STATE OF LOUISIANA
LEGISLATIVE AUDITOR

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

March 10, 1998

Financial and Compliance Audit Division

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Legislative Auditor

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BATON ROUGE MAIN OFFICE OPERATIONS
STATE OF LOUISIANA

Baton Rouge, Louisiana

Management Letter
Dated February 20, 1998

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.

March 10, 1998

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February 20, 1998

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, 1997, we conducted certain procedures at the Department of Health and Hospitals (Baton Rouge Main Office Operations). Our procedures included (1) a review of the department's internal controls; (2) tests of financial transactions; (3) tests of adherence to applicable laws, regulations, policies, and procedures governing financial activities; and (4) a review of compliance with prior year report recommendations.

The Annual Fiscal Report of the Department of Health and Hospitals (Baton Rouge Main Office Operations) was not within the scope of our procedures, and, accordingly, we offer no opinion or any other form of assurance on that report. The department's accounts are an integral part of the State of Louisiana's financial statements upon which the Louisiana Legislative Auditor expresses an opinion.

Our procedures included interviews with management personnel and other selected department personnel. We also evaluated selected documents, files, reports, systems, procedures, and policies as we considered necessary. After analyzing the data, we developed recommendations for improvements. We then discussed our findings and recommendations with appropriate management personnel before submitting this written report.

In our prior audit, for the year ended June 30, 1996, we reported findings relating to provider overpayments, movable property, contract monitoring, Medicaid cash management, accounting for block grant expenditures, medical assistance trust fund, cash management of block grants, on-line time and leave entry system and associated time and attendance records, uncollected loans, cost allocation, audits of federal subrecipients and state contractors, Recovery Home Loan Program, cash subsidy program, audits of Medicaid providers, Medicaid third party liability, Medicaid eligibility determination errors, public hearings, and drug-free workplace. The findings relating to medical assistance trust fund, cash management of block grants, drug-free workplace, uncollected loans, cost allocation errors, public hearings, Recovery Home Loan Program, contract monitoring, accounting for block grant expenditures, and audits of Medicaid providers have been resolved by the department. The remaining findings have not been resolved and are addressed again in this report.

Based on the application of the procedures referred to previously, all significant findings are included in this report for management's consideration.

Inadequate Controls Over Movable Property

For the twelfth consecutive year, various offices within the Department of Health and Hospitals (DHH) did not maintain adequate controls over movable property and did not comply with the state's movable property laws and regulations. Louisiana Administrative Code (LAC) 34:VII.307 requires that all acquisitions of qualified property be tagged and all pertinent inventory information be sent to the Louisiana Property Assistance Agency (LPAA) within 45 days after receipt of property and LAC 34:VII.313(A) requires the property manager to record the true and actual results of the annual physical inventory.

Our review disclosed the following:

- Thirteen of 131 items ($11,250 of $143,010) purchased during the year were not tagged and added to the inventory system until 50 to 420 days after receipt of the property.

- In our prior year audit, one item (costing $751) could not be located. The department still cannot locate this item and has not taken any steps to remove the item from its inventory.

- In our prior audit, we found that the New Orleans Mental Health Center's (NOMHC) inventory list contained 62 items that were not under the custody of the NOMHC's property manager. During this audit, we found that three of these items (costing $2,369) remain on the NOMHC's inventory list but are still not under the custody of the NOMHC's property manager. Two of these items valued at $1,727 were located at the Region 1 Pharmacy and are listed on the Region 1 Pharmacy inventory list. NOMHC's inventory records indicated that one item costing $642 was at the Chartres-Pontchartrain Mental Health Center (CPMHC). However, we could not determine from a review of the CPMHC's current movable property inventory the status of this item.

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

The department should ensure that all property is tagged and the required information is transmitted to LPAA timely and that all departmental movable property procedures are being followed. The department should also review the movable property inventories of NOMHC, CPMHC, and Region 1 Pharmacy and make all necessary corrections. In a letter dated November 20, 1997, Ms. Clarice Eichelberger, Executive Officer of Louisiana State Planning Council on Developmental Disabilities, concurred with the finding. She stated that all items applicable to the council in the first bullet are tagged and in the system. She also stated that the unlocated item mentioned in the second bullet has been placed on the unlocated list. In a letter dated August 6, 1997, Mr. Alton E. Hadley, Assistant Secretary of the Office of Alcohol and Drug Abuse, concurred with the portion of the first bullet applicable to that office. He also stated that he would work with the regional clinic and inpatient managers to ensure compliance with the administrative code requirements. In a letter dated July 28, 1997, Mr. Andrew P. Twyman, Deputy Assistant Secretary of the Office of Mental Health, stated that the three items from the prior audit that had not been corrected at the New Orleans Mental Health Center had been submitted to LPAA. He further stated that LPAA apparently failed to make the requested correction. He stated that the Office of Mental Health would contact LPAA to correct these items. In regard to the tagging problem noted in the first bullet, Mr. Twyman stated that the item under his bureau was not lost or missing and the regional offices would be contacted to emphasize the importance of compliance with applicable property laws and regulations.

Medicaid Cash Management Errors

For the fourth consecutive year, DHH has not complied with the Cash Management Improvement Act (CMIA) agreement. The agreement was entered into between the State of Louisiana and the U.S. Department of the Treasury to achieve greater efficiency, effectiveness, and equity in the transfer of federal funds as required by the Cash Management Improvement Act of 1990, as amended by the Cash Management Improvement Act Amendments of 1992. The Code of Federal Regulations (31 CFR 205) applies to the agreement and specifies the procedures to be used for the five types of draws made by the department for the Medical Assistance Program (CFDA 93.778, Medicaid). Our examination disclosed the following:

1. On June 17, 1997, the department overdrew assistance payments by $26,659,660. The department discovered the error and corrected it with the draw of funds for August 13 and 14, 1997. Interest penalty is estimated at $218,266.

   The department has failed to timely adjust federal draws for refund payments received from providers. The CMIA agreement requires that

the federal share of refunds in excess of $10,000 be returned within 24 hours. On 10 occasions, adjustments for refunds totaling $16,591,423 were made from 27 to 161 days late. We estimated interest liability for these overdraws to be $202,940.

The department drew funds for Monday, October 14, 1996, Columbus Day, a federal holiday, for receipt on the day after the holiday. The CMIA agreement allows states to draw funds for receipt on the day before a federal holiday, and the department should have drawn the funds for receipt on the Friday preceding the holiday. In addition, funds drawn for October 15, 1996, were not requested in time for receipt that day and were not received until October 16, 1996. Estimated interest forgone totaled $7,742.

As a result, the department has incurred an estimated $421,206 in interest penalties and has forgone an estimated $7,742 in interest earned for errors related to drawing funds for medical claims (assistance) payments.

2. The department has forgone estimated interest earnings of $150,549 for underdrawn payroll and administrative costs. DHH was underdrawn by as much as $10,830,661 during the period July 1, 1996, through March 27, 1997. The department did not begin drawing allowable indirect administrative costs until February 13, 1997. A portion of the error was due to application of a federal financial participation rate that was not in effect.

3. The department has forgone estimated interest earnings of $6,293 for underdrawn Medicare Buy-In funds. Medicaid pays the insurance premiums for certain qualifying Medicare recipients. The CMIA agreement requires that funds be wired to the Health Care Financing Administration (HCFA) on the same day that the federal funds are received. Our examination of five buy-in draws disclosed that on two occasions, premium payments were wired to HCFA from one to seven days in advance of receiving the federal funds.

The department did not comply with the CMIA agreement because it did not establish adequate procedures or did not consistently follow procedures that would have ensured compliance with the agreement. Failure to properly calculate the amount of each federal draw and to draw those funds timely exposes the state to an estimated interest

penalty totaling $421,206 and an estimated loss of interest revenues totaling $164,584--a total cost of $585,790 for interest costs and interest forgone.

DHH should establish procedures to ensure that funds are drawn timely and in compliance with the CMIA Agreement. In a letter dated October 7, 1997, Mr. Stan Mead, Director of the Division of Fiscal Management, concurred with the finding and outlined the corrective action taken by the department.

Noncompliance With Payroll Regulations

DHH did not consistently follow its internal control procedures that are designed to ensure that the department has complied with Civil Service rules and regulations and that time and attendance records supporting its $125,207,031 of expenditure for personal services are complete and accurate. We examined the controls and records of 21 timekeeping units and noted the following conditions:

- At 14 of the 21 offices tested, the timekeeper performs incompatible functions because the same employee who keys in the time and leave also reviews the reports generated by the Uniform Payroll System for accuracy. A good internal control system should provide adequate segregation of duties so that no one employee would be in a position to both initiate and conceal errors or irregularities. This is the third consecutive year this condition has been reported.

- Thirty-eight of 496 employees (7.7 percent) did not certify (sign) their time and attendance records and there was no supervisor certification of 101 of 496 (20.4 percent) attendance records. In addition, there were no time sheets present for 48 of 496 employees (9.7 percent). Civil Service Rule 15.2 requires the employee and supervisor to certify the number of hours of attendance or absence from duty on the time and attendance record. This is the fourth consecutive year the department has failed to ensure that all time records are certified and the third consecutive year that timekeepers have assumed an 8-hour work day when attendance records are incomplete.

- For 678 instances where leave was reported, there were no leave slips to support hours of sick and/or annual leave taken by 20 employees (3 percent). Also, seven leave slips, although present, were unsigned by the employee or the supervisor. DHH Policy Number 1215-92, Section XVIII requires that all leave be supported by a leave slip signed by both

the employee and the employee's supervisor. This is the third consecutive year this condition has been reported.

- Of 104 employees reporting overtime worked, 22 (21 percent) were paid for a total of 86 hours of overtime although the timekeepers did not have documentation that the overtime was authorized as required by DHH Policy Number 1215-92, Section XI. This is the second consecutive year this condition has been reported.

- At two of the 21 offices tested, we found a total of nine time sheets that were blank except for the supervisor's approval. Pre-signed time sheets represent a weakness in internal control because they can be used to process time and attendance without a physical review by the supervisor responsible for the accuracy of the attendance data.

Although the department has policies and procedures that contain many elements of a good internal control system, these procedures are not uniformly followed. Because Civil Service regulations and the department's internal control procedures were not always followed, there is increased risk that inaccurate, unsupported, or fraudulent data could be entered and processed and such errors may not be detected within a reasonable time.

DHH should reemphasize the need to follow its internal control policies and procedures regarding the On-Line Time and Leave Entry System and the related time and attendance records. In a letter dated October 7, 1997, Mr. David W. Hood, Secretary, concurred with the finding and recommendation. Mr. Hood stated that he has written a letter to all assistant secretaries, bureau chiefs within the Office of the Secretary, and division directors within the Office of Management and Finance directing them to take whatever action is necessary to ensure compliance with departmental policies regarding time and attendance records. Mr. Hood also included individual corrective action plans for the items cited in the finding.

Audits of Federal Subrecipients and State Contractors Not Obtained

For the second consecutive year, DHH failed to adhere to federal requirements and departmental policies that require audits of subrecipients and social services contractors. The Single Audit Act of 1984 (Public Law 98-502), as amended by the Single Audit Act Amendments of 1996 (Public Law 104-156), requires the department to ensure that each subrecipient of federal pass-through funds totaling $300,000 or more has an annual audit in accordance with the Office of Management and Budget

Circular A-133. In addition, departmental policy requires that (1) all subrecipients who receive between $25,000 and $300,000 and (2) all state/local governments and corporations (profit/non-profit) other than subrecipients that have a social services contract with DHH and receive $100,000 or more in funds from one or more state contracts must have a financial and compliance audit performed in accordance with *Government Auditing Standards*.

During the fiscal year ended June 30, 1996, the department developed a comprehensive monitoring system to track contracts that require audits and to monitor the receipt of audit reports and the resolution of any findings. In addition, policy numbers 3175-95 and 3105-96 were issued defining responsibility in the department for audit report monitoring and defining federal and departmental audit requirements.

Our review of the monitoring system disclosed the following:

1. Fifteen of the 153 contracts that required audits for the fiscal year ended June 30, 1996, were not submitted by June 30, 1997, although they were due by December 31, 1996. Total expenditures for these contracts were $2,947,083.

2. Twenty-seven of the 138 audits performed for the fiscal year ended June 30, 1996, had unresolved audit findings at June 30, 1997. Total expenditures for these contracts were $3,784,426.

3. During our audit of the fiscal year ending June 30, 1996, we found and reported that 92 of the 251 contracts that required audits for the fiscal year ended June 30, 1995, were not submitted by June 30, 1996, although they were due by December 31, 1995. As of June 30, 1997, audit reports for 63 of the contracts still had not been received. Total expenditures for these contracts were $7,013,528.

4. During our audit of the fiscal year ending June 30, 1996, we found and reported that 32 of the 159 audits performed for the fiscal year ended June 30, 1995, had unresolved audit findings at June 30, 1996. At June 30, 1997, the department still had not resolved the audit findings on 22 of these contracts. Total expenditures for these contracts were $2,135,614.

These results indicate that employees are not following the established procedures for reporting audit information to the contracts management section, for ensuring that

required audits are performed, and for ensuring that all findings are reviewed for subsequent resolution in a timely manner.

Failure to ensure that federal subrecipients or state contractors receive the required audits and failure to promptly follow up on reported findings increase the risk that federal and/or state funds will not be expended in accordance with applicable laws and regulations.

DHH should make employees aware of the importance of following departmental policies regarding audit requirements to ensure that federal subrecipients and social services contractors are audited as required by applicable laws and regulations and that all findings are reviewed for subsequent resolution in a timely manner. In a letter dated October 7, 1997, Mr. David W. Hood, Secretary, concurred with the finding and recommendation. Mr. Hood stated that he has written a letter to all assistant secretaries, bureau chiefs within the Office of the Secretary, and division directors within the Office of Management and Finance directing them to take whatever action is necessary to ensure compliance with the department's policies. Mr. Hood also said that the contract review committee has recommended that the department not review or initiate new contracts with contractors that are not in compliance with department policies.

Cash Subsidy Program Procedures
Not Always Followed

For the second consecutive year, DHH did not always follow established guidelines for monitoring families receiving cash subsidy payments under the Community and Family Support System. In addition, the department also did not consistently follow procedures required for the annual review of eligible families. A cash subsidy payment is a monetary payment to eligible families of children with developmental disabilities to offset the costs of caring for the child at home. Expenditures of the program totaled approximately $2.9 million for the year ended June 30, 1997. The Louisiana Administrative Code 48:16123-16125, as well as internal policies and procedures established by the department, require the regional staff to contact each family at least every 90 days to monitor the status of the child. In addition, each family must complete an annual parent report and submit a copy of the child's current individualized education program (IEP) plan or its equivalent to the regional office. Our review of 60 case files disclosed that 10 (17 percent) case files examined did not contain the annual parent report or a copy of the child's current IEP plan and did not contain documentation to support monitoring at least every 90 days.

These conditions occurred because management has not placed sufficient emphasis on monitoring and reporting procedures. As a result, the department could incur unnecessary expenditures because (1) ineligible families were allowed to participate in the program, or (2) families who become ineligible for the program would not be discovered and removed from the program in a timely manner.

The department should develop procedures to ensure that all required information is obtained and that each case is monitored in accordance with department policy and program guidelines contained in the Louisiana Administrative Code. In a letter dated July 8, 1997, Mr. Bruce C. Blaney, Assistant Secretary of the Office for Citizens With Developmental Disabilities, outlined the department's plans to correct this matter.

Medicaid Third Party Liability Errors

For the second consecutive year, DHH has not adequately identified and recorded the existence of private health insurance for all recipients of the Medical Assistance Program (CFDA 93.778, Medicaid), and DHH has not ensured that Medicaid recipients have been informed that assignment of rights to private insurance to Medicaid is automatic. The Code of Federal Regulations (42 CFR 433.135-433.154) requires that state agencies take reasonable measures to determine the legal liability of third parties and requires assignment of those third party liability (TPL) rights to Medicaid. The CFR establishes the procedures by which the requirement is to be met. In addition, 42 CFR 433.146(c) allows states to make the assignment of TPL rights to Medicaid automatic under state law, eliminating the need for individual assignment of these rights, provided that the recipient is informed of the terms and consequences of the state law. Louisiana Revised Statute 46:153(E) provides automatic assignment under state law.

Our audit included a review of case files for recipients whose eligibility determinations are made by DHH and the Department of Social Services (DSS), Office of Family Support (OFS). OFS processes applications for recipients of Temporary Assistance to Needy Families (CFDA 93.558, TANF). TANF recipients are automatically eligible for Medicaid. The approximate number of TANF recipients for whom DSS made determinations is 214,000, which is approximately 26 percent of the 818,250 recipients eligible for Medicaid for calendar year 1996.

Our audit of recipient case files for compliance with TPL regulations disclosed the following:

1. Of 57 case files tested for compliance with eligibility determinations, four indicated TPL coverage. A review of these recipients' records in the

Medicaid Management Information System (MMIS), the computer system through which claims are processed and providers are paid, did not indicate any third party coverage. The claims paid for these recipients totaled $59,096.

2. Of 56 cases reviewed for compliance with TPL regulations, 23 determinations were made by OFS. The application used by OFS does not include any statement indicating an assignment of TPL rights or that assignment of these rights is automatic in accordance with Louisiana law. In addition, there was no documentation in these 23 case files to show that recipients had been informed of the federal regulation and state statute requiring assignment of third party benefits.

   One case file indicated TPL coverage. A review of this recipient's records in MMIS did not indicate any third party coverage. The claims paid for this recipient totaled $2,100.

DHH management has not placed sufficient emphasis on controls to ensure compliance with federal regulations and state law.

Failure to adequately identify third party insurance and to ensure that MMIS files accurately reflect information contained in the recipient case files results in noncompliance with federal regulations and state law and potential overpayments to providers. Failure to ensure that there is documentation indicating that recipients have been informed that assignment of TPL rights to Medicaid is required and automatic results in noncompliance with federal and state regulations and laws for 214,000 Medicaid recipients, 26 percent of the total number of Medicaid recipients.

DHH should ensure that the existence of TPL coverage for Medicaid recipients is adequately identified and that MMIS files accurately reflect information contained in the recipient case files. DHH should ensure that TANF applications include assignment of TPL rights to Medicaid. In a letter dated October 23, 1997, Ms. Dexa Alexander responded on behalf of Mr. Thomas D. Collins, Director of the Bureau of Health Services Financing. Ms. Alexander stated that the department has issued a directive to the Medicaid regional administrators with instructions for correcting matters related to third party information gathered but not entered on the MMIS resource file. A change in computer programming has been requested to resolve the problem of Medicare coverage that was not electronically transmitted to the MMIS resource file. Ms. Alexander also included correspondence from DSS that indicates DSS began using a form in January 1997 that clearly explains assignment of rights.

Medicaid Eligibility Determinations Errors

For the second consecutive year, DHH has not established eligibility for recipients in the Medical Assistance Program (CFDA 93.778, Medicaid) in accordance with federal and state regulations and departmental policies and procedures. DHH has paid $156,478 for medical claims on behalf of Medicaid recipients for which documentation does not adequately support eligibility certifications. The Code of Federal Regulations, 42 CFR 435, establishes the federal requirements for establishing Medicaid eligibility. The CFR contains requirements for required programs as well as guidance for allowable optional programs. DHH maintains a Medicaid Eligibility Manual containing the policies and procedures to be used by eligibility determinations examiners to establish Medicaid eligibility. Generally, in accordance with federal regulations, eligibility redeterminations are conducted annually for recipients to ensure their continued eligibility.

Medicaid eligibility is generally based on qualification in certain categories of assistance combined with restrictions on income and/or resources.

1. We reviewed 60 Medicaid recipients' case files and noted the following errors in 15 case files (25 percent). Claims paid are based on on-line data from the computer system through which payments are processed and usually will not extend beyond 18 months:

    a. Of 12 case files examined for deemed eligible children, we noted errors in five. Children are deemed to be Medicaid eligible if, on their date of birth, their mothers are eligible to receive Medicaid benefits. These case files lacked documentation certifying the pregnancy of the mother at the time of her certification and/or documentation supporting the birth of the deemed eligible child or documentation of the mother's pregnancy was unclear. In addition, income was not documented sufficiently in three files. Claims paid for these recipients total $15,486.

    b. One case file was examined for a recipient receiving welfare-related Medicaid benefits only. The recipient's application was not signed. Claims paid for this recipient total $20.

    c. Of nine case files examined for CHAMP-Pregnant Woman, we noted errors in three. The Child Health and Maternity Program (CHAMP) is designed to provide prenatal care to pregnant women and care to infants and children. These case files lacked

sufficient or clear documentation of the mother's pregnancy, which is required for the program. Claims paid for these recipients total $5,803.

d. Of 14 case files examined for CHAMP Child, we noted errors in one. CHAMP children are children born on or after October 1, 1983. Income was not sufficiently documented or supported. Claims for this recipient total $1,755.

e. Of two case files examined for Spend-Down in the Medically Needy Program, we noted errors in one. The Spend-Down program provides assistance to individuals with large medical bills and who are not able to pay these bills based on income and/or resources. The case file did not adequately document that a search for resources had been conducted. Claims paid for this recipient total $18,215.

f. One case file was examined for a disabled adult child. There was no evidence that resources had been determined. No claims were paid for this recipient.

g. One claim was examined for a Supplementary Security Income (SSI) related recipient in a long-term care facility. These recipients may not meet the requirements to qualify for SSI, but may meet certain categorical requirements to receive Medicaid. There was no documentation to support the determination of income or resources. Claims paid for this recipient total $10,569.

h. Of five case files examined for Qualified Medicare Beneficiaries (QMBs), errors were noted in one. QMBs are individuals whose income and resources are below certain levels and for whom Medicaid pays their Medicare premiums. This case file did not include an income calculation, and we were unable to determine that resources had been reviewed at the most recent date of eligibility redetermination. Claims paid for this recipient total $429.

i. Of two cases examined for welfare or SSI-related recipients in intermediate care facilities for the handicapped, we noted errors in one. This case file lacked the required medical certification to qualify the individual for benefits. Claims paid for this recipient total $5,986.

2. During our tests of Medicaid recipients, we requested 124 case files. During the process of obtaining the requested files from the local offices, the department inadvertently threw away nine case files and could not locate two other case files. Claims paid for these recipients total $98,986.

Case files for the above 26 recipients do not adequately support eligibility determinations and claim payments totaling $156,478. Failure to establish eligibility in accordance with federal and state laws and regulations and to maintain documentation to support eligibility determinations results in potential overpayments to providers for Medicaid recipients. Failure to comply with federal and state laws and regulations and department policies and procedures may result in questioned costs and/or disallowances.

DHH should review the eligibility determination process and the training program for the eligibility determinations examiners. The department may consider a review of case files for the types of errors noted to ensure that their occurrence has not affected eligibility, which would result in a liability for overpayments to providers or in potential questioned costs and/or disallowances. In a letter dated October 7, 1997, Mr. Thomas D. Collins, Director of the Bureau of Health Services Financing, concurred with the findings of procedural errors and/or the need for policy clarification. Mr. Collins outlined various corrective actions that will be implemented. He also stated that a major corrective action initiative was undertaken to address the problems discovered in the prior audit and pointed out that some of the sample items fell into the time period before that corrective action was begun. Mr. Collins stated that the corrective efforts begun in November 1996 and will be continued and refined.

Laboratory Services Payment Errors

For the second consecutive year, DHH may have overpaid providers in the Medical Assistance Program (CFDA 93.778, Medicaid) for automated chemistry and urinalysis laboratory procedures. The overpayment is estimated at $184,756.

Medicare, Medicaid, and Louisiana rules and regulations govern the provider payments for laboratory services and require that certain automated tests for chemistry and urinalysis be "bundled" into panels for billing purposes. Specific combinations of tests, when billed as a single procedure rather than as individual tests, result in a lower cost to the program. Our examination of provider payments for the calendar year 1996 disclosed the following:

1. Of 50 claims sampled for automated chemistry billings, which totaled $1,092, all contained errors that resulted in potential overpayments totaling $427. When statistically projected to the population of 21,456 claims totaling $468,616, the potential overpayment to providers is $183,384, or 39.13 percent of the population dollars.

2. Of 50 claims sampled for automated urinalysis billings, which totaled $322, all contained errors that resulted in potential overpayments totaling $133. When statistically projected to the population of 515 claims paid totaling $3,317, the potential overpayment to providers is $1,372, or 41.36 percent of the population dollars.

We estimate that total overpayments to providers for 1996 paid claims total $184,756, and we estimate the amount due to the Health Care Financing Administration for the federal share of these overpayments is $153,107.

While the Medicaid Management Information System (MMIS), which is operated by the fiscal intermediary, UNISYS, includes edits to ensure that automated chemistry tests are properly bundled, these edits do not appear to be sufficient to detect and prevent payment for tests that are not properly bundled and/or duplicated. In addition, there were no edits to ensure urinalysis tests are properly bundled. As a result, overpayments that are significant either in dollars or as a percentage of total claims for a specific category, as described previously, may occur. This condition indicates that additional provider overpayments in other areas may have occurred and not been detected timely.

DHH and its program integrity section should review the potential overpayments and refer them to the Surveillance Utilization Review System (SURS), DHH internal legal counsel, and/or the Louisiana Attorney General's Medicaid Fraud Control Unit for investigation and recoupment of any amounts due from providers for overpayments. In addition, the department should review the MMIS computer edits to determine why they are not operating as defined and should consider adding edits for urinalysis tests. Finally, DHH should determine what impact the previous conditions may have on other categories of provider payments. In a letter dated November 4, 1997, Mr. Thomas D. Collins, Director of the Bureau of Health Services Financing, concurred with the finding. He stated that the condition occurred because some codes were omitted when the edits to correct the prior year finding were implemented. Mr. Collins stated that the logic changes were subsequently made and all claims with the three codes in question were reprocessed on September 23, 1997. At that time, a recoupment of $293,160 was established.

Failure to Reimburse Federal Share of Provider Overpayments

DHH understated the balance of provider overpayments in the Medical Assistance Program (CFDA 93.778, Medicaid) by $585,432, and failed to return an estimated $428,292 in federal financial participation (FFP) for this overpayment to the Health Care Financing Administration (HCFA). The Code of Federal Regulations (42 CFR 433.300 - 433.320) requires that in most cases states are to refund the federal share of identified provider overpayments to the federal government within 60 days of the identification of the overpayment, regardless of whether the overpayment was collected from the provider.

Some provider overpayments are identified 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. Our audit of identified provider overpayments disclosed one account maintained by the AG that had not been reported by the department, even though the judgment was entered October 31, 1995. The balance of this account at June 30, 1997, is $585,432, and the FFP that should have been returned is $428,292.

This condition occurred because DHH management has not ensured that balances reported by the department are accurate and that accounts maintained at DHH are reconciled with the AG accounts and reported accurately. Because DHH did not accurately report provider overpayments, they are in noncompliance with federal regulations and have incurred questioned costs of $428,292.

DHH should establish controls to ensure that accounts maintained by the AG are reconciled with reports at DHH and that the federal share of these payments is returned in accordance with federal regulations. In a letter dated November 4, 1997, Mr. Stan Mead, Director of the Division of Fiscal Management, concurred with the finding. Mr. Mead stated that the department was not informed by the AG that there was an outstanding judgment against the provider. Mr. Mead stated that the department notifies the AG monthly of the accounts on its books, requesting verification within 10 days. However, the department assumes that the listing is correct if the AG fails to respond. Mr. Mead said that the department has notified the AG of the finding and has requested a corrective action plan. He also stated that the receivable will be reported on the next report to HCFA.

Unfavorable Budget Variance

DHH made expenditures totaling $3,619,834 in excess of its budget authority. Act 17 of the 1996 Regular Session specifically restricted payments to private providers of non-emergency medical transportation to $9,500,000; however, the department expended $13,119,834 to private providers for these services. The department was aware of the excessive expenditures in this category, but did not take timely action to reduce expenditures to an acceptable level and/or request a budget increase. Failure to comply with budget restrictions may unnecessarily penalize other programs from which funds must be taken to pay for the unauthorized cost overruns.

The department should monitor its budget and take immediate corrective action when projected expenditures exceed budgetary authority. In a letter dated July 21, 1997, Mr. Thomas D. Collins, Director of the Bureau of Health Services Financing, agreed that the problem of remaining within the $9.5 million cap should have been brought to the attention of the Joint Legislative Committee on the Budget before the actual over-expenditure of the cap, but pointed out that there was a surplus in the Medicaid program for fiscal year 1997 and, therefore, no other portion of the program was actually penalized because of the overexpenditure in non-emergency medical transportation. Mr. Collins pointed out several circumstances that made compliance with the cap problematic, but did not present a plan of corrective action because the non-emergency transportation program is not capped for fiscal year 1998.

Failure to Reimburse Federal Share of Checks Outstanding More Than 180 Days

DHH has failed to properly account for Medical Assistance Program (CFDA 93.778, Medicaid) checks outstanding more than 180 days. The Code of Federal Regulations (42 CFR 433.40) requires that checks that remain uncashed beyond 180 days from the date of issue are no longer allowable program expenditures, and the federal financial participation (FFP) that was originally claimed must be repaid. In addition, good internal controls would require that reports be updated timely for checks that are voided.

Our audit of DHH's report of checks outstanding 180 days or more at June 30, 1997, disclosed the following:

1. Checks ranging from 185 to 712 days old, totaling $449,934, were not reported to the Health Care Financing Administration (HCFA). The FFP claimed for these checks by the department totaled $368,258.

2. The schedule of outstanding checks was overstated by $109,956,822 because a check payable to the Medical Center of Louisiana at New Orleans was not voided from the UNISYS computer system even though the check was replaced by two individual checks. Both the original check and the replacement checks were dated October 15, 1996.

3. Checks held at UNISYS, the fiscal intermediary, totaled $1,295,187. These checks are held because overpayments to providers remain unresolved. Of this amount, checks totaling $46,439 were voided in the UNISYS system but were still being held. The FFP for these checks totaled $35,013.

These conditions occurred because DHH has not ensured that the fiscal intermediary has adjusted transactions timely. As a result, DHH has failed to return $368,258 in FFP in accordance with federal regulations. The department's report of checks outstanding more than 180 days is overstated by $109,956,822, and the department has returned $35,013 in FFP in excess of the amount required.

DHH should ensure that outstanding checks are accurately reported and/or voided timely and that FFP is returned to HCFA as required by the CFR. In a letter dated October 29, 1997, Mr. Stan Mead, Director of the Division of Fiscal Management, concurred with the finding and stated that the main reason this occurred is that the cancellation process is manual and involves three offices passing paperwork to each other. Mr. Mead prepared a corrective action plan that includes allocation of additional resources to the matter and various improvements that should reduce processing time. Mr. Mead pointed out that although the department's list of checks outstanding more than 180 days did include a check for $109,956,822 in error, all reports had been manually adjusted to account for this error. This error required special processing from the Department of Social Services, Division of Information Services to be removed and this has been accomplished at this time. Mr. Mead further stated that in the future, all checks will be obtained from UNISYS before initiating cancellations to avoid duplicate credits to HCFA resulting from the cancellation of checks held by UNISYS.

Electronic Data Processing Control Weaknesses

DHH has not ensured that UNISYS, the fiscal intermediary with which the department contracts to process over $3 billion in medical claims for the Medical Assistance Program (CFDA 93.778), has established an adequate internal control structure relating to electronic data processing (EDP) controls. General EDP controls are part of the control environment as well as control procedures over (1) application program development and maintenance, (2) logical access to programs and data, (3) computer

operations, and (4) segregation of incompatible duties. Good general EDP controls are necessary to preserve the integrity of the system and to provide reliance on the results produced by the system.

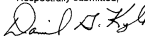
Control deficiencies relating to program changes, system changes, access to systems, access to data, segregation of duties, supervision, and documentation were observed during our review of general EDP controls. These deficiencies could affect the integrity of programs, processing, and data. As a result, a general risk exists that programs and data could be accessed and modified without proper authorization, review, and approval.

DHH should ensure that UNISYS establish an adequate internal control structure relating to EDP controls to ensure the integrity of programs, processing, and data. In a letter dated January 15, 1998, Mr. Thomas D. Collins, Medicaid Director, concurred with the finding and recommendation. Mr. Collins' response includes a detailed corrective action plan.

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

By provisions of state law, this report is a public document, and it has been distributed to appropriate public officials.

Respectfully submitted,



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Legislative Auditor

JES:MWB:dl

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