LOUISIANA DEPARTMENT OF HEALTH

STATE OF LOUISIANA

FINANCIAL AUDIT SERVICES
MANAGEMENT LETTER
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Louisiana Legislative Auditor

Michael J. "Mike" Waguespack, CPA

Louisiana Department of Health

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Introduction

As a part of our audit of the State of Louisiana's Annual Comprehensive Financial Report and our work related to the Single Audit of the State of Louisiana (Single Audit) for the fiscal year ended June 30, 2021, we performed procedures at the Louisiana Department of Health (LDH) to provide assurances on financial information that is significant to the state's Annual Comprehensive Financial Report; evaluate the effectiveness of LDH's internal controls over financial reporting and compliance; and determine whether LDH complied with applicable laws and regulations. In addition, we determined whether management has taken actions to correct the findings reported in the prior year.

Results of Our Procedures

Follow-up on Prior-year Findings

Our auditors reviewed the status of the prior-year findings reported in the LDH management letter dated April 16, 2021. We determined that management has resolved the prior-year findings related to Inadequate Controls over Consideration of Lottery Winnings for Medicaid Eligibility, Weaknesses in Controls over LaMEDS, Lack of Internal Controls over and Noncompliance with Subrecipient Monitoring Requirements, and Lack of Internal Controls over Program Expenditures.

The prior-year findings related to Inadequate Internal Control over Eligibility Determinations, Noncompliance with Managed Care Provider Enrollment Requirement, Noncompliance with Provider Revalidation and Screening Requirements, Inadequate Controls over Billing for Behavioral Health Services, Inadequate Controls Over Service Providers with Closed Enrollment, Inadequate Controls over Waiver Services Providers, Inadequate Controls over Payroll, Noncompliance with Third-Party Liability Assignment, Noncompliance with Prenatal Service Third-Party Liability Requirements, and Inadequate Controls over Monitoring of Abortion Claims have not been resolved and are addressed again in this letter.

Current-year Findings

Failure to Provide a Listing of Food Benefits Paid for the WIC Program

LDH, Office of Public Health (OPH) could not provide a detailed listing of food benefits paid, including dollar value, to eligible participants during fiscal year 2021 for the WIC Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). In fiscal year 2021, OPH reported $75.3 million in WIC program expenditures in its Schedule of Expenditures of Federal Awards (SEFA). OPH should have a mechanism to account for all program funds received and expended, including food benefits paid to participants. After numerous requests, conference calls, and conversations with OPH personnel, OPH could not provide a detailed listing of food benefits paid to participants in fiscal year 2021. Reports provided to us by OPH included quantities of items purchased without detail of dollar amounts paid to participants by the program. Since OPH began using electronic benefits transfer (EBT) cards instead of paper checks/vouchers in fiscal year 2019, OPH management stated that the federal grantor does not require state agencies to review benefits paid to participants.

Federal regulations require state agencies to maintain a financial management system which provides accurate, current, and complete disclosure of the financial status of the program. This shall include an accounting for all property and other assets and all program funds received and expended each fiscal year. In addition, agencies are required to maintain records which adequately identify the source and use of funds expended for program activities.

Since OPH was unable to provide a detailed listing of food benefits paid, including dollar value, in fiscal year 2021, we were unable to obtain sufficient appropriate audit evidence to adequately test the activities allowed or unallowed compliance requirement for this program. We consider this a scope limitation for our audit.

OPH should continue to work with its contractor to develop a reporting mechanism to account for and track the costs of WIC food benefits paid by participants. Management did not concur with the finding.

Additional Comments: Management noted that a summary report detailing every transaction for every WIC participant in fiscal year 2021 does not exist and would take tremendous time and effort to develop; however, this information was produced by OPH in previous audits of the WIC program. To test the purchase of supplemental foods for participants, we requested a report detailing food packages (benefits) paid or a report detailing specific payments made to vendors. OPH provided a listing of transactions paid to WIC authorized vendors and a listing of EBT redemption amounts by clinic site; however, these reports only included summary totals of payments without detailed purchases of supplemental foods. In addition, OPH provided a listing of EBT card transactions with redeemed food quantities; however, since the listing did not contain dollar amounts, we were unable to determine the accuracy and completeness of the data. Management stated on May 6, 2022, that the actual claim amounts for vendor transactions specific to EBT redemptions with transaction level data would be provided by May 13, 2022. OPH provided a listing of EBT card transactions with redeemed food quantities; however, once again the listing did not contain dollar amounts.

OPH further notes that it has controls in place to adequately track and account for its federal program expenditures to demonstrate compliance; however, the Office of Management and Budget (OMB) Compliance Supplement requires the auditor to identify the types of activities which are either specifically allowed or prohibited by federal statutes, select a sample of transactions, and perform procedures to verify that the transaction was for an allowable activity. We were unable to obtain necessary information to conduct procedures for testing to determine compliance with the activities allowed or unallowed requirement or if controls over compliance with the activities allowed or unallowed requirement for the WIC program were adequate. (See Appendix A, pages 1-4)

Noncompliance with Managed Care Provider Enrollment and Screening Requirement

For the fourth consecutive year, LDH did not enroll and screen Healthy Louisiana managed care providers and dental managed care providers as required by federal regulations. Currently, the managed care plans continue to enroll and screen all managed care providers, in violation of federal regulations. As a result, LDH cannot ensure the accuracy of provider information obtained from the Louisiana Medical Assistance Program (Medicaid) managed care plans and cannot ensure compliance with enrollment requirements defined by law and the Medicaid and Children's Health Insurance Program (CHIP) state plan. LDH accepted 89.9 million Healthy Louisiana encounter claims totaling $6.6 billion and 3.1 million dental encounter claims totaling $116.3 million in fiscal year 2021 from the managed care plans and paid $9.7 billion in Healthy Louisiana premiums and $289.6 million in dental premiums.

Federal regulations require that the enrollment process include providing the Medicaid agency with the provider's identifying information including the name, specialty, date of birth, Social Security number, national provider identifier, federal taxpayer identification number, and state license or certification number of the provider. Additionally, the state agency is required to screen enrolled providers, require certain disclosure, provide enhanced oversight of certain providers, and comply with reporting of adverse provider actions and provider terminations. By using the federally required process, managed care providers must participate in the same screening and enrollment process as Medicaid and CHIP fee-for-service (FFS) providers.

LDH was required to enroll and screen all Healthy Louisiana managed care providers by January 2018 and dental managed care providers by July 2018. LDH failed to do this and is in violation of federal law. LDH noted that enrollment and screening of managed care providers was to be performed as part of a new provider management system. After cancellation of the new provider management system contract, the state's current provider enrollment vendor, Gainwell Technologies Inc., began the progress of creating a web-based portal for Medicaid and its providers to complete the necessary screenings required by federal regulations; however, the portal was not operational during fiscal year 2021.

LDH should ensure all providers are screened, enrolled, and monitored as required by federal regulations. Management concurred in part with the finding and provided a corrective action plan. (See Appendix A, pages 5-6)

Noncompliance with Provider Revalidation and Screening Requirements

For the fourth consecutive year, LDH did not perform five-year revalidations; screenings based on categorical risk of fraud, waste, or abuse; and monthly checks of the federal excluded party database, as required by federal regulations for all Medicaid and CHIP FFS providers. LDH submitted and received the Medicaid State Plan approval in fiscal year 2012 regarding compliance with revalidation and screening requirements. Proper enrollment and revalidation, including screening based on categorical risk and monthly checks of required databases, would enable the state to identify ineligible providers that should be rejected or excluded from the program.

Based on information provided by LDH, approximately 76% of providers with claims activity in fiscal year 2021 have not had a risk-based screening with a majority of those providers enrolled more than five years ago.

In addition, LDH did not routinely check one of the required federal databases to determine if providers have been excluded from participation in federal programs. Federal regulations required LDH to check the List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) on at least a monthly basis. While LDH checked the LEIE on a monthly basis, it did not perform checks of the SAM monthly as required. The SAM database includes information on providers excluded from contracting with the federal government.

Providers are enrolled by LDH and can provide services to either Medicaid and/or CHIP recipients as applicable. Federal regulations require that LDH screen all providers according to the provider's categorical risk level upon initial enrollment, re-enrollment, or revalidation of enrollment. LDH must complete a revalidation of enrollment for all providers, regardless of type, at least every five years. The required screening procedures for each provider varies based on the risk score – limited, moderate, or high. For example, a high-risk score requires additional screening procedures including criminal background checks and fingerprinting.

In response to the prior-year finding, LDH amended the Gainwell contract to accomplish provider revalidations with the Centers for Medicare and Medicaid Services (CMS) approved enhance funding. An online application portal was to be built by Gainwell and prepopulated with provider data. Through the portal, providers would be able to submit their enrollment applications online and Gainwell would revalidate them according to federal regulations. However, the enrollment portal created by Gainwell for providers was not launched until after state fiscal year 2021.

LDH should ensure all providers are screened based on categorical risk level upon initial enrollment, re-enrollment, and revalidation of enrollment as required by federal regulations. Also, LDH should perform revalidation of enrollment on all providers at least every five years. In addition, LDH should ensure all required databases are checked at least on a frequency required by federal regulations. Management concurred in part with the finding and provided a corrective action plan. (See Appendix A, pages 7-9)

Lack of Internal Controls over Program Expenditures

LDH, OPH lacked internal controls to ensure compliance with regulations over the Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) program related to the activities allowed or unallowed and the allowable costs/cost principles compliance requirements.

In a sample of 60 payments made in fiscal year 2021 to vendors who provided services related to the ELC program, the following payments were noted with exceptions, some with multiple exceptions:

- Three (5%) were not approved by an appropriate supervisor.
- Five (8%) did not include enough information to determine if the expenditure was appropriate and in accordance with federal regulations.
- Eleven (18%) did not include enough information to determine if the account coding was accurate.

Federal regulations require that records documenting compliance with federal statutes must be sufficient to establish that funds have been used in accordance with the terms and conditions of the federal award. Failure to adequately maintain supporting documentation and approve program expenditures increases the risk of unallowable costs requiring reimbursement to the federal grantor. The results of our procedures noted $4.8 million in questioned costs due to noncompliance.

OPH should ensure that adequate internal controls are established and followed to ensure all expenditures of federal awards are adequately supported and approved by an appropriate supervisor. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 10-13)

Inadequate Controls over Annual Financial Reporting

LDH did not have adequate controls over financial reporting to ensure its financial reports were accurate, complete, and prepared in accordance with instructions from the Division of Administration, Office of Statewide Reporting and Accounting Policy (OSRAP). As a result, LDH submitted an inaccurate Annual Fiscal Report (AFR) for LDH Medical Vendor Payments for the fiscal year ended June 30, 2021, to the Division of Administration, OSRAP. In addition, LDH also submitted inaccurate federal schedules used to prepare the SEFA.

In the AFR for Medical Vendor Payments, we noted the following errors in the Accounts Payable Adjustment notes.

- For full accrual, Due to Medical Claims was overstated by $10.5 million, Due to Audit Payables was overstated by $115.8 million, and Due to Federal Government was understated by $9 million.

- For modified accrual, Due to Medical Claims was overstated by $10.5 million, Due to Audit Payables was overstated by $194.5 million, and Due to Federal Government was overstated by $25.3 million.

In the AFR for Medical Vendor Payments, we noted the following errors in the Accounts Receivable Adjustment notes.

- For full accrual, Due from Federal Government was overstated by $108.1 million, and Due from Medical Providers was overstated by $13.9 million.

- For modified accrual, Due from Federal Government was overstated by $157.3 million, and Due from Medical Providers was overstated by $75.2 million.

In addition, Medicaid and CHIP settlements totaling $11.4 million for the quarter ending June 30, 2021, were included on Schedule 14 despite OSRAP's instructions noting that Schedule 14 should not be used by LDH. The amounts should be included in the payable note instead.

In the SEFA reporting for Medicaid, LDH did not record all expenditures related to COVID-19 funding as a separate line item as instructed by OSRAP and in accordance with federal requirements. The COVID-19 related expenditures for one quarter were combined with the non-COVID Medicaid expenditures. This resulted in an overstatement of non-COVID Medicaid expenditures of $131.1 million and an understatement of COVID-19 related expenditures of $131.1 million. In addition, LDH's supporting financial documentation contained an error that resulted in an overstatement of $29 million to the Medicaid and CHIP expenditures reported.

Good internal control over financial reporting should include adequate procedures and oversight to identify, calculate, and compile financial data needed to prepare accurate and complete financial reports that are presented in accordance with instructions provided by OSRAP and federal requirements. LDH's review process did not identify errors in amounts reported or ensure compliance with OSRAP instructions.

LDH management should strengthen its internal control over the financial reporting process to ensure accuracy of amounts provided to fiscal by program sections. In addition, management should perform a thorough review that will identify preparation errors and correct those errors before submission of reports to OSRAP for inclusion in the state's Annual Comprehensive Financial Report. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 14-15)

Inadequate Controls over Required Reporting on the Schedule of Expenditures of Federal Awards

LDH, OPH submitted inaccurate information for the SEFA for the year ended June 30, 2021. As a result, Immunization Cooperative Agreements program expenditures were understated by $6,873,390; Commodity Supplemental Food program expenditures and amounts provided to non-state subrecipients were understated by $109,281; and HIV Care Formula Grants program expenditures were overstated by $7,669,832 and amounts provided to non-state subrecipients were

understated by $7,967,375. In addition, a note disclosure for the Human Immunodeficiency Virus program was not submitted to OSRAP. Also, the required reconciliation of the SEFA information to OPH financial statements was not completed prior to submitting the SEFA information to OSRAP.

Failure to properly compile and review the SEFA information increases the likelihood that errors and omissions may occur and remain undetected in the state's SEFA, which is included in the state's Single Audit Report. Good internal controls over financial reporting should include adequate procedures to prepare, review, and transmit accurate and complete financial information for OSRAP to compile the state's SEFA. OPH management did not perform a review of the SEFA information, the notes to the SEFA, and the required reconciliation of the SEFA prior to submitting to OSRAP.

Management should ensure proper controls over the financial reporting process have been designed and implemented effectively. In addition, management should perform a thorough review of the SEFA information to identify and correct errors before submitting to OSRAP. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 16-17)

Inadequate Internal Controls over Eligibility Determinations

For the second consecutive year, LDH lacked adequate internal controls over eligibility determinations in the Medicaid and CHIP programs for the state fiscal year ending June 30, 2021. Federal regulations require that in order to be considered eligible, a recipient must meet all eligibility factors and the recipient case record must include facts to support agency eligibility decision. Federal regulations also require annual renewal of eligibility. LDH has outlined eligibility criteria and documentation to support determinations and renewals in its Medicaid eligibility manual. Proper eligibility determination and renewals are critical to ensuring appropriate service eligibility, appropriate premium payments, and appropriate federal match rate on expenditures.

From a population of 1,946,600 recipients, a sample of 60 Medicaid and 60 CHIP recipients were tested. Three (5%) out of 60 Medicaid recipients and four (7%) out of 60 CHIP recipients tested did not have adequate documentation to support the eligibility determination within the recipient's case record.

The following errors were noted for Medicaid:

- For one recipient, the case record did not contain information to support closure and reenrollment of the recipient.
- For two recipients, renewals were not performed during the state fiscal year as required by federal regulations.

During our testing of managed care premiums, we identified an additional recipient with eligibility not supported by the case record. The recipient's case record did not reflect timely transition into an appropriate case type based on the recipient's age.

Under the public health emergency (PHE), LDH had to continue eligibility determinations and renewals, but could only remove recipients in very limited circumstances. We did not note any questioned costs related to the above errors due to certain restrictions on eligibility actions during the PHE.

The following errors were noted for CHIP:

- For two recipients, the case records do not reflect timely transition from the CHIP program after the recipients turned 19 years old.

- For two recipients, renewals were not performed during the state fiscal year as required by federal regulations.

We noted questioned costs totaling $3,246 ($2,716 federal funds and $530 state funds) in relation to the two recipients not timely transitioned from CHIP. Under the PHE, there were no restrictions on transitioning recipients between programs with equal or greater benefits. We did not note any additional questioned costs related to other errors due to certain restrictions on eligibility actions during the PHE.

LDH did not adhere to established control procedures to ensure case records support eligibility decisions, including performance of annual renewals. LDH should ensure its employees follow procedures relating to eligibility determinations and renewals in the Medicaid and CHIP programs to ensure the case records support the eligibility decisions. Management did not concur with the finding and noted that CMS provided certain flexibilities in meeting the timeliness of renewals in accordance with 42 CFR 435.912(e)(2) and LDH used these flexibilities to suspend renewals during the PHE. LDH also indicated, while there was no particular documentation in the "case note" section of the LaMEDS, LDH provided audit staff with LaMEDS log tables which indicated the renewals were set to a future date.

In addition, LDH made the decision to stop processing the jobs for those aging out of current coverage groups (i.e. turning age 19 and transitioning out of child related programs) to mitigate the possibility of cases inappropriately closing or transitioning beneficiaries to groups with lesser benefits. Management decided to not process these transitions until the beneficiary's next scheduled renewal. (See Appendix A, pages 18-20)

Additional comments: The LaMEDS log tables were considered by the auditor. For one exception, the renewal date was set at 7/31/2019, and there was no evidence of any systems being checked within the data logs provided by LDH during state fiscal year 2021.

For the remaining three exceptions, the renewal date was set to 12/31/2099, and there was no evidence of any systems being checked within the data logs provided by LDH during state fiscal year 2021. We believe that setting an indefinite date of 12/31/2099 ultimately suspended renewals. Although CMS granted flexibilities for completing the renewals at a future date, it did not appear that CMS was granting approval for suspension of renewals. CMS also notified LDH that federal regulation requires the agency to document the reason for the delay in each case record; LDH agreed that there was no particular documentation regarding suspensions in the case notes. We considered the log tables which indicated the renewals were set to a future date, but we do not

believe that the indefinite date of 12/31/2099 alone sufficiently documents the reason for the delay in the case record as required by 42 CFR 435.912(f).

For the errors related to case transitions, the transitions were not performed until the next scheduled renewal, which is not considered timely in accordance with LDH's Medicaid Eligibility Manual and federal regulations. Under the PHE, there were no restrictions on transitioning these recipients between programs. Therefore, we do not believe the requirement was met.

Inadequate Controls Over and Noncompliance with National Correct Coding Initiative Requirements

LDH failed to properly implement and monitor National Correct Coding Initiative Requirements (NCCI) for Medically Unlikely Edits (MUE) and Procedure-to-Procedure (PTP) edits for the Medicaid Fee-for-Service (FFS) claims. MUE is an edit on claims in which the number of units billed on the claim are more than what is considered necessary/allowed for a particular procedure code and PTP is an edit on claims in which one specific procedure code is not allowed to be billed with a different specific procedure code on the same recipient on the same day by the same provider. Federal regulations require State Medicaid agencies to incorporate NCCI edits into the State Medicaid program for FFS claims. Federal regulations and NCCI Medicaid Technical Guidance Manual contains requirements for implementation of the NCCI methodologies.

Our testing of NCCI edits included all FFS claims for durable medical equipment (DME), outpatient hospital service (OP), and practitioner and ambulatory surgical center (PRA) paid in state fiscal year 2021. These claims were subject to two edit types: MUE and PTP.

In a test of 11,744,241 paid claims to determine if the proper NCCI MUE and PTP edits had been implemented, the following was noted:

- 21,022 claims for DME, OP, and PRA were paid but should have been evaluated by an NCCI MUE and denied. These NCCI MUE edit errors resulted in questioned costs of $818,620 ($602,372 federal funds and $216,248 state funds). LDH noted that required NCCI MUE edits have not been applied to OP and DME FFS claims due to system constraints.

- 173 claims for DME, OP, and PRA were paid but should have been evaluated by an NCCI PTP edit and denied. These NCCI PTP edit errors resulted in questioned costs of $4,582 ($3,394 federal funds and $1,188 state funds).

The errors noted occurred due to inadequate NCCI edit monitoring procedures by LDH and instances of noncompliance with the federal regulations and guidance manuals. Failure to properly implement and enforce all required NCCI edits increases the likelihood that FFS claims, which should be denied, could potentially be paid. Management should ensure all required NCCI edits are properly applied to FFS claims. Management partially concurred with the finding and provided a corrective action plan. (See Appendix A, pages 21-23)

Additional Comments: Management's response stated, "The data pull does not consider historical claims or the final adjudication." However, LLA data analysis included historical claims and final adjudication for FFS claims paid in state fiscal year 2021.

Inadequate Controls over Drug Rebate Collections

LDH did not have adequate controls in place to monitor its contract with Magellan Medicaid Administration, Inc. (Magellan) and was unable to identify a control that would address the timely collection of partially paid drug rebates invoices. Without procedures to address drug manufacturers (manufacturers) that do not pay the entire quarterly balance, there is a risk that appropriate rebates will not be collected.

Federal regulations require manufacturers that wish to have their covered outpatient drugs covered by Medicaid to enter into an agreement under which the manufacturers agree to pay rebates for drugs dispensed and paid for by state Medicaid agencies under the state plan. Those rebates are shared between the state and federal government. Drug rebates are to be paid by the drug manufacturers no later than 30 days after the date of receipt of the utilization data from the state or provide notice of disputed items not paid because of discrepancies found. The state should perform follow up procedures to attempt to collect any unpaid balances in a timely manner.

LDH contracted with Magellan for support in performing the federal and supplemental drug rebates processing for the LDH Medicaid program, including but not limited to invoicing, reconciliation, dispute resolution, and follow up on manufacturer non-payment and aged balances for all of LDH's Medicaid drug rebate programs. The contract sets a frequency in which a written delinquency notice (dunning notice) should be sent to manufacturers with unpaid invoices, but does not address manufacturers who make partial payments towards their quarterly invoice. Magellan personnel confirmed that dunning notices are only sent to manufacturers who have not made any payments towards an invoice. For instance, and as described by Magellan, Magellan would not send a dunning notice to a manufacturer who submits a partial payment of even a penny.

In a sample of 60 drug rebate invoices, three tested (5%) revealed only a partial payment had been collected and no disputes had been made by the manufacturer. Magellan personnel also confirmed that a dunning notice was not sent to these manufacturers for the unpaid balances.

LDH should ensure that agency personnel are adequately monitoring contract provisions for the drug rebate program and follow-up procedures are performed for all drug rebate invoices that have not been fully collected or disputed in a timely manner. This may include LDH amending the contract with Magellan to address those manufacturers who only make partial payments towards their invoice balance. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 24-25)

Inadequate Controls over Billing for Behavioral Health Services

For the third consecutive year, LDH, the managed care organizations (MCOs), and Magellan did not have adequate controls in place to ensure that behavioral health services in the Medicaid and CHIP programs were properly billed and that improper encounters were denied. For fiscal year 2021, we identified approximately $8.4 million in encounters for services between July 1, 2020, and June 30, 2021, that were paid by the MCOs and Magellan even though the encounters do not appear to comply with LDH's encounter coding requirements and/or approved fee schedules. The billing errors could be avoided by LDH, the MCOs, and Magellan applying system edits that would flag encounters for further review when encounter coding and/or fee schedule requirements are not followed. Our analysis identified the following instances of billing errors:

- Providers were paid $6,946,683 for 113,224 encounters that were billed using incorrect procedure and modifier codes. LDH's fee schedule outlines procedure codes for services and the applicable billing rates. Some services require that procedure codes also contain modifier codes which indicate information such as the age of the recipient, location where the service was provided, the educational background of the person providing the service, and the license(s) they have obtained. Without the required modifiers, the encounter does not contain enough information to determine that the billing was appropriate.

- Providers were paid $1,462,493 more than indicated on approved fee schedules for 26,707 encounters for behavioral health services. The approved fee schedules outline different rates depending on the procedure code and modifier codes. The MCOs can optionally pay more than the minimum LDH fee schedule. However, LDH does not currently maintain a list of these providers and therefore cannot determine if an encounter paid at an excessive rate was improperly billed. For the amount noted above, the MCOs confirmed that they did not have alternative fee schedules.

It is important that encounter data is accurate because LDH and other stakeholders, such as the Medicaid Fraud Control Unit within the Attorney General's Office, use this data to identify improper payments and potential fraud. LDH also uses this encounter data to establish per member per month rates for the MCOs.

LDH management should implement adequate internal controls to ensure that encounters are coded correctly, which could include edit checks to flag potential improper billings for further review. Management concurred with the finding and provided a corrective action plan. (See Appendix A, page 26)

Inadequate Controls over Payroll – Office of Public Health

LDH, OPH did not ensure payroll expenditures were timely certified and approved for the Public Health Emergency Preparedness program, the HIV Prevention Activities Health Department Based program, the Epidemiology and Laboratory Capacity for Infectious Diseases program, the WIC Special Supplemental Nutrition Program for Women, Infants, and Children, and the Coronavirus Relief Fund program. This is the second consecutive year payroll internal control

deficiencies have been reported for Public Health Emergency Preparedness, HIV Prevention Activities Health Department Based, and Coronavirus Relief Fund. Exceptions for each federal program are as follows:

- For the Public Health Emergency Preparedness program, we selected a sample of 60 payroll transactions tested from a population of 1,444 transactions totaling $3,717,081. Twenty-seven (45%) time statements were not timely approved by the employees' supervisors, of which ten (17%) were not approved at all, and two (3%) were not certified by the employees.

- For the HIV Prevention Activities Health Department Based program, we selected a sample of 60 payroll transactions tested from a population of 1,039 transactions totaling $434,959. Twenty-two (37%) time statements were not timely approved by the employees' supervisors, of which five (8%) were not approved at all, and two (3%) were not certified by the employees.

- For the Epidemiology and Laboratory Capacity for Infectious Diseases program, we selected a sample of 40 payroll transactions tested from a population of 1,509 transactions totaling $2,280,115. Seventeen (43%) time statements were not timely approved by the employees' supervisors, of which ten (25%) were not approved at all, and three (8%) were not certified by the employees.

- For the WIC Special Supplemental Nutrition Program for Women, Infants, and Children, we selected a sample of 25 payroll transactions tested from a population of 6,535 transactions totaling $9,592,395. One (4%) of 25 time statements was not timely approved by the employee's supervisor and was approved 143 days after the posting date.

- For the Coronavirus Relief Fund program, we reviewed 100% of the time statements from April 5, 2021 through June 27, 2021, in which we identified 802 (10%) of 7,884 time statements that were not approved by the employees' supervisors.

As a result of the high exception rates noted above, additional procedures were performed to determine the exception rate of time statements that were not certified or approved for all OPH employees during the entire fiscal year. OPH uses electronic time statements, which allows for an electronic determination of employee certification and supervisor approval. Based on audit procedures conducted on all payroll transactions in fiscal year 2021, we identified 2,050 (6%) of 36,374 time statements that were not certified by employees and 5,049 (14%) of 36,374 time statements that were not approved by the employees' supervisors, which includes the exceptions noted above for each program.

State policy requires employees and supervisors to certify and/or approve time statements for accuracy by 10:00 p.m. on the Wednesday following the close of the pay period. Time administrators are responsible for reviewing the LaGov ZP 241 eCertification report prior to processing to identify any employees who have not certified their time statements and any supervisors who have not approved their staff's time statements. Federal regulations require that

records must be supported by a system of internal control, which provides reasonable assurance that the charges are accurate, allowable, and properly allocated. Furthermore, the records must comply with the established accounting policies and practices of the non-federal entity. OPH lacked sufficient controls to ensure electronic time statements were properly certified and approved prior to the posting date in accordance with federal and state regulations.

Failure to adequately approve program expenditures increases the risk that unallowable costs could be reimbursed by the federal grantor. OPH should ensure employees comply with existing policies and procedures, including properly certifying and approving electronic time statements in a timely manner. Management concurred with the finding and provided a corrective action plan. (See Appendix A, page 27)

Inadequate Controls Over Payroll – Office of Behavioral Health

LDH, Office of Behavioral Health (OBH), did not ensure payroll expenditures were approved in accordance with agency policy. These expenditures were submitted to the Division of Administration (DOA) for reimbursement by the Coronavirus Relief Fund (CRF) program.

In a sample of 40 payroll timesheets from a population of 30,582 transactions submitted by LDH for reimbursement totaling $69,440,828, we noted three (8%) instances at Central Louisiana State Hospital and Eastern Louisiana Mental Health System where payroll documentation was not approved by the payroll posting date as required by agency policy and used to request reimbursement from DOA.

Federal regulations require that charges to federal awards for salaries and wages must be based on records that accurately reflect the work performed and these records must be supported by a system of internal control which provides reasonable assurance that the charges are accurate, allowable, and properly allocated. OBH payroll policies require supervisors to approve timesheets and supporting documentation in a timely manner. OBH lacked sufficient controls to ensure all payroll timesheets were properly supported, in accordance with federal regulations and agency policy, and approved prior to the payroll posting date. Failure to maintain adequate supporting documentation, including proper approvals of program expenditures, increases the risk that unallowable costs could be reimbursed by the federal grantor.

OBH should ensure employees comply with existing policies and procedures, including properly approving timesheets in a timely manner and maintaining adequate documentation to support all expenditures of federal awards. Management concurred with the finding and provided a corrective action plan. (See Appendix A, page 28)

Inadequate Controls over Waiver and Support Coordination Service Providers

For the tenth consecutive year, LDH paid Medicaid Home and Community Based Services (HCBS) claims for the New Opportunities Waiver (NOW) for waiver services that were not documented in accordance with established policies. In addition, for state fiscal year 2021, LDH also paid claims for support coordination services that were not documented in accordance with

established policies. These errors resulted in questioned costs of $28,896 ($21,243 federal funds and $7,653 state funds).

Our testing of waiver services included 670 claims paid in state fiscal year 2021 totaling $115,245 paid to two providers for 11 recipients. The recipients received services from one waiver type, NOW. NOW is administered by the LDH, Office for Citizens with Developmental Disabilities (OCDD). Auditors used LDH's provider manuals to identify required documentation. Provider manuals are intended to give a provider the information needed to fulfill its vendor agreement with the state of Louisiana, and is the basis for federal and state reviews of the program. Our test identified errors for 166 claims, totaling $28,431; some claims having multiple errors. The following errors were noted.

- For six claims for three recipients, the waiver services provider did not provide documentation to support consistent deviations from the approved plan of care (POC).

- For 109 claims for ten recipients, the waiver services provider did not provide adequate documentation to support billed services.

- For 60 claims for one recipient, the waiver services provider did not have an adequate POC present in the case records therefore, we were unable to determine if a deviation from the POC occurred.

LDH HCBS waivers implemented electronic visit verification (EVV) in fiscal year 2019. EVV is a web-based system that electronically records and documents the precise date, start time, and end times that services are provided to recipients. Time documented through EVV should be the time billed to Medicaid for services. Providers are required to maintain certain other supporting documentation to support all time billed.

The recipients case record is required to include a copy of the approved POC, including any revisions. The POC documents the recipient's assessed needs and types and quantity of services to address those needs and costs related to services. Direct service providers provide care to a recipient based on the approved POC. According to the NOW provider manual, an occasional or temporary deviation from a recipient's scheduled services is acceptable as long as the services altered are recipient-driven, person-centered, and occur within the prior authorization. Without adequate documentation, a provider cannot substantiate and auditors cannot verify that the deviations were recipient-driven and person-centered as required.

Waiver services are accessed through support coordinators who assist with development and monitoring of the recipient's POC. In addition to testing waiver services, we also tested claims paid for support coordination services for the 11 waiver recipients tested. In our test of 130 claims paid in state fiscal year 2021 totaling $20,036 paid to four support coordination providers for the 11 recipients, the following was noted:

- For three claims for two recipients, the support coordination service provider did not provide adequate documentation to support billed services. These claims totaled $465.

According to the LDH service coordination provider manual, service logs are the means for clearly documenting services billed and must be reviewed by supervisors.

The errors noted in testing occurred because LDH failed to ensure that NOW waiver and support coordination providers follow LDH policies related to proper record keeping and supporting documentation. Without adequate supporting documentation and compliance with LDH established policies there is reduced assurance that billed services were actually performed, recipients are receiving needed services, and limited resources are allocated appropriately.

LDH should ensure all departmental policies for waiver and support coordination services are enforced, including documentation to support claims and evidence that deviations from the approved POC meet the needs of the recipient. LDH should consider additional provider training regarding documentation requirements. Management concurred in part with the finding and provided a corrective action plan. (See Appendix A, pages 29-31)

Additional Comments: Management noted that OCDD sent documentation to the LLA, but the finding does not reflect the information.

During one provider's site visit, incomplete supporting documentation was provided by the provider. After the auditor questioned the supporting documentation, the provider provided documentation that appeared to have been altered. As a result, LLA did not accept this documentation or other documentation from this provider.

During other site visits, supporting documentation could not be provided for selected test items, with one provider informing us that the documentation was never completed/submitted by the provider's staff prior to termination of employment. Providers are required to maintain supporting documentation and make such documentation available to the auditor in a reasonable time.

Inadequate Controls over Backup and Recovery - OPH

On October 20, 2021, an Office of Technology Services (OTS) employee unknowingly deleted critical supporting financial records, including certain supporting schedules for its SEFA, on an OPH server during a workstation operating system upgrade. In addition, OTS contracted with a vendor to perform various tasks, including backups, without any prescribed procedures. The contractor performed periodic backups of this data on a USB drive, rather than using more secure and reliable backup processes. OTS recovered the previously deleted records on December 22, 2021, two months after the initial loss.

OPH did not identify the criticality of the workstation's data to OTS to ensure inclusion on the inventory of OPH's data during its Business Impact Analysis. As a result, OTS was unaware of the information on the affected server and did not prioritize security of its data and monitoring of the contractor's services. In addition, the OTS employee performing the workstation upgrade did not properly communicate with the contractor before performing the upgrade, and problems restoring the backup caused additional delays.

We evaluated IT controls based on the *Control Objectives for Information and Related Technologies* (COBIT) framework by ISACA[1] and the OTS Information Security Policy. According to COBIT APO 8.04, agencies should properly coordinate and communicate changes with all relevant stakeholders. Per COBIT DSS 4.07, agencies should also establish requirements for on-site and off-site backup storage and properly consider frequency, mode of backup, type of backup, and type of media. According to the OTS Information Security Policy – Information Asset Management, agencies should identify all information assets and their value to support any operational impact analysis.

The failure to identify the existence of the server with critical data to OTS and failure by the OTS employee to communicate with the contractor prior to performing the workstation upgrade resulted in a loss of data. The use of unreliable backup methods by the contractor increased the risk of incomplete, untimely data restoration.

OPH should ensure all critical data is identified to OTS for proper consideration in the Business Impact Analysis. OTS should properly coordinate all critical operations, including upgrades, with relevant contractors and ensure communication of prescribed methods of backup to contractors that provide for the complete and efficient restoration of data. Management did not concur with the finding. Management asserts that the data was never in jeopardy of being lost or unprotected and was never identified as critical data. (See Appendix A, pages 32-33)

Additional Comments: OPH personnel notified auditors via email on November 9, 2021, that the data was lost on October 20, 2021, when OTS performed an upgrade to Windows 10 by reimaging over the data. Although OPH was able to recreate supporting schedules from other systems after the reimaging, it was still unable to timely restore its original work and could not originally provide a timeline for the restoration due to challenges it communicated to the auditors, expressing that it appeared "bleak" that it could be recovered. Since this data supports the amounts on the SEFA, OPH should have identified it as critical to financial reporting.

Inadequate Controls over Monitoring of Abortion Claims

For the third consecutive year, LDH did not have adequate controls to ensure compliance with federal regulations prohibiting the use of federal funding for abortion claims. As a result, claims paid by the managed care health plans for abortion services that do not meet exceptions noted in federal regulations may go undetected and LDH may accept these improper claims as encounter claims. Under managed care, LDH pays the health plans monthly premiums for enrolled recipients. The health plans pay provider claims for services provided to enrolled recipients and submit the claims to LDH as encounter claims. Encounter claims are considered in future premium rate setting and are used for reporting and monitoring of Medicaid and CHIP.

LDH included provisions in the Healthy Louisiana managed care contracts requiring the health plans to comply with the federal regulations regarding funding of prohibited abortion services, but LDH did not have adequate procedures in place to monitor the health plans' compliance with the federal regulations. While LDH received monthly self-reported information from the health plans,

[1] Formally known as the Information Systems Audit and Control Association, ISACA is an international organization that provides standards for IT governance.

management confirmed that the reported information was not being compared to encounter data or validated in any other way to ensure the reporting was accurate and complete. In addition, the instructions provided to the health plans concerning how to complete the reports are not detailed and could potentially lead to all five health plans reporting different information.

Federal requirements prohibit Medicaid and CHIP funding for abortion services except in instances where abortion is necessary to save the mother's life or if the pregnancy is the result of an act of rape or incest.

LDH should develop procedures to validate self-reported information from the health plans to ensure compliance with federal regulations regarding funding of prohibited abortions claims. Management concurred in part with the finding and provided a corrective action plan. (See Appendix A, pages 34-36)

Noncompliance with Prenatal Service Third-Party Liability Requirements

For the third consecutive year, LDH failed to implement controls to ensure compliance with third-party liability (TPL) requirements for prenatal and pregnancy related services. As a result, the managed care health plans may have paid for services that should have been cost avoided. Managed care claims payments are sent to LDH as encounters which are used by LDH's actuary for future rate setting.

Federal regulations require that Medicaid and CHIP are the payers of last resort. In most cases, federal law requires states to apply cost avoidance measures to claims by which all other payers are identified and payments from those identified payers are applied to the claim first. Federal funds would then be used for the remaining balance as applicable. Previously, regulations considered prenatal and pregnancy related services an exception to the cost avoidance requirement and required States to pay prenatal and pregnancy related claims without regard to any other liable third party. States could seek to recover payments from another liable third party at a later date through a process known as pay and chase. The Bipartisan Budget Act of 2018 (Public Law 115-123) revised the Social Security Act, the authorizing legislation for Medicaid and CHIP programs, to eliminate the cost avoidance exception for prenatal services and pregnancy related services effective February 2018.

The Medicaid Eligibility manual was updated in June 2021, the General Information and Administration Provider manual was updated in April 2021, and the MCO contracts were updated effective January 2021 to reflect the revised requirement. LDH also issued a Health Plan Advisory in April 2021 directing the health plans to make required system changes to comply with the revised requirement. While LDH updated manuals, policies, and contracts, LDH did not implement controls to monitor managed care plan compliance with the revised regulation.

LDH should ensure that the Medicaid and CHIP programs are the payers of last resort by ensuring that cost avoidance measures are applied by the managed care health plans for prenatal services and pregnancy related services as required by federal regulations. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 37-38)

Inadequate Controls Over Service Providers with Closed Enrollment

For the second consecutive year, LDH paid claims totaling $6,833 ($5,032 in federal funds and $1,801 in state funds) in state fiscal year 2021 with service dates occurring after the service providers were no longer enrolled. LDH lacked adequate procedures to ensure claims are only paid for service dates in which the service provider is enrolled. Payments made for services provided on dates that service providers are not enrolled in the program increases the risk that payments were made to providers that should not be providing services to Medicaid and CHIP recipients.

LDH enrolls FFS providers into the Medicaid and CHIP programs which includes entering into provider agreements as required by federal regulations. Provider enrollment can end for various reasons, such as inactivity for a prolonged period, state or federal exclusion, license issues, or the provider elects to terminate enrollment.

In an analysis of 23,611 service providers with claims activity during fiscal year 2021, we noted 184 providers with enrollment end dates during the fiscal year or prior. Of the 184 providers, we noted 21 providers with claims paid for service dates after the providers' enrollment end date. After reviewing this analysis and information with LDH, errors were noted for eight providers as detailed below.

- Five providers with Medicare crossover claims totaling $4,990 in which LDH did not ensure the service providers were enrolled in Medicaid on the service dates being billed. Even if a provider is enrolled with CMS as a Medicare provider, the provider must be enrolled as a Medicaid provider to perform and be paid for services in the Medicaid programs.

- One provider with claims paid totaling $1,076 in which the enrollment end date was applied retroactively by LDH; however, LDH had already paid claims for service dates that were after the applied enrollment end date.

- One provider with claims totaling $767 in which the provider's license had expired. The provider was given the following month to send in its renewal application, during which time the provider was allowed to continue to submit claims for payment. The provider did not renew its license within the allotted timeframe; therefore, the original expiration date should have been the end enrollment date.

- One provider had a change of address, which generated a new license number. This process resulted in the provider being incorrectly disenrolled. While the provider did have claims paid for service dates after the erroneous end enrollment date, the claims are not considered improper due to the error by LDH. This error could have been identified if LDH had a review process.

LDH should ensure provider enrollment end dates are entered accurately and should develop and implement procedures to ensure claims are only paid for dates of service during time periods in which the provider was enrolled in the program. In cases of retroactive closures, LDH should develop and implement procedures to consider and address, as necessary, any claims already paid

during that retroactive closure period. Management concurred with the finding and provided a corrective action plan. (See Appendix A, pages 39-41)

Noncompliance with Third-Party Liability Assignment

For the fifth consecutive year, LDH failed to maintain evidence of notification of TPL assignment as required for eligibility in the Medicaid and the CHIP programs. Per federal regulations, Medicaid is the payer of last resort. As a condition of eligibility, each applicant/enrollee must assign to the state their individual rights to medical support and other third-party payments, and such rights of any other eligible individuals under their legal authority. By state law and per LDH policy, TPL assignment is automatic but notification must be provided to the applicant/enrollee. Historically, LDH provided notification to an applicant/enrollee by including assignment language on Medicaid and CHIP applications. LDH utilizes both paper and electronic applications.

Prior to the new eligibility system, LaMEDS, implemented in 2018, TPL assignment language was not included as part of electronic application summaries in all recipient case records. LDH planned corrective action in conjunction with the launch of LaMEDS, but LDH's corrective action was prospective in nature and did not attempt to remedy cases in which recipients with case files lacking TPL assignment notification do not complete a new application in LaMEDS. In response to the fiscal year 2020 finding, LDH planned to include the notification in Decision Letters for all approvals and renewals which each recipient would receive at least annually. Although, the decision letters included the TPL assignment notification beginning in October 2020, LDH did not send decision letters to most recipients/enrollees during fiscal year 2021 and was unable to provide adequate evidence regarding the number of recipients' case files still lacking the notification.

Third parties are legally-liable individuals, institutions, corporations (including insurers), and public or private agencies who are or who may be legally responsible for paying medical claims. Without the assignment of TPL rights, the state may be at risk for payments that should be the legal obligation of another party.

LDH should ensure notification of TPL assignment is provided to each recipient and support is maintained in each Medicaid and CHIP recipient case record as part of required documentation to support the eligibility decision. Management concurred in part with the finding and provided a corrective action plan. (See Appendix A, pages 42-43)

Annual Comprehensive Financial Report – State of Louisiana

As a part of our audit of the Annual Comprehensive Financial Report for the year ended June 30, 2021, we considered internal control over financial reporting and examined evidence supporting LDH's Medical Vendor Payments (Agency 306) non-payroll expenditures, federal revenue, Medicaid current and non-current accruals, federal disallowed cost, and critical information systems and related user controls.

Based on the results of these procedures, we reported a finding related to Inadequate Controls over Annual Financial Reporting, as described previously. In addition, the account balances and classes of transactions tested, as adjusted, are materially correct.

Federal Compliance - Single Audit of the State of Louisiana

As a part of the Single Audit for the year ended June 30, 2021, we performed internal control and compliance testing as required by Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) on LDH's major federal programs, as follows:

- WIC Special Supplemental Nutrition Program for Women, Infants, and Children (Assistance Listing 10.557)
- Coronavirus Relief Fund (Assistance Listing 21.019)
- Public Health Emergency Preparedness (Assistance Listing 93.069)
- Immunization Cooperative Agreements (Assistance Listing 93.268)
- Epidemiology and Laboratory Capacity for Infectious Diseases (Assistance Listing 93.323)
- Children's Health Insurance Program (Assistance Listing 93.767)
- Medicaid Cluster (Assistance Listing 93.775, 93.777, and 93.778)
- HIV Prevention Activities Health Department Based (Assistance Listing 93.940)

Those tests included evaluating the effectiveness of LDH's internal controls designed to prevent or detect material noncompliance with program requirements and tests to determine whether LDH complied with applicable program requirements. In addition, we performed procedures on information submitted by LDH to the Division of Administration's Office of Statewide Reporting and Accounting Policy for the preparation of the state's SEFA and on the status of the prior-year findings for the preparation of the state's Summary Schedule of Prior Audit Findings, as required by Uniform Guidance.

Based on the results of these Single Audit procedures, we reported findings located in the Current-year Findings section. These findings will also be included in the Single Audit for the year ended June 30, 2021. In addition, LDH's information submitted for the preparation of the state's SEFA and the state's Summary Schedule of Prior Audit Findings, as adjusted, is materially correct.

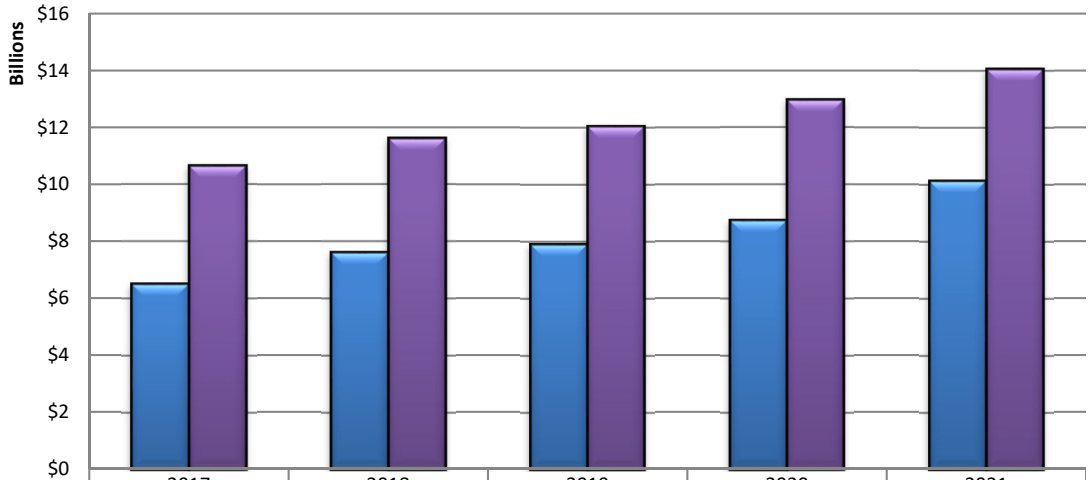
Trend Analysis

We compared the most current and prior-year financial activity using LDH's Annual Fiscal Reports and system-generated reports and obtained explanations from LDH's management for any significant variances.

Exhibit 1 provides an analysis of LDH's Healthy Louisiana managed care expenditures over the past five years which accounted for more than 70% of LDH's expenditures in Medical Vendor Payments in fiscal year 2021.

On Friday, March 13, 2020, the President declared a national emergency in response to the COVID-19 pandemic. Federal legislation authorized a 6.2% increase in federal Medicaid matching funds provided states meet certain conditions. As a result, LDH continued eligibility determinations and renewals, but could only remove recipients in very limited circumstances. Increased enrollment accounts for the majority of the increase in Health Louisiana expenditures.

Exhibit 1
Healthy Louisiana Managed Care Expenditures
Compared to Total Program
Five-Year Trend by State Fiscal Year



	2017	2018	2019	2020	2021
HEALTHY LOUISIANA	$6,498,739,297	$7,604,277,019	$7,903,544,878	$8,736,973,527	$10,127,059,232
TOTAL PROGRAM	$10,636,119,498	$11,596,329,818	$12,043,735,432	$12,950,115,160	$14,049,902,727

Source: Statewide Accounting and LDH Medicaid Year-End Financial Reporting

Other Reports

The Louisiana Legislative Auditor has other audit sections that issue reports regarding LDH. These reports are available on the Louisiana Legislative Auditor's website.

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

Under Louisiana Revised Statute 24:513, this letter is a public document, and it has been distributed to appropriate public officials.

Respectfully submitted,

Michael J. "Mike" Waguespack, CPA
Legislative Auditor

ABS:AHC:BH:EFS:ch

LDH2021

APPENDIX A: MANAGEMENT'S RESPONSES

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Public Health

June 15, 2022

Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
1600 North Third Street
P.O. Box 94397
Baton Rouge, LA 70804-9397

RE: Failure to Provide a Listing of Food Benefits Paid for the WIC Program

Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated May 23, 2022, regarding a reportable audit finding related to Failure to Provide a Listing of Food Benefits Paid for the WIC Program. LDH appreciates the opportunity to provide this response to your office's findings.

The Office of Public Health (OPH), Bureau of Nutrition Services (BONS) Management is committed to ensuring that the WIC Program has mechanisms in place to account for all program funds received and expended, including the electronic benefit transfer (EBT) claim reimbursements paid to WIC-authorized vendors (grocery stores) using WIC food expenditures, to demonstrate compliance with 2 CFR 200.302(a), 2 CFR 200.430(i), 7 CFR 246.13(a), and 7 CFR 246.13(c).

Finding: Failure to Provide a Listing of Food Benefits Paid for the WIC Program

Recommendation: OPH should continue to work with its contractor to develop a reporting mechanism to account for and track the costs of WIC food benefits paid by participants.

LDH Response: LDH does not concur with this finding.

Rationale: OPH-WIC has several reporting mechanisms in place to account for all program funds received and expended, including the EBT claim reimbursements paid to WIC-authorized vendors with federal funds designated for WIC food expenditures.

It is critical to understand that WIC benefits do not include any direct cash assistance to participants. Program participants receive benefits in the form of a food package (i.e.: two cartons of milk, one box of cereal, two loaves of bread, etc.) which have no set dollar value. The dollar value of specific food items that make up a WIC food package varies according to the price set by individual WIC-authorized vendors and the maximum reimbursement levels as established through required and USDA-approved WIC cost containment procedures. All Program cash expended for food package benefits is disbursed to WIC-authorized vendors per their claims, not to WIC participants.

OPH-WIC sets the maximum dollar amount for food package items per USDA policies and procedures related to not-to-exceed amounts (NTE) and maximum allowable reimbursement levels (MARL) as outlined in Bullet #3 on page 3. These procedures strictly control Program food costs, ensure integrity, and safeguard against misuse of Program funds, dictating a maximum allowable dollar amount that an authorized vendor may claim for each food item included in a food package (such as milk), sold to a WIC participant. Therefore, the LLA's reference to "food benefits paid to participants" throughout the preliminary Single Audit Report is erroneous and does not capture the actual process of benefit issuance and claim reimbursement. Bullets #2 and #3 on page 3 of this response provide further detail on benefit issuance and claim reimbursement.

OPH-WIC has made every attempt possible over the course of this audit to provide LLA with all data and supporting documentation as requested, as evidenced by a detailed timeline of requests and responses (available for review upon request), and will continue to do so. Data and documentation provided to date have included transactions paid to WIC-authorized vendors, EBT redemption amounts by clinic site, and EBT card transactions with redeemed food quantities. The LLA did not request transactions by card number until April 13, 2022. Upon receiving this request, OPH-WIC immediately provided clarification and requested a meeting. OPH-WIC explained the EBT transaction and claims process and the monitoring of WIC food expenditures, provided LLA with access to its management information system (MIS), and offered meetings on several occasions.

Additionally, OPH-WIC explained that a summary report detailing every transaction for every WIC participant in state fiscal year 2021 (SFY21) does not exist and would take tremendous time and effort to develop, resulting in millions of lines of data. Every WIC transaction is captured by the EBT processor (Solutran) and accounted for in the Solutran Online Account Reporting (SOAR) system. Each transaction is directly linked to an EBT card with one Primary Account Number (PAN) as assigned in the MIS. All data and transactions are accounted for in the OPH-WIC systems; however, although the summary report requested does not exist, OPH-WIC has prepared a report that outlines the manual process to review individual transactions by EBT card number using the existing MIS and EBT system. This, in addition to the details outlined below, demonstrates that OPH-WIC does have systems in place to account for all of the dollars paid to WIC-authorized vendors for WIC transactions completed via a WIC EBT card when participants redeem their benefits. These systems fully account for all cash that OPH-WIC pays Vendors who have provided participants food that is a part of their benefit package.

Further explanation and specific reasons why OPH-WIC does not concur with this finding and how it has tools in place to account for all Federal Program funds received and expended:

1. As part of the Healthy, Hunger-Free Kids Act of 2010, the United States Department of Agriculture (USDA), WIC's Federal Funder, mandated that all WIC State Agencies implement an EBT method by October 1, 2020. The Louisiana WIC transition to the EBT delivery of supplemental food benefits along with a new MIS was completed in October 2019, taking approximately five years and representing a fundamental shift in how Louisiana WIC operates. The new MIS, called the Louisiana WIC Information Network (LAWIN), replaced the outdated and error ridden Public Health Automated Management Enabler (PHAME) system. The new EBT delivery system replaced the outdated paper voucher-based system, allowing for the delivery of WIC benefits and reconciliation of payments through an EBT system that is cost-effective and efficient. Because of the

controls built into LAWIN and the EBT system, LA WIC has benefited from increased program integrity and efficiencies, further contributing to reductions in any potential fraud, waste, and abuse. Louisiana WIC complied with all of the EBT implementation requirements and remains compliant with its USDA-approved policies and procedures, including those specific to vendor EBT claim reimbursements and the monitoring of food fund expenditures.

2. In regards to benefit issuance, eligible and certified WIC participants must be categorically-eligible, income-eligible, residents of Louisiana, and at nutritional risk. Supplemental food benefits are prescribed to eligible and certified participants on EBT cards in the form of food packages with maximum monthly allowances as defined by federal regulations. One EBT card with one Primary Account Number (PAN) is assigned to one WIC-enrolled family and all WIC food benefits have start and end dates (first and last day of the issuance month). Using the EBT card, certified participants or caregivers can access WIC-approved food items that are linked directly to UPC/PLU codes found on the Approved Product List at WIC-authorized vendors. A flowchart summary of WIC EBT benefit issuance and redemption is available for review upon request.
3. In regards to vendor claim reimbursement, Louisiana WIC has established and implemented USDA-approved policies and procedures related to not-to-exceed amounts (NTE) and maximum allowable reimbursement levels (MARL) which apply limits to the amount of reimbursement allowed based on a vendor's peer group. Any WIC-approved food item presented for payment during the transaction settlement process that exceeds the NTE will have the reimbursement for that particular food item reduced to the NTE level. The post-payment MARL is the reimbursement level, based on vendor peer group. In addition, the State Agency makes price adjustments during month end processing to ensure the WIC-approved food item is not paid above the post-payment MARL. The evaluation of transactions for post-payment MARL adjustments adds an additional level of review for EBT transactions. All these measures ensure Louisiana WIC is compliant with retail food delivery system claims and vendor cost containment.
4. The LAWIN Advanced Find Redemption Report (available for review upon request) by EBT card number/PAN (family) showing food quantities redeemed by month by clinic was provided to LLA on May 6, 2022. This report demonstrates LAWIN's tracking of issuance and redemptions by PAN.
5. The Manual Review of WIC EBT Transactions by PAN (available for review upon request) demonstrates a process to review individual PAN/EBT card numbers against the individual transactions in the Solutran Online Account Reporting (SOAR) system to retrieve the dollar value of the food benefit redemptions at WIC-authorized vendors. These dollar values coincide with the reimbursements paid to vendors.
6. The Solutran Monthly Bank Statement (available for review upon request) details the daily EBT claim reimbursements made to vendors for one process month and serves as back up documentation to support federal drawdowns of food grant funds completed by LDH Fiscal.
7. The WIC EBT Distribution Report (available for review upon request) details a monthly breakdown of EBT claim reimbursements by WIC-authorized vendors and serves as back up documentation for the Solutran Monthly Bank Statement. These reports were provided to LLA on March 30, 2022.
8. As outlined in the above bullets, every expenditure can be tied to a food item reimbursed to a vendor that was part of a food package associated with a specific PAN on an EBT card issued to a WIC-eligible participant. However, since there is no automated summary report

available, this would have to be done manually for each PAN associated with a WIC participant/family. Using the manual method outlined in Bullets #4 and 5 on page 3, it took Program staff six minutes to do this for each transaction for one PAN. There are approximately eight transactions on one EBT card each month, which translates to 48 minutes for one PAN for one month and 9.6 hours of work to track reimbursements to vendors for one PAN for one year. Assuming there are on average two participants associated with one PAN and there are approximately 85,400 participants in SFY21, then there would be approximately 42,700 PANs to manually review for SFY21. Manually reviewing and compiling data for 42,700 PANs x 8 hours of work (rounded down from 9.6) would result in 341,600 hours of work requiring 164 FTE to complete this task in a one-year period of time. This amount of work could not be undertaken with the current BONS staffing.

Corrective Action Plan: OPH-WIC is in compliance and will remain in compliance with all federal regulations that require State Agencies to maintain a financial system that provides accurate, current, and complete disclosure of the financial status of the Program. The LAWIN MIS and EBT system (Solutran/SOAR) and WIC reports, as well as the existing LDH accounting system and procurement procedures, establish that OPH-WIC does have controls in place to adequately track and account for its federal program expenditures to demonstrate compliance in its financial processes and program integrity. OPH remains committed to collaboratively working with LLA on this audit and any future audits of the WIC Program. To assist with that collaboration, we would like to request that the LLA provide an entrance conference so they can better understand how the WIC Program works, to outline the scope of the audit and to determine what is feasible for the available staff to provide in a given period of time, as well as to identify a single point of contact for WIC as well as for LLA to centralize the multiple requests for documentation.

You may contract Jennifer Nicklas, BONS Director, at 225-342-7988 or via email at Jennifer.Nicklas@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary, Louisiana Department of Health

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

January 25, 2022

Mr. Michael J. "Mike" Waguespack, CPA
Legislative Auditor
P. O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Noncompliance with Managed Care Provider Enrollment and Screening Requirement

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated January 11, 2022, regarding a reportable audit finding related to Noncompliance with Managed Care Provider Enrollment and Screening Requirement. LDH appreciates the opportunity to provide this response to your office's findings.

Finding:
The Louisiana Department of Health (LDH) did not enroll and screen Healthy Louisiana managed care providers and dental managed care providers as required by federal regulations. Currently, the managed care plans continue to enroll and screen all managed care providers, in violation of federal regulations.

Recommendation:
LDH should ensure all providers are screened, enrolled, and monitored as required by federal regulations.

Response:
LDH partially concurs with your finding that LDH did not enroll and screen Healthy Louisiana managed care providers and dental managed care providers as required by federal regulations in 2021. LDH amended the Gainwell contract to accomplish provider revalidations, with CMS – approved funding. Gainwell was able to construct an online application portal, which launched in July 2021. Since then, 10,658 fee for service (FFS) and managed care organizations (MCO) providers have successfully gone through the

portal and submitted their application to be enrolled with 2,906 completing enrollment. While Gainwell continues to make user-friendly enhancements to the portal, LDH seeks a longer-term solution that will modernize the provider management system and achieve the CMS preference of modularity. LDH continues to keep CMS informed of our progress toward achieving compliance with CMS regulations.

You may contact Mr. Patrick Gillies, Medicaid Director by telephone at (225) 219-7810 or by email at Patrick.Gillies@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

CP/pg

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

March 25, 2022

Mr. Michael J. "Mike" Waguespack, CPA
Legislative Auditor
P. O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Noncompliance with Provider Revalidation and Screening Requirements

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated March 16, 2022, regarding a reportable audit finding related to Noncompliance with Provider Revalidation and Screening Requirements. LDH appreciates the opportunity to provide this response to your office's findings.

Finding:
The Louisiana Department of Health (LDH) did not perform five-year revalidations; screenings based on categorical risk of fraud, waste, or abuse; and monthly checks of the federal excluded party database, as required by federal regulations for all Medical Assistance Program (Assistance Listing 93.778, Medicaid) and Children's Health Insurance Program (Assistance Listing 93.767, CHIP) fee-for-service providers.

Based on information provided by LDH, approximately 76% of providers with claims activity in fiscal year 2021 have not had a risk-based screening with the majority of those providers enrolled more than five years ago.

In addition, LDH did not routinely check one of the required federal databases to determine if providers have been excluded from participation in federal programs. While LDH checked the List of Excluded Individuals/Entities (LEIE) on a monthly basis, it did not perform checks of the System for Award Management (SAM) monthly as required.

Recommendation:
LDH should ensure all providers are screened based on categorical risk level upon initial enrollment, re-enrollment, and revalidation of enrollment as required by federal regulations. Also, LDH should perform revalidation of enrollment on all providers at least every five years. In addition, LDH should ensure all required databases are checked at least on a frequency required by federal regulations.

LDH Response:

- LDH agrees with the finding that it did not perform five-year revalidations.

- LDH partially agrees with the finding that LDH did not perform screenings based on categorical risk of fraud, waste, or abuse (FWA). LDH has performed screenings based on categorical risk of FWA on all new FFS providers initially enrolled for several years. LDH agrees it has not performed screenings based on categorical risk of FWA on actively, enrolled FFS providers requiring revalidations in fiscal year 2021.

- LDH partially agrees with the finding that LDH did not perform monthly checks of the federal excluded party database, as required by federal regulations for all Medical Assistance Program (Assistance Listing 93.778, Medicaid) and Children's Health Insurance Program (Assistance Listing 93.767, CHIP) fee-for-service providers. LDH has performed monthly LEIE checks on all active FFS enrolled providers. LDH agrees it has not performed monthly SAMs checks on actively, enrolled FFS providers in fiscal year 2021.

- LDH agrees with the finding, "based on information provided by LDH, approximately 76% of providers with claims activity in fiscal year 2021 have not had a risk-based screening with the majority of those providers enrolled more than five years ago." LDH agrees it has not performed five-year revalidations using risk-based screenings on actively, enrolled FFS providers in fiscal year 2021.

- LDH agrees with the finding that LDH did not routinely check one of the required federal databases to determine if providers have been excluded from participation in federal programs. LDH agrees it has not performed monthly System for Award Management (SAM) checks on actively enrolled fee-for-service (FFS) providers for fiscal year 2021.

Corrective Actions:
LDH amended the Gainwell contract to accomplish provider revalidations, with CMS-approved funding in Amendments 20 and 21 dated January 2021. Since the launch of the online Provider Enrollment Portal, 20,461 FFS and

Managed Care Organization (MCO) providers have successfully completed or submitted their enrollment applications.

Gainwell, on behalf of LDH, is performing monthly monitoring on Enrollment Complete (EC) provider portal records against OIG-LEIE, CMS Medicare Exclusion Database (MED) and SAM databases. Gainwell checks these databases on all FFS providers at the time of new enrollment, re-enrollment, or a change of ownership including OIG exlcusions. Gainwell has performed categorical risk-level scoring for FFS providers upon initial enrollment for several years. All FFS revalidations which includes screening and risk-based scoring, are performed using the Provider Enrollment Portal which commenced on July 1, 2021. Monthly monitoring for the Provider Enrollment Portal project, which includes categorical risk level scoring for initial enrollment, re-enrollment and revalidations, is being conducted on all MCO and FFS providers. FFS monthly monitoring for SFY21 (July 1, 2020-June 30, 2021) and SFY22 (July 1, 2021-February 2022) documentation has been provided by Gainwell.

The LDH Program Integrity Section will begin performing monthly checks of the SAM database on FFS providers not yet revalidated or newly enrolled beginning March 2022.

LDH and Gainwell continue to make enhancements to the portal and processes to become fully compliant.

You may contact Patrick Gillies at (225) 219-7810 or via e-mail at Patrick.Gillies@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

CP/pg

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health

May 19, 2022

VIA E-MAIL ONLY

Mr. Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Lack of Internal Controls over Program Expenditures

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated April 25, 2022, regarding a reportable finding related to Lack of Internal Controls Over Program Expenditures of the Office of Public Health (OPH) Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) program. LDH appreciates the opportunity to provide this response to your office's finding.

The LDH's response to the LLA's finding, shown below, is delineated into three "sub-findings" detailed in the report. From LLA's sample of 60 payments:

- Sub-finding 1: Three (5%) were not approved by an appropriate supervisor.
- Sub-finding 2: Five (8%) did not include enough information to determine if the expenditure was appropriate and in accordance with federal regulations.
- Sub-finding 3: Eleven (18%) did not include enough information to determine if the account coding was accurate.

Finding: Lack of Internal Controls over Program Expenditures

Recommendation:
OPH should ensure that adequate internal controls are established and followed to ensure all expenditures of federal awards are adequately supported and approved by an appropriate supervisor.

LDH Response:
The OPH concurs with the finding and concurs with the recommendation.

Sub-finding 1: Three (5%) were not approved by an appropriate supervisor.

LDH Response to Sub-finding 1: The OPH concurs with this sub-finding.

The OPH were unable to provide evidence that all vendor invoices were approved by the appropriate supervisor.

Sub-finding 1 Corrective Action Plan:

- Program monitors, fiscal monitors, and leads for the ELC EDX grant meet biweekly. Starting at the May 3, 2022 meeting, the team will review the spreadsheet/Monday.com tracking process for invoices. Each department (BID, ID-EPI, BRCO, and Lab) maintains a spreadsheet or Monday.com board tracking the timeline of each invoice:

a. Receipt of invoice	b. Invoice and support documentation reconciliation
c. Approver signature	d. Payment memo (if needed) attached to invoice
e. Invoice packet saved to appropriate folder	f. Invoice packet uploaded to payment management (SharePoint)

- Beginning in May 2022, when invoices are submitted for processing, they will also be sent to the Program Manager for the grant who will review for appropriate management signature and to assure supporting documentation is included. In addition, the Program Manager for the grant and the Fiscal Lead will collaborate with the Office of Payment Management to ensure unsigned invoices are returned to the program for corrective action.

Sub-finding 2: Five (8%) did not include enough information to determine if the expenditure was appropriate and in accordance with federal regulations.

LDH Response to Sub-finding 2: The OPH concurs with this sub-finding.

In review of the auditor's final findings, the OPH concurs we are not able to provide evidence all vendor invoice activities were appropriate.

Sub-finding 2 Corrective Action Plan:

- At the May 3, 2022 meeting (described in the Sub-finding 1 response), the team will review the spreadsheet/Monday.com tracking process for invoices. Effective May 16, when invoices are submitted for processing, they will also be sent to the Program Manager of the grant, who will review for appropriate supporting documentation.

- The ELC EDX activity leads will meet separately to review current contract scopes of work and invoice supporting documentation for all vendors. They will:
  1) Evaluate the quality of supporting documents, and determine if any vendors must provide additional information.
  2) Determine if any amendments are necessary to reflect a change in the scope of work or payment schedule.
  3) Maintain a schedule of a quarterly review of invoices and contracts/amendments, to ensure there is no scope drift, and activities continue to be accurately reflected in the invoices and the contracts.

Sub-finding 3: Eleven (18%) did not include enough information to determine if the account coding was accurate.

LDH Response to Sub-finding 3: The OPH concurs with this sub-finding.

In review of the auditor's final findings, the OPH concurs we were not able to provide evidence all account coding was accurate to the auditor's satisfaction. Data transactions identifying coding that were submitted to the auditor demonstrating correct coding were not deemed acceptable as evidence of correct coding.

Sub-finding 3 Corrective Action Plan:

- For Payroll: Effective May 1, The Fiscal Lead sends email notifications to all staff and supervisors regarding all coding information and updates, including updates on the LaGov coding crosswalk.
- For non-Payroll: Effective May 1, Teams will utilize the LaGov coding crosswalk to verify correct codes and either make use of an official Payment Memo or save an email showing account coding assigned for any non-IT procurement (since OTS has an existing form for all IT purchases). Teams will not rely on verbal or in-person review of coding. Purchase Order and coding will be listed either on the invoice or in the SharePoint individual payment request notes section or on a

coversheet uploaded to SharePoint. The grant's Business Analyst and Program Monitor will perform monthly review of expenditures reports to identify coding errors and to ensure timely correction.

You may contact Dorian Gittleman, ELC EDX Program Manager by telephone at (347) 684-3148, or by email at dorian.gittleman@la.gov, or you may contact Dr. DeAnn Gruber, Director, Bureau of Infectious Disease, by telephone at (504) 568-7474, or by email at deann.gruber@la.gov with any questions concerning this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

CP/kh

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

December 9, 2021

Michael J. "Mike" Waguespack, CPA
Legislative Auditor
P. O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Controls Over Annual Financial Reporting

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of your correspondence dated November 18, 2021, wherein the Louisiana Legislative Auditor (LLA) notified LDH of a reportable finding related to inadequate controls over annual financial reporting. LDH appreciates the opportunity to provide this response to your findings. Along those lines, please allow this correspondence to serve as the LDH official response thereto.

Recommendation - LDH should strengthen its internal control over the financial reporting process to ensure accuracy of amounts provided to fiscal by program sections. In addition, management should perform a thorough review that will identify preparation errors and correct those errors before submission of reports to OSRAP for inclusion in the state's Annual Comprehensive Financial Report.

LDH Response - Management concurs that, for fiscal year 2021, LDH did not perform a comprehensive review of financial data before it was submitted to OSRAP for inclusion in the state's Annual Comprehensive Financial Report. LDH Management recognizes its responsibility to accurately report financial data.

LDH management will implement a corrective action plan that will encompass a thorough review of procedures to collect and review data from program offices and incorporate cross training amongst the Fiscal staff to ensure multiple levels of staff are trained to review the Medicaid AFR data before final submission. The anticipated completion date of this corrective action plan is June 30, 2022. Helen Harris, LDH Fiscal Director, is responsible for the execution and implementation of this corrective action.

You may contact Helen Harris, Fiscal Director, by telephone at (225) 342-9568 or by email at Helen.Harris@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

December 20, 2021

Michael J. "Mike" Waguespack, CPA
Legislative Auditor
P. O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Controls Over Required Reporting on the Schedule of Expenditures of Federal Awards

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of your correspondence dated December 8, 2021, wherein the Louisiana Legislative Auditor (LLA) notified LDH of a reportable finding related to inadequate controls over required reporting on the schedule of expenditures of federal awards LDH appreciates the opportunity to provide this response to your findings. Along those lines, please allow this correspondence to serve as the LDH official response thereto.

Recommendation - LDH should strengthen its internal control over the financial reporting process to ensure accuracy of amounts provided to fiscal by program sections. In addition, management should perform a thorough review that will identify preparation errors and correct those errors before submission of reports to OSRAP for inclusion in the state's Annual Comprehensive Financial Report.

LDH Response - Management concurs with this finding.

LDH Management will implement a corrective action plan that will encompass a thorough review of procedures to collect and review data from program offices and incorporate cross training among the Fiscal staff to ensure multiple levels of staff are trained to review the Medicaid Annual Financial Reporting data before final submission. The anticipated completion date of this corrective action plan is June 30, 2022. Helen Harris, LDH Fiscal Director, is responsible for the execution and implementation of this corrective action.

You may contact Helen Harris, Fiscal Director, by telephone at (225) 342-9568 or by email at Helen.Harris@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health

May 18, 2022

Mr. Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Internal Controls over Eligibility Determinations

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated May 9, 2022, regarding a reportable audit finding related to Inadequate Controls over Eligibility Determinations. LDH appreciates the opportunity to provide this response to your office's findings.

The Management of the Bureau of Health Services Financing (BHSF), which is responsible for the Medicaid program in Louisiana, is committed to ensuring that proper eligibility determinations and renewals are completed and recipients meet all eligibility factors.

Finding: Inadequate Controls over Eligibility Determinations

Recommendation: LDH should ensure its employees follow procedures relating to eligibility determinations and redeterminations in the Medicaid and CHIP programs to ensure the case records support the eligibility decisions.

LDH Response: LDH does not concur with this finding.

As mentioned in the Medicaid Audit Unit's report, the audit covered SFY21, which ended June 30, 2021. The entire audit period occurred during an unprecedented Public Health Emergency (PHE). The national declaration of the COVID-19 PHE and passage of the Families First Coronavirus Response Act (FFRCA) in response to the PHE impacted "normal" federal and state Medicaid and CHIP policy and procedures. The federal Centers for Medicare & Medicaid Services (CMS) which has oversight of the Medicaid and CHIP programs has also issued a number of guidance documents which set forth and at times changed actions and steps states should be taking to comply with the FFRCA continuous eligibility provision, as well as preparing for the end of the PHE.

Program decisions that affected normal policy and procedures were made based on guidance at that particular time while also being cautious not to jeopardize enhanced federal matching funds under the FFRCA by inappropriately terminating an individual's coverage during the PHE.

Audit staff indicated four instances of beneficiaries not having renewals performed and documented per the Medicaid eligibility manual. LDH provided documentation of a March 25, 2020 request for concurrence from CMS on certain flexibilities in meeting the timeliness of Medicaid renewals in accordance with 42 CFR § 435.912(e)(2) and subsequent email response from CMS which stated, in part:

> Louisiana has indicated that the agency expects that it will be unable to meet timeliness requirements for processing applications, completing renewals and acting on changes in circumstances through the duration of the emergency. We understand that to prevent coverage from being terminated inappropriately if Louisiana is unable to complete renewals timely, the agency may need to set a future renewal date in the eligibility system. Federal regulation at 42 CFR 435.912(f) requires the agency to document the reason for delay in each applicant's and beneficiary's case record.

LDH, as did other states, used this flexibility to suspend renewals during the PHE. LDH continued to try and process renewals through an ex parte basis and only suspended those that would require requesting information from beneficiaries. While there was no particular documentation in the "case note" section of the Louisiana Medicaid Eligibility Determination System (LaMEDS), LDH provided Audit staff with LaMEDS log tables which indicated the renewals were set to a future date. LDH firmly believes the "case record" contemplated in CFR 435.912(f) includes all aspects of data repositories or system actions in the case, along with text fields in the case notes and the documents in the LDH document management system. In accordance with 42 CFR 433.112(b) and 45 CFR 164.312(b), LaMEDS logs system activity and enables the State to examine system actions.

Audit staff also cited three instances of beneficiaries not transitioning to other coverage groups when aging out of the current coverage group (i.e. turning age 19 and transitioning out of child related programs). To ensure compliance with the FFRCA at the beginning of the PHE, LDH made the decision to stop processing the jobs for those aging out of coverage groups to mitigate the possibility of cases inappropriately closing or transitioning to one with lesser benefits. With later clear guidance from CMS on acceptable transitions, LDH again started processing the age out jobs and transitioning beneficiaries when appropriate. Due to system and workload considerations, it was decided for

those not previously processed under the age out job to be reviewed for transition at their next scheduled renewal.

LDH did agree with Audit staff in one instance there was not sufficient information in the case record to support an eligibility decision for a short coverage period. However, the other instances cited were the result of decisions made and documented and taken together, LDH does not agree there was a lack of internal controls over eligibility determinations that warrant a finding.

You may contact Tara Leblanc, Medicaid Deputy Director, at (225) 317-4484 or via e-mail at Tara.Leblanc@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

CP/pg

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health

June 10, 2022

Mr. Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Controls Over and Noncompliance with National Correct Coding Initiative Requirements

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated May 24, 2022, regarding a reportable audit finding related to Inadequate Controls Over and Noncompliance with National Correct Coding Initiative (NCCI) requirements. LDH appreciates the opportunity to provide this response to your office's findings.

The Management of the Bureau of Health Services Financing (BHSF), which is responsible for the Medicaid program in Louisiana, is committed to ensuring that Medicaid fee-for-service (FFS) claims are properly edited and reimbursed.

Finding: Inadequate Controls Over and Noncompliance with National Correct Coding Initiative Requirements

Recommendation: Management should ensure all required NCCI edits are properly applied to FFS claims.

LDH Response: LDH partially concurs with this finding.

LDH disagrees with the premise that a simple data pull compared with NCCI quarterly files represents an accurate and final adjudication of claims in a claims processing system. LDH disagrees that such a data pull could be used as the basis of a determination of inappropriate adjudication.

The data pull does not consider historical claims or the final adjudication. Our review located examples outside of the processing dates utilized by LLA of the NCCI edits being correctly applied in subsequent processing dates. A single data pull by the LLA may not dependably reflect the accurate final outcome of the applied edits.

Fee-for-service (FFS) NCCI editing occurs within the integrated Change Healthcare (CHC) 'ClaimCheck' product. System constraints of both the fiscal intermediary and 'ClaimCheck' preclude applying NCCI Medically Unlikely Edits (MUE) to outpatient hospital and durable medical equipment (DME) claims.

The LLA has been previously informed that Medicaid FFS is working with the fiscal intermediary and Change Healthcare to implement and integrate the newest version of the clinical editing product, 'ClaimsXten' which houses the complete Medicaid NCCI editing. This product replaces 'ClaimCheck' and will not have the same constraints in applying NCCI edits. LDH is currently in the process of converting to 'ClaimsXten'. The estimated completion date is end of calendar year 2022 or early 2023.

The LLA is also aware that FFS Medicaid applies the Medicaid NCCI 'procedure to procedure' (PTP) edits for practitioner, outpatient hospital, and durable medical equipment (DME) as well as the MUE for practitioners. DME and outpatient hospital MUE are not applied due to previously mentioned system constraints. CMS is aware of the methodologies applied to Louisiana Medicaid FFS claims.

LDH concurs that not all the Medicaid NCCI edit methodologies are in place due to the limitations of the fiscal intermediary and the current integrated editing product ('ClaimCheck').

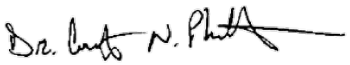
Corrective Action Plan:

As ongoing corrective action, LDH is working with both the FI and CHC to integrate and implement the updated clinical editing product 'ClaimsXten' that will allow full compliance with all of the NCCI edit methodologies.

LDH will continue to perform biweekly reviews that include examples of FFS NCCI edits to assure correct functionality. Once 'ClaimsXten' is implemented, all methodologies will be able to be monitored. The estimated completion date is end of calendar year 2022 or early 2023.

You may contact Dawn Tate, Program Operations and Compliance program manager, via e-mail at Dawn.Tate@la.gov with any questions about this matter.

Sincerely,



Dr. Courtney N. Phillips
Secretary

CP/kp

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

VIA E-MAIL ONLY

April 22, 2022

Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Controls over Drug Rebate Collections

Dear Mr. Waguespack,

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor dated April 14, 2022, regarding a reportable audit finding related to Inadequate Controls over Drug Rebate Collections. LDH appreciates the opportunity to provide this response to your office's findings.

Finding: Inadequate Controls over Drug Rebate Collections.

Recommendation: LDH should ensure that agency personnel are adequately monitoring contract provisions for the drug rebate program and follow-up procedures are performed for all drug rebate invoices that have not been fully collected or disputed in a timely manner. This may include LDH amending the contract with Magellan to address those manufacturers who only make partial payments towards their invoice balance.

LDH Response: LDH concurs with this finding and recommendation.

In regards to procedures for collection of partial payments, Magellan invoices quarterly and includes invoices for past quarters not fully paid in the subsequent quarter. In addition, after 210 days of not receiving payment in full, Magellan's Rebate team reviews outstanding balances and reaches out to manufacturers.

LDH will implement a corrective action plan in order to improve the outstanding balances process for all drug rebate invoices that have not been fully collected or disputed in a timely manner.

Magellan will modify the collections process in the following manner based on LDH approval:

1) Magellan will regularly provide LDH with an Aged Receivables and Disputes Dashboard. This visual spreadsheet will show open balance data for federal and supplemental rebate programs, along with original invoice information, collection rates, and open disputes over the past 4 quarters (starting the week of April 24, 2022). LDH will meet with Magellan to review the dashboard.
2) Magellan will begin the process of building a team to work on rebate related manufacturer operations focused on accounts receivables and disputes.
3) Magellan will begin emailing all labelers with outstanding balances. An email template is being created and will be provided to LDH during the week of April 24, 2022 for approval.
4) Magellan will change its Dunning Notices process to include labelers that only made partial payments. This procedural change will help increase the collection rate.

You may contact Patrick Gillies at (225) 219-7810 or via e-mail at Patrick.Gillies@la.gov or Germaine Becks-Moody, Medicaid Program Manager at (225) 342-9479 or via email at germaine.becks-moody@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

CP/gm

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

April 18, 2022

VIA E-MAIL ONLY

Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Controls over Billing for Behavioral Health Services

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor dated March 24, 2022, regarding a reportable audit finding related to billing controls for behavioral health services. LDH appreciates the opportunity to provide this response to your office's findings.

Finding: Inadequate Controls over Billing for Behavioral Health Services.

Recommendation: LDH management should implement adequate internal controls to ensure that encounters are coded correctly, which could include edit checks to flag potential improper billings for further review.

LDH Response:
LDH concurs with this recommendation. LDH will identify a sampling methodology in order to provide for the performance of spot checks on Medicaid Managed Care behavioral health encounters in order to validate the accuracy of modifiers and payments in light of the SBHS fee schedule. LDH or its designee will consult with MCOs on any encounters identified by the review.

You may contact Karen Stubbs, OBH Assistant Secretary by telephone at (225) 342-1435 or by e-mail at karen.stubbs@la.gov with any questions concerning this matter.

Sincerely,

Dr. Courtney N. Phillips

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

VIA E-MAIL ONLY

May 4, 2022

Mr. Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Controls Over Payroll - OPH

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor dated April 13, 2022, regarding a reportable audit finding related to inadequate controls over payroll at the Office of Public Health (OPH). LDH appreciates the opportunity to provide this response to your office's findings.

Finding: Inadequate Controls Over Payroll

Recommendation: OPH should ensure employees comply with existing policies and procedures, including properly certifying and approving electronic time statements in a timely manner.

LDH Response: LDH concurs with the finding and recommendation.

As part of a comprehensive agency-wide plan to address this finding, OPH Program Areas will work with OPH leadership and LDH's Division of Human Resources to develop a plan to enact control measures available to them. This plan will involve employees, supervisors and time administrators being more diligent in certifying time and ensuring time statements that have not been certified timely get certified as soon as possible by running reports to ensure any missing timesheet approvals are addressed/corrected in a timely manner.

You may contact Omar Khalid, OPH Chief of Staff, by telephone at (225) 953-2784, or by e-mail at omar.khalid@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Behavioral Health

VIA E-MAIL ONLY

May 4, 2022

Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Controls Over Payroll

Dear Mr. Waguespack,

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor dated April 28, 2022, regarding a reportable audit finding related to Inadequate Controls Over Payroll. LDH appreciates the opportunity to provide this response to your office's findings.

Finding: Inadequate Controls Over Payroll

Recommendation: OBH should ensure employees comply with existing policies and procedures, including properly approving timesheets in a timely manner and maintaining adequate documentation to support all expenditures of federal awards.

LDH Response: LDH concurs with the finding and recommendation.

The LDH 24-hour State Facilities adopted the Operational Instruction #A-12 on April 25, 2022. This Operational Instruction establishes internal payroll audit protocols for the LDH 24-hour State Facilities to ensure compliance with applicable federal and state regulations, and with LDH policies and Civil Service Rules. In-service training related to this topic is presently underway across all state-operated facilities.

You may contact Greg Andrus, Deputy Assistant Secretary 3, at (225) 342-0987 or via email at greg.andrus@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

VIA E-MAIL ONLY

May 6, 2022

Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Controls over Waiver and Support Coordination Service Providers

Dear Mr. Waguespack,

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated April 19, 2022, regarding a reportable audit finding related to Inadequate Controls over Waiver and Support Coordination Service Providers. LDH appreciates the opportunity to provide this response to your office's findings.

The LDH's response to the LLA's finding, shown below, is delineated into the four "sub-findings" detailed the report.

- Sub-finding 1: Lack of documentation to support consistent deviations from the approved plan of care.
- Sub-finding 2: Lack of adequate Plan of Care (POC) present in the case records.
- Sub-finding 3: Lack of adequate documentation to support billed services.
- Sub-finding 4: Lack of adequate documentation to support billed services of support coordination service provider.

Finding: Inadequate Controls over Waiver and Support Coordination Service Providers.

LDH Response: Over the past ten years, Office for Citizens with Developmental Disabilities (OCDD) and Office of Aging and Adult Services (OAAS) have taken steps to address concerns with lack of documentation to support deviations in the number of hours provided for Home and Community Based Waiver participants based on their plan of care. OCDD and OAAS made updates to the Waiver Manuals and conducted trainings to direct support provider agencies and families to assist with ensuring adequate controls.

LDH continues to assert there are sufficient controls over the waiver service providers to prevent financial harm to the state and harm to the health and welfare of participations. There are over 9 million hours of waiver service provided to OCDD participants annually. LDH continues with implementation of the geo-coded Electronic Visit Verification system (EVV), which only allows providers to bill for time actually worked. Through EVV, the Louisiana Department of Health data contractor, Statistical Resources, Inc. (SRI), captures both the location and time when a worker clocks in and out. SRI also uses algorithms that block overlapping services and prevents two workers from billing on a single individual at the same time or one worker for billing for two individuals at different locations at the same time. SRI programming also identifies workers on the Louisiana Adverse Action List and blocks billing for that worker if there is a finding. Additional checks and balances to ensure sufficient safety and financial controls include the following:

- Support coordinators contact participants at least monthly to check on participants and ask questions regarding service delivery and care;
- Waiver services are subject to both prior and post authorization by Statistical Resources, Inc. (SRI) before claims can be filed and payments made to providers;
- The LDH Program Integrity Section investigates instances of possible fraud;
- Gainwell Technologies runs random audits on provider agency services as well as audits on agencies where there may be a problem; and
- The Attorney General's Office Medicaid Fraud Control Unit (MFCU) investigates complaints of fraud, waste, and abuse.

Sub-finding 1: Lack of documentation to support consistent deviations from the approved plan of care.

LDH Response to Sub-finding 1: The OCDD concurs in part with this finding. In a review of the information provided by the LLA, some of these deviations were as little as 15 minutes, others as much as a few hours. Billing was completed on time actually worked, so there was no billing completed without documentation.

Sub-finding 2: Lack of adequate Plan of Care (POC) present in the case records.

LDH Response to Sub-finding 2: OCDD concurs with the finding. OCDD provided training to the Service Provider and the Support Coordination agency in regards to recipient transfers and the requirements in keeping current Revisions and Plans of Care in the case record.

Sub-finding 3: Lack of adequate documentation to support billed services.

LDH Response to Sub-finding 3: OCDD concurs with this finding; however, OCDD requested and received documentation from the provider(s). OCDD sent the documentation to the LLA but the final report does not reflect this information.

Sub-finding 4: Lack of adequate documentation to support billed services of support coordination service provider.

LDH Response to Sub-finding 4: OCDD concurs in part. Supporting documentation was present for two of the three requests, submitted to the LLA.

Recommendation: LDH should ensure all departmental policies for waiver and support coordination services are enforced, including documentation to support claims and evidence that deviations from the approved POC meet the needs of the recipient. LDH should consider additional provider training regarding documentation requirements.

CORRECTIVE ACTION PLAN
In response to these findings and recommendation, LDH will engage in the following corrective actions to ensure adequate controls over waiver and support coordination service providers:

1. Engage a focus group with relevant stakeholders, i.e. individuals receiving services, family members of individuals receiving services, Local Governing Entity representatives, Support Coordination representatives, Personal Care Attendant (PCA) Provider representatives, and advocacy organizations, to discuss findings of audit and develop recommended strategies to address this concern. The group will provide a formal report within 30 days of receipt of final draft of audit published for public view.
2. Update all necessary policies, procedures, and / or waiver manuals to reflect needed changes identified from the focus group within 30 days of approval of formal report.
3. Conduct mandatory training of these updates with all relevant stakeholders, i.e. Support Coordination agencies, PCA provider agencies, and Local Governing Entities, within two weeks of update of policies, procedures, and manuals. The LDH Program Integrity will review any agency who fails to participate in mandatory training for appropriate action.
4. LDH will initiate audits of a random sample of providers to assure compliance following the mandatory training.

You may contact Paul Rhorer at 225-342-8804 or via e-mail at Paul.Rhorer@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips

CP/pr

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

VIA E-MAIL ONLY

May 4, 2022

Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Controls over Backup and Recovery

Dear Mr. Waguespack,

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor dated April 20, 2022, regarding a reportable audit finding related to Inadequate Controls over Backup and Recovery. LDH appreciates the opportunity to provide this response to your office's findings.

Finding: Inadequate Controls over Backup and Recovery.

Recommendation: OPH should ensure all critical data is identified to OTS for proper consideration in the Business Impact Analysis. OTS should properly coordinate all critical operations, including upgrades, with relevant contractors and ensure communication of prescribed methods of backup to contractors that provide for the complete and efficient restoration of data.

LDH Response: LDH Fiscal and OTS do not concur with this finding based upon the following:

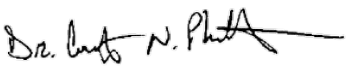
- The Office of Technology Services performed a routine upgrade of a Windows 7 workstation, which had not been properly identified as a server for Fiscal in New Orleans or the Office of Public Health, to a more secure Windows 10 configuration as a part of an ongoing project.
- It was initially reported that prior year's financial records, including certain supporting schedules for its Schedule of Expenditures of Federal Awards, were lost.
- While the data as presented in the Schedule of Expenditures templates was inaccessible for LDH Fiscal, who manages fiscal operations for OPH, the data itself was NOT considered as critical data and could have been easily

reconstructed by the fiscal staff from systems of record. It also did not impact business operations.

- Data contained on this workstation (server) was never in jeopardy of being lost or not secured as stated in this finding. The restoration of this data has shown that the data was never lost, but was only being compiled on the workstation (server) for display in templates created by OPH for reporting purposes.
- Although it took two months to restore the display of data into the templates, the data itself was never lost or unprotected.
- The data contained on this workstation (server) was never identified as critical data during the Business Impact Analysis process.
- The contractor in this instance had worked for LDH Fiscal in New Orleans for nearly 20 years, and had been historically managed by New Orleans Fiscal. All of LDH Fiscal data is now on a single server managed by OTS.

You may contact Helen Harris, Fiscal Director, at (225) 342-9568 or via email at helen.harris@la.gov with any questions about this matter.

Sincerely,



Dr. Courtney N. Phillips
Secretary

CP/gm

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

March 31, 2022

Mr. Michael J. "Mike" Waguespack, CPA
Legislative Auditor
P. O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Controls over Monitoring of Abortion Claims

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated March 18, 2022, regarding a reportable audit finding related to Inadequate Controls over Monitoring of Abortion Claims. LDH appreciates the opportunity to provide this response to your office's findings.

Finding:
LDH included provisions in the Healthy Louisiana managed care contracts requiring the health plans to comply with the federal regulations regarding funding of prohibited abortion services, but LDH did not have adequate procedures in place to monitor the health plans' compliance with the federal regulations. While LDH received monthly self-reported information from the health plans, management confirmed that the reported information was not being compared to encounter data or validated in any other way to ensure the reporting was accurate and complete.

In addition, the instructions provided to the health plans concerning how to complete the reports are not detailed and could potentially lead to all five health plans reporting different information.

Claims paid by the health plans for abortion services that do not meet exceptions noted in federal regulations may go undetected and LDH may accept these improper claims as encounter claims. Encounters are considered in future premium rate setting and are used for reporting and monitoring of the Medicaid and CHIP programs.

Recommendation:
LDH should develop procedures to validate self-reported information from the health plans to ensure compliance with federal regulations regarding funding of prohibited abortions claims.

Response:
Overall, LDH partially concurs with the finding.

LDH does not concur with the portion of the finding that LDH did not have adequate procedures in place to monitor the MCOs' compliance with the federal regulations. LDH monitors compliance by reviewing MCO reports on paid claims for elective abortions. This alone comprises substantial oversight because of the nature of the claims for abortion services.

Clinically, "abortion" is not a specific term and can refer to a number of events and/or procedures. For example, a miscarriage is a type of abortion (spontaneous abortion). For the purposes of federal law, LDH is seeking to identify elective abortions, defined as a procedure to induce termination of a pregnancy. This does not include procedures performed to treat a fetal death that has already occurred, defined as death before the complete expulsion or extraction from the mother of a product of human conception, irrespective of the duration of pregnancy.

Analysis of encounter data has very significant limitations because the same procedure codes are used for an elective abortion as for treatments of a fetal death that has already occurred (miscarriage). Therefore, oversight must be clinically oriented, which is why LDH designed its process to leverage the clinical expertise of the MCOs. All MCOs perform clinical review of potential elective abortion claims to assure compliance with the law and LDH receives and reviews the results. Of note, LDH does not have any evidence that any abortion claims not meeting the federally required exception criteria were paid by the MCOs or fee-for-service (FFS) Medicaid under the current controls.

LDH concurs with the portion of the finding that it does not review the reports against MCO encounter data. LDH did not originally include a review of MCO encounter data as it has significant limitations, as stated above. As a corrective action plan, LDH proposes to add an additional 'spot check' of MCO encounters. This spot check will look at a sampling of MCO encounters with the procedure codes in question and a diagnosis of 'elective abortion'. This would be compared to MCO reporting on the pertinent 137 reports. Each MCO would be reviewed at least quarterly to validate that their reporting is complete. If the review uncovers a discrepancy, LDH would require the MCO justify the payment and explain why it was not included on the 137 report. If it is determined the service was paid inappropriately, the MCO would follow

the current process of recoupment from the provider and voiding of the MCO's encounter. Non-compliance by the MCO could result in the levying of monetary penalties by LDH.

LDH concurs with the finding that instructions provided to the MCOs concerning how to complete the reports are not detailed. Our corrective action plan is to review and revise the reporting instructions to the MCOs to mitigate the potential for misunderstanding by the MCOs.

You may contact Patrick Gillies by telephone at (225) 219-7810 or by e-mail at Patrick.Gillies@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

CP/pg

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Management and Finance

VIA E-MAIL ONLY

March 31, 2022

Mr. Michael J. "Mike" Waguespack, CPA
Legislative Auditor
P. O. Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Noncompliance with Prenatal Service Third-Party Liability Requirements

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated March 21, 2022, regarding a reportable audit finding related to Noncompliance with Prenatal Service Third-Party Liability Requirements. LDH appreciates the opportunity to provide this response to your office's findings.

Finding:
For the third consecutive year, the Louisiana Department of Health (LDH) failed to implement controls to ensure compliance with third-party liability requirements for prenatal and pregnancy related services. As a result, the managed care health plans may have paid for services that should have been cost avoided.

Recommendation:
LDH should ensure that the Medicaid and CHIP programs are the payers of last resort by ensuring that cost avoidance measures are applied by the managed care health plans for prenatal services and pregnancy related services as required by federal regulations.

Response:
LDH concurs with the individual finding and recommendation.

Corrective Action Plan:
LDH plans to develop and review monitoring reports from the managed care programs that demonstrate their compliance to the federal regulations.

You may contact Patrick Gillies at (225) 219-7810 or via e-mail at Patrick.Gillies@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

CP/pg

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health

VIA E-MAIL ONLY

April 4, 2022

Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Inadequate Controls Over Service Providers with Closed Enrollment

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor dated March 24, 2022, regarding a reportable audit finding related to inadequate controls over service providers with closed enrollment. LDH appreciates the opportunity to provide this response to your office's findings.

Finding:
For the second consecutive year, the Louisiana Department of Health (LDH) paid claims totaling $6,833 ($5,032 in federal funds and $1,801 in state funds) in state fiscal year 2021 with service dates occurring after the service providers were no longer enrolled in the Medical Assistance Program (Assistance Listing 93.778, Medicaid) and Children's Health Insurance Program (Assistance Listing 93.767, CHIP).

In an analysis of 23,611 service providers with claims activity during fiscal year 2021, we noted 184 providers with enrollment end dates during the fiscal year or prior. Of the 184 providers, we noted 21 providers with claims paid for service dates after the providers' enrollment end date. After reviewing this analysis and information with LDH, errors were noted for eight providers as detailed below.

- Five providers with Medicare crossover claims totaling $4,990 in which LDH did not ensure the service providers were enrolled in Medicaid on the service dates being billed. Even if a provider is enrolled with the Centers for Medicare and Medicaid Services (CMS) as a Medicare provider, the provider must be enrolled as a Medicaid provider to perform and be paid for services in the Medicaid programs.

- One provider with claims paid totaling $1,076 in which the enrollment end date was applied retroactively by LDH; however, LDH had already paid claims for service dates that were after the applied enrollment end date.
- One provider with claims totaling $767 in which the provider's license had expired. The provider was given the following month to send in its renewal application, during which time the provider was allowed to continue to submit claims for payment. The provider did not renew its license within the allotted timeframe, therefore, the original expiration date should have been the end enrollment date.
- One provider had a change of address which generated a new license number. This process resulted in the provider being incorrectly disenrolled. While the provider did have claims paid for service dates after the erroneous end enrollment date, the claims are not considered improper due to the error by LDH. This error could have been identified if LDH had a review process.

Recommendation:
LDH should ensure provider enrollment end dates are entered accurately and should develop and implement procedures to ensure claims are only paid for dates of service during time periods in which the provider was enrolled in the program. In cases of retroactive closures, LDH should develop and implement procedures to consider and address, as necessary, any claims already paid during that retroactive closure period.

LDH Response:
LDH concurs with this finding and recommendation.

Medicare crossover claims deny at adjudication with a MES edit installed denying claims when providers are not enrolled with Medicaid. The edit was initially installed June 2021. The edit was found to have errors and was re-installed February 2022.

Program Integrity will review FFS for providers with paid claims after disenrolled from Medicaid. Program Integrity's policy "Disenrolled Provider Payments" indicates a data run will be performed once a calendar year or fiscal year or as directed by management. The last data run was January 12, 2022. All identified paid claims to providers disenrolled are referred to Program Integrity's Internal SURS Unit for recoupment.

You may contact Jarrod J. Coniglio, Program Integrity Section Chief at (225) 219-4150 or via email at jarrod.coniglio@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

CP/jc

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

VIA E-MAIL ONLY

February 11, 2022

Michael J. "Mike" Waguespack, CPA
Louisiana Legislative Auditor
P.O Box 94397
Baton Rouge, Louisiana 70804-9397

Re: Noncompliance with Third-Party Liability Assignment

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor dated January 28, 2022, regarding a reportable audit finding related to noncompliance with third-party liability (TPL) assignment for Medicaid recipients. LDH appreciates the opportunity to provide this response to your office's findings.

The Management of the Bureau of Health Services Financing, which is responsible for the Medicaid program in Louisiana, is committed to ensuring that all Medicaid recipients have assigned to the LDH their rights to any TPL payments for medical care.

Finding:
The LDH failed to maintain evidence of notification of TPL assignment as required for eligibility in the Medical Assistance Program (Assistance Listing 93.778, Medicaid) and the Children's Health Insurance Program (Assistance Listing 93.767, CHIP).

Recommendation:
LDH should ensure notification of TPL assignment is provided to each recipient and support is maintained in each Medicaid and CHIP recipient case record as part of required documentation to support the eligibility decision.

LDH Response:
LDH concurs in part with this finding and recommendation.

LDH agrees not every current beneficiary's case record will contain support documentation of the TPL notification assignment. However, LDH did

implement a Plan of Correction as outlined in the Department's response dated January 6, 2021 to the fiscal year 2020 TPL assignment finding. The adding of language to the notices was completed in October 2020 and letters sent for approved applications and for existing beneficiaries extended at renewal have been filed in the case record since then.

Typically, all beneficiaries would cycle through the renewal process within approximately 12 months, and either be closed or extended, in which case the coverage extension letter would be sent. The continuation of the COVID-19 public health emergency (PHE) has caused interruptions in the renewal process and delayed the completion of some renewals in 2021. To comply with the Families First Coronavirus Response Act (FFCRA) for enhanced federal matching, a state may not terminate coverage of beneficiaries during the PHE except for death, moving out of state or voluntary request for termination. This means renewals that were completed which found the beneficiary ineligible or those not completed because the beneficiary failed to provide needed information could not be terminated. In turn, because continued eligibility was not established, the coverage extension letter was not sent.

Under the current federal guidance issued on August 13, 2021, after the end of the PHE states will have to complete a renewal of all individuals who remained opened due to the FFCRA and when finished all beneficiaries will have the TPL assignment language documented in the case record.

You may contact Tara Leblanc, Medicaid Deputy Director, by telephone at (225) 317-4484 or email at Tara.Leblanc@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

CP/rd

APPENDIX B: SCOPE AND METHODOLOGY

We performed certain procedures at the Louisiana Department of Health (LDH) for the period from July 1, 2020, through June 30, 2021, to provide assurances on financial information significant to the State of Louisiana's Annual Comprehensive Financial Report, and to evaluate relevant systems of internal control in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States. Our procedures, summarized below, are a part of the audit of the Annual Comprehensive Financial Report and our work related to the Single Audit of the State of Louisiana (Single Audit) for the year ended June 30, 2021.

- We evaluated LDH's operations and system of internal controls through inquiry, observation, and review of its policies and procedures, including a review of the laws and regulations applicable to LDH.

- Based on the documentation of LDH's controls and our understanding of related laws and regulations, we performed procedures to provide assurances on certain account balances and classes of transactions to support our opinions on the Annual Comprehensive Financial Report.

- We performed procedures on the WIC Special Supplemental Nutrition Program for Women, Infants, and Children (Assistance Listing 10.557), Coronavirus Relief Fund (Assistance Listing 21.019), Public Health Emergency Preparedness (Assistance Listing 93.069), Immunization Cooperative Agreements (Assistance Listing 93.268), Epidemiology and Laboratory Capacity for Infectious Diseases (Assistance Listing 93.323), Children's Health Insurance Program (Assistance Listing 93.767), Medicaid Cluster (Assistance Listing 93.775, 93.777, and 93.778), and HIV Prevention Activities Health Department Based (Assistance Listing 93.940) for the year ended June 30, 2021, as a part of the 2021 Single Audit.

- We performed procedures on information for the preparation of the state's Schedule of Expenditures of Federal Awards and on the status of prior-year findings for the preparation of the state's Summary Schedule of Prior Audit Findings for the year ended June 30, 2021, as a part of the 2021 Single Audit.

- We compared the most current and prior-year financial activity using LDH's Annual Fiscal Reports and system-generated reports to identify trends and obtained explanations from LDH management for significant variances.

The purpose of this report is solely to describe the scope of our work at LDH and not to provide an opinion on the effectiveness of LDH's internal control over financial reporting or on compliance. Accordingly, this report is not intended to be, and should not be, used for any other purposes.

We did not audit or review LDH's Annual Fiscal Reports, and accordingly, we do not express an opinion on those reports. LDH's accounts are an integral part of the state of Louisiana's Annual Comprehensive Financial Report, upon which the Louisiana Legislative Auditor expresses opinions.