity.

According to LDH management, the process for transferring monies into the Medicaid Fraud Fund was not done correctly between fiscal years 2012 and 2017³ due to unclear guidance in the law and lack of internal policy. LDH stated that it is not sure whether the fines or monetary penalties it assesses should be categorized as civil awards or settlements, which is what the law⁴ states should be deposited into the Medicaid Fraud Fund. According to LDH, memos directing employees on where to deposit these fines and monetary penalties did not specifically state to deposit these funds into the Medicaid Fraud Fund.⁵ This lack of clarity regarding the proper distribution of funds could result in additional fines and monetary penalties that should have been deposited into the Medicaid Fraud Fund from its inception in fiscal year 1998 through fiscal year 2011. LDH management reported that it has corrected its process and deposited \$112,892 into the Medicaid Fraud Fund for fiscal year 2018.⁶

The AG lacks an effective process to ensure all required funds are deposited into the Medicaid Fraud Fund. As a result, the AG did not deposit \$712,713 into the Medicaid Fraud Fund in fiscal year 2016 in accordance with state law. The AG relies on MFCU’s Chief Auditor to prepare and issue memos to the financial department regarding amounts that should be deposited into the Medicaid Fraud Fund. However, there are no procedures that require the Chief Auditor’s determinations to be reviewed to ensure the accuracy of the memos, or that confirm whether all memos are submitted. We obtained memos from fiscal years 2013 through 2016⁷ to calculate the amounts that should have been contributed to the Medicaid Fraud

³ Because LDH’s record retention policy is only six years, information for fiscal years 2011 and prior are not available. As a result, LDH cannot determine whether the process was done correctly during that timeframe.

⁴ R.S. 46:440.1

⁵ The memo directed LDH employees to deposit funds into the “Fraud Account” instead of the “Medical Assistance Programs Fraud Detection Fund,” which LDH management stated confused LDH employees.

⁶ This amount includes \$26,373 reclassified to the Medicaid Fraud Fund in January 2018, in addition to \$86,519 in penalties received in fiscal year 2018.

⁷ The AG had previously compiled memos for fiscal years 2013 through 2016 for LLA financial audit staff. Since fiscal year 2012 files were outside of the AG’s retention schedule and fiscal year 2017 memos would have to be pulled from their warehouse, we used the fiscal years 2013 through 2016 memos for our analysis.

Fund and compared this information to what was actually deposited into the Medicaid Fraud Fund based on Department of Treasury documents. In fiscal year 2016, the AG deposited \$712,713 less than the amount indicated by the memos we received. Once we identified this issue, AG staff confirmed the results and appropriately deposited these monies into the Medicaid Fraud Fund in May and June 2018.⁸ In addition, the AG could not provide memos to support \$23,782 in deposits that were made to the Medicaid Fraud Fund between fiscal years 2013 and 2015.

Although the AG assigns a unique tracking number to each of its investigations (cases), it does not have a case tracking system to track the collections for each case, such as the amounts that should go to make Medicaid whole and the amounts that should go to the Medicaid Fraud Fund. In addition, the memos that direct monies to the Medicaid Fraud Fund do not include the case number, which sometimes results in payments being credited to the wrong account. For example, there was an instance where an account manager tracked and billed the incorrect provider because the providers had the same last name, with a similar first name.

Tracking of funds earmarked for the Medicaid Fraud Fund is further complicated by the fact that legislation can direct monies, such as those associated with Average Wholesale Price (AWP)⁹ cases that would normally be deposited into the Medicaid Fraud Fund, into other funds. In these cases, current AG audit and financial department staff do not always have the documentation necessary to identify the fund to which these monies were distributed. With no clear tracking process in place, it is difficult for management to reconcile amounts that should be directed to the Medicaid Fraud Fund. According to AG staff, the agency has recently established additional steps and procedures such as including case numbers and formulas to memos, monthly reconciliation reports, and quarterly meetings to review deposits to ensure improved communication for the accuracy of deposits to the Medicaid Fraud Fund.

As a result of Act 597 of the 2012 legislative session, \$15,416,707 that would normally be deposited into the Medicaid Fraud Fund was directed to another fund in fiscal year 2013. A large source of revenues to the Medicaid Fraud Fund during our audit period included AWP cases related to settlements with large pharmaceutical companies. However, Act 597 of the 2012 legislative session directed \$15,416,707 in MAPIL additional recoveries¹⁰ to go to the Medical Assistance Trust Fund instead of the Medicaid Fraud Fund. The Medical Assistance Trust Fund consists of monies generated by provider fees from certain provider types, such as nursing facilities,¹¹ and is appropriated by the legislature to obtain federal financial participation to fund these health care provider groups.

⁸ AG financial staff reported that an additional \$217,361 is being held in escrow as the case has entered into bankruptcy proceedings and is awaiting final determination from the court.

⁹ The AWP is a benchmark used for pricing and reimbursement of prescriptions. Reimbursements are made based on AWP; however, pharmacies purchase drugs based on the wholesale acquisition cost. AWP cases arise as a result of collusion between AWP publishers and wholesalers in an attempt to artificially inflate the AWP, which in turn, increases the amount paid by the government, private insurance programs, and consumers.

¹⁰ MAPIL additional recoveries include costs of investigation and penalties collected, excluding amounts received to make Medicaid whole.

¹¹ Provider types that are required to pay provider fees are established in R.S. 46:2625. These provider groups include nursing facilities, intermediate care facilities for the developmentally disabled, pharmacies, and medical transportation providers.

Recommendation 1: LDH should continue to develop and implement clear policies and procedures for the contribution of monies to the Medicaid Fraud Fund.

Summary of Management's Response: LDH agrees with this recommendation and stated that it revised its memo templates in January 2018 to provide clear and specific information for depositing penalties into the Medicaid Fraud Fund.

Recommendation 2: The AG should continue to develop a process to ensure that all required funds are properly deposited into the Medicaid Fraud Fund, including the use of case-numbered memos, verification of the accuracy of these memos and the amounts deposited to the Medicaid Fraud Fund, and the development of a database that allows for tracking of state and federal funds.

Summary of Management's Response: The AG agrees with this recommendation and stated that it has made updates to memos which include case numbers and formulas to check the amounts contributed to the Medicaid Fraud Fund. The AG also stated that it has implemented a monthly reconciliation process to ensure that funds are deposited appropriately and/or forwarded to LDH or other entities where appropriate.

Matter for Legislative Consideration 1: The legislature should consider amending R.S. 46:440.1 to clarify required types of contributions to the Medicaid Fraud Fund.

LDH incorrectly deposited \$323,570 into the Medicaid Fraud Fund in fiscal year 2012 that should have been deposited to the Nursing Home Residents' Trust Fund.

R.S. 40:2009.11 established the Nursing Home Residents' Trust Fund, which is comprised of civil fines and interest from nursing homes that have violations that may pose a threat to the health, safety, rights, or welfare of nursing home residents. The fund is subject to annual appropriation by the Legislature and shall be used solely to protect the health and property of residents of nursing homes that are found to be deficient, pay for the relocation of residents to other facilities, maintain operation of a facility pending correction of deficiencies or closure, reimburse residents for personal funds lost, educate residents to improve their health and welfare, reimburse a nursing home for evacuation expenses, or any other purpose approved by Centers for Medicare and Medicaid Services (CMS).

According to LDH management, in 2014 the department identified monies earmarked for the Nursing Home Residents' Trust Fund that were deposited into the Medicaid Fraud Fund in error during fiscal years 2012 through 2014. LDH retroactively transferred these monies from the Medicaid Fraud Fund into the Nursing Home Residents' Trust Fund for fiscal years 2013 and 2014, but did not correct for fiscal year 2012. LDH has appropriately deposited funds into the Nursing Home Residents' Trust Fund in each year since; however, LDH cannot determine if this

issue existed prior to fiscal year 2012 because the department does not have source documents for deposits made prior to that time.¹² As a result, LDH is unable to determine whether deposits of \$3,661,636 made to the Medicaid Fraud Fund between fiscal years 2000 and 2011 were made appropriately.

Recommendation 3: LDH should retroactively transfer the monies from the Medicaid Fraud Fund that should have been designated for the Nursing Home Residents' Trust Fund in fiscal year 2012.

Summary of Management's Response: LDH agrees with this recommendation and stated that it transferred \$323,570 into the Nursing Home Residents' Trust Fund on June 4, 2018.

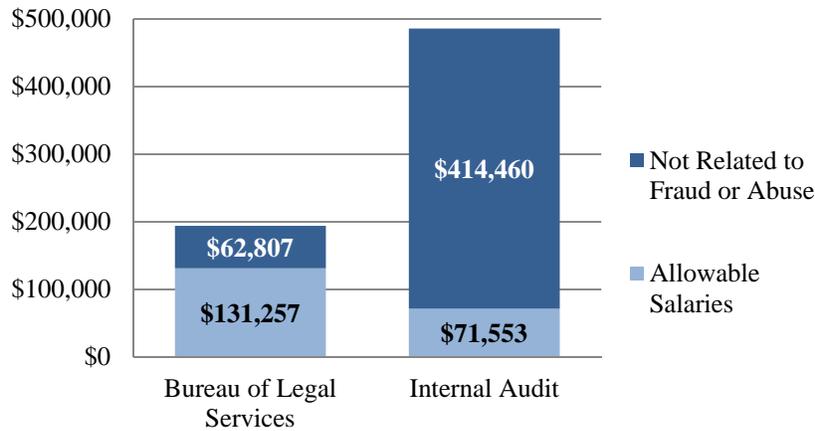
LDH spent \$477,266 from the Medicaid Fraud Fund in fiscal year 2017 for salaries that do not appear to meet the intended purpose of contributing to the prevention and detection of Medicaid fraud and abuse. In addition, LDH spent \$642,593 from the Medicaid Fraud Fund in fiscal year 2012 on software that could not be implemented due to system compatibility issues.

Information obtained from LDH regarding Medicaid Fraud Fund expenditures shows that LDH has used the Medicaid Fraud Fund to cover salaries of Program Integrity, Legal, and Internal Audit staff. According to LDH management, these positions' salaries were paid through the Medicaid Fraud Fund as a result of the fiscal year 2016 Deficit Elimination Plan and in order to maximize LDH's statutory dedications before turning to the general fund for financing. Additional expenditures from the fund between fiscal years 2012 and 2017 included data processing software, postage, office supplies, building maintenance, and travel expenses. Appendix C summarizes expenditures from the Medicaid Fraud Fund from fiscal years 2012 through 2017.

LDH spent \$477,266 from the Medicaid Fraud Fund in fiscal year 2017 for salaries that do not appear to meet the intended purpose of contributing to the prevention and detection of Medicaid fraud and abuse. While Program Integrity is directly involved with the prevention and detection of Medicaid fraud and abuse, the role of the legal staff and internal auditors is less clear. To determine whether these salaries were funded by the Medicaid Fraud Fund in accordance with state law, we reviewed the job descriptions for these employees. We noted that in several of the job descriptions, prevention and detection of Medicaid fraud and abuse were not listed as job duties. Exhibit 4 on the following page shows the salary amounts for Legal and Internal Audit staff funded out of the Medicaid Fraud Fund, as well as the salary amounts that are associated with positions not related to Medicaid fraud and abuse according to the job descriptions.

¹² LDH's record retention schedule for deposits is six years, including the current year.

Exhibit 4
LDH Internal Audit and Legal Salaries Paid from Medicaid Fraud Fund
Fiscal Year 2017



Source: Prepared by legislative auditor’s staff using information from Business Objects and LDH.

Of the eight Internal Audit salaries paid from the Medicaid Fraud Fund, only two (25%) had job descriptions with duties associated with the prevention and detection of Medicaid fraud, and none of the positions were 100% associated with Medicaid fraud activities. While looking for indicators of fraud is a key component of any audit position, the role of the internal audit function is to look for indicators of fraud within the department as opposed to external sources, such as healthcare providers within Medicaid. LDH staff stated that the job descriptions were out of date and not reflective of the true work performed by the internal audit staff. However, we analyzed the 20 projects performed by the LDH Internal Audit section in fiscal year 2017 and determined that 15 (75%) had no Medicaid fraud component. Exhibit 5 below shows whether fraud was a component of projects conducted by LDH Internal Audit staff in fiscal year 2017.

Exhibit 5 LDH Projects Performed by Internal Audit with Fraud Component Fiscal Year 2017			
Determination	Audits	Percentage	Examples
Yes	3	15%	Reviews of eligibility error rates and excluded Medicaid providers.
Partial	2	10%	Improper use of Medicaid funds as one part of an audit or investigation that had multiple components.
No	15	75%	Investigations into unethical hiring practices and usage of purchase and travel cards and audits of operations of specific offices within LDH.
Total	20		

Source: Prepared by legislative auditor’s staff using information from LDH.

We also found that the salary associated with one of the three legal positions did not meet the statute’s intended purpose for expenditures. The other two legal positions did contribute in some form to Medicaid fraud prevention and detection, with one position 100% associated with Medicaid fraud detection and prevention.

LDH spent \$642,593¹³ from the Medicaid Fraud Fund in fiscal year 2012 for software that could not be implemented due to system compatibility issues. In June 2012, LDH purchased 2,017 licenses¹⁴ for Microsoft Dynamics 365. According to LDH's IT Request Form, this software was intended to integrate Medicaid systems related to tracking health care related events and identifying fraud, waste, and abuse in Medicaid. LDH attempted to implement the software for three years but could not due to system compatibility issues.

Recommendation 4: LDH should ensure that job descriptions are current and reflective of the actual work performed by its employees.

Summary of Management's Response: LDH agrees with this recommendation and stated that it will review and update Internal Audit and Legal job descriptions to reflect current job duties. LDH anticipates this will be completed by July 31, 2018.

Recommendation 5: LDH should determine the percentage of each employee's salary that should be funded out of the Medicaid Fraud Fund based on the employee's updated job descriptions.

Summary of Management's Response: LDH agrees with this recommendation and stated that it will make determinations of time spent on Medicaid fraud related activities and will adjust the salaries derived from the Medicaid Fraud Fund as appropriate. LDH anticipates this will be completed by July 31, 2018.

The AG expended \$7,062,076 from the Medicaid Fraud Fund during fiscal years 2012 through 2017 in accordance with the requirements of R.S. 46:440.1.

R.S. 46:440.1 states that monies in the fund are to be used to enhance fraud and abuse detection and prevention activities related to Medicaid. According to AG financial staff, the funding of the MFCU's operations is paid entirely through the Medicaid Fraud Fund.¹⁵ MFCU's primary role is to investigate and prosecute instances of Medicaid provider fraud, as well as patient abuse and neglect in Medicaid facilities. Accordingly, the AG expended a total of \$7,062,076 in expenditures between fiscal years 2012 and 2017 on salaries for MFCU employees, MFCU operating costs, and other MFCU expenditures, which is consistent with the requirements of the state law.¹⁶ Appendix C summarizes expenditures from the Medicaid Fraud Fund from fiscal years 2012 through 2017.

¹³ A federal match of \$642,592 was also spent for this software, for a total cost of \$1,285,185.

¹⁴ In addition to the licenses, LDH also purchased external connector licenses and server licenses.

¹⁵ The federal government has a 75/25 match with the state for Medicaid fraud control activities, and as a result the federal government will pay 75% of the state's operating costs, while the state is responsible for the remaining 25% of these expenses.

¹⁶ Other expenditures included acquisitions, data processing and software, office supplies, postage, and maintenance/repairs.

APPENDIX A: MANAGEMENT'S RESPONSES



State of Louisiana
Louisiana Department of Health
Office of Management and Finance

July 18, 2018

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

RE: Medical Assistance Programs Fraud Detection Fund

Dear Mr. Purpera:

We have carefully reviewed the above referenced reportable audit findings. In our view, the crux of this audit was our prior policy of classifying the fines and penalties collected by LDH Program Integrity as self-generated revenue instead of depositing them directly into the Fraud Fund.

It is important to note that these funds were deposited into other LDH accounts, and the agency has accounted for and reported these funds every year. When this administration learned from the auditor that there were questions about the proper account in which to deposit these funds, LDH Fiscal, Program Integrity, and Legal personnel implemented corrective steps immediately. In less than a month, the full amount of \$2.79 million was transferred into the Fraud Fund.

LDH also updated and strengthened its policies and procedures, retrained staff about the Fund, and properly reallocated any funds deposited into the Nursing Home Resident's Trust Fund into the Fraud Fund.

Specific to the findings, LDH concurs and provides the following response to the recommendations documented in the report.

Finding 1, Recommendation 1:

LDH should continue to develop and implement clear policies and procedures for the contribution of monies to the Fraud Fund.

Response:

LDH Fiscal, Program Integrity, and Legal personnel met in January 2018 to ensure that all sections have a better understanding of the requirements stated in Louisiana R.S. 46:440.1 and the relevant responsibilities of each section and to strengthen internal policies and procedures. In January 2018, Program Integrity revised templates of its memos to Fiscal to include clear and specific information for depositing these types of penalties into the Medicaid Fraud Fund.

Finding 2, Recommendation 3:

LDH should retroactively transfer the monies from the Medicaid Fraud Fund that should have been designated for the Nursing Home Residents' Trust Fund in fiscal year 2012.

Response:

LDH transferred \$323,569.56, the FY 2012 monies, from the Medicaid Fraud Fund to the Nursing Home Residents' Trust Fund on June 4, 2018.

Finding 3, Recommendation 4:

LDH should ensure that job descriptions are current and reflective of the actual work performed by its employees.

Response:

LDH will review and update as needed the job descriptions for Internal Audit and Legal positions referenced in the report to ensure they are complete and reflective of current job duties. We anticipate this work to be complete by July 31, 2018.

Finding 3, Recommendation 5:

LDH should determine the percentage of each employee's salary that should be funded out of the Fraud Fund based on the employee's updated job descriptions.

Response:

LDH will make determinations regarding accurate percentage of time spent on Medicaid Fraud related activities within each updated job description in Internal Audit and Legal and based on that determination will adjust the amount of salary for the respective employees that is derived from the Fraud Fund as appropriate. We anticipate this work will be complete by July 31, 2018.

Please contact Michael Breland at (225) 342-8158, michael.breland@la.gov, if you have any questions.

Sincerely,



W. Jeff Reynolds
Undersecretary

WJR/ap



Jeff Landry
Attorney General

State of Louisiana
DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL
P.O. BOX 94005
BATON ROUGE
70804-9005

June 14, 2018

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

Dear Mr. Purpera:

On behalf of the Louisiana Department of Justice, please accept the following response to the performance audit report regarding the Medical Assistance Programs Fraud Detection Fund. We concur with the recommendation of the Legislative Auditor that we continue to develop a process to ensure that all required funds are properly deposited into the Medical Assistance Programs Fraud Detection Fund. Prior to receiving the draft audit report from the Legislative Auditor, employees at the Department of Justice had begun implementing changes to clarify how funds received by the Medicaid Fraud Control Unit are properly deposited and tracked. Additional steps and procedures have already been put into place to ensure improved communication for accuracy of deposits. Updates to the memos have been made which will be inclusive of case number and formulas for checks and balances of amounts deposited. Our staff is also implementing a monthly reconciliation process to ensure that all funds are deposited appropriately and/or forwarded to LA Department of Health or other entities where appropriate.

The Legislative Auditor identified \$712,713 that was not deposited into the Medicaid Fraud Fund in fiscal year 2016. Once this matter was brought to our attention, we immediately took steps to identify the funds that were not deposited and correct this matter with the deposit of the additional funds. The new format for our memos and the monthly reconciliation process that we are implementing should ensure that this does not occur again and that all required funds are properly deposited into the Medicaid Fraud Fund.

The Legislative Auditor also identified \$23,782 in deposits to the Medicaid Fraud Fund for which we were unable to provide supporting documentation. We would like to clarify that we believe these funds were properly deposited into the Medicaid Fraud Fund. Again, the new format for our memos and the monthly reconciliation process that we are implementing should ensure that this does not occur again and that all required funds are properly deposited into the Medicaid Fraud Fund.

We also would like to bring to your attention that the MFCU does in fact have a case tracking system which tracks the collections on each case. This is inclusive of amounts that should go to make Medicaid whole and the amounts that should be deposited in the Medicaid Fraud Fund. However, this system was designed to meet federal reporting requirements which require the reporting of consolidated state and federal recoveries, rather than reporting state and federal dollars separately. The information regarding state only funds is reported in the case tracking system in a comment field. All of the necessary

information is included in the current case tracking system, but the current system does not have a mechanism to report the comment field in column that will automatically tabulate the contents. The Department is currently working on the procurement of a case tracking system that will allow for more detailed record keeping of both state and federal funds. Until the new case tracking system is implemented, MFCU staff will make additional entries and comments in the case tracking system to clarify what funds were actually received by the Medicaid Fraud Control Unit and which funds were actually received directly by our Federal counterparts. Additionally, we have developed a spreadsheet that will keep track of all monies actually received directly by the MFCU and the appropriate distribution of those monies. This spreadsheet is part of the reconciliation process discussed above.

As always, we appreciate the work and professionalism of the Louisiana Legislative Auditor and his staff.

Sincerely,



Wilbur L. Stiles, III

Chief Deputy Attorney General

APPENDIX B: SCOPE AND METHODOLOGY

This report provides the results of our performance audit of the Louisiana Department of Health's usage of the Medicaid Fraud Fund. We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. This audit primarily covered the time period of July 1, 2011, through June 30, 2017, although we analyzed time periods outside of that scope for certain analyses. Our audit objective was:

To determine whether LDH and the AG deposited and expended funds from the Medicaid Fraud Fund from fiscal years 2012 through 2017 in accordance with state law.

We conducted this performance audit in accordance with generally-accepted *Government Auditing Standards* issued by the Comptroller General of the United States. 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 objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. To answer our objective, we reviewed internal controls relevant to the audit objective and performed the following audit steps:

- Reviewed relevant laws, policies, and procedures.
- Reviewed Medicaid Fraud Fund contributions and expenditures, using data provided by the Office of the State Treasury for both LDH and the AG.
- Obtained job descriptions from the State Civil Service to determine the extent job duties pertained to prevention and detection of Medicaid fraud, waste, and abuse.
- Reviewed information from Program Integrity's Surveillance Utilization and Review section regarding assessed and collected penalties.
- Obtained memos from the AG that direct funds into the Medicaid Fraud Fund and compared this to contributions made to the Medicaid Fraud Fund across the audit scope.
- Interviewed agency staff at LDH and the AG to determine agency procedures and policies.
- Obtained Business Objects data regarding expenditures and staffing for LDH and the AG.

APPENDIX C: MEDICAID FRAUD FUND EXPENDITURES FISCAL YEARS 2012 THROUGH 2017

Expenditure	2012		2013		2014		2015		2016		2017		Total	
	LDH	AG	LDH	AG	LDH	AG	LDH	AG	LDH	AG	LDH	AG	LDH	AG
Accounting and Auditing	\$106,393	\$0	\$74,097	\$0	\$31	\$0	\$57	\$0	\$0	\$0	\$8,789	\$0	\$189,367	\$0
Acquisitions	0	10,186	0	8,172	0	13,656	0	16,098	0	23,465	0	21,291	0	92,868
Capitalized Acquisitions	0	7,303	0	0	0	78,069	0	5,585	0	1,381	0	109,901	0	202,238
Data Processing/ Software	642,593	0	71	505	4,244	1,275	0	125	17,967	0	0	990	664,875	2,895
Dues and Subscriptions	0	7,602	9	10,623	6,932	12,893	22,805	15,055	821	23,213	2,511	20,795	33,078	90,182
Employee Salaries and Benefits	9,676	801,856	50,667	932,536	466,658	933,182	714,944	1,023,981	1,013,282	996,779	2,047,535	1,135,538	4,302,762	5,823,871
Interagency Transfers	0	54,606	1,863	57,990	21,499	57,813	0	57,821	0	58,147	243,293	68,886	266,656	355,262
Mail, Delivery, and Postage	0	286	0	935	250	368	0	695	8	347	5	177	263	2,808
Maintenance and Repairs	0	8,216	0	11,345	35,457	8,526	21,807	8,605	703	13,204	0	13,448	57,967	63,344
Miscellaneous Charges	0	728	0	8,249	227,267	37	477,557	965	0	0	0	0	704,824	9,978
Office Supplies	0	1,656	0	2,356	4,271	3,178	1,156	2,435	3,572	2,295	67	2,404	9,065	14,325
Operating Expenses	0	40,644	0	34,795	2,135	37,649	562	29,302	461,822	21,307	0	44,955	464,519	208,652
Professional Services	9,000	197	0	250	90	486	206,151	713	259,133	1,641	0	200	474,374	3,486
Recovery Audit Contractor	0	0	0	0	0	0	0	0	83,994	0	0	0	83,994	0
Rentals	0	844	0	3,286	0	3,502	0	3,532	0	4,901	0	4,458	0	20,523
Travel	0	13,055	0	29,443	1,931	23,717	6,164	29,617	23,770	31,096	729	44,716	32,594	171,644
Total	\$767,662	\$947,177	\$126,707	\$1,100,486	\$770,765	\$1,174,350	\$1,451,203	\$1,194,528	\$1,865,070	\$1,177,775	\$2,302,930	\$1,467,760	\$7,284,338	\$7,062,076

Note: Cells may not sum to totals due to rounding. In addition, totals shown in this appendix may not match total expenditures shown in Exhibits 1 and 2 in the introduction. This is because certain expenditures in the Business Objects reporting category that denotes the Medicaid Fraud Fund are reimbursed at 50%.

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