LOUISIANA DEPARTMENT OF HEALTH

STATE OF LOUISIANA

FINANCIAL AUDIT SERVICES

Management Letter
Issued April 12, 2023

LOUISIANA LEGISLATIVE AUDITOR

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

LEGISLATIVE AUDITOR
MICHAEL J. "MIKE" WAGUESPACK, CPA

FIRST ASSISTANT LEGISLATIVE AUDITOR
ERNEST F. SUMMERVILLE, JR., CPA

Under the provisions of state law, this report is a public document. A copy of this report has been submitted to the Governor, to the Attorney General, and to other public officials as required by state law. A copy of this report is available for public inspection at the Baton Rouge office of the Louisiana Legislative Auditor and online at www.lla.la.gov. When contacting the office, you may refer to Agency ID No. 3347 or Report ID No. 80220051 for additional information.

This document is produced by the Louisiana Legislative Auditor, State of Louisiana, Post Office Box 94397, Baton Rouge, Louisiana 70804-9397 in accordance with Louisiana Revised Statute 24:513. One copy of this public document was produced at an approximate cost of $1.28. This material was produced in accordance with the standards for state agencies established pursuant to R.S. 43:31.

In compliance with the Americans With Disabilities Act, if you need special assistance relative to this document, or any documents of the Legislative Auditor, please contact Jenifer Schaye, General Counsel, at 225-339-3800.

Louisiana Legislative Auditor

Michael J. "Mike" Waguespack, CPA

Louisiana Department of Health

April 2023

Audit Control # 80220051

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, 2022, 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 June 22, 2022. We determined that management has resolved the prior-year findings related to Failure to Provide a Listing of Food Benefits Paid for the WIC Program, Lack of Internal Controls over Program Expenditures, Inadequate Controls over Required Reporting on the Schedule of Expenditures of Federal Awards, Inadequate Controls Over Payroll – Office of Behavioral Health, Inadequate Controls over Waiver and Support Coordination Service Providers, Inadequate Controls over Backup and Recovery – OPH, Noncompliance with Prenatal Service Third-Party Liability Requirements, Inadequate Controls over Service Providers with Closed Enrollment and Noncompliance with Third-Party Liability Assignment.

The prior-year findings related to Noncompliance with Managed Care Provider Enrollment and Screening Requirement, Noncompliance with Provider Revalidation and Screening Requirements, Inadequate Controls over Annual Financial Reporting, Inadequate Internal Controls over Eligibility Determinations, Inadequate Controls Over and Noncompliance with National Correct Coding Initiative Requirements, Inadequate Controls over Drug Rebate Collections, Inadequate Controls over Billing for Behavioral Health Services, Inadequate Controls over Payroll – Office of Public

Health, and Inadequate Controls over Monitoring of Abortion Claims have not been resolved and are addressed again in this letter.

Current-year Findings

Noncompliance with Managed Care Provider Enrollment and Screening Requirement

For the fifth consecutive year, LDH did not enroll and screen Healthy Louisiana managed care providers and dental managed care providers as required by federal regulations. During fiscal year 2022, the managed care plans continued to enroll and screen some 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 96 million Healthy Louisiana encounter claims totaling $7.5 billion and 2.8 million dental encounter claims totaling $125.8 million in fiscal year 2022 from the managed care plans and paid $14.7 billion in Healthy Louisiana premiums and $375.8 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 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. (Gainwell), began the process of creating a web-based portal for Medicaid and its providers to complete the necessary screenings required by federal regulations.

In July 2021, LDH launched the enrollment portal created by Gainwell. Although the enrollment portal was launched in fiscal year 2022, LDH gave providers until December 31, 2022, to enroll. Therefore, LDH did not enroll and screen all of the Healthy Louisiana managed care providers and dental managed care providers as required by federal regulations before the fiscal year-end.

LDH should ensure all providers are screened and enrolled as required by federal regulations. Management concurred in part with the finding and provided a corrective action plan. (See Appendix A, pages 1-2.)

Noncompliance with Provider Revalidation and Screening Requirements

For the fifth 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 71% of providers with claims activity in fiscal year 2022 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 required federal databases to determine if providers have been excluded from participation in federal programs. Federal regulations require LDH to check the List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) on at least a monthly basis. Although LDH began checking SAM on a monthly basis beginning March of 2022, a check was not performed for all providers for all months during fiscal year 2022.

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.

LDH noted that revalidation and screening of 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, began the process of creating a web-based portal for Medicaid and its providers to complete the necessary screenings required by federal regulations.

In July 2021, LDH launched the enrollment portal created by Gainwell. Although the enrollment portal was launched in fiscal year 2022, LDH gave providers until December 31, 2022, to enroll. Therefore, LDH did not revalidate and screen all of the providers as required by federal regulations before the fiscal year-end.

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 partially concurred with the finding and provided a corrective action plan. (See Appendix A, pages 3-4.)

Inadequate Controls over Annual Financial Reporting

For the second consecutive year, 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, 2022, to OSRAP. In addition, LDH also submitted inaccurate federal schedules used to prepare the Schedule of Expenditures of Federal Awards (SEFA).

In the AFR for Medical Vendor Payments, the following errors were noted in the Accounts Payable Adjustments note:

- For full accrual, Due to Audit Payables was understated by $276.5 million, and Due to Federal Government was understated by $288.5 million.
- For modified accrual, Due to Audit Payables was understated by $111.3 million, and Due to Federal Government was understated by $288.5 million.

In the AFR for Medical Vendor Payments, the following errors were noted in the Accounts Receivable Adjustments note:

- For full accrual, Due from Federal Government was understated by $193.9 million and Due from Medical Providers was understated by $344.6 million.
- For modified accrual, Due from Federal Government was understated by $29.6 million and Due from Medical Providers was understated by $332 million.

In addition, the following errors were noted in the SEFA reporting for LDH's Medical Vendor Payments and Medical Vendor Administration:

- LDH double counted the prior year 13th period when performing the SEFA reconciliations for both Medical Vendor Payments and Medical Vendor Administration. This caused the SEFA reporting for Medical Vendor Payments to be overstated in total by $75.5 million and the SEFA reporting for Medical Vendor Administration to be overstated in total by $38.3 million.

- For Medical Vendor Payments, due to an error during LDH's reconciliation process, expenditures of $282.6 million were incorrectly included in the Medical Assistance Program – COVID total. This resulted in an overstatement of $282.6 million in Medical Assistance Program – COVID expenditures and an understatement of $282.6 million in Medical Assistance Program – non-COVID.

- For Medical Vendor Administration, LDH incorrectly coded funds to Maternal Opioid Misuse Program of $86,061. These funds belonged to the Multipurpose Grants to States and Tribes Program. LDH also incorrectly selected the Research & Development designation for the Medical Assistance Program - ARRA.

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 and reconciliation process over annual financial reporting 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 and the state's Single Audit Report. Management concurred with the finding and provided a plan of corrective action. (See Appendix A, pages 5-6.)

Inadequate Internal Controls over Eligibility Determinations

For the third consecutive year, LDH lacked adequate internal controls over eligibility determinations in the Medicaid and CHIP programs for the state fiscal year ending June 30, 2022. 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 1,919,113 Medicaid recipients, a sample of 60 Medicaid recipients was tested. Five (8.3%) out of 60 Medicaid recipients tested did not have adequate documentation to support the eligibility determination or redetermination within the recipient's case record.

The following errors were noted for Medicaid:

- For one recipient, LDH personnel did not discontinue coverage on a beneficiary that was invalidly enrolled prior to the start of the public health emergency (PHE).

- For one recipient, LDH personnel did not discontinue coverage on a recipient who moved out of state.

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

During our testing of Medicaid 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.

We noted questioned costs totaling $77,983 in federal funds in relation to the two Medicaid recipients whose coverage was not discontinued. We did not note any questioned costs related to the other errors due to certain restrictions on eligibility actions during the PHE.

In addition, from a population of 212,933 CHIP eligibility recipients, a sample of 60 recipients was tested. For two (3.3%) out of 60 CHIP recipients tested, LDH did not perform renewals during the state fiscal year as required by federal regulations. We did not note any questioned costs related to the two 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 Center for Medicare & Medicaid Services (CMS) provided certain flexibilities in meeting the timeliness of renewals in accordance with 42 CFR 435.912(e)(2), and LDH used this flexibility to suspend renewals during the PHE. LDH also indicated, 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 documented system jobs called "data fixes" that were completed which set certain renewals to a future date per the approved flexibility.

In addition, on the one instance of coverage that was not discontinued on a beneficiary invalidly enrolled prior to the start of the PHE, LDH noted that in November 2020 CMS issued an Interim Final Rule (CMS-9912-IFC) which provided additional information concerning the continuous enrollment period and allowable terminations and transitions during the PHE for beneficiaries invalidly enrolled. LDH's opinion is the Interim Final Rule nor the FAQ guidance that followed provided any instruction to review or take action on cases that were prevented from termination

prior to its release, therefore LDH applied the clarification of "validly enrolled" on decisions going forward. (See Appendix A, pages 7-9.)

Additional comments: The LaMEDS log tables were considered during testing by the auditor. For the exceptions related to renewals above, there was no evidence of any systems being checked with the data logs provided by LDH during state fiscal year 2022. 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, but there was no evidence of this in the exceptions noted above.

In reference to the one beneficiary invalidly enrolled prior to the start of the PHE, LDH should have implemented the CMS Interim Final Rule (CMS-9912-IFC) to include all months during the PHE in order to discontinue coverage on a beneficiary that was invalidly enrolled prior to the start of the PHE or during the PHE.

Weakness in Controls over and Noncompliance with Provider Overpayments

LDH's control over compliance with federal regulations regarding the refunding of provider overpayments to CMS was not operating effectively for all quarters for the fiscal year ending June 30, 2022. In addition, in a sample of 60 provider overpayments we were unable to obtain sufficient appropriate audit evidence to determine if the federal portion of provider overpayment collections were returned to CMS in the appropriate quarter, as LDH did not provide proper supporting documentation.

According to federal regulations, states have up to one year from the date of discovery of the overpayment to recover or attempt to recover the overpayment from the provider before the federal share must be refunded to CMS via the CMS 64 quarterly report, regardless of whether recovery is made from the provider. The state must credit the federal share to CMS either in the quarter in which the recovery is made or in the quarter in which the one-year period following discovery ends, whichever is earlier.

During our review of LDH's reconciliations related to the return of the federal share of provider overpayments that have reached the one-year reporting deadline, we noted that one out of four (25%) CMS 64 quarterly reports was reconciled using the incorrect data. For the quarterly report ending September 30, 2021, LDH inadvertently pulled the June 2020 report as a starting point instead of the June 2021 report when creating its one-year reconciliation. This resulted in the amount reported on the quarterly report ending September 30, 2021, to be overstated by approximately $20 million. LDH did not identify this error during its review process of the September 30, 2021 report, but did discover this error later and corrected the error on the CMS 64 quarterly report ending December 31, 2021. Therefore, we do not consider the overstatement to be questioned costs. Provider overpayments that reached the one-year deadline in September 2021, were not accurately reported until

the December 2021 CMS 64 report was completed, causing them to be late and not in compliance with the federal regulations.

LDH should strengthen its controls over the preparation of the quarterly CMS 64 reports to ensure compliance with federal regulations. In addition, LDH should ensure it is able to provide supporting documentation timely for amounts reported in the CMS 64 reports for overpayments. Management did not concur with the finding noting LDH Fiscal is currently in the process of revising procedures to ensure provisions of the 365-Day Receivable report as supporting documentation for provider overpayments. (See Appendix A, pages 10-11.)

Inadequate Controls and Noncompliance over ADP Risk Analysis and System Security Review

LDH did not have adequate controls in place to ensure that the Magellan Medicaid Administration (Magellan) Service Organization Control (SOC) 1 type 2 report was reviewed in accordance with the Automated Data Processing (ADP) Risk Analysis and System Security Review federal requirements for the year ending June 30, 2022.

LDH contracted with Magellan in fiscal year 2022 to provide services that include maintaining system controls related to the drug rebates program. Federal regulations require that state agencies review the ADP system security involved in the administration of LDH programs on a biennial basis. In addition, regulations require the state agency to maintain reports of its biennial ADP system security reviews, together with pertinent supporting documentation, for on-site review. LDH received the required SOC 1 type 2 report from Magellan, but was unable to provide any evidence to support its review and did not have written procedures regarding the review of the SOC report.

Good internal controls require that policies and procedures are established and followed to ensure compliance with federal requirements. Proper review of the required SOC report is critical to ensuring the controls utilized by Magellan are adequate and operating effectively. LDH should design and implement procedures to document and support its review of all ADP system security reports. Management partially concurred with the finding and provided a corrective action plan. (See Appendix A, pages 12-13.)

Inadequate Controls over Payroll – Office of Public Health

LDH, Office of Public Health (OPH) did not ensure payroll expenditures were timely certified and approved for the WIC Special Supplemental Nutrition Program for Women, Infants, and Children (AL 10.557), the Public Health Emergency Preparedness program (AL 93.069), the Epidemiology and Laboratory Capacity for Infectious Diseases program (AL 93.323), and the HIV Prevention Activities Health Department Based program (AL 93.940). This is the third consecutive year payroll internal control deficiencies have been reported for AL 93.069 and AL 93.940, and the second consecutive year for AL 10.557 and AL 93.323. Exceptions for each federal program are as follows:

- For the WIC Special Supplemental Nutrition Program for Women, Infants, and Children, a sample of 60 payroll transactions was tested from a population of 6,184 transactions totaling $8,970,425. Five (8%) time statements were not timely approved by the employees' supervisor, of which two (3%) were not approved at all, and two (3%) were not certified timely by the employees ranging from 13 to 236 days after the posting date.

- For the Public Health Emergency Preparedness program, a sample of 60 payroll transactions was tested from a population of 1,394 transactions totaling $3,988,398. Twenty-one (35%) time statements were not timely approved by the employees' supervisors, of which 12 (20%) were approved ranging from 23 days to 447 days after posting date and seven (12%) were not approved at all; two (3%) were not certified by the employees; and two (3%) were approved before certified.

- For the Epidemiology and Laboratory Capacity for Infectious Diseases program a sample of 60 payroll transactions was tested from a population of 3,933 transactions totaling $5,190,684. Nine (15%) time statements were not timely approved by the employees' supervisors, of which four (7%) were not approved at all; one (2%) was not certified by the employee; and one (2%) was approved before certified.

- For the HIV Prevention Activities Health Department Based program, a sample of 60 payroll transactions was tested from a population of 1,024 transactions totaling $386,769. Nine (15%) time statements were not timely approved by the employees' supervisors, of which one (2%) was not approved at all; seven (12%) were approved ranging from one day to 351 days after the posting date; and one (2%) was not certified by the employee.

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 ZP241 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, pages 14-15.)

Weaknesses in Controls Over Payroll

LDH did not follow established payroll policies and procedures for the certification and approval of time sheets, as well as, for the approval of leave requests.

LDH utilizes electronic time sheets and leave requests in the Cross-Application Time Sheet (CATS) system. In our review of payroll system reports for LDH for the period July 1, 2021, through June 30, 2022, we noted the following:

- 34,243 (25%) of 135,278 time sheets were either not certified or not reissued after being declined by the employee prior to payroll processing.
- 3,824 (3%) of 135,278 time sheets were certified between one and 379 days after the payroll posting date.
- 43,831 (32%) of 135,278 time sheets were either not approved or not reissued after being rejected by the supervisor prior to payroll processing.
- 12,534 (9%) of 135,278 time sheets were approved by the employees' supervisor between one and 362 days after the payroll posting date.
- 7,308 (4%) of 180,216 leave requests were auto approved by the system. This occurs when leave has been requested, but the employee's supervisor did not take timely action to approve/reject the system leave request before the end of the pay period in which the leave was taken. All open leave requests in the system will be auto approved on the last day of the applicable pay period in order for the employee to receive payment.

LDH policy, as well as the payroll and e-certification timelines, require time sheet approvers to ensure entries are submitted and certified by employees by Wednesday following the close of the pay period. Approvers are also responsible for reviewing time sheets for accuracy and approving or rejecting the time sheets by the Wednesday following the close of the pay period. LDH policy also requires supervisors to take appropriate system action for all leave requests prior to the end of the applicable pay period.

LDH employees did not adhere to the established payroll policies and procedures over payroll to certify and approve time sheets in a timely manner or properly approve leave requests. As a result, there is an increased risk that errors and/or fraud could occur and not be detected in a timely manner.

Management should ensure employees comply with existing policies and procedures, including properly certifying and approving time sheets and leave requests in a timely

manner. Management concurred with the finding and outlined a plan of corrective action. (See Appendix A, pages 16-17.)

Inadequate Controls Over and Noncompliance with National Correct Coding Initiative Requirements

For the second consecutive year, 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 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 the 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 2022. These claims were subject to two edit types: MUE and PTP.

In a test of 10,115,246 paid claims to determine if the proper NCCI MUE and PTP edits had been implemented, the following was noted:

- 19,683 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 $732,101 in federal funds. LDH noted that required NCCI MUE edits have not been applied to OP and DME FFS claims due to system constraints.

- 269 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 $33,463 in federal 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 18-19.)

Additional Comments: Management's response stated, "The data pull does not consider the final adjudication of claims." However, LLA data analysis included final adjudication for FFS claims paid in state fiscal year ended June 30, 2022.

Inadequate Controls over Drug Rebate Collections

For the second consecutive year, LDH did not have adequate controls in place to monitor its contract with 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 for fiscal year 2022 these dunning notices are only sent to manufacturers who have not made any payments towards an invoice.

In following its corrective action plan from fiscal year 2021, LDH began the process of implementing new controls to improve the outstanding balances process for all drug rebate invoices that have not been fully collected or disputed in a timely manner. Specifically, Magellan is in the process of changing its Dunning Notices process as part of the RxLink implementation to include manufacturers that only made partial payments. This process was not implemented during fiscal year 2022 though, and is expected to go live in fiscal year 2023.

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. Management did not concur with the finding noting it did not have sufficient time in fiscal year 2022 for corrective action and provided its progress on addressing the finding. (See Appendix A, pages 20-22.)

Inadequate Controls over Billing for Behavioral Health Services

For the fourth 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 2022, we identified approximately $8.8 million in encounters for services between July 1, 2021, and June 30, 2022, 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 $8,329,594 for 125,734 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 $489,342 more than indicated on approved fee schedules for 13,019 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.

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 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 outlined a plan of corrective action. (See Appendix A, pages 23-26.)

Inadequate Controls over Monitoring of Abortion Claims

For the fourth consecutive year, LDH did not have adequate controls to ensure compliance with federal regulations prohibiting the use of federal funding for abortion

claims. 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. 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, LDH was not comparing or validating the self-reported information to ensure the reporting was accurate and complete for the entire year. 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.

In fiscal year 2022, LDH began the process of implementing new controls to validate the health plans self-reported information in order to ensure compliance with federal regulations regarding the funding of prohibited abortion claims. Specifically, in July of 2022 LDH began a spot check review of the health plans self-reported encounter claims information and reviewed data retroactively for the 3rd and 4th quarter of fiscal year 2022 (January 2022 to June 2022). However, this process was not fully implemented during fiscal year 2022, nor did it cover the first two quarters of the audit period of July 1, 2021, to December 31, 2021. It is expected this process will cover all four quarters beginning in fiscal year 2023.

LDH should continue its process to validate self-reported information from the health plans and ensure its process is operating effectively 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 27-28.)

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, 2022, 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.

We also considered internal control over financial reporting and examined evidence supporting LDH's OPH (Agency 326) expenditures.

Based on the results of these procedures, we reported findings related to Inadequate Controls over Annual Financial Reporting and Weaknesses in Controls over Payroll, 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, 2022, 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)
- 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 Schedule of Expenditures of Federal Awards (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, 2022. 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/or system-generated reports and obtained explanations from LDH's management for any significant variances.

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:REW:BH:EFS:aa

LDH2022

APPENDIX A: MANAGEMENT’S RESPONSES

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, 2023

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 13, 2023, 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: Noncompliance with Managed Care Provider Enrollment and Screening Requirement

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

LDH 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 2022.

LDH amended the Gainwell Technologies contract to accomplish provider revalidations, with CMS – approved funding. Gainwell Technologies was able to construct an online application portal, which launched in July 2021. Since then, 38,618 fee for service (FFS) and managed care entities (MCE) providers have successfully gone through the portal and submitted their application to be enrolled with 37,613 completing enrollment. Throughout 2022 Gainwell Technologies continued to make user-friendly enhancements to the portal, such as adding a provider enrollment portal lookup tool to show the provider's status as either enrollment complete, action required, application not

submitted, or currently in process by Gainwell Technologies. The department and MCEs also completed extensive outreach efforts such as direct contact, hand delivered letters, and provider webinars aimed at unenrolled providers during 2022.

Providers who had not completed enrollment on or before December 31, 2022, will have their claims denied for dates of service on or after January 1, 2023.

Corrective Action Plan

LDH is seeking a longer-term solution through the National Association of State Procurement Officials (NASPO) Value Point that will modernize the provider management system and achieve the CMS preference of modularity. The new Provider Management Module solution will be a modern, web based, self-service solution that will support provider enrollment, re-validation, and maintenance. The vendor will provide a configurable, web based, self-service solution that allows healthcare providers to enroll electronically and provide an option for provider self-service updates. LDH continues to keep CMS informed of our progress toward achieving compliance with CMS regulations.

You may contact Tara A. Leblanc, Medicaid Director at (225) 219-7810 or via e-mail at Tara.LeBlanc@la.gov or Brandon Bueche, Medicaid Section Chief at (225) 384-0460 or via email at Brandon.Bueche@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary

CP/bb

DocuSign Envelope ID: 64C28822-C9E6-446E-9C48-FE342876FD6B

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 8, 2023

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 February 27, 2023, 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: Noncompliance with Provider Revalidation and Screening Requirements.

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 partially concurs with your finding that it did not perform five-year revalidations. Louisiana is actively working on compliance with this requirement which is detailed in the corrective action plan.

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, 39,151 Fee-For-Service (FFS) and Managed Care Organization (MCO) providers have successfully completed or submitted their enrollment applications.

DocuSign Envelope ID: 64C28822-C9E6-446E-9C48-FE342876FD6B

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 exclusions. 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.

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

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

You may contact Tara A. Leblanc, Medicaid Director at (225) 219-7810 or via e-mail at Tara.LeBlanc@la.gov or Brandon Bueche, Medicaid Section Chief at (225) 384-0460 or via email at Brandon.Bueche@la.gov with any questions about this matter.

Sincerely,

DocuSigned by:
3/8/2023
Jacques Molaison
23872BC3058B487...

Jacques Molaison
Chief of Staff

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

VIA E-MAIL ONLY

December 30, 2022

Michael J. "Mike" Waguespack, CPA
Louisiana 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 correspondence from the Louisiana Legislative Auditor dated December 20, 2022, regarding a reportable audit finding related to controls over annual financial reporting at the LDH. The LDH appreciates the opportunity to provide this response to your office's findings.

Finding: Inadequate Controls over Annual Financial Reporting

Recommendation: 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 and the state's Single Audit Report.

LDH Response: LDH concurs with the finding and recommendation.

Management concurs that, for fiscal year 2022, the LDH comprehensive review of financial data was inadequate before submittal to OSRAP for inclusion in the state's Annual Comprehensive Financial Report. LDH Management recognizes its responsibility to accurately report financial data.

LDH management acknowledges that the year-end close out process for FY22 was complex, as it required accounting for transactions in multiple systems. Due to the closing in two systems, balancing between the systems increased time and work efforts, and led to constant review of data as the financial reports continued to change even after the submission of the LDH's Schedule of Expenditures of Federal Awards (SEFA). LDH

fiscal management will implement a corrective action plan that will encompass a detailed documented process of SEFA preparation that includes the reports in LaGov.

Corrective Action Plan

The LDH will create a SEFA review task committee within the Fiscal staff to review all SEFA's prior to submission. The corrective action plan will also incorporate cross training amongst the Medicaid Federal Reporting Fiscal staff to ensure training of multiple levels of staff to review the Medicaid AFR data before final submission. We anticipate completion of the documented procedure for SEFA preparation by April 30, 2023 and the SEFA review task committee will be in place by August 30, 2023. The cross training of the staff for AFR review is anticipated to be completed by September 30, 2023.

You may contact Helen Harris, LDH Fiscal Director, by telephone at 225-342-9568 or by e-mail at helen.harris@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 Management and Finance

VIA E-MAIL ONLY

February 24, 2023

Michael J. "Mike" Waguespack, CPA
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 February 13, 2023, 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.

Finding: Inadequate Internal 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.

The audit period occurred during the COVID-19 Public Health Emergency (PHE). The federal Centers for Medicare & Medicaid Services (CMS) which has oversight of the Medicaid and CHIP programs has 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 to not jeopardize enhanced federal matching funds under the FFRCA by inappropriately terminating an individual's coverage during the PHE.

Audit staff indicated three instances of Medicaid and two instances of CHIP beneficiaries not having renewals performed and documented per the Medicaid eligibility manual.

Bienville Building • 628 N. Fourth St. • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone: (888) 342-6207 • Fax: (225) 342-9508 • www.dhh.la.gov
An Equal Opportunity Employer

LDH notified audit staff it was still operating under a March 25, 2020 approved waiver from CMS on certain flexibilities in meeting the timeliness of Medicaid renewals in accordance with 42 CFR § 435.912(e)(2). CMS' approval 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 documented system jobs called "data fixes" that were completed which set certain renewals to a future date per the approved flexibility. LDH continues to firmly believe 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 and document system actions.

Audit staff cited one instance of coverage that was not discontinued on a beneficiary invalidly enrolled prior to the start of the PHE. LDH staff did not timely act on a task to terminate coverage for this beneficiary prior to the beginning of the PHE in March 2020. Under the continuous eligibility provision of the FFCRA of 2020, a state could not terminate individuals from Medicaid if such individuals were enrolled in the program as of the date of the beginning of the emergency period, unless the individual voluntarily terminates eligibility or is no longer a resident of the state. No exceptions were noted for delays in taking negative action, therefore, when LDH staff tried to process the termination in April 2020, system implemented restrictions for the continuous enrollment provision prevented it.

In November 2020, CMS issued an Interim Final Rule (CMS-9912-IFC) which provided additional information concerning the continuous enrollment period and allowable terminations and transitions during the PHE. The Interim Final Rule clarified that states may terminate coverage prior to the end of the PHE for beneficiaries not validly enrolled. Defined at 42 CFR 433.400, a beneficiary is not validly enrolled if the agency determines that the determination of eligibility was incorrect at the most recent determination,

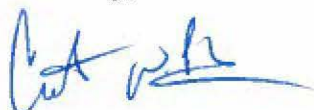
redetermination, or renewal of eligibility because of agency error or fraud. CMS guidance for the Interim Final Rule issued as an update to the Frequently Asked Questions (FAQ) for the continuous enrollment section of the FFRCA indicated that "as of November 2, 2020, references to "coverage" in this FAQ should be read as "enrollment" and the continuous enrollment condition should be applied only to "validly enrolled" beneficiaries as defined at § 433.400(a)." The Interim Final Rule nor the FAQ guidance that followed provided any instruction to review or take action on cases that were prevented from terminating prior to its release. LDH applied the clarification of "validly enrolled" on decisions going forward therefore the beneficiary's coverage remained open.

LDH did agree with Audit staff in the one instance where the beneficiary was not terminated for moving out of state. Established procedures were not followed to confirm the out of state address and terminate coverage appropriately.

With the explanation provided to audit staff during their review and repeated here, LDH does not agree there was a lack of internal controls over eligibility determinations that warrant a finding.

You may contact Tara A. Leblanc, Medicaid Executive Director at (225) 219-7810 or via e-mail at Tara.LeBlanc@la.gov or Rhett Decoteau, Medicaid Section Chief at (225) 342-9044 or via email at Rhett.Decoteau@LA.GOV with any questions about this matter.

Sincerely,



Dr. Courtney N. Phillips
Secretary

CP/rd

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 27, 2023

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

RE: Weakness in Controls over and Noncompliance with Provider Overpayments

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of your correspondence dated March 20, 2023, wherein the Louisiana Legislative Auditor (LLA) notified LDH of a reportable finding related to weakness in controls over provider overpayments. LDH appreciates the opportunity to provide this response to your findings. Please consider this correspondence to serve as the LDH official response.

Finding: Weakness in Controls over and Noncompliance with Provider Overpayments

Recommendation: LDH should strengthen its controls over the preparation of the quarterly CMS 64 reports to ensure compliance with federal regulations. In addition, LDH should ensure it is able to provide supporting documentation timely for amounts reports in the CMS 64 reports for overpayments.

LDH Response: LDH management does not concur with the Legislative Auditor's finding for weakness in controls and noncompliance with provider overpayments.

LDH Fiscal discovered the error in reporting the federal share of the provider overpayments on the CMS 64 for the September 2021 reporting period and made the correction during the December 2021 reporting period. LDH implemented corrective action measures to include updated procedures for accounting for the 365-Day Receivable report as well as training for the reporting staff to ensure compliance. LDH agrees that it should be able to provide supporting documentation timely for reports in the CMS 64 reports for overpayments. Supporting documentation was limited to meet auditor requests timely, due to lack of familiarity with audit requirements in this area. As a result, the requested supporting documentation provided by LDH Fiscal to auditors was limited and required additional time to gather and understand. The LDH Fiscal is

currently in the process of revising procedures to ensure provision of the 365-Day Receivable Report as supporting documentation for provider overpayments. LDH respectfully requests consideration for this issue to be only a topic for discussion at the Management Letter audit exit meeting.

You may contact Helen Harris, LDH Fiscal Director, by telephone at 225-342-9568 or by e-mail at helen.harris@la.gov with any questions about this matter.

Sincerely,

Stephen Russo
Executive Counsel

DocuSign Envelope ID: 64C28822-C9E6-446E-9C48-FE342876FD6B

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 8, 2023

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

Re: Inadequate Controls and Noncompliance over ADP Risk Analysis and System Security Review

Dear Mr. Waguespack:

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor (LLA) dated February 27, 2023, regarding a reportable audit finding related to Inadequate Controls and Noncompliance over ADP Risk Analysis and System Security Review. LDH appreciates the opportunity to provide this response to your office's findings.

Finding: Inadequate Controls and Noncompliance over ADP Risk Analysis and System Security Review.

Recommendation: LDH should design and implement procedures to document and support its review of all ADP system security reports.

LDH Response: LDH partially concurs with this finding.

LDH received and reviewed Service Organization Control (SOC) 1 reports, however there was no written communication between LDH and Magellan regarding the reports. LDH will respond to Magellan SOC 1 reports in writing in the future. LDH Pharmacy adopted the SOC 1 Audit Report procedure for SOC audit review in January 2023 and will utilize it for SFY2023 and subsequent years.

LDH did not request a CAP for the requested reports due to the following:

- The report indicated controls were not operating effectively however it was determined the controls were not related to Louisiana:

DocuSign Envelope ID: 64C28822-C9E6-446E-9C48-FE342876FD6B

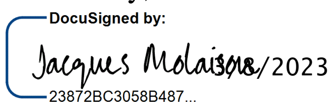
    - The cover letter and Section V, Other Information Provided by Magellan Rx Management, LLC, note "Management's Responses to Exceptions Noted" section Magellan indicated "…is not a part of Magellan Rx's description of its Rebate Processing system made available to user entities during the period July 1, 2021 to June 30, 2022, hence is not applicable to LDH."
- In addition, Magellan management provided responses, which clarified or rectified the exceptions noted.

Corrective Action Plan

LDH will respond to Magellan SOC 1 reports in writing in the future. LDH Pharmacy adopted the SOC 1 Audit Report procedure for SOC audit review in January 2023, and will utilize it for SFY2023 and subsequent years.

You may contact Tara A. LeBlanc at (225) 219-7810 or via e-mail at Tara.LeBlanc@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,



Jacques Molaison
Chief of Staff

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

VIA E-MAIL ONLY

March 22, 2023

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 (LLA) dated March 8, 2023, regarding a reportable audit finding related to Inadequate Controls over Payroll. This finding pertains to the following programs in the Office of Public Health (OPH): Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Public Health Emergency Preparedness (PHEP), Epidemiology and Laboratory Capacity for Infectious Diseases (ELC), and HIV Prevention Activities (HIV). LDH appreciates the opportunity to provide this response to your office's finding.

Finding: Inadequate Controls over Payroll - OPH

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

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

As part of a comprehensive agency-wide plan to address this finding, OPH has developed a corrective action plan to enact control measures and monitor the certification and approval of electronic time statements.

OPH has a Time Entry Policy in final draft form that will be in place and distributed to all staff by March 24, 2023. This policy includes employee, supervisor, and time administrator responsibilities regarding the certification and approval of electronic time statements.

Bienville Building • 628 N. Fourth St. • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone: (888) 342-6207 • Fax: (225) 342-9508 • www.ldh.la.gov
An Equal Opportunity Employer

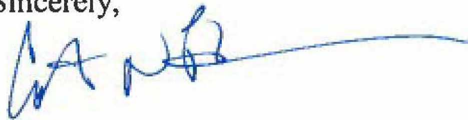
OPH has a new compliance position, and will be reviewing compliance of policies and procedures across the agency. Controls over payroll, including the electronic certification and approval of time statements, will be one of the areas of focus for this position. The position will be filled on March 20, 2023.

Each pay period, LDH Human Resources sends all LDH and OPH time administrators an email that includes Time Administrator Payroll Timelines and reports that must be run each pay period. This also includes reports that indicate errors that must be corrected prior to payroll close and the eCertification Report used to identify any electronic time statements that have not been certified or approved for follow-up.

LDH Human Resources has in-person trainings currently scheduled for LDH and OPH time administrators across the state.

You may contact Devin George, OPH Deputy Assistant Secretary, by telephone at (225) 342-2655, or by email at devin.george@la.gov.

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

November 21, 2022

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

Re: Weaknesses in Controls Over Payroll - LDH

Dear Mr. Waguespack,

The Louisiana Department of Health (LDH) acknowledges receipt of correspondence from the Louisiana Legislative Auditor dated November 10, 2022, regarding a reportable audit finding related to weaknesses in controls over payroll at the LDH. The LDH appreciates the opportunity to provide this response to your office's findings.

Finding: Weaknesses in Controls Over Payroll - LDH

Recommendation: Management should ensure employees comply with existing policies and procedures, including properly certifying and approving timesheets and leave requests in a timely manner.

LDH Response: LDH concurs with the finding and recommendation.

LDH Human Resources (HR) will review instances of non-compliance to inform training during the coming months. HR implemented a process in September 2022 that included sending each time administrator an email reminder of the various reports to run at the end of each payroll period (Thursday or Friday). LDH HR will offer training to LDH Supervisors and time administrators beginning in December 2022 with emphasis on LDH policies and procedures including properly certifying and approving timesheets and leave requests in a timely manner. This training will result in employees, supervisors and time administrators being more aware of their responsibilities to be 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.

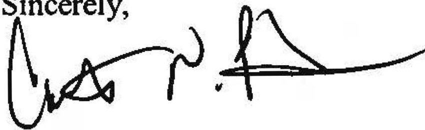
Corrective Action Plan

Bienville Building • 628 N. Fourth St. • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone: (888) 342-6207 • Fax: (225) 342-9508 • www.ldh.la.gov
An Equal Opportunity Employer

LDH HR will offer training on properly certifying and approving timesheets and leave requests as described above beginning in December 2022 in order to address LLA's finding and recommendation. In addition, LDH HR will provide any support needed to assist LDH appointing authorities in reviewing the data provided and taking any actions involving individual employees found to be violation of LDH policies regarding time administration. We anticipate completion of the training program by January 31, 2023.

You may contact Tammy Brown, HR Manager, by telephone at 225-342-5932 or by e-mail at tammy.brown@la.gov with any questions about this matter.

Sincerely,



Dr. Courtney N. Phillips
Secretary

DocuSign Envelope ID: 64C28822-C9E6-446E-9C48-FE342876FD6B

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 8, 2023

Michael J. "Mike" Waguespack, CPA
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 February 27, 2023, regarding a reportable audit finding related to Inadequate Controls Over and Noncompliance with National Correct Coding Initiative Requirements. LDH appreciates the opportunity to provide this response to your office's findings.

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 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 the final adjudication of claims. Our review identified examples outside of the processing dates utilized by LLA where the NCCI edits applied and claims denied correctly in subsequent processing dates. A single data pull by the LLA may not dependably reflect the accurate final outcome of the applied edits.

DocuSign Envelope ID: 64C28822-C9E6-446E-9C48-FE342876FD6B

Fee-for-service (FFS) NCCI editing occurs within the integrated ClaimsXten Portfolio (CXT P) (formerly Change Healthcare) 'ClaimCheck' product. System constraints of both the fiscal intermediary and ClaimCheck preclude applying 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 (FI) and CXT P to implement and integrate the newest version of the clinical editing product, 'ClaimsXten' which houses all of the Medicaid NCCI methodologies. 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 March 24, 2023.

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

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

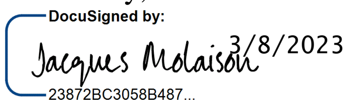
Corrective Action Plan:

As ongoing corrective action, LDH is working with both the FI and CXT P 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 March 24, 2023.

You may contact Tara A. Leblanc, Medicaid Director at (225) 219-7810 or via e-mail at Tara.LeBlanc@la.gov or Brandon Bueche, Medicaid Section Chief at (225) 384-0460 or via email at Brandon.Bueche@la.gov with any questions about this matter.

Sincerely,



3/8/2023

Jacques Molaison
Chief of Staff

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

January 24, 2023

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 January 10, 2023, 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.

LDH Response: LDH does not concur with this finding and recommendation.

LLA issued a finding April 14, 2022 regarding partially paid invoices. LDH responded to the finding on April 22, 2022 regarding 2021 procedures. LLA immediately audited SFY 2022 after the SFY 2021 finding. As a result, there was not enough time to build out the CAP before the end of the SFY22, June 30, 2022.

Based on the finding and response in late April, it was determined Magellan Medicaid Administration would email labelers at the 45-day late letter mark. The 45-day mark for the May 2022 invoicing cycle was on July 11, 2022. The 45-day mark before that would have been April 11, 2022, before the finding.

In the brief interim before the end of SFY 2022, measures were taken by LDH and Magellan (end of April, May & June) to begin setting up the mechanisms to address collections on partial payment accounts. First quarter partial payment

accounts were addressed with the 45 day Dunning Notices, July 11, 2022 and are currently being monitored. Magellan has been manually sending Dunning Notices to all manufacturers that made partial payments. This procedural change is to help increase collection rates.

Corrective Action Plan and progress addressing the findings are listed below:

1) Magellan regularly provides LDH with an Aged Receivables and Disputes Dashboard. This visual spreadsheet shows 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 holds weekly meetings with Magellan to review the data and recommend changes. The dashboard is updated quarterly.

2) Magellan has built a team to work on rebate related manufacturer operations focused on accounts receivables and disputes.
   - Magellan has built a manufacturer-focused team.
   - Magellan has addressed partial payments by sending Dunning Notices to manufacturers.

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.
   - LDH approved an-email template. However, after additional consideration it was determined this was not needed.
   - Upon further review and discussion by LDH and Magellan it was determined that Magellan would not email all Labelers with outstanding balances over 150 days. The "late" letters Magellan sends to manufacturers at 45-day, 75-day, and 90-day marks were sufficient. The letters serve as a 60 day letter, per ODR statute. The 45-day and the 75-day letters can suffice as the reminder letter to be sent to the debtor to pay the debt within 60 days before transfer to ODR.

4) Magellan will change its automated Dunning Notices process to include labelers that made partial payments. This procedural change will continue to help increase the collection rate.
   - Magellan began emailing all labelers with partial payments. Magellan sent the first email on 7/11/22 to all labelers that made partial payments to the 1Q22 invoices
   - The automated Dunning Notices process will be changed to include labelers that made partial payments as part of the RxLink implementation, which is planned to go live in February 2023.
   - In the interim, the updated process for late letters that includes partial payments has been:

1. Dunning #1A sent through an automated process to labelers that made no payments– 45 days after original postmark
2. Dunning #1B manually emailed to labelers that made partial payments and for which the total outstanding balance is greater than $25 - 45 days after original postmark.
3. Dunning #2A sent through an automated process to labelers that made no payments – 75 days after original postmark
4. Dunning #2B manually emailed to labelers that made partial payments and for which the total outstanding balance is greater than $25 - 75 days after original postmark
5. Next Quarterly Invoice plus Prior Period Statement – includes total balance due for prior periods
6. Dunning #3A sent through an automated process to labelers that made no payments – 90 days after original postmark
7. Dunning #3B manually emailed to labelers that made partial payments and for which the total outstanding balance is greater than $25 - 90 days after original postmark
8. Dunning #4 sent through an automated process to labelers that made no payments – 210 days after original postmark

Effective 02/2023, all dunning letters will be sent through an automated process to labelers that made no payments and to labelers that made partial payments. This will be part of RxLink Implementation.

In regards to additional procedures for collection of partial payments, Magellan previously invoiced quarterly and included 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 reviewed outstanding balances and reached out to manufacturers.

You may contact Tara A. LeBlanc at (225) 219-7810 or via e-mail at Tara.LeBlanc@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

TL/gm

John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of the Secretary

February 10, 2023

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 February 6, 2023, 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.

As noted in previous audit responses, LDH holds the Managed Care Organizations (MCOs) accountable for implementing necessary claim system edits, as identified in the FY2022 contracts between Bureau of Health Services Financing (BHSF) and each individual MCO. Further, the MCOs must incorporate all National Correct Coding Initiative (NCCI) edits to applicable claims, as well as have the ability to update national standard code sets such as Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (CPT/HCPCS), International Classification of Diseases Codes (ICD-10-CMS), and move to future versions as required by CMS or LDH.

In order to meet the above requirements, the MCOs implement a variety of edits that are not dependent on the use of modifiers, including the use of

information readily available through interfaces with their provider enrollment and service authorization data. The multiple systems that interface with the MCOs' claims processing systems assist in the validation of claims accuracy based on information such as the provider's qualifications and specialties, the appropriate fee schedule and/or contracted rate for which the provider is eligible, the number and types of services for which the recipient is authorized and the eligibility of the recipient for the service. This is the most effective way for the MCO to adjudicate the claims while reducing administrative burden and preventing provider abrasion. This results in the MCO not being dependent upon modifiers, which may or may not be valid, to process and pay these claims as clean, rather than denying and requiring unnecessary resubmission. The MCOs are also required to perform internal audit reviews to confirm claim edits are functioning properly.

System edit checks are a critical function of ensuring the appropriateness of claims payments. However, these edits and functions should not conform to the standard Medicaid SBHS schedule in that this would interfere with the requirement to be adaptable to continuously changing provider specific agreements, out of network agreements, recipient specific agreements; in addition to the accommodation of all of the nuances related to billing and payment methodologies required and/or allowed in contract and as permitted via a variety of Medicaid programs and fee schedules.

In reality, claims adjudication systems are incapable of accounting for every variable in a managed care environment that not only encourages, but also requires, flexibility related to alternative payment methodologies. These methodologies include incentivizing providers in rural and other areas with limited access to necessary services; in response to individual client cases in order to ensure that their person-centered medical needs are met, and defining payment rates based on outcomes and performance versus volume.

While the managed care entity's independent claims system can accommodate a number of edits, an encounter repository system such as Medicaid's Data Warehouse is further limited as it would be impossible to implement uniform edits across multiple managed care entities which pay varying rates, offer varying services, hold unique provider specific agreements and offer provider specific incentives.

Medicaid's Managed Care model places emphasis on efficacy and efficiency, which may not necessarily align with hard coded claims logic across multiple populations, providers and patients' varying medical needs. MCOs may offer additional benefits and rates that are outside the scope and fee of core State

Plan benefits and services to individual members on a case-by-case basis, based on medical necessity, cost-effectiveness, the wishes of the member and/or member's family, the potential for improved health status of the member, and functional necessity.

In a preliminary review of unique claim numbers provided by the LLA, OBH identified several instances where the SBHS fee schedule was not the source document and where the rate paid did align with the Medicaid rate on file. In reviewing data related to "Bad Modifiers", OBH found more than 5,000 encounters to contain no behavioral health diagnosis. Examples of questionable encounters include those for family practice physician clinics, neurologists, DME, newborn and well child visits, diabetes and hypertension diagnoses. Because Healthy Louisiana Plans pay both physical and behavioral health claims, manually sorting through encounters has shown a wide variety of services are being captured in the review. In combination with just a very small sample of physicians as identified through our partial review, we are questioning over 5,000 encounters totaling over $490,000.

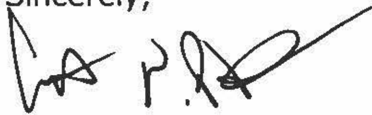
Corrective Action Plan

LDH will continue to review best practices related to the independent claims processing systems of MCOs, and ensure compliance with and, as needed, development of, contract language to ensure due diligence on their part. Further, LDH has contracted with a third party through the LDH Medicaid office for expansion of the CMS External Quality Review, Protocol 5. While hard edits of encounters against the Medicaid fee schedule are not feasible in Managed Care due to the flexibility MCEs have in reference to payment methodologies for their contracted providers, the EQR will include validation of a representative sample of encounters against the Medicaid fee schedule on file at the time of service delivery, inclusive of modifier utilization.

OBH will investigate any discrepancies in order to identify whether those encounters are reflective of an approved alternate payment rate or agreement versus a claim paid outside of the fee schedule, in error. MCEs will be responsible for addressing any erroneous claims inclusive of adjustments or necessary recoupments. Implementation of this protocol began in SFY 2022, with the first report covering the second quarter of the fiscal year that is the basis of this audit. The initial report is due prior to the end of SFY 2023.

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 Management and Finance

VIA E-MAIL ONLY

January 31, 2023

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 January 20, 2023, 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: Inadequate Controls over Monitoring of Abortion Claims

Recommendation: LDH should continue its process to validate self-reported information from the health plans and ensure its process is operating effectively to ensure compliance with federal regulations regarding funding of prohibited abortions claims.

LDH Response:

LDH concurs with the finding that it did not compare or validate the monthly Managed Care Organziation (MCO) self-reported information to ensure the reporting was accurate and complete for the entire fiscal year.

LDH developed and proposed an additional review procedure in March 2022 that would validate encounter data to the MCOs self-reported monthly report, but the procedure was not in place prior to the end of state fiscal year 2022. Analysis of encounter data has very significant limitations because the same procedure codes used for an elective abortion are the same procedure codes used for treatments of a fetal death that has already occurred (miscarriage). Therefore, oversight had to be clinically-oriented, which added complexity to the process.

The additional review procedure was implemented in July 2022 and reviewed data retrospectively for Janaury 2022 through June 2022.

LDH will continue its process to validate the self-reported information from the Managed Care Organizations against encounter data on an ongoing basis and this will be completed for all of Fiscal Year 2023.

LDH partially concurs with the finding that the instructions provided to the MCOs concerning how to complete the reports are not detailed and could potentially lead to all five health plans reporting different information. The monthly report includes a definitions tab that includes information on what and how data should be reported. By reviewing reports submitted and encounter data, LDH is able to make determinations on how each MCO is reporting data. However, LDH will review and revise the reporting instructions to include more detail for the MCOs in order to mitigate the potential for misunderstanding by the MCOs.

You may contact Tara A. Leblanc, Medicaid Director at (225) 219-7810 or via e-mail at Tara.LeBlanc@la.gov or Brandon Bueche, Medicaid Section Chief at (225) 384-0460 or via email at Brandon.Bueche@la.gov with any questions about this matter.

Sincerely,

Dr. Courtney N. Phillips
Secretary
CP/bb

APPENDIX B: SCOPE AND METHODOLOGY

We performed certain procedures at the Louisiana Department of Health (LDH) for the period from July 1, 2021, through June 30, 2022, 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, 2022.

- 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); 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, 2022, as a part of the 2022 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, 2022, as a part of the 2022 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's 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.