STATE OF LOUISIANA
LEGISLATIVE AUDITOR

Department of Health and Hospitals
State of Louisiana
Baton Rouge, Louisiana

Management Letter
March 22, 1995

Financial and Compliance Audit Division

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Legislative Auditor

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STATE OF LOUISIANA

Baton Rouge, Louisiana

Management Letter
Dated January 19, 1995

March 22, 1995

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January 19, 1995

DEPARTMENT OF HEALTH AND HOSPITALS
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, 1994, we conducted certain procedures at the Department of Health and Hospitals. Our procedures included (1) a review of the department's internal control structure; (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 June 30, 1994, Annual Financial Report of the Department of Health and Hospitals was not audited or reviewed by us, and, accordingly, we do not express an 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 selected department personnel. We also evaluated 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 of the Department of Health and Hospitals for the year ended June 30, 1993, we reported findings relating to carry-over of funds, contract management system, time and attendance records, allocation of block grant funding, rate setting, movable property records, internal audit function, on-line date entry system, on-line time and leave entry system, overpayments to Medicaid providers, and Medicaid third-party liability. The findings relating to carry-over of funds, contract management system, time and attendance records, on-line time and leave entry system, and overpayments to Medicaid providers have been resolved by the department. The remaining findings have not been resolved and are addressed again in this report.

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

Provider Audits

The Department of Health and Hospitals (DHH) has not established adequate internal controls to assure that receivables and payables resulting from audits of providers participating in the Medical Assistance Program (CFDA 93.778, Medicaid) are recorded in the department's financial records and subsequently reported in the Comprehensive Annual Financial Report (CAFR) of the State of Louisiana. In addition, DHH has not assured that the federal share of provider overpayments has been reported and reimbursed to the Health Care Financing Administration (HCFA) within 60 days of the date of discovery as required by the Code of Federal Regulations [42 CFR 433.320(a)(2)].

The department contracts with Blue Cross of Mississippi to audit the cost reports of Medicaid providers. Letters notifying the department of amounts due to/from Medicaid providers are received by the Institutional Reimbursements Section where the transactions should be recorded in the subsidiary records and notices sent to the fiscal management section. However, for fiscal year 1994, fiscal management was not made aware of all letters received by institutional reimbursements. As a result, our review of Blue Cross audit letters issued on or before June 30, 1994, revealed the following:

1. Institutional reimbursements had not updated the subsidiary records for amounts due from 10 providers totaling $26,892,934. The omission also results in an increase in amounts due to the federal government of $19,763,617. The 11 audit letters comprising these amounts were dated from August 22, 1991, through June 29, 1994.

   Institutional reimbursements had not updated the subsidiary records for amounts due to 22 providers totaling $32,757,757. The omission also results in an increase in the amount due from the federal government of $24,073,676. The 32 audit letters comprising these amounts were dated from February 1, 1991, through June 29, 1994.

Had these omissions remained undetected, they would have caused receivables on the CAFR to be understated by $50,966,610 and payables to be understated by $52,521,274.

2. Of the 11 audit letters issued for amounts due from providers, 9 were over 60 days old. Because these letters had not been recorded in the subsidiary records by institutional reimbursements, the department did not include the federal share of these amounts, $692,299, on the HCFA 64 expenditure report for June 30, 1994, as required by 42 CFR 433.320(a)(2).

After our review, proposed audit adjustments were accepted by the department and incorporated into the CAFR.

The department should establish adequate controls to ensure that audit letters issued by Blue Cross are recorded in the subsidiary records and forwarded to fiscal management and that federal regulations are adhered to relating to overpayments. In a letter dated November 28, 1994, Mr. Thomas D. Collins, Acting Director, Bureau of Health Services Financing, concurred with the finding and recommendation and stated corrective action will be taken.

Non-Emergency Medical Transportation Program

DHH, Bureau of Health Services Financing, does not have adequate controls to properly administer the Medical Assistance Program (CFDA 93.778, Medicaid) Non-Emergency Medical Transportation (NEMT) Program in Louisiana. Prudent business practices mandate the development and implementation of adequate internal controls to prevent the loss of funds through fraud and abuse and other errors and irregularities.

In a report dated July 27, 1994, the Legislative Auditor's Performance Audit Division reported the results of its audit of the NEMT Program administered by DHH for the period February 1, 1993, through October 31, 1993.

The report contained three findings as follows:

- DHH had no written criteria for setting and adjusting provider reimbursement rates. Without written criteria for setting and adjusting provider reimbursement rates, the department is at risk of reimbursing excessive rates that are not based on actual cost data.

- Analysis of one NEMT service region for the period February 1, 1993, through October 31, 1993, disclosed $2.4 million, or 46 per cent, of all reimbursements in that region did not match authorizing information and therefore were questionable. All reimbursements made without adequate supporting documentation, such as reconciliation of the service data, are questionable costs and are subject to be disallowed. Total reimbursements for all eight NEMT service regions for fiscal year ending June 30, 1994, was $72,741,584.

- The current review process used for the NEMT Program groups all transportation providers together when the computerized statistical analysis is performed. This increases the probability that small providers could abuse the program without being detected.

These conditions can be attributed to management's lack of emphasis for sufficient internal controls as the program has greatly expanded over the years.

We recommend that the department take immediate steps to implement the following recommendations proposed by the Legislative Auditor's Performance Audit Division:

- DHH should establish a written policy for setting and adjusting reimbursement rates. This policy should be based on either actual cost information submitted by providers and/or independent cost data from outside sources.

- DHH should implement policies to ensure that dispatch centers send authorizing data to UNISYS, the fiscal intermediary. The information sent should include at a minimum the prior authorization number, date of service, Medicaid recipient identification number, and provider identification number.

- DHH should require the fiscal intermediary to use the authorizing data to verify that claims for reimbursement were authorized by the dispatch center. The claims to be paid should be matched to the authorizing data before the claims are paid.

- Once DHH has paid, the prior authorization number should be cancelled so a second claim for the same trip cannot be submitted and paid.

- DHH should require the Surveillance and Utilization Review Section to stratify providers into meaningful subgroups based on volume.

- DHH should thoroughly investigate all discrepancies regarding prior authorization numbers and reimbursements.

In a letter dated December 22, 1994, Mr. Thomas D. Collins, Acting Director of the Bureau of Health Services Financing, concurred with the finding and recommendations and outlined a plan of corrective action.

Annual Appropriation Act

DHH, Office of the Secretary, expended funds that did not conform to the provisions of Act 14 of the 1993 Regular Session of the Louisiana Legislature. Louisiana Revised Statute 39:73(A) requires that obligations incurred or expenditures made will not exceed the amount appropriated. The department did not adequately monitor the billings of all its contractors and did not properly record liabilities for invoices received within 45 days of the end of the fiscal year. Consequently, liabilities of $1,996,952 existed for services rendered before June 30, 1994, but were not recorded by the Office of the Secretary. As a result of recording these liabilities, the office's expenditures exceeded the appropriated amount by $1,279,365, resulting in noncompliance with state law.

DHH should monitor the billings of all contractors to determine that all services rendered by the end of the fiscal year are billed timely and should assure that all invoices received within the 45 day accrual period are classified and recorded into the proper fiscal year. In a letter dated December 15, 1994, Mr. Stan Mead, Director, Division of Fiscal Management, stated that management concurred with the finding and recommendation and corrective action will be taken by the department.

Medicaid Cash Management

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 CMIA of 1990. The agreement 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. The department overdrew funds on four Medicaid assistance draw dates. These draws, totaling $10,279,576, were made from November 9, 1993, to May 27, 1994, and resulted in potential interest liability of $105,736.

2. Of the 18 disproportionate share (DISPRO) draws made from July 1, 1993, to October 12, 1993, the department overdrew in 7 instances. These draws, totaling $14,910,115, resulted in potential interest liability of $30,574.

3. The department did not ensure that funds due to the Health Care Financing Administration (HCFA) for Medicare buy-in premiums (Medicaid pays the Medicare insurance premium for qualified recipients) were wire-transferred out on the same day they were received as required by the CMIA Agreement. Of the 12 transactions for the year, the state treasury held funds from one to 3 days for 4 draws, resulting in potential interest liability of $2,645.

4. The department has used an estimated average payroll expenditure amount in determining the amount of payroll dollars to be drawn. The CMIA Agreement specifies a method of drawing these funds that we interpret to mean that actual dollars expended be used. Of five payroll draw transactions tested for the year, the department was consistently underdrawn on each of them in amounts ranging from $5,706 to $23,851. No interest penalties would be incurred as a result of these underdrawn amounts. However, failure to follow the method prescribed in the agreement increases the risk that penalties and interest may be imposed on the department for errors in draws.

5. *The department inadvertently included expenditures for another program* in the administrative expenditure draws. Of five transactions tested, the department included expenditures for the Developmental Disabilities Basic Support and Advocacy Grants (CFDA 93.630) in the Medicaid administrative draws. These errors are cumulative, since the administrative draws consider expenditures year-to-date. We estimate the department was overdrawn an average of $2,637 per week, a cumulative total of $137,124. The potential interest liability of the department for these errors is $2,397.

6. The department did not draw funds for payroll and administrative costs on a consistent basis, drawing funds as many as seven weeks apart from August through September 1993, or drawing funds as often as once per week in October 1993. Failure to draw payroll and administrative funds timely results in the department being consistently underdrawn for the federal share of these expenditures, resulting in the state providing 100 per cent of the funds necessary to cover these expenditures longer than would be required.

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 comply with the requirements of the CMIA Agreement has subjected the department to potential interest liabilities of $141,352.

We recommend that the department establish procedures to ensure that funds are drawn in compliance with the CMIA Agreement and that they are drawn on a timely basis. In a letter dated December 14, 1994, Mr. Stan Mead, Director of Fiscal Services, concurred with the finding and recommendation and outlined a plan for corrective action.

Allocation of Block Grant Funding

DHH did not comply with the statutory formula for disbursing Substance Abuse Prevention and Treatment (SAPT) Block Grant (CFDA 93.959) funds. The Code of Federal Regulations (45 CFR 96.120-137) requires that at least 20 per cent of the total grant award be used for prevention, at least 5 per cent be used to expand services for pregnant women and women with dependent children, and at least 2 per cent for

treatment and intervention for the Human Immunodeficiency Virus (HIV). However, data within the cost allocation system indicates that the required allocations for prevention, expanded women's services, and HIV were not met by a total of $760,020 as follows:

	Required Allocation	Actual Allocation	Variance
Prevention	$3,516,269	$3,129,107	$387,162
Expanded Women's Services	879,067	667,035	212,032
HIV Treatment/Intervention	351,627	190,801	160,826
Total	$4,746,963	$3,986,943	$760,020

These conditions occurred because the department does not have sufficient monitoring procedures in place to ensure that the disbursement of block grant funds is in accordance with federal funding requirements. Failure to comply with federal funding requirements can result in questioned costs to the state.

The department should enhance current programs and/or implement new programs to meet the allocation requirements of the grant. In addition, the department should develop and implement monitoring procedures to ensure that the disbursement of block grant funds is in accordance with federal funding requirements.

In a memorandum dated December 21, 1994, Mr. Joseph Williams, Jr., Assistant Secretary of the Office of Alcohol and Drug Abuse, concurred that the department does not have adequate monitoring and reporting procedures. Corrective actions to eliminate these deficiencies were outlined. Mr. Williams does not agree that the set asides for expanded women's services and HIV treatment/intervention were not met and although he concurs that the set aside for prevention services was not met, he does not agree with the amount reported above. Mr. Williams believes some expenditures relating to the programs in question have not been adequately captured and reported.

Additional Comment: Although the department may be able to collect additional data to support its position that there are additional expenditures for these programs that have not been captured and reported, failure to have this data available in a timely manner for our review is further evidence that appropriate monitoring procedures are not in place.

Rate Setting

For the third consecutive year, DHH, Office of the Secretary, set prospective reimbursement rates for clients in residential facilities, those facilities that contract with the Office of Mental Health (OMH) and the Office of Alcohol and Drug Abuse (OADA), using cost reports that have not been independently audited to ensure that costs are accurate and allowable. These cost reports are submitted to DHH Rate Administration and are desk reviewed for accuracy and allowability of costs using a checklist of procedures including analytical reviews, recalculations, and automatic questioning of certain types of expenditures. Although DHH Rate Administration performs these procedures, a complete audit of these cost reports was not required by the department. In our tests of 1994 residential contracts, we noted that DHH amended the contracts to include a requirement that an independent auditor render an opinion on the 1994 cost reports. However, the audited cost reports will not be available for establishing reimbursement rates until the 1996 contract year.

According to the DHH Rate Setting for Residential Care System Manual, all cost reports will be submitted in accordance with generally accepted accounting principles as well as state and federal regulations. The manual further states that the Medicare Provider Reimbursement Manual (HIM-15) is the final authority for rates set unless a provision in the Rate Setting Manual is more restrictive. While the desk reviews of the cost reports are performed and the department has initiated corrective action, the department does not have audited cost reports of the residential facilities to ensure that the expenditures included in the cost reports are accurate and allowable under HIM-15. Given the magnitude of the state and federal funds totaling $4,295,047 required to reimburse 31 residential providers during the year, it is imperative that only audited data be used as a basis to set reimbursement rates.

The department should use audited cost reports to establish reimbursement rates as soon as possible. In a letter dated November 21, 1994, Mr. Thomas D. Collins, Acting Director of the Bureau of Health Services Financing, concurred with the finding and

recommendation. He further stated that the department has amended the 1994 facility contracts to include a requirement that the independent auditor render an opinion on the cost reports for residential facilities that contract with OMH and OADA.

Audit Report Monitoring

DHH does not have a monitoring system to ensure that all of its subrecipients receiving $25,000 or more of federal funds and cost-reimbursement contractors funded with $50,000 or more of state funds are audited in accordance with *Government Auditing Standards*. Federal laws (OMB Circulars A-128 and A-133) require the department to ensure that each subrecipient of federal pass-through funds totaling $25,000 or more has an audit performed that will comply with the applicable circular. In addition, departmental policy requires that all nongovernmental providers receiving $50,000 or more in state funds from one or more cost-reimbursement contracts secure a financial and compliance audit.

Although procedures have been developed for review of audit reports and resolution of audit findings, the department has not consistently followed those procedures to ensure that all audit reports are received and reviewed. Furthermore, we could not determine that the department had adequately addressed findings, including disallowed costs, internal control comments, and noncompliance with laws and regulations with the subrecipient agency. In addition, the department has not ensured that qualified employees are responsible for reviewing audit reports for compliance with *Government Auditing Standards* and OMB Circular A-128 or OMB Circular A-133 audit requirements, as applicable.

Failure to ensure that federal subrecipients or cost-reimbursement contracts are audited in accordance with *Government Auditing Standards* increases the risk that federal subrecipients or nongovernmental providers will not expend federal financial assistance or state funds, respectively, in accordance with applicable laws and regulations.

DHH should enhance its established procedures to ensure that federal subrecipients and cost-reimbursement contractors are audited in accordance with *Government Auditing Standards* as required by applicable laws and regulations and that all findings are reviewed for subsequent resolution in a timely manner. In a letter dated November 22, 1994, Mr. Stan Mead, Director of Fiscal Services, concurred with the finding and

recommendation. He further stated that the department intends to have an audit tracking, monitoring, and resolution system in place by March 1, 1995.

Medical Assistance Trust Fund

DHH has not maintained adequate controls over fees due from providers to the Medical Assistance Trust Fund to ensure that amounts reported by providers are accurate and to enforce collections of outstanding provider balances. Fees due to the Medical Assistance Trust Fund are established by Louisiana Revised Statutes (LSA-R.S.) 46:2601-2605. Providers are responsible for preparing and submitting reports of fees due to the fund and for remitting payments at that time. A good system of internal control would provide assurance that all fees are accurately reported and remitted by providers, recorded by the department, and would ensure that all available means of enforcing collections were used. Trust fund collections totaled $77,715,392 for the year ended June 30, 1994. Our review of the accounts receivable balance and collections for the Medical Assistance Trust Fund disclosed the following:

1. The department has a contract with an independent accounting firm for audits of fees due from pharmacies. Pharmacy fee collections constitute only 5 per cent of total collections. No other audit procedures/contracts were in place for any other provider types that make up the remaining 95 per cent of collections, nor were any other procedures in place to provide assurance that providers are reporting and remitting the correct fees.

2. The department is not adequately enforcing fee collections. Based on the providers who have filed reports for the quarter ended May 31, 1994, we estimate these providers owe a total of $3,204,115; $129,960 more than the original amount reported by the department. These providers have been delinquent ranging anywhere from 10 months to 23 months (inception date of program). Relating to the $3,204,115, 93 per cent is owed by only 14 providers with one provider owing 60 per cent ($1,909,332) for 3 facilities.

3. The department has not enforced the requirement that all providers report fees established in LSA-R.S. 46:2601-2605. At June 30, 1994, 61 providers had not filed reports for periods ranging from 2 to 8

quarters. Based on the number of beds available to the providers and the average occupancy rate, we estimate these providers owe the department $1,020,145; $107,392 more than the original amount reported by the department.

4. The accounts receivable system does not automatically update accounts for interest and penalties charged to providers. Our estimate of interest and penalties resulted in an increase to receivables of $679,252.

5. The accounts receivable system used by the department does not produce aging reports.

As a result of the deficiencies mentioned previously, we estimate that the accounts receivable balance in the Medical Assistance Trust Fund was understated by $916,604, or 7 per cent, of the outstanding balance reported at June 30, 1994. After our review, proposed audit adjustments were accepted by the department and incorporated into the Comprehensive Annual Financial Report (CAFR) of the State of Louisiana.

Failure to establish adequate controls over reports filed by providers increases the likelihood that material misstatements in fees due can occur or that errors may occur and go undetected. In addition, the longer provider balances remain past due, it is unlikely that they will be collectible, resulting in lost revenues. Finally, failure to establish controls in the accounts receivable system decreases the ability to adequately monitor amounts due and collect amounts that become past due.

DHH should establish procedures to ensure accurate monitoring and reporting of fees due from providers to the Medical Assistance Trust Fund and for enforcement of collections of past due balances. Furthermore, the department should implement measures that will enable it to produce accurate aging reports, automatically calculate penalty and interest, maintain complete account histories, et cetera. In a letter dated December 9, 1994, Mr. Stan Mead, Director of Fiscal Services, concurred with the finding and recommendation and outlined the plan of corrective action to be implemented by the department.

Internal Audit Function

DHH did not have a fully operational internal audit function to serve management of the department by examining, evaluating, and reporting on the internal control structure (including electronic data processing) and to ensure compliance with the policies and procedures that comprise the control structure. The department did establish an internal audit function during 1993-94. However, because of the timing of the creation of the Bureau of Internal Audit and length of time necessary for the bureau to become fully functional, the services normally provided by internal auditors were not available in time for them to be effective for the year under audit. Given the size of the department, its assets ($330,328,585) and operating budget (revenues of $4,129,410,411), we believe that an effective internal audit function is important to ensure that the department's assets are safeguarded and that the department's policies and procedures are uniformly applied. This is the seventh consecutive year that we have cited the department for failure to have an effective internal audit function.

DHH should continue in its efforts to integrate the internal audit function as an effective part of the department's control structure. In a letter dated July 29, 1994, Ms. Gwen B. Johnson, CPA, Director of Internal Audit, concurred with the finding and recommendation.

Provider Credit Balances

DHH has not complied with federal law relating to provider credit balances for the Medical Assistance Program (CFDA 93.778, Medicaid). Federal law [42 CFR 433.312(a)(1)] requires the department to return the federal share of identified provider overpayments within 60 days of their discovery, and 42 CFR 433.320(a)(2) requires that the reimbursement for provider overpayments be made on the HCFA-64 quarterly report for the quarter [submitted to the Health Care Financing Administration (HCFA)] in which this 60-day period ends. Our examination of provider credit balances disclosed the following:

1. Providers who determine that they have been overpaid for Medicaid services may voluntarily remit these overpayments to DHH. The department cannot produce, nor did it retain, a report listing the provider refunds reported to HCFA at June 30, 1994, totaling $7,819,021.

Because the detail of this balance is not available, we could not verify the accuracy of that amount.

2. The department has not maintained documentation supporting amounts owed by providers determined by the Survey and Utilization Review System (SURS). SURS reviews payments to providers to determine if there have been Medicaid overpayments resulting from fraud or abuse. At June 30, 1994, the department reported an outstanding balance totaling $302,481 for 12 SURS accounts. However, the department could not provide assessment letters that established the original balances for 4 providers' accounts totaling $56,635.

3. DHH's Fiscal Management Section submits a listing of outstanding SURS balances each month to the Program Integrity Section. There is no indication that the two sections are reconciling their balances to ensure their accuracy.

4. The department has no formal policy to determine disposition of old accounts. Of the 12 SURS accounts outstanding at June 30, 1994, 2 had activity during the fiscal year. There has been no activity in the remaining 10 accounts for periods ranging from 2 to 13 years.

Management has not placed sufficient emphasis for compliance with federal law relating to provider credit balances. As a result of the conditions mentioned previously, there is no assurance that the provider credit balances reported and reimbursed to HCFA are accurate, subjecting the department to noncompliance with federal law.

We recommend that management of DHH retain adequate supporting documentation and develop formal policies and procedures for the reconciliation and disposition of SURS account balances. In a letter dated December 19, 1994, Mr. Stan Mead, Director of the Division of Fiscal Management, agreed that the department did not have a listing of the provider for whom refunds were on hand at June 30, 1994; however, he believes this would not result in an error on the HCFA-64 because the amount reported is the actual amount on hand regardless of whether or not the providers are identified. He agreed that some of the records relating to the SURS providers have been destroyed but believes that the amounts reported are still accurate and is currently reviewing each of the cases to determine appropriate action to be taken. He further stated that the

fiscal section is now requesting confirmation from the Program Integrity Section to ensure that the monthly balance reports are accurate and expects the resolution of inactive accounts to be completed in the 1995 fiscal year.

Cash Management of Block Grants

DHH requested federal funds under the Block Grants for Community Mental Health Services (CFDA 93.958) and Block Grants for Substance Abuse Prevention and Treatment (CFDA 93.959) in excess of its immediate needs during the fiscal year ended June 30, 1994. Our examination disclosed the following:

1. On May 3, 1994, the department overestimated its cash needs for the Block Grants for Community Mental Health Services by $606,360. The Common Rule for Uniform Administrative Requirements for Grants and Cooperative Agreements with State and Local Governments (C.20.b.7) states that procedures must be followed to minimize the time elapsing between the transfer of funds from the United States Treasury and disbursement by grantees when advance payment procedures are used. Within the federal cash management field, there is an implied "three-day rule" on cash advances that has become accepted as the standard.

   Although the procedures established by the department would minimize the time between the transfer of funds and disbursement by the department if followed, on May 3, 1994, the previous drawdown of $606,360 was inadvertently omitted from the cumulative revenue total used in estimating the department's cash needs causing the department to overdraw. The excess funds were not fully expended until approximately July 19, 1994. As a result, these funds were not available to the federal government for investment or other uses during the period held by the department and create a potential interest liability due to the federal government.

2. At year-end, the department had excess cash of $991,740 on hand for the Block Grants for Substance Abuse Prevention and Treatment (SAPT) because the department continued to draw funds after the maximum amount appropriated by the legislature to be spent from federal sources was reached. The State of Louisiana entered into the Cash Management

Improvement Act (CMIA) Agreement with the U.S. Treasury to achieve greater efficiency, effectiveness, and equity in the transfer of federal funds as required by the Cash Management Improvement Act of 1990. The agreement specifies the procedures to be used to draw funds for the SAPT grant. Although the department consistently applied the procedures to calculate the amounts drawn, $991,740 of expenditures used in the calculation that would normally have been eligible to be paid with federal funds were no longer eligible because the department did not submit a budget amendment to increase the legislative appropriation. These excess funds were not fully expended until October 11, 1994, and create a potential interest liability of $5,579 due to the federal government.

The department should follow established procedures to properly estimate its needs for federal funds to ensure that excess balances are not maintained and should adjust those procedures to prevent the drawing of excess funds when the maximum amount of federal funds appropriated by the legislature has been reached. In a letter dated December 19, 1994, Mr. Stan Mead, Director of Fiscal Services, concurred with the finding and recommendation and further stated that the department strives to follow established procedures.

Professional Service Contract Monitoring

DHH did not adequately monitor contracts with an international public accounting firm. Approximately one-half of contract expenditures are charged to the Medical Assistance Program (CFDA 93.778, Medicaid) as administrative costs. Prudent business practices and adequate internal controls require that the department pay only for services that meet the needs of the department, are acceptable, and fulfill the terms of the contract. In addition, Office of Management and Budget (OMB) Circular A-87, Section C, provides that costs are allowable when necessary and reasonable, and allocable to a particular federal program to the extent of the benefits received.

In our review of a three-year contract beginning April 20, 1992, and totaling $1,244,500 for providing desk reviews, cost report audits, and reimbursement rates for long-term care and adult day health care services, and conducting long-term care cost surveys, we noted the following:

- The department paid the accounting firm for desk reviews of Intermediate Care Facilities for the Mentally Retarded (ICF/MR) that did not meet the needs of the department. The department intended to use the desk reviews as a foundation to re-base the per diem rates used to reimburse ICF/MRs with Medicaid funds. Therefore, it was imperative that all disallowed costs be identified in the desk reviews to ensure that the costs used to re-base the rates were accurate. However, the department did not ensure that the accounting firm was aware that all disallowed costs should be identified for purposes of re-basing. During its internal analysis of the desk reviews, the department found that certain non-allowable costs were not reflected, causing operating costs of ICF/MRs to be overstated. As a result, the department was forced to perform its own desk reviews of approximately 346 ICF/MR cost reports to ensure that costs were allowable. Although desk reviews are not a separately itemized cost in the contract, they are a required contract deliverable and are included in the overall cost of the contract.

- The department paid $141,000 for audit services rendered by the accounting firm without ensuring that all audit reports were received by the department and were acceptable.

- The department paid $100,000 for two Long-Term Care Cost Surveys for nursing facilities and ICF/MR facilities for which they were unable to determine if the surveys were received and fulfilled the terms of the contract.

In addition, the department paid the accounting firm, under a separate contract, $212,000 for the development and implementation of a new reimbursement methodology for inpatient hospital services under Medicaid of Louisiana without receiving all of the required contract deliverables. The 18-month contract expired March 15, 1994, and the department failed to extend the contract deadline. As a result, the department entered into a second contract for $49,999 to compensate the accounting firm for work that exceeded the scope of the original contract and for completion of contract deliverables from the original contract. As of November 30, 1994, the second contract has expired and the department could not provide us with all of the contract deliverables required in either contract. The department has paid $17,575 on the second contract. The department should consider forfeiting the

contract's performance bond in the event that the accounting firm does not submit all contract deliverables within a timely manner.

Because the department did not adequately monitor the contracts, the risk increases that the department will pay for services that do not meet its needs, were never rendered or do not fulfill the terms of the contract. Furthermore, because these contracts were funded in part with federal Medicaid funds, payments are subject to noncompliance with OMB Circular A-87 and could result in questioned costs.

DHH should ensure that desk reviews meet the needs of the department. In addition, the department should adequately monitor contracts to ensure that contract deliverables are received and fulfill the terms of the contract before payment.

In a letter dated December 22, 1994, Mr. Thomas D. Collins, Acting Director of the Bureau of Health Services Financing, provided the following:

- The department concurs that it did not ensure that the desk reviews met the department's needs when re-basing. Corrective action was outlined to eliminate this condition.

- The department concurs that it paid for some audits without assuring that all the reports were received. Corrective action was outlined to eliminate this condition.

- Subsequent to our investigation the department identified that the two Long-Term Care Cost Surveys it had previously been unable to provide had actually been received.

- The department does not concur that the contract for the development and implementation of a new reimbursement methodology for Medicaid inpatient hospital services was not adequately monitored. Various extenuating circumstances were cited.

Additional Comments: Although the department was able to locate the long-term cost surveys and therefore prove that it did not pay for a product not received, the department's inability to provide the reports on a timely basis and uncertainty that the reports existed further indicate that the delivery of services is not being properly

monitored. We concur that there were various extenuating circumstances that would justify both extending the due date and increasing the compensation of the contractor for the development and implementation of a new reimbursement methodology. However, this is not what occurred. The department allowed a contract to expire without receiving the deliverables it contracted for and paid the entire amount of the contract. Although the second contract has again expired without receipt of all the deliverables, the department is attempting to finalize the receipt of the deliverables and is withholding final payment to the contractor.

Timely Processing of Medicaid Applications

DHH did not make eligibility determinations on applications for the Medical Assistance Program (CFDA 93.778, Medicaid) within required time frames. Federal law (42 CFR 435.911) allows the department 90 days to make a final determination for applicants who apply for Medicaid on the basis of disability and 45 days for all other applicants.

The department did not meet the time frames for any month in the 1993-1994 fiscal year. As of June 30, 1994, 312 applications required to be completed within 90 days and 6,188 applications required to be completed within 45 days were still pending although the times allowed for processing had expired. Management attributes these conditions to a lack of personnel in the processing of applications. Failure to comply with federal regulations places the department at risk of losing federal funds and receiving federal sanctions or disallowances.

DHH should immediately take corrective action to ensure that all eligibility determinations on Medicaid applications are made within required time frames. In a letter dated December 21, 1994, Mr. Thomas D. Collins, Acting Director of the Bureau of Health Services Financing, concurred with the finding and further stated that the department has taken corrective action to implement the recommendation.

Confidentiality of Medicaid Recipient Information

DHH has not provided sufficient controls to ensure that the confidentiality of eligibility information of recipients of the Medical Assistance Program (CFDA 93.778, Medicaid) is maintained. Federal law (42 CFR 431.300-306) requires the department to have

criteria that safeguards the use or disclosure of information concerning Medicaid applicants and recipients. Before releasing information to other agencies to verify eligibility, the department must execute data exchange agreements with those agencies. As required by federal law, state law [LSA-R.S. 46:56(I)] also mandates confidentiality over recipient information and imposes penalties for violations of confidentiality. However, our review disclosed the following:

1. Although there was no data exchange agreement with Louisiana State University Medical Center at New Orleans (LSUMC), a tape containing eligibility information for recipients in a three parish area was provided to LSUMC on a monthly basis. DHH was unaware that this tape was being provided to LSUMC because it was first requested in 1979 and the program producing the tape was not named according to the standard conventions that would identify a program containing confidential information.

2. DHH provided a monthly tape containing eligibility information to a private contractor engaged by the Louisiana Health Care Authority (LHCA) to provide revenue enhancement and operational improvement initiatives. Section 2080.18.A of the State Medicaid Manual requires this particular contractor to be an agent of DHH. Because the contract is with LHCA and not DHH, the contractor is not acting as an agent of the department. Furthermore, DHH could provide no documentation giving assurance that the information provided was used only in accordance with federal and state law.

3. LHCA also engaged a private contractor to provide retroactive revenue recovery services. This contractor provides a member of the LHCA staff with a tape of potential Medicaid recipients for whom services were rendered by LHCA facilities and which should be billed to Medicaid if the patient is eligible. The LHCA employee then runs the tape against DHH's eligibility information using the Department of Social Services Information Services computer. However, the program used for the match was not in a protected library that would ensure unauthorized changes were not made and that the outside contractor was not receiving unauthorized data.

These conditions occurred because the department is not properly monitoring the release of eligibility information to ensure compliance with federal and state law. Failure to comply with these regulations subjects the department to federal sanctions and to penalties imposed by LSA-R.S. 46:56(I).

The department should discontinue providing eligibility information to other agencies or contractors of other agencies until their need to have the information is assessed, required agreements are obtained, and adequate safeguards are in place to ensure compliance with federal and state law. Furthermore, the program used to match contractor's bills to recipients should be reviewed for unauthorized changes and moved to a protected library. Finally, DHH should consider performing the match as noted in item 3 with its own personnel. In a letter dated December 22, 1994, Mr. Thomas D. Collins, Acting Director of the Bureau of Health Services Financing, concurred with the finding and recommendations and outlined a plan of corrective action.

Cash Receipt and Disbursement Controls

DHH has not provided adequate controls or segregation of duties over certain cash receipt and disbursement functions. A good internal control structure should provide for segregation of duties so that no one employee is in a position to both initiate and conceal errors and irregularities. Also, reconciliations between cash receipts and subsidiary records are required to ensure accountability over cash collections and the accuracy of the subsidiary records.

The department did not ensure adequate segregation of duties and/or other adequate control procedures over receipts and disbursements in the following areas:

1. Adding vendors to the Louisiana State Purchasing Office's vendor listing - Access to add vendors or change existing vendor information is available to the same employees who are responsible for entering and approving transactions on the On-Line Data Entry System (ODES) and receiving vendor checks for mailing.

2. Automatic payments - Automatic payments are disbursements that are automatically processed on a periodic basis without routine authorization. The department has two types of automatic payments, family subsidy payments and leases, which are the responsibility of the

Contract Management Section. This section is also responsible for setting up the automatic payments. There is no independent or subsequent review of these automatic payments to ensure that payments are valid and authorized by management.

3. Petty cash and travel transactions - Accountants receive approved petty cash and travel transactions vouchers and enter the information on the Travel Management System. Although duties are segregated so that the individual who verifies travel checks to supporting documentation does not routinely enter the travel information on the Travel Management System, that individual has access to enter travel information and does so when necessary. In addition, that individual enters petty cash documents on the Travel Management System and verifies the petty cash check to supporting documentation. No one performs an independent review of petty cash transactions to ensure that information entered on the system has been authorized. Furthermore, no one independent of the travel section compares the checks to supporting documentation to ensure that all checks are adequately supported and approved.

4. Receipts of the Drug Rebate Program - Under this program, pharmaceutical companies participating in the Medical Assistance Program (CFDA 93.778, Medicaid) are required to issue rebates to the department based on the amount of drugs provided Medicaid participants by the department. A pharmacy rebate auditor performs the incompatible functions of receiving payments, recording payments to a check log, and posting payments to the subsidiary records.

5. Receipts of the Controlled and Dangerous Substances Program and the Health Standards licensing fees - Designated employees perform incompatible functions by receiving fees, recording fees to a receipt log, and posting fees to subsidiary ledgers or payor folders. No independent reconciliation is performed between the record of deposits and the subsidiary ledgers or the number of licenses issued.

Failure by management to emphasize the importance of implementing an adequate internal control structure increases the risk that errors and/or irregularities could occur and not be detected in a timely manner.

We recommend that the department take steps to ensure adequate controls and segregation of duties are established over all of its cash receipt and disbursement functions. In a letter dated December 16, 1994, Mr. Stan Mead, Director of Fiscal Services, concurred with the finding and recommendation and outlined a plan for corrective action.

On-Line Data Entry System

For the second consecutive year, DHH has not established adequate internal control procedures in the On-Line Data Entry System (ODES) for the input of transactions into the Financial Accountability Control System (FACS). Access to the system is restricted by the use of passwords and user ID codes. However, this access was not properly restricted to prevent the existence of incompatible functions. Our review disclosed that three employees had both data entry and approval user ID codes. The ODES prints transaction reports that show the data entry code and approval code for transactions on the ODES to enable supervisors to search for improper access or entries. However, these reports were not reviewed by a supervisor to ensure that the security of the system had been maintained. In addition, the department has not established written procedures relating to the issuance and deletion of user ID codes. We noted that two employees who were no longer employed in their positions as of March 28, 1994, and April 29, 1994, respectively, continued to have access to ODES until May 16, 1994. Another employee who was transferred to another state agency on June 6, 1994, continues to have access.

An adequate internal control structure should provide for adequate segregation of duties so that no one employee would be in a position to both initiate and approve transactions and that only authorized personnel have access to the system. Without adequate segregation of duties and restricted access, there is an increased risk that errors or irregularities could occur and not be detected in a timely manner.

The department should develop and implement written procedures to limit employee access to the system to either data entry or approval access and should review transaction reports to ensure that the security of the system has been maintained. In addition, the department should establish written procedures relating to the issuance and deletion of user ID codes. In a letter dated January 19, 1995, Mr. Stan Mead, Director, Division of Fiscal Management, stated that management concurred with the finding and outlined the plan of corrective action to be implemented by the department.

Movable Property Records

For the ninth consecutive year, various offices within DHH have not maintained adequate controls over movable property and did not comply with the state's movable property laws and regulations. Louisiana Administrative Code 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. We selected 71 items purchased during the year and found that 51 items ($56,047 of $82,399) were not tagged and added to the inventory system until 51 to 149 days after receipt of the property, and as of the date of our review, two of these items have not yet been added to the inventory system even though 304 days have elapsed since receipt.

These problems continue because the property manager is not receiving timely information from the department's property coordinators and/or other difficulties in monitoring remote movable property locations. 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.

The department should ensure that all property is tagged and transmitted to LPAA timely. Management of the various offices responded that they concurred with the findings and recommendations and outlined plans for corrective action.

Cash Subsidy Program

DHH, Office of Mental Health, did not follow established guidelines to determine continuing eligibility for families receiving cash subsidy payments under the Community and Family Support System. A cash subsidy payment is a monetary payment to eligible families of children with developmental disabilities to offset the costs of services and equipment. According to departmental guidelines, a family receiving these payments is required to submit an Annual Parent Report to the Office of Mental Health regional office to confirm continuing eligibility or subsidy payments will be terminated. In addition, regional staff are required to contact families at least every 90 days to monitor the status of the child.

Our random sample of nonpayroll expenditures included two transactions for cash subsidy payments. For one of these cases in Region 2, we noted that the family did not

submit an Annual Parent Report; however, cash subsidy payments continued for 1994. In addition, there was no documentation that the family was contacted regarding the status of the child. The child was removed from the home in April 1994, but it was not until October 1994, when we called it to management's attention that the Office of Mental Health determined that the child would not be returning home and that the cash subsidy payments for 1995 should be terminated.

We expanded our test in Region 2 and noted there were a total of 23 contracts, of which we tested an additional 5. These 5 did not include the Annual Parent Report, and 4 did not have documentation to support monitoring at least every 90 days. As a result, we were unable to determine if the 5 cases in question were eligible for cash subsidy payments.

Management has not placed sufficient emphasis on following established guidelines. Therefore, families who are not entitled to receive cash subsidy payments are receiving them in some cases and in other cases we are unable to make this determination, thus limiting the funds to eligible families and subjecting the regional staff to noncompliance with established guidelines.

DHH should mandate that regional staff follow established guidelines to ensure that only eligible families receive cash subsidy payments. In a letter dated December 20, 1994, Mr. Andrew P. Twyman, Deputy Assistant Secretary, Office of Mental Health, concurred with the finding and recommendation and further stated that the department has taken appropriate action to implement the recommendation.

Code of Ethics

The manager for Region 6 (contract monitor) within the Office of Alcohol and Drug Abuse did not comply with certain provisions of the Louisiana Code of Governmental Ethics and departmental policy. Louisiana Revised Statute 42:1112(A) and departmental policy prohibit a state employee from participating in a transaction in which he has a substantial economic interest. This manager, assigned to approve payments and monitor the contract between DHH and the Louisiana Black Alcoholism Council, Inc., cosigned a promissory note for $10,000 between the Louisiana Black Alcoholism Council, Inc., and the Farmers Bank and Trust of Cheneyville. A similar arrangement was entered for fiscal year 1995, although the amount increased to $15,000. Because of the manager's economic interest in the contractor, the department's risk that all

payments made to the contractor are not legitimate obligations of the state is increased. The manager acted independently without the knowledge and approval of management even though the department has written policies and procedures to require and enforce compliance with the Louisiana Code of Governmental Ethics.

The department should reassign the contract monitoring duties of the manager until this particular impairment is removed. Furthermore, the department should reemphasize to all employees the need for compliance with departmental policies and procedures requiring adherence to all provisions of the Louisiana Code of Governmental Ethics. In a letter dated December 8, 1994, Mr. Joseph Williams, Jr., Assistant Secretary, Office of Alcohol and Drug Abuse, concurred with the finding and recommendation and stated that another monitor has been assigned effective November 15, 1994. In addition, in a letter dated December 21, 1994, Mr. H. K. "Woody" Sweeney, Undersecretary, issued a memorandum to all employees reminding them of their obligations under the Louisiana Code of Governmental Ethics.

Medicaid Third Party Liability

For the third consecutive year, DHH has not adequately identified the existence of private health insurance for all recipients of the Medical Assistance Program (CFDA 93.778, Medicaid). The Code of Federal Regulations (42 CFR 433.135-433.154) requires the department to take reasonable measures to determine the legal liability of third parties (TPL) to pay for services furnished under the state plan and establishes the procedures by which the requirement is to be met. However, we noted the following:

1. DHH field staff are required to gather data on Medicaid recipients and enter it into the Department of Social Services Welfare Information System (WIS) and the DHH computer system. Recipient information is entered through WIS and then updated automatically (via magnetic tape) for Medicaid eligibility in the DHH Medicaid Management Information System (MMIS).

   Our examination of 60 eligibility case files for Medicaid recipients disclosed one case file with evidence that a recipient's spouse maintained dependent medical insurance through his employer. However, the TPL information had not been entered by DHH in the WIS and, as a result, did not get updated into MMIS.

A provider claim was filed for services rendered on June 14, 1994, for $27 and was paid on August 23, 1994. Had the TPL been indicated in the MMIS, the claim would have been denied and returned to the provider for a determination of the amount of the liability.

2. The department contracts with a private company to use Medicaid recipient social security numbers from the MMIS recipient and resource files and match them against private health insurance carriers' eligibility files. If the MMIS files indicate third party coverage and the insurance carrier files do not, then the contractor is disregarding the exception and is not billing the insurance carrier. This practice does not consider the possibility of errors in the insurance companies' records that could result in Medicaid payments for claims that are the legal liability of third parties.

Failure to establish or to assure that adequate controls are in place to identify the existence of third party liability subjects the department to noncompliance with federal regulations and increases the possibility of other overpayments to providers.

DHH should assure that the existence of TPL coverage for Medicaid recipients is adequately identified. Also, we recommend that the department include the consideration of TPL resource information available on the MMIS file in contracting with the private company to identify and collect from legally liable third parties. In a letter dated October 18, 1994, Mr. Thomas D. Collins, Acting Director, Bureau of Health Services Financing, concurred with the finding and recommendation and stated corrective action will be taken.

Time and Attendance Records

DHH does not have adequate internal control procedures to ensure compliance with the Department of State Civil Service rules and regulations relating to the certification of employee time and attendance records. An adequate system of internal control and Civil Service Rule 15.2 require the employee and supervisor (appointing authority) to certify the number of hours of attendance or absence from duty on the time and attendance records. This would minimize the risk that time and attendance records are processed for nonexistent or former employees or that these records are processed with incorrect hours worked/and or leave taken.

The department assigns an appointing authority to each cost unit and requires that the appointing authority approves the time and attendance record of employees in his or her cost unit. However, the department allows the appointing authorities to approve their own time and attendance records, thereby creating an internal control weakness and noncompliance with Civil Service Rule 15.2.

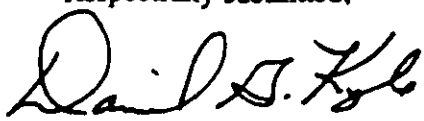
In our test of 16 managers' time and attendance records for pay period ending June 3, 1994, 15 of the 16 managers were designated as the appointing authority for their cost unit. Of the 15 managers tested, 7 certify their own time and attendance record, and 5 allow their timekeepers to approve their time and attendance record. In addition, 2 managers' time and attendance records are not certified by anyone.

DHH should revise its personnel policies to ensure compliance with Civil Service Rule 15.2. In addition, the department should instruct all timekeepers to ensure that all time and attendance records contain the appropriate certifications before they are processed into the On-Line Time and Leave Entry System. Furthermore, the timekeepers should return any time and attendance records with missing signatures for correction before paychecks are issued. In a letter dated December 13, 1994, Mr. Stan Mead, Director of Fiscal Services, concurred with the finding and recommendation and further stated that the department has taken appropriate action to implement the recommendation.

The recommendations in this report represent, in our judgment, those most likely to bring about beneficial improvements to the operations of the department. The varying nature of the recommendations, the implementation costs, and the 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,



Daniel G. Kyle, CPA, CFE
Legislative Auditor

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