DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

JUL 14 2009

Report Number: A-06-08-00023

Mr. Alan Levine
Secretary
Louisiana Department of Health and Hospitals
628 North Fourth Street
Baton Rouge, Louisiana 70821

Dear Mr. Levine:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Southeast Louisiana Hospital's Hurricane-Related Uncompensated Care Claims." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to call me, or contact Patricia Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-08-00023 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF SOUTHEAST LOUISIANA HOSPITAL'S HURRICANE-RELATED UNCOMPENSATED CARE CLAIMS

Daniel R. Levinson
Inspector General

July 2009
A-06-08-00023

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

In response to Hurricane Katrina, section 6201 of the Deficit Reduction Act of 2005 authorized Federal funding for the total costs of medically necessary uncompensated care furnished to evacuees and affected individuals without other coverage in eligible States; i.e., States that provided care to such individuals in accordance with section 1115 projects.

Pursuant to section 1115 of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) approved Louisiana's request for demonstration authority related to Hurricane Katrina. CMS also approved an uncompensated care pool to reimburse providers for medically necessary services provided to Hurricane Katrina evacuees and affected individuals without other coverage. In approving the State's uncompensated care pool plan (the UCCP plan), CMS authorized reimbursement for uncompensated care provided to Katrina evacuees and affected individuals from August 24, 2005, through January 31, 2006. The pool was 100 percent federally funded.

Before CMS approved the UCCP plan, Louisiana published an emergency regulation stating that reimbursement from the uncompensated care pool was available for specified services covered under the State Medicaid plan. In approving the UCCP plan, CMS specified that payment would be made in accordance with both the Medicaid plan and the UCCP plan and that expenditures above those limits were not reimbursable. The Medicaid plan limits inpatient psychiatric coverage for patients in institutions for mental diseases to those who are under age 21, and in some cases under age 22, as well as to those who are age 65 or older.

As of December 31, 2006, the Louisiana Department of Health and Hospitals (the State agency) reported $123.2 million in uncompensated care reimbursement to 834 health care providers. Southeast Louisiana Hospital (the Hospital), an institution for mental diseases, received $8.3 million of this reimbursement.

OBJECTIVE

Our objective was to determine whether the State agency claimed reimbursement for services provided by the Hospital in accordance with Federal and State laws and regulations and with the approved provisions of the UCCP plan.

SUMMARY OF FINDINGS

The State agency did not always claim reimbursement for services provided by the Hospital in accordance with Federal and State laws and regulations or with the approved provisions of the UCCP plan. Of the $8,312,198 in costs claimed for services provided to 134 patients, $564,361 was allowable. However, the State agency claimed $7,747,837 of unallowable costs for 127 patients, including:

- 119 patients whose care was not covered under the Medicaid plan because they were between the ages of 21/22 and 65,

- 43 patients whose costs were paid by other sources,

- 27 patients who did not receive services on the dates claimed, and

- 2 patients for whom the State agency had submitted duplicate claims.

Some patients' costs were unallowable for more than one of these reasons.

The State agency claimed the unallowable costs because it (1) did not have procedures to ensure that it claimed uncompensated care costs only for services covered under the Medicaid plan, (2) did not instruct the Hospital to analyze its uncompensated care claims to determine whether payments had been received from other sources, (3) relied on the Hospital to verify that the costs claimed were based on actual inpatient days, and (4) did not have procedures to ensure that it identified all duplicate claims.

RECOMMENDATION

We recommend that the State agency refund to CMS the $7,747,837 in unallowable costs claimed. Because the State's authorization to obtain Federal reimbursement for hurricane-related uncompensated care has ended, we are not making procedural recommendations.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency disagreed with our findings and recommendation. The State agency said that it intended that its expenditure authority under the section 1115 demonstration project should be interpreted to include inpatient psychiatric services for all Hospital patients, including those between ages 22 and 65. With respect to our findings that the State agency claimed reimbursement for patients whose costs had been paid by other sources, patients who did not receive services on the dates claimed, and patients for whom the Hospital had submitted duplicate claims, the State agency said that it was reviewing those claims.

The State agency's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency's comments caused us to revise our findings or recommendation.

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INTRODUCTION

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Section 1115 Hurricane-Related Demonstration Projects

Section 1115 of the Act permits the Secretary to authorize demonstration projects to promote the objectives of the Medicaid program. Pursuant to section 1115, CMS may waive compliance with any of the requirements of section 1902 of the Act and provide Federal matching funds for demonstration expenditures that would not otherwise be included as expenditures under the State Medicaid plan.

In response to Hurricane Katrina, CMS announced that States could apply for section 1115 demonstration projects to ensure the continuity of health care services for hurricane victims. A State with an approved hurricane-related section 1115 demonstration project was eligible under section 6201 of the Deficit Reduction Act of 2005 for Federal payment of the total costs of uncompensated care incurred for medically necessary services and supplies furnished to Hurricane Katrina evacuees and affected individuals who did not have other coverage for such assistance.

Louisiana's Approved Uncompensated Care Pool Plan

In a November 10, 2005, letter, CMS approved Louisiana's request for section 1115 demonstration authority and for an uncompensated care pool to reimburse providers for medically necessary services and supplies for Hurricane Katrina evacuees who did not have insurance coverage or other available options. In a March 24, 2006, letter, CMS approved Louisiana's uncompensated care pool plan (the UCCP plan) and authorized reimbursement from the pool for services provided to Katrina evacuees and affected individuals from August 24, 2005, through January 31, 2006. The UCCP plan proposed to reimburse providers that incurred uncompensated care costs for which there was no other source of payment. In the approval letter, CMS specified that payment would be made in accordance with both the State Medicaid plan and the UCCP plan and that expenditures above those limits were not reimbursable.

Louisiana's UCCP plan listed the broad categories of services that would be covered through the uncompensated care pool, including inpatient psychiatric services, and stated that payments would be based on the Louisiana Medicaid rate. Only Medicaid providers were eligible for reimbursement. The UCCP plan also provided that all claims would be reviewed before any

payment and that applicable Federal and State laws and regulations would govern the prepayment investigation.

On March 20, 2006, before CMS approved the UCCP plan, the State published an emergency regulation to govern reimbursement from the uncompensated care pool.[1] Pursuant to the regulation, reimbursement was available for specified services covered under the State Medicaid plan, including inpatient psychiatric services. The State later published a final rule affirming that coverage through the uncompensated care pool was available for services covered under the Medicaid plan.[2]

The Louisiana Department of Health and Hospitals (the State agency) administered the uncompensated care pool, which was 100 percent federally funded. As of December 31, 2006, the State agency reported $123.2 million in uncompensated care reimbursement to 834 health care providers, including State-operated inpatient psychiatric facilities. Southeast Louisiana Hospital (the Hospital), located in Mandeville, received $8.3 million of this reimbursement based on claims that the State agency submitted to CMS.

Reimbursement to Institutions for Mental Diseases

The Act provides that Federal reimbursement is not available under the State Medicaid plan for services furnished to certain patients in institutions for mental diseases (IMD). Clause (B) in the paragraph following section 1905(a)(28) of the Act excludes from the definition of medical assistance "any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases." However, the State may opt to cover inpatient psychiatric hospital services for individuals under age 21. Pursuant to section 1905(h) of the Act, a State that elects to cover these services for individuals under age 21 may, in some cases, cover individuals up to age 22. Louisiana's approved Medicaid plan includes such coverage. Therefore, Federal reimbursement to the State is not available for services furnished to IMD patients between the ages of 21/22 and 65 under the Medicaid State plan.

Federal regulations (42 CFR § 435.1010) define an IMD as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.

Southeast Louisiana Hospital

The Hospital is a State-operated inpatient psychiatric treatment facility that provides services to adults, adolescents, and children. The Hospital meets the definition of an IMD.

During our audit period, the Hospital received reimbursement of $581.11 per day for inpatient psychiatric services. Before and after the dates of service covered by the UCCP plan, costs

[1] 32 La. Reg. 377 (March 2006).

[2] 32 La. Reg. 1902 (October 2006) (to be codified at La. Admin. Code 50: XXII, chapters 41–53).

incurred by the Hospital for treating patients who had no other source of payment were paid with State funds.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed reimbursement for services provided by the Hospital in accordance with Federal and State laws and regulations and with the approved provisions of the UCCP plan.

Scope

Our audit covered the $8.3 million in uncompensated care costs that the State agency reimbursed the Hospital and claimed for Federal reimbursement as of December 31, 2006. The Hospital incurred these costs for services provided to Hurricane Katrina evacuees and affected individuals during the period August 24, 2005, through January 31, 2006.

We did not review the State agency's or the Hospital's overall internal control structure. We limited our review to obtaining an understanding of the policies and procedures used to identify and claim uncompensated care costs, account for billable inpatient days, and collect payments for patients who had another source of income.

We conducted our fieldwork at the Hospital in Mandeville, Louisiana, and at the State agency in Baton Rouge, Louisiana.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws and regulations, the approved State Medicaid plan, CMS approval letters, the approved section 1115 demonstration, and the approved UCCP plan;

- interviewed State agency and Hospital officials to (1) gain an understanding of claim procedures and supporting documentation and (2) determine the source of payment for the costs incurred for treating patients before and after the dates of service claimed under the UCCP plan;

- obtained the State agency's database of uncompensated care claims paid to providers as of December 31, 2006, which totaled $123.2 million;

- verified that all paid uncompensated care claims were included on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program," Form CMS-64, for our audit period;

- extracted from the State agency's database claims totaling $8,312,198 paid to the Hospital for treating 134 patients during the period August 24, 2005, through January 31, 2006; and

- reviewed the claims and supporting documentation (patient financial records) to verify, for each of the 134 patients, that:

    - the services claimed were covered under the Medicaid plan,

    - the patient did not have another source of payment available for the services under Medicare, Medicaid, private insurance, or a State-funded health insurance program,

    - the patient received services on the dates of service claimed and the claims were for eligible dates of service,

    - the amount claimed for the patient was accurately calculated, and

    - the patient's home address was within one of the individual assistance designation counties listed in an attachment to the UCCP plan.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATION

The State agency did not always claim reimbursement for services provided by the Hospital in accordance with Federal and State laws and regulations or with the approved provisions of the UCCP plan. Of the $8,312,198 in costs claimed for services provided to the 134 patients, $564,361 was allowable. However, the State agency claimed $7,747,837 of unallowable costs for 127 patients, including:

- 119 patients whose care was not covered under the Medicaid plan because they were between the ages of 21/22 and 65,

- 43 patients whose costs were paid by other sources,

- 27 patients who did not receive services on the dates claimed, and

- 2 patients for whom the State agency had submitted duplicate claims.[3]

[3]Some patients' costs were unallowable for more than one reason. We questioned these costs only once.

Appendix A shows a breakdown, by patient, of the reasons for the unallowable costs.

The State agency claimed the unallowable costs because it (1) did not have procedures to ensure that it claimed uncompensated care costs only for services covered under the Medicaid plan, (2) did not instruct the Hospital to analyze its uncompensated care claims to determine whether payments had been received from other sources, (3) relied on the Hospital to verify that the costs claimed were based on actual inpatient days, and (4) did not have procedures to ensure that it identified all duplicate claims.

UNALLOWABLE COSTS

Services Not Covered Under the Medicaid Plan

In approving the UCCP plan, CMS specified that payment would be in accordance with both the Medicaid plan and the UCCP plan and that expenditures above those limits were not reimbursable. Pursuant to 32 La. Reg. 1902, reimbursement from the uncompensated care pool was available for inpatient psychiatric services covered under the Medicaid plan. The Medicaid plan limits IMD inpatient psychiatric coverage to individuals who are (1) under age 21, or under age 22 if the individual was receiving such services immediately preceding the date on which he or she reached age 22, or (2) age 65 or older.

The State agency inappropriately claimed costs for 119 patients age 22 through 64 because it did not have procedures to ensure that it claimed uncompensated care costs only for services covered under the Medicaid plan.

Reimbursement Received From Other Sources

Section 1.B of the UCCP plan limited reimbursement to services provided to evacuees and affected individuals for whom there were no other sources of payment. Section 1.D of the UCCP plan stated that an attestation would be required from providers. The attestation form, which was signed by the acting assistant secretary of the State agency's Office of Mental Health, stated: "I certify that no payment, either in full or in part, has been received from another entity on the above listed claims."

The State agency inappropriately claimed costs for 43 patients for whom the Hospital had received payments from other sources. Specifically, the Hospital had received Medicare payments for 34 patients, Medicaid payments for 13 patients' Medicare coinsurance payments, private insurance payments for 2 patients, and payments from 33 patients.[4] The Hospital did not offset its uncompensated care claims by the amounts of these payments.

The State agency did not instruct the Hospital to analyze its uncompensated care claims to determine whether payments had been received from other sources. The Hospital also was not aware that it should have offset the claims by payments received from other sources.

[4]For 29 patients, the Hospital received reimbursement from more than one other source.

Services Not Received

Section I.C of the UCCP plan stated: "Payments will be made only for covered services provided to eligible populations . . . ." Section 1.D of the UCCP plan stated that an attestation would be required from providers. The attestation form, which was signed by the acting assistant secretary of the State agency's Office of Mental Health, stated: "I certify that on this invoice . . . the goods, services and/or supplies . . . were actually provided to the above listed individual . . . ."

The State agency inappropriately claimed costs for 27 patients who did not actually receive the services claimed. These patients were away from the Hospital on overnight passes for a total of 310 days claimed. According to State agency officials, if a patient was not in his or her bed at midnight, the Hospital should not have been reimbursed for that day.[5]

To ensure the validity of uncompensated care costs claimed on behalf of the Hospital, the State agency provided the Hospital with a list of potentially eligible patients and their potential dates of service and instructed the Hospital to perform random checks to verify the accuracy of the list. The Hospital confirmed that the individuals on the list were patients during the specified periods of service. However, the Hospital did not check patient records for days when patients were away on overnight passes and made no adjustments to the State agency's list to account for those days. As a result, the State agency claimed costs for services that were not received.

Duplicate Claims Submitted

In the March 24, 2006, letter approving the UCCP plan, CMS specified that the approved plan included the "minimum methodologies" that the State must use to ensure program integrity, specifically including procedures to identify duplicate claims.

The State agency did not have procedures to ensure that it identified all duplicate claims. The State agency inappropriately claimed costs for two patients for whom the Hospital had submitted duplicate claims.

RECOMMENDATION

We recommend that the State agency refund to CMS the $7,747,837 in unallowable costs claimed. Because the State's authorization to obtain Federal reimbursement for hurricane-related uncompensated care has ended, we are not making procedural recommendations.

[5]In administering the Medicaid program, the State agency followed Medicare guidance regarding billable patient days for inpatient psychiatric facilities (IPF) under the IPF prospective payment system. According to CMS's "Medicare Claims Processing Manual," Pub. No. 100-04, chapter 3, section 190.10.7, an IPF is to account for interrupted stays by counting from the day of discharge (e.g., the day that the patient leaves the facility on a pass) through the last day that the patient was not present in the facility at midnight. The IPF should not be reimbursed for those days.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency disagreed with our findings and recommendation. The State agency said that, under its section 1115 demonstration project, CMS permitted Louisiana to claim Federal reimbursement for "all expenditures for medical services provided to individuals who are receiving inpatient psychiatric services under the demonstration project in freestanding facilities." The State agency stated that it intended that this expenditure authority should be interpreted to include inpatient psychiatric services for all Hospital patients, including those between ages 22 and 65.

The State agency said that it had followed the processes outlined in its approved section 1115 demonstration project and in its approved UCCP plan and that it had clear procedures to ensure that it claimed uncompensated care costs only for services covered under the State Medicaid plan. The State agency explained that the benefits contained in its approved section 1115 demonstration project were broadly defined as those of the State Medicaid plan and included inpatient psychiatric services. The State agency said that it had intended to get 100-percent Federal funds for the psychiatric services provided at the Hospital. Furthermore, the State agency said that CMS had stated that the uncompensated care pool could be used to provide reimbursement for benefits not covered under Title XIX in the State.

With respect to our findings that the State agency claimed reimbursement for patients whose costs had been paid by other sources, patients who did not receive services on the dates claimed, and patients for whom the Hospital had submitted duplicate claims, the State agency said that it was reviewing those claims.

The State agency's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency's comments caused us to revise our findings or recommendation. The State agency furnished no evidence to support its contention about the intent of the demonstration provision and no evidence that Hospital patients were included in discussions with CMS. Furthermore, the State agency's intention is not evident in the broad wording of the expenditure authority. Thus, we have no basis to conclude that CMS approved Federal reimbursement for services provided to Hospital patients between ages 22 and 65.

As to the State agency's assertion that CMS had stated that the uncompensated care pool could be used to provide reimbursement for benefits not covered under Title XIX in the State, the State's own emergency rule, issued on March 20, 2006, limited uncompensated care pool coverage to benefits under the State Medicaid plan. The State's rule specified that "reimbursement is available under the UCC [uncompensated care] pool for the following services covered under the Louisiana Medicaid State Plan." The covered services included "inpatient psychiatric services (free-standing psychiatric hospitals and distinct part psychiatric units)." Like other covered services listed in the State's emergency rule, inpatient psychiatric services furnished by psychiatric hospitals and distinct-part psychiatric units are covered under

Louisiana's Medicaid State plan. However these services are covered under the State plan only for individuals under age 21/22 and age 65 or older.

In addition, the State agency provided no evidence that it did not claim reimbursement for patients whose costs had been paid by other sources, patients who did not receive services on the dates claimed, or patients for whom the Hospital had submitted duplicate claims.

APPENDIXES

REASONS FOR UNALLOWABLE COSTS FOR EACH PATIENT

1 The services were not covered under the State Medicaid plan.
2 Reimbursement was received from other sources.
3 The services were not received.
4 Duplicate claims were submitted.

Office of Inspector General Review Determinations on the 134 Patients

Patient	1	2	3	4	No. of Deficiencies
1	X	X			2
2	X				1
3	X				1
4	X				1
5	X				1
6	X	X			2
7	X	X	X		3
8	X				1
9	X		X		2
10	X	X			2
11	X				1
12	X				1
13		X			1
14					0
15	X				1
16	X				1
17	X				1
18	X	X			2
19	X	X			2
20	X				1
21			X		1
22	X	X			2
23			X		1
24	X				1
25	X				1
26					0
27	X	X			2
28	X	X			2
29	X				1
30	X	X			2
31	X	X			2
32	X				1
33	X				1

Patient	1	2	3	4	No. of Deficiencies
34	X	X	X		3
35	X		X		2
36	X	X			2
37	X				1
38	X	X	X		3
39	X		X		2
40	X				1
41	X				1
42	X	X			2
43	X			X	2
44	X		X		2
45	X				1
46	X				1
47			X		1
48	X	X			2
49	X				1
50	X				1
51	X				1
52	X				1
53			X		1
54	X				1
55	X				1
56	X				1
57	X		X		2
58	X	X			2
59	X	X			2
60	X			X	2
61	X	X			2
62	X	X			2
63	X	X			2
64	X				1
65	X				1
66	X				1
67	X				1
68					0
69	X	X	X		3
70	X				1
71					0
72	X				1
73	X				1
74	X				1
75	X	X			2
76	X	X			2

Patient	1	2	3	4	No. of Deficiencies
77	X	X			2
78	X				1
79					0
80	X				1
81	X		X		2
82	X				1
83	X	X			2
84	X	X			2
85	X				1
86	X	X			2
87	X				1
88	X				1
89	X				1
90	X				1
91	X	X			2
92	X		X		2
93	X	X	X		3
94	X				1
95	X				1
96	X				1
97	X	X			2
98	X				1
99	X		X		2
100	X				1
101	X	X			2
102	X	X			2
103			X		1
104					0
105	X	X	X		3
106	X				1
107	X		X		2
108		X	X		2
109	X		X		2
110	X				1
111	X	X			2
112	X				1
113	X				1
114	X				1
115	X				1
116	X	X	X		3
117	X	X			2
118	X				1
119	X		X		2

Patient	1	2	3	4	No. of Deficiencies
120	X				1
121		X	X		2
122	X	X			2
123	X		X		2
124	X				1
125	X				1
126	X				1
127	X				1
128	X				1
129					0
130	X	X			2
131	X				1
132	X	X			2
133	X				1
134	X		X		2
Total	**119**	**43**	**27**	**2**	**191**

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

April 3, 2009

Gordon Sato,
Regional Inspector General for Audit Services
Department of Health and Human Services
1100 Commerce, Room 632
Dallas, Texas 75242

RE: Report Number A-06-08-00023 – "Review of Southeast Louisiana Hospital's Hurricane-Related Uncompensated Care Claims"

Dear Mr. Sato:

The Louisiana Department of Health and Hospitals (LDHH) acknowledge receipt of your March 4, 2009, correspondence and the draft report titled "Review of Southeast Louisiana Hospital's Hurricane-Related Uncompensated Care Claims." It is our understanding that the report stems from a financial review to determine if Louisiana Medicaid claimed reimbursement for services provided by the Hospital in accordance with Federal and State laws and regulations and with the approved provisions of the UCCP plan. As a result of this review, it appears that your office recommends findings in four distinct areas and a return to CMS of $7,747,837 in unallowable costs. LDHH appreciates the opportunity to provide written comments regarding the recommendations contained in the report. For the reasons specifically mentioned in the following paragraphs, the LDHH respectfully disagrees with the recommend findings and refund.

The first area wherein findings were recommended relates to services not being covered under the Medicaid Plan. Specifically, the report alleges that the Louisiana State Plan and related regulations limits payments from the UCC pool to inpatient psychiatric services covered under the plan. The recommendation goes on to state that the Louisiana plan limits IMD inpatient psychiatric coverage individuals who are under age 21, or under age 22 in certain circumstances, or age 65 or older. The findings allege that LDHH inappropriately claimed costs for 119 patients age 22 through 64. To the contrary, Louisiana Medicaid meticulously followed the processes outlined in its approved section 1115 demonstration project and its approved UCC pool plan. In following these processes, it is indisputable that Louisiana had clear procedures in place to ensure that it claimed uncompensated costs only for services covered under the Medicaid plan.

As you are more than aware, on August 29, 2005, Louisiana was devastated by the landfall of Hurricane Katrina. This event is widely recognized as the worst natural disaster in the history of the United States. The main impacted area was southeast Louisiana, specifically the New Orleans area. As if Louisiana was not faced with a big enough emergency, on September 24, 2005, Louisiana was hit by Hurricane Rita. Hurricane Rita impacted southwestern Louisiana. Together, these two hurricanes placed Louisiana in a situation of medical crisis for all its citizens, especially the Medicaid and uninsured populations.

In response to this situation, Section 6201 of the Deficit Reduction Act (DRA) of 2005 authorized federal funding for the total costs of medically necessary uncompensated care furnished to evacuees and affected individuals. In order to receive this 100% federal funding, states had to operate pursuant to a Section 1115 project. Louisiana submitted a Section 1115 waiver for Katrina evacuees that were memorialized in correspondence dated November 1, 2005, from Dr. Fred Cerise, then Secretary of LDHH, to Dr. Mark McClellan, then Administrator for CMS. Attached to this waiver request was a draft Louisiana Hurricane Relief Waiver Uncompensated Pool Plan. The purpose of this pool, as made clear at the time, was to give the State access to federal funds that could be used to pay for medical services provided to individuals not eligible for Louisiana Medicaid. The specifics included Pool Coverage Eligibility Determinations, the definition of eligible populations, broken down by evacuee status, income and medical necessity, the definition of available benefits, and the eligibility process. The application packet of November 1, 2005, also contained a Multi-State Section 1115 Demonstration Application template. Finally, this packet contained CMS Special Terms and Conditions.

According to this packet and attachments, the benefits of this project were broadly defined as those of the State plan Title XIX program in Louisiana. Without question, this definition included inpatient psychiatric services. Further, the attachments to the packet clearly listed out what Louisiana determined to be Louisiana Medicaid cost not otherwise matchable that it believed would be matched under this demonstration project. Included therein were "all expenditures for medical services provided to individuals who are receiving inpatient psychiatric services under the demonstration project in freestanding facilities."

CMS approved Louisiana's request for 1115 demonstration authority, which included the UCC pool methodology, via letter dated November 10, 2005. Therein, CMS specifically approved the UCC pool methodology for Louisiana in order to reimburse providers that incur uncompensated care costs for medically necessary services and supplies for evacuees. CMS expressly stated that the pool may also be used to provide reimbursement for benefits not covered under Title XIX in the State. Attached to this approval was the above mentioned explanation of Louisiana Medicaid costs not otherwise matchable which included the same language. Finally, in a letter dated March 24, 2006, CMS provided express approval for Louisiana's UCC pool plan for Katrina evacuees. Attached to the letter was Louisiana's Hurricane Relief UCC Pool Plan for Katrina and Rita. In that letter, CMS clearly authorized Louisiana to reimburse providers

that incurred uncompensated care costs for medically necessary services and medically necessary supplies for Katrina evacuees and affected individuals who do not have other coverage under Medicare, Medicaid, SCHIP, private insurance, or under State-funded health insurance programs. It was clearly stated that payment for services reimbursed from the pool will be in accordance with Louisiana's State plan in place on August 24, 2005, and the UCCP. Further, the UCC pool plan contained a specific section that outlined what would be considered allowable payments. Simply put, allowable payments were defined as payments for "covered services" provided to eligible populations. "Covered services" were defined in subsection C(1) and included, among other things, inpatient psychiatric services.

One of the providers participating in the UCC pool was SELH. SELH is a freestanding facility that provides inpatient psychiatric services. It provides these services to a wide range of ages, including individuals aged 22 to 65. Louisiana is aware that federal matching funds are not available under Title XIX for services provided in institutions for mental diseases (IMD) for this age group. However, Louisiana, in the case in question, was not, and is not, seeking federal matching funds under its State Plan for these services. At each and every turn of this process, Louisiana Medicaid made it clear that it was seeking a demonstration "waiver" to lead to the formation of a UCC pool with 100% federal dollars. It is obvious that this was not the normal Medicaid funding process involving state and federal matching funds. On at least two separate occasions, Louisiana Medicaid provided CMS with a statement outlining Louisiana Medicaid costs not otherwise matchable.

Clearly, the whole purpose of this statement was to get 100% funds for the psychiatric services provides at SELH. Louisiana Medicaid would not have to seek any federal authority to make payments for the 21 and under population, or the over 65 individuals, as it already is allowed to make payments for these services under the current provisions. These services would never fit under "Louisiana Medicaid costs not otherwise matchable" as they are expressly matchable. The main services that would not otherwise be matchable are obviously inpatient psychiatric services provided in freestanding facilities that would fall into the definition of IMDs.

The second area where findings were recommended relates to reimbursement received from other sources. According to the draft report, the state agency inappropriately claimed costs for 43 patients for whom SELH had received payments from other sources. Based on this information, the LDHH is currently reviewing these claims to verify what actually occurred. When this investigation is completed, LDHH will provide more detail.

The third area where findings were recommended relates to "services not received." Specifically, the draft report alleges that the state agency inappropriately claimed costs for 27 patients that did not actually receive the services claimed. The vast majority of these claims relate to overnight passes. LDHH is currently investigating the process and procedures related to these overnight passes. At the conclusion of this investigation, LDHH will forward its findings to your attention.

The fourth and final area where findings were recommended relates to duplicate claims. According to the report, the state agency inappropriately claimed costs for two patients for whom SELH had submitted duplicate claims. LDHH is currently investigating these incidents and will forward the results of same to you attention.

While analyzing this situation, we cannot lose sight of the fact that we were faced with the worst natural disaster this country has ever seen. This demonstration project was focused on delivering "services" to evacuees and affected citizens where Louisiana could find them as the storms literally spread them out all over the country. The demonstration project, and participation in the UCC pools, was not "situs driven". The whole theme of this mission from day one was to insure quick delivery of needed services. One such service, especially at a time of crisis of epic proportions, was inpatient psychiatric services in freestanding facilities. At such a time, the service delivery site was not contemplated and such was clearly communicated to CMS. Louisiana Medicaid's main goal was to provide services to individuals in need that did not have coverage otherwise.

If you have any questions or concerns, please feel free to contact me at 225-342-3891.

Sincerely,

Jerry Phillips,
Medicaid Director