PROGRESS REPORT:
PREVENTION, DETECTION, AND RECOVERY OF IMPROPER MEDICAID PAYMENTS IN HOME AND COMMUNITY-BASED SERVICES PROGRAMS

LOUISIANA DEPARTMENT OF HEALTH

MEDICAID AUDIT UNIT
ISSUED JULY 12, 2017

LOUISIANA LEGISLATIVE AUDITOR
1600 NORTH THIRD STREET
POST OFFICE BOX 94397
BATON ROUGE, LOUISIANA 70804-9397

LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

ASSISTANT LEGISLATIVE AUDITOR
FOR STATE AUDIT SERVICES
NICOLE B. EDMONSON, CIA, CGAP, MPA

DIRECTOR OF PERFORMANCE AUDIT SERVICES
KAREN LEBLANC, CIA, CGAP, MSW

FOR QUESTIONS RELATED TO THIS PERFORMANCE AUDIT, CONTACT KAREN LEBLANC, PERFORMANCE AUDIT DIRECTOR, AT 225-339-3800.

This document is produced by the Louisiana Legislative Auditor, State of Louisiana, Post Office Box 94397, Baton Rouge, Louisiana 70804-9397 in accordance with Louisiana Revised Statute 24:513. Four copies of this public document were produced at an approximate cost of $2.40. This material was produced in accordance with the standards for state agencies established pursuant to R.S. 43:31. This report is available on the Legislative Auditor's website at www.lla.la.gov. When contacting the office, you may refer to Agency ID No. 9726 or Report ID No. 40140064 for additional information.

In compliance with the Americans With Disabilities Act, if you need special assistance relative to this document, or any documents of the Legislative Auditor, please contact Elizabeth Coxe, Chief Administrative Officer, at 225-339-3800.

LOUISIANA LEGISLATIVE AUDITOR
DARYL G. PURPERA, CPA, CFE

July 12, 2017

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

Dear Senator Alario and Representative Barras:

This report provides the results of our evaluation of the Louisiana Department of Health's progress toward implementing recommendations in our September 2011 report titled *Prevention, Detection, and Recovery of Improper Medicaid Payments in Home and Community-Based Services Programs*. I hope this report will assist you in your legislative decision-making process. The report contains our findings, conclusions, and recommendations.

We would like to express our appreciation to the Louisiana Department of Health staff for their assistance during this audit.

Sincerely,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

DGP/aa

HCBP FOLLOWUP17

Louisiana Legislative Auditor

Daryl G. Purpera, CPA, CFE

Progress Report: Prevention, Detection, and Recovery of Improper Medicaid Payments in Home and Community-Based Services Programs

Louisiana Department of Health

July 2017

Audit Control # 40140064

Introduction

We evaluated the Louisiana Department of Health's (LDH) progress toward implementing recommendations made in an audit report in September 2011 titled *Prevention, Detection, and Recovery of Improper Medicaid Payments in Home and Community-Based Services Programs (HCBS).*[1] In this report, we evaluated whether LDH implemented the nine recommendations related to improper payments.

LDH offers several Medicaid HCBS programs, including six waivers and a long-term care personal care services (LT-PCS) program that provides long-term care services for the elderly or individuals with developmental or physical disabilities. LDH's Office of Adult and Aging Services (OAAS) provides oversight of HCBS programs that serve the elderly and individuals with physical disabilities, and the Office of Citizens with Developmental Disabilities (OCDD) oversees programs that serve individuals with developmental disabilities. Exhibit 1 summarizes these programs and their enrollment and expenditures in fiscal years 2015 and 2016.

Exhibit 1
Medicaid HCBS Waivers and LT-PCS Expenditures and Number of Recipients
Fiscal Years 2015 and 2016

Program	FY 15		FY 16	
	Expenditures	Enrollment	Expenditures	Enrollment
OAAS				
Adult Day Health Care Waiver	$9,167,911	898	$8,877,968	794
Community Choices Waiver	113,642,085	5,369	112,288,439	5,287
LT-PCS	198,421,304	17,303	159,973,858	15,380
OCDD				
Children's Choice Waiver	11,788,973	1,374	12,033,105	1,435
New Opportunities Waiver	444,685,378	8,869	443,258,896	8,909
Residential Options Waiver	834,409	31	655,801	28
Supports Waiver	12,063,785	1,711	12,159,170	1,953
Overall Totals	**$790,603,845**	**35,555**	**$749,247,237**	**33,786**

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

[1] Report available at https://app.lla.state.la.us/PublicReports.nsf/218F6CA2C70C3D668625790A006A3894/$FILE/00021FC6.pdf

Overall, we found that LDH fully implemented four recommendations, partially implemented two recommendations, and did not implement three recommendations. We also identified approximately $1.3 million in potentially improper payments and two additional issues that LDH should address to improve its processes for preventing and identifying improper payments. Each of these recommendations and LDH's progress toward implementation is summarized on the following pages. Appendix A provides LDH's response; Appendix B details our scope and methodology; and Appendix C provides a list of the recommendations included in this report and whether each was implemented, not implemented, or partially implemented.

Objective: To evaluate LDH's progress in implementing recommendations to improve their processes for preventing, detecting, and recovering improper payments in Medicaid home and community-based services.

Overall, we found the following:

- **Although LDH implemented an edit check to prevent direct care workers who work for two different companies from claiming overlapping times for different recipients, a more comprehensive edit is needed.** We identified approximately $620,000 in potentially improper payments for overlapping services that the edit did not identify during calendar years 2011 to 2015.

- **LDH has not implemented an effective process to prevent payments to providers while recipients were hospitalized or in nursing facilities.** We identified $326,915 in potentially overlapping claims that were not identified by LDH during its back-end review process during calendar years 2012 to 2015.

- **Since July 2014, LDH has required that direct care workers provide full Social Security numbers (SSN) to help ensure that workers who have been excluded from Medicaid are not providing services.** However, LDH should ensure that workers provide valid SSNs, as we compared SSNs collected by LDH to driver's license data from the Office of Motor Vehicles and found approximately 1,450 workers whose SSNs matched a driver's license with a different name.

- **LDH has not fully implemented the use of a call-in system to capture actual time worked and reduce instances of improper payments.** As a result, LDH could not ensure that direct care workers were reporting their actual arrival and departure times. We identified 52,222 instances where direct care workers were required to travel from 10 to 100 miles between two different locations where they worked consecutive hours and did not indicate travel time at an approximate cost of $340,000.

- **Although LDH has developed a process to monitor LT-PCS, it has not implemented a systematic financial monitoring process over all HCBS providers to help ensure that services billed are supported with documentation.** Financial monitoring, including periodically verifying claims to supporting documentation, would help LDH identify additional improper payments.

- **LDH has improved in its assessment of penalties for providers with improper payments and has developed a penalty matrix that helps ensure it assesses fines consistently and appropriately.** From calendar years 2012 to 2016, LDH assessed approximately $2 million in fines to HCBS providers compared to the $96,000 it assessed from 2005 to 2010. However, LDH did not always assess fines in accordance with its penalty policy and still does not assess penalties for first offenses.

We also identified the following new issues:

- **LDH should ensure that certain HCBS monitoring visits occur when the direct care worker is present and providing services, as required by policy.** We found that approximately 14% of monitoring visits that required observation of services occurred when a worker was not present.

- **LDH does not have a sufficient process to verify that individuals on the Direct Service Worker Registry are not providing services.** We identified approximately 100 workers who provided services totaling $2.5 million even though they were on the registry for abuse, neglect, or misappropriation of recipient property.

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

Although LDH implemented an edit check to prevent direct care workers who work for two different companies from claiming overlapping times for different recipients, a more comprehensive edit is needed. We identified approximately $620,000 in potentially improper payments for overlapping services from calendar years 2011 to 2015.

In 2011, we found that LDH's lack of preventative edit checks resulted in providers claiming from $700,000 to $1.3 million in potentially improper payments. In July 2014, LDH required that its contractor, Statistical Resources Inc. (SRI),[2] implement an edit check to prevent individuals who worked for two different companies from claiming overlapping times for providing services to different recipients. However, LDH wanted to identify the most egregious cases before fully implementing the edit, which resulted in some overlapping times not being blocked. In 2015, SRI implemented a more comprehensive edit that blocked most of the overlaps. However, that edit still did not identify cases when there were four or more overlapping services billed by the same worker when that worker was employed by more than two different companies. As a result, we identified 217,729 instances of overlapping times which equaled approximately $620,000 in potentially improper payments from calendar years 2012 to 2015, as shown in Exhibit 2.

[2] SRI is responsible for prior authorizing and tracking all HCBS services. SRI uses its Louisiana Services Tracking System (LAST) and Case Management Information System (CMIS) to track these services. Our analysis relied on data from these two systems as well as data from Molina's Medicaid Management Information System (MMIS).

Exhibit 2 Overlapping Services Calendar Years 2012-2015		
Calendar Year	**Overlapping Units**	**Approximate Amount Paid**
2011	32,741	$93,312
2012	91,099	259,631
2013	69,335	197,606
2014	24,318	69,306
2015	236	674
Total	**217,729**	**$620,529**
Source: Prepared by legislative auditor's staff using data from LDH.		

Recommendation 1: LDH should require that SRI implement a more comprehensive edit that looks across multiple records.

Summary of Management's Response: LDH agrees with this recommendation and states that it will implement an additional edit by September 30, 2017. See Appendix A for LDH's full response.

LDH has not implemented an effective process to prevent payments to providers while recipients were hospitalized or in nursing facilities. As a result, we identified $326,915 in potentially overlapping claims that were not identified by LDH during their back-end review process from calendar years 2012 to 2015.

In 2011, we identified $194,163 in potentially improper payments to waiver or LT-PCS providers when recipients they claimed to be serving were hospitalized or in nursing facilities. We recommended that LDH develop a review of pending claims to check for duplicative services, and LDH agreed with this recommendation. To address this recommendation, LDH asked Molina, its fiscal intermediary, to develop an edit check to prevent these claims from being paid. However, according to Molina, the timing of the submission of these types of claims makes it impossible to develop an edit because HCBS providers may submit claims daily, while hospitals may submit monthly and all providers have a year in which to submit a claim.

According to LDH, Molina does identify these overlapping services on the back end and recoups improper payments. According to Molina, they identified $233,922 in overlapping claims from calendar years 2012 to 2015 and recouped $231,130. However, our analysis identified $326,915 more in potentially overlapping claims than Molina did for the same time period. Exhibit 3 summarizes the amount Molina identified and recouped for calendar years 2012 to 2015 and how much we identified after subtracting the amount we both identified.

Exhibit 3 Overlapping Claims – HCBS and Institutional Care Calendar Years (CY) 2012 to 2015			
CY	**Amount Identified**	**Amount Recouped**	**Additional Amount Identified by LLA***
2012	$54,428	$54,428	$72,376
2013	63,383	63,383	77,950
2014	33,652	30,860	93,711
2015	82,459	82,459	82,878
Total	**$233,922**	**$231,130**	**$326,915**
* This total excludes any claims that both Molina and LLA identified. **Source:** Prepared by LLA staff using data from Molina and SRI.			

The difference in the amounts identified are likely due to the fact that LDH reviews claims data for overlap, and our analysis reviewed actual time coded in SRI's LAST system. All HCBS providers use this system to track their work hours, so this data provides more detailed information than claims data, which only includes claims at the provider agency level. According to SRI, LAST data matches paid claims 93% of the time. In addition, according to LDH, another reason our analysts identified more is because the data LDH used to conduct its analysis of overlapping claims did not contain Medicare crossover claims and claims that were paid by Healthy Louisiana. LDH has modified its analysis to include these claims in the future.

Recommendation 2: LDH should consider using data from SRI's LAST system to conduct its overlap analysis of HCBS services and institutional care.

Summary of Management's Response: LDH states that it will consider implementing this recommendation and will compare the two systems to determine the most accurate methodology for conducting overlap analysis. See Appendix A for LDH's full response.

Since July 2014, LDH has required that direct care workers provide full Social Security numbers (SSN) to help ensure that workers who have been excluded from Medicaid are not providing services. However, LDH should ensure that workers provide valid SSNs, as we compared SSNs collected by LDH to driver's license data from the Office of Motor Vehicles and found approximately 1,450 workers whose SSNs matched a driver's license with a different name.

In 2011, we recommended that LDH require provider agencies to submit accurate and complete employee SSNs to the LAST system so LDH could use this database to periodically check employees against state and federal exclusion data. Exclusion data includes individuals who have been excluded from providing Medicaid services because of physical abuse, theft, fraud, etc. Provider agencies are

prohibited from hiring workers who are currently on this list and are required to check the list upon initial employment and monthly after that. We made this recommendation because LDH did not have an efficient method to verify that providers were making these checks as required.

LDH implemented this recommendation in July 2014 and began requiring SRI to collect full SSNs on direct care workers. As of December 2016, SRI identified 44 direct care workers who were hired and provided services even though they were excluded from Medicaid prior to or during their employment. For example, one worker who was excluded in August 2012 because of Medicaid fraud, was hired in December 2014, and provided services for two years until December 2016.

Exhibit 4 summarizes how long each of these 44 workers was employed prior to being identified by SRI. Potentially-excluded workers[3] identified by SRI are summarized on a report that LDH can access and recoup funds from these providers. From calendar years 2011 to 2016, LDH has recouped $484,298 in Medicaid funds from workers who provided services while excluded.

Exhibit 4
Length of Time Excluded Workers Provided Services

Timeframe	Number	Percent
Less than 1 year	27	61.4%
1 to 2 years	6	13.6%
2 to 3 years	4	9.1%
3 to 4 years	4	9.1%
4 to 5 years	2	4.5%
Over 5 years	1	2.3%
Total	**44**	

Source: Prepared by legislative auditor's staff using data from SRI and PI.

LDH should develop a process to validate SSNs. Validating SSNs is important when verifying the identity of the direct care worker as their identification information (e.g., SSN and name) is used to match against the list of excluded individuals upon providing any services. We compared SSNs collected by LDH with driver's license data from the Office of Motor Vehicles and found approximately 1,450 workers whose SSNs matched a driver's license with a different name. Therefore, LDH should consider requiring that providers verify SSNs. This could be done either by requiring copies of their employees' SSN cards or subscribing to a SSN verification service. For example, the Social Security Administration offers a free look-up service to verify SSNs.

Recommendation 3: LDH should require that providers validate the SSNs of their employees either through a copy of their SSN card or through a verification service.

Summary of Management's Response: LDH agrees with this recommendation and states that it will work to implement a mechanism for validating social security numbers. See Appendix A for LDH's full response.

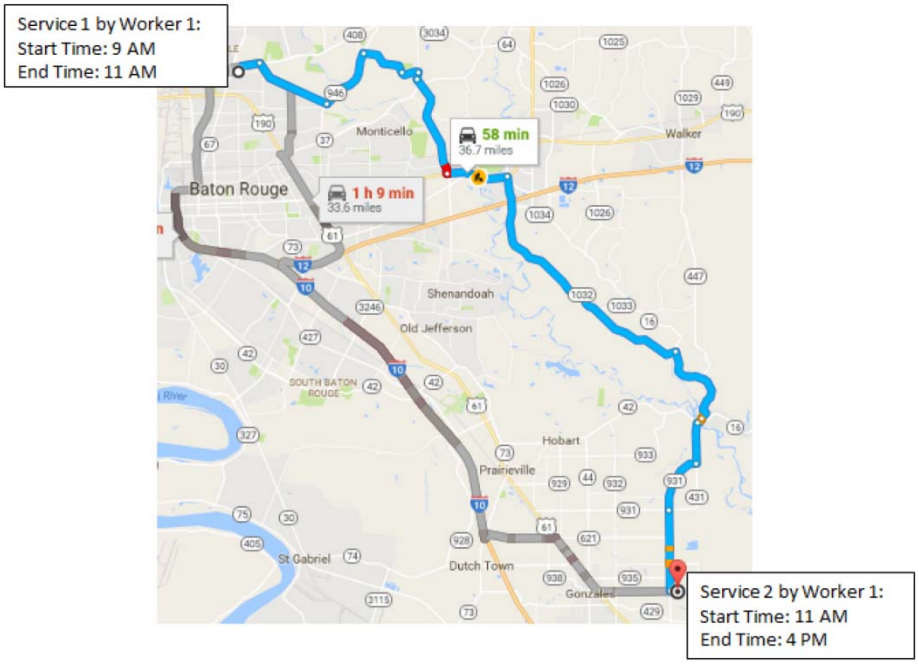
[3] Potentially excluded because SRI matches on various criteria including SSN, date of birth, and name or some combination of the three, so the match may not always be valid.

LDH has not fully implemented the use of a call-in system to capture actual time worked. We identified 52,222 instances where direct workers were required to travel from 10 miles to 100 miles between two different locations where they worked consecutive hours, but did not indicate travel time at an approximate cost of $340,000.

In 2011, we recommended that LDH consider implementing a call-in system to help prevent improper payments. These systems require that direct care workers check in and check out by calling from a recipient's home to verify arrival and departure times. Providers are then only paid for time recorded via the call-in system, which interfaces with the state's payment system. Currently, LDH has implemented a similar system, called an electronic visit verification system (EVV) developed by its contractor, SRI. This system has been fully implemented only in center-based care, such as adult day health care centers and day habilitation centers, but is currently being piloted at 47 HCBS provider agencies before being implemented statewide.

To determine if workers were entering their scheduled time as opposed to their actual time, we identified workers who worked at two different locations during the same day and calculated the driving distance between the locations. We identified 52,222 instances from calendar years 2011 to 2015 when direct care workers were required to travel from 10 miles to 100 miles between two different locations that they served consecutively but did not indicate travel time. We estimate the cost of this travel was approximately $340,000. For example, a worker worked from 9:00 a.m. to 11:00 a.m. at one location and then indicated that they worked from 11:00 a.m. to 4:00 p.m. at another location approximately one hour away, as shown in Exhibit 5.

Exhibit 5: Example of Distance Between Locations



According to LDH, they have selected a contractor for implementing an EVV in all HCBS programs, and the system will be fully implemented statewide by January 2018. According to LDH, this system will cost approximately $2.8 million per year. However, the system will reduce improper payments through its use of GPS and check-ins and outs on workers' smartphones and will also benefit providers by eliminating the manual entry of time sheet data.

Recommendation 4: LDH should ensure that the EVV system is implemented statewide, as it will address many of the issues identified in this report.

Summary of Management's Response: LDH agrees with this recommendation and states that it will complete statewide implementation of the EVV by January 1, 2018. See Appendix A for LDH's full response.

Although LDH has developed a process to monitor LT-PCS, it has not implemented a systematic financial monitoring process to help ensure that services billed are supported with documentation.

In 2011, we recommended that LDH expand its provider monitoring process to include LT-PCS providers and include financial monitoring. At that time, LDH was only monitoring a random sample of 5% of recipients who received waiver services. Since 2013, LDH has contracted with Xerox to conduct monthly phone calls and quarterly in-home visits to monitor the LT-PCS program. In addition, OAAS performs data mining to detect questionable patterns of billing and target unannounced field audits of agencies based on this analysis. According to LDH, these efforts have resulted in 400 referrals to LDH Program Integrity and the Medicaid Fraud Control Unit within the Attorney General's office as of June 2017.

However, while LDH has developed a process to monitor LT-PCS providers, it has not developed a systematic process to conduct financial monitoring of all HCBS providers. Financial monitoring would include comparing actual paid claims to supporting documentation during on-site monitoring visits with providers and would provide LDH the opportunity to identify more improper payments. Other states, such as Kentucky and Florida, conduct billing audits to ensure that paid claims match service documentation. While LDH may periodically look at billing as part of other monitoring, allegations, or Surveillance and Utilization Review (SURS) cases, there is no systematic process to review billing records.

Recommendation 5: LDH should develop a more systematic financial monitoring process to ensure HCBS providers are billing for services that are supported by documentation.

Summary of Management's Response: LDH agrees with this recommendation and states that the implementation of the EVV will facilitate the accuracy of billing and documentation. See Appendix A for LDH's full response.

LDH has improved in its assessment of penalties for providers with improper payments. From calendar years 2012 to 2016, LDH assessed approximately $2 million in fines to HCBS providers compared to the $96,000 it assessed from 2005 to 2010. However, LDH did not always assess fines in accordance with its penalty policy, and it still does not assess penalties for first offenses.

In our 2011 report, we found that LDH's penalty structure and assessment of fines was not sufficient to deter provider noncompliance. From 2005 to 2010, LDH only assessed approximately $96,000 in fines to providers, even though these providers had nearly $4.7 million in improper payments. We made three recommendations, including strengthening of the sanction rule to impose higher fines based on the provider's overpayment, considering assessing fines for first offense, and ensuring that all fines are assessed consistently and appropriately.

Since 2011, LDH has developed penalty guidelines that help ensure consistency, because penalties are determined by the amount of overpayment and the number of occurrences. As a result, LDH has increased its use of penalties. From calendar years 2012 to 2016, LDH assessed approximately $2 million in fines to providers who had approximately $11.1 million in improper payments. Exhibit 6 summarizes the amount of improper payment identified and recouped, as well as the fine amount for calendar years 2012 to 2016.

Exhibit 6
Improper Payments identified and Recouped and Fines
CY 2012 to 2016

Year	Identified	Recouped	Fine Amount	% Recouped
2012	$2,365,701	$2,153,321	$82,239	91.0%
2013	1,850,591	1,684,955	52,502	91.0%
2014	4,211,048	1,612,737	748,745	38.3%
2015	1,768,160	1,334,553	550,331	75.5%
2016	987,542	793,692	548,480	80.4%
Total	**$11,183,042**	**$7,579,257**	**$1,982,297**	**67.8%**

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

Although LDH increased its use of fines, it does not always assess fines in accordance with its penalty matrix and still does not penalize providers for their first offense, regardless of the size of the improper payment. We analyzed cases involving improper payments from 2012 to 2016 and found 106 providers that never received a fine even though these providers individually had multiple violations, or had more than $10,000 in improper payments. In total, these 106 providers had $6.4 million in improper payments, of which approximately $3.3 million was recouped, but these providers received no fines. Although LDH regulations allow discretion when assessing sanctions, had LDH assessed fines strictly in accordance with its penalty matrix, it could have assessed these providers at least $124,500. If LDH assessed fines for first offenses, this amount would have increased to $251,000. According to LDH, the penalty matrix specifically allows for flexibility in assessing

penalties, as each provider's situation is unique. In the case of first offenses, LDH stated that it gives providers a chance to improve through education or training instead of imposing a penalty.

Additional Issues

LDH should ensure that certain HCBS monitoring visits occur when the direct care worker is present and providing services, as required by policy. We found that approximately 14% of monitoring visits that required observation of services occurred when a direct care worker was not present.

Currently, LDH monitors whether HCBS recipients are receiving adequate services and are satisfied with these services through its contracts with case management agencies. According to these contracts, case management agencies are required to, at a minimum, make monthly phone calls and quarterly visits to HCBS recipients to ensure they are receiving services and are satisfied with those services. Case management agencies are required to report their monitoring contacts to the Case Management Information System (CMIS), which documents the date of the service contact, the begin and end times, the place of service contact, and the purpose of service contact (e.g., observation of services). If case management agencies meet these requirements, they are reimbursed by Medicaid for a monthly fee averaging $140 per recipient. In fiscal year 2016, LDH spent $28 million on case management in HCBS. SRI reviews the information reported in CMIS to make sure that required monthly and quarterly contacts are fulfilled before issuing monthly payment authorization.

Although quarterly in-person visits are required for all HCBS programs, only OCDD requires its case management agencies to perform at least one unannounced observation of services annually for low-risk waiver participants and two unannounced observations of services annually for high-risk recipients. Unannounced visits must occur when the direct care worker is present and are an important tool for ensuring that services are actually provided. Since 2012, OAAS has not required its case management agencies to perform monitoring visits while the worker is present. We conducted an analysis to determine whether OCDD's case management monitoring visits occurred at a time when direct care workers coded time on their time sheet as providing services. As shown in Exhibit 7, we found that 14% of the service observations that case management agents claimed to have performed from calendar year 2011 to 2015 did not have a direct care worker present, as required by policy.

Exhibit 7
OCDD Case Management Service Observations with No Direct Care Worker Present
CY 2011 to 2015

CY	Number of Service Observations Performed	Number of Service Observations with No Direct Care Worker Present	Percentage
2011	23,602	3,596	15%
2012	17,568	2,530	14%
2013	17,048	2,265	13%
2014	17,449	2,139	12%
2015	20,364	2,758	14%
Total	**96,031**	**13,288**	**14%**

Source: Prepared by legislative auditor's staff using data from SRI.

Recommendation 6: LDH should develop a method to ensure that certain HCBS monitoring visits occur when workers are present and providing services. Because SRI maintains both databases, it could develop an automated method to ensure that the service observations that case managers claim also have a corresponding claim during the same timeframe as the direct care worker.

Summary of Management's Response: LDH agrees with this recommendation and states that it will implement the EVV for Support Coordination by December 31, 2018, which will provide LDH with the ability to verify visits. See Appendix A for LDH's full response.

Recommendation 7: LDH should consider requiring that a certain number of OAAS monitoring visits occur when the worker is present.

Summary of Management's Response: LDH states that it will consider implementing this recommendation and evaluate the most appropriate monitoring methods for the recipient, worker, and support coordinator. See Appendix A for LDH's full response.

LDH does not have a sufficient process to verify that workers on the Direct Service Worker Registry are not providing services. We identified approximately 100 workers who provided services totaling $2.5 million even though they were on the registry for abuse, neglect, or misappropriation of recipient property.

Louisiana regulations require that LDH maintain a Direct Service Worker Registry that includes individuals who have substantiated findings of abuse, neglect, exploitation, or extortion. HCBS providers are required to access the online registry for new employees prior to hiring and every six months thereafter. If a worker is on the registry, they are prohibited from subsequent employment as a direct service worker. However, LDH does not have a sufficient process to verify that providers are checking the registry before hiring an employee. Currently, LDH relies on Health Standards

surveys to verify this by reviewing required documentation in files during site visits, which is usually a printout that an employee's name was not found on the registry. From calendar years 2012 to 2016, LDH cited 270 deficiencies to providers for not checking the registry. Although reviewing documentation can help ensure that providers are checking the registry as required, LDH's goal is to only conduct onsite monitoring of providers every three years, which prevents LDH from timely identifying registered individuals continuously providing services.

We matched the DSW registry with current direct service workers and found that 107 workers listed on the direct care registry provided $2,522,811 in HCBS services after they were placed on the registry. Currently, LDH does not conduct any data matches of the registry with employees of HCBS providers. However, as discussed previously, SRI automatically performs these checks of employees against state and federal exclusion lists. Therefore, LDH should also require that SRI perform checks of the registry.

Recommendation 8: LDH should develop a process or require that SRI perform automated checks of direct service workers against the DSW registry on a continuous basis.

Summary of Management's Response: LDH agrees with this recommendation and will work to implement an automated check by June 30, 2018. See Appendix A for LDH's full response.

APPENDIX A: MANAGEMENT'S RESPONSE

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health

July 7, 2017

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

Re: Progress Report: Prevention, Detection and Recovery of Improper Medicaid Payments in Home and Community Based Programs.

Dear Mr. Purpera,

Thank you for the opportunity to respond to the findings of your Performance Audit Progress Report on Prevention, Detection and Recovery of Improper Medicaid Payments in Home and Community Based Programs. The Louisiana Department of Health (LDH) is committed to eliminating improper Medicaid payments associated with Home and Community Based Programs through appropriate management controls.

Recommendation 1: *LDH should require that SRI implement a more comprehensive edit that looks across multiple records.*

LDH agrees with this recommendation and LDH's contractor will implement an additional edit by September 30, 2017.

Recommendation 2: *LDH should consider using data from SRI's LAST system to conduct its overlap analysis of HCBS services and institutional care.*

LDH will consider this recommendation and will compare the two systems, Molina and LAST, to determine the most accurate methodology for conducting overlap analysis.

Recommendation 3: *LDH should require that providers validate the social security numbers of their employees either through a copy of the SSN card or through a verification service.*

LDH agrees with this recommendation and will work to implement a mechanism for validating employee social security numbers through the Social Security Administration. However, if there is a charge for this service, funding will need to be identified.

Recommendation 4: *LDH should ensure that the EVV system is implemented statewide as it will address many of the issues identified in this report.*

LDH agrees with this recommendation, is currently phasing in EVV, and will complete statewide implementation by January 1, 2018.

Recommendation 5: *LDH should develop a more systematic financial monitoring process to ensure providers are billing for services that are supported by documentation.*

LDH agrees with this recommendation and has developed a more systematic financial monitoring process. The implementation of EVV will facilitate the accuracy of billing and documentation.

Recommendation 6: *LDH should develop a method to ensure that certain HCBS monitoring visits occur when workers are present and providing services. Because SRI maintains both databases, it could develop an automated method to ensure that service observations that case managers claim also have a corresponding claim at the same timeframe as the direct care worker.*

LDH agrees with this recommendation and will implement EVV for Support Coordination by December 31, 2018, which will provide ability for LDH to verify each support coordinator's monitoring visit.

Recommendation 7: *LDH should consider requiring that a certain number of OAAS monitoring visits occur when the worker is present.*

LDH will consider this recommendation and evaluate the most appropriate monitoring methods for the recipient, worker, and support coordinator.

Recommendation 8: *LDH should develop a process or require that SRI perform automated checks of direct service workers against the DSW registry on a continuous basis.*

LDH agrees with this recommendation and will work to implement an automated check to ensure a comprehensive check is performed against state and federal exclusion lists as well as the DSW Registry by June 30, 2018.

Sincerely,

W. Jeff Reynolds, Undersecretary

APPENDIX B: SCOPE AND METHODOLOGY

We conducted this performance audit under the provisions of Title 24 of the Louisiana Revised Statutes of 1950, as amended. We conducted this audit to determine the implementation status of nine recommendations related to improper payments we made to the Louisiana Department of Health (LDH) in our performance audit issued in 2011. These recommendations were made to improve LDH's processes for preventing, detecting, and recovering improper Medicaid payments in home and community-based services (HCBS) programs. This audit covers the time period calendar year 2011 to calendar year 2016.

We conducted this performance audit in accordance with generally-accepted *Government Auditing Standard*s issued by the Comptroller General of the United States. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. To answer our objective, we performed the following audit steps:

- Interviewed LDH, SRI, and Molina SURS staff and obtained documentation to gain information on the implementation status of the recommendations related to improper payments from the September 2011 report.
- Interviewed LDH's OAAS and OCDD staff and obtained relevant documents to determine how the services provided to the recipients are being monitored through case management services.
- Obtained and analyzed Medicaid claim data maintained by Molina and direct care services and case management services data maintained by SRI to identify improper payments made to undelivered services.
- Analyzed direct care workers' timesheet data and identified instances where workers traveled from one location to another and did not code any travel time; used a GIS tool to calculate the minimal travel distance between the two locations.
- Validated direct care workers' Social Security numbers using with driver's license data from the Office of Motor Vehicles.
- Obtained and analyzed HCBS provider cases from LDH and its policy for monetary penalties to determine if LDH assessed fines in accordance with its penalty policy and if it assessed penalties for first offenses.
- Compared excluded providers data and direct care worker registry data against direct care service data to identify instances where excluded individuals continued

to provide services after being prohibited from providing services in HCBS programs.

- Provided identified exceptions to OAAS, OCDD, and SRI for review and adjusted our analytic methodologies based on their feedback.

APPENDIX C: STATUS OF RECOMMENDATIONS

Recommendation	Implementation Status
1. LDH should develop an edit check that prevents direct care workers who work for two different agencies from submitting overlapping claims.	**Implemented.** However, edit needs to be more comprehensive
2. LDH should consider developing a review of pending claims to check for duplicative LT-PCS, nursing home, ADHC, and hospital services.	**Not Implemented.** According to LDH, this recommendation is not feasible due to how claims are submitted.
3. LDH should require that provider agencies submit accurate and complete employee Social Security numbers to the LAST system so that LDH can use this database to periodically check employees against exclusion data.	**Implemented.** However, LDH should also require that Social Security numbers be validated.
4. LDH should consider systems used in other states for implementing a call-in system for all home and community based services. The call-in system should be linked to the Medicaid payment system to ensure that providers are only paid for the period of time recorded by the system. This system would help eliminate some of the problems with overlapping services outlined in the report.	**Partially Implemented.** LDH has implemented an electronic visit verification system at center-based care, such as Adult Day Health Care centers, and recently began piloting it with 47 providers.
5. DHH should consider strengthening its sanction rule to impose higher fines based on the provider's identified overpayment.	**Implemented.** LDH developed a penalty matrix that increases fines based on the number of occurrences and the amount of the overpayment.
6. LDH should consider imposing fines for first offenses.	**Not Implemented.** LDH does not impose fines for the first offense, no matter how large the overpayment is.
7. LDH should ensure that all fines are assessed consistently and appropriately.	**Partially Implemented.** LDH developed a penalty matrix to help ensure consistency in fines, but we found it did not always follow this matrix
8. LDH should expand its programmatic monitoring process to include LT-PCS providers.	**Implemented.** LDH has developed a process to monitoring LTPCS providers.
9. LDH should expand its programmatic monitoring process to include financial monitoring to ensure that services billed by providers are actually provided to recipients.	**Not Implemented.** LDH has not developed a financial monitoring process.
Source: Prepared by legislative auditor's staff based on the analysis for this progress report.	