Department of Health and Hospitals
State of Louisiana

Financial Audit Services
Management Letter
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Louisiana Legislative Auditor
Daryl G. Purpera, CPA, CFE

Department of Health and Hospitals

December 2015

Audit Control # 80150097

Introduction

As a part of our audit of the state of Louisiana's Comprehensive Annual Financial Report (CAFR) and the Single Audit of the State of Louisiana (Single Audit) for the year ended June 30, 2015, we performed procedures at the Department of Health and Hospitals (DHH), including the Office of Public Health, to provide assurances on financial information that is significant to the state's CAFR; evaluate the effectiveness of DHH's internal controls over financial reporting and compliance; and determine whether DHH complied with applicable laws and regulations. In addition, we determined whether management has taken actions to correct findings reported in the prior year.

Prior to fiscal year 2015, a separate management letter was issued on the Office of Public Health. Management requested that the Office of Public Health, beginning in fiscal year 2015, be included in the DHH management letter.

DHH is the largest department in Louisiana state government and administers an array of health programs to Louisiana residents. The mission of DHH is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the state of Louisiana.

Results of Our Procedures

Follow-up on Prior-year Findings

Our auditors reviewed the status of the prior-year findings reported in a management letter dated November 26, 2014. We determined that management has resolved the prior-year findings related to noncompliance with federal and state regulations over the contract for the new Medicaid Dental program, improper payments of Medicaid claims, and noncompliance with approved consolidated cost allocation plan. The findings relating to inadequate controls to monitor timely filing and prompt payment of Medicaid claims, improper payments to non-emergency medical transportation services providers, inaccurate annual fiscal reports, improper payments to waiver services provider, and lack of controls over federal cash management requirements have not been resolved and are addressed again in this letter.

Current-year Findings

Noncompliance with Third-Party Liability Requirements

DHH failed to keep required processes, after December 31, 2014, that identify and recover paid claims where a third party is liable to pay for medical services provided for a Medicaid-eligible recipient. In addition, DHH did not establish alternate procedures to pursue and recover previously identified instances of third-party liability (TPL) that totaled approximately $29 million.

DHH maintained a contract for identification and collection of TPL on previously-paid claims through December 31, 2014. Upon expiration, DHH did not renew the contract, contract with another vendor, or establish internal processes to identify and recover TPL. Without the required TPL processes, DHH may not identify and recover funds due to the Medicaid program from individuals, insurance companies, or other entities and programs that may be liable for payment.

Per federal regulations, Medicaid is the payer of last resort for Medicaid- and LaCHIP-eligible recipients. DHH is required to take reasonable measures to determine the legal liability of third parties and seek recovery for any applicable amounts. State law allows DHH to identify and submit a claim for recovery of TPL for up to three years after the date the medical service was provided and requires the third-party insurer to pay DHH on any properly submitted claims that were the responsibility of the third party.

Currently, without required processes in place for almost a year, DHH's ability to identify and pursue recovery on instances of TPL is now limited to the time remaining in the allowable three-year period: two years or less depending on when the original Medicaid claim was filed. In addition, DHH's past contractor estimated approximately $29 million in TPL receivables prior to the end of its contract that DHH has not recovered. DHH has also not established any new TPL receivables since December 2014.

DHH should establish adequate processes to ensure that federal Medicaid requirements for TPL identification and collection are met, and pursue and recover any TPL receivable amounts previously identified. Management concurred with the finding and provided a corrective action plan (see Appendix A, page 1).

Improper Uncompensated Care Payments to Two Hospitals

DHH paid two hospitals $17,308,694 for uncompensated care costs (UCC) that did not follow the approved Medicaid state plan. One hospital was paid prior to the determination qualifying it for UCC payments. The other hospital was paid more than 100% of its uncompensated care costs. UCC payments are made to disproportionate share hospitals to cover the costs of providing care to uninsured patients. Qualifying hospitals serve a disproportionate number of low-income patients. Payments using federal Medicaid funds that are not in accordance with the approved Medicaid state plan places DHH in noncompliance with federal regulations. We consider the $17,308,694 in UCC payments to be questioned costs.

Our testing of fiscal year 2015 uncompensated care payments noted the following:

- DHH issued payments totaling $10,670,403 (including $7,670,403 in federal funds) to New Orleans East Hospital (NOEH) prior to obtaining the required information that qualified the hospital as a disproportionate share hospital and eligible for UCC payments. NOEH is owned by the City of New Orleans and is operated by Louisiana Children's Medical Center, also the state hospital partner for University Medical Center.

- DHH paid $6,638,291 (including $4,119,060 in federal funds) over the maximum amount allowed by the approved state plan to Eastern Louisiana Mental Health System. The UCC payment exceeded 100% of the hospital's documented uncompensated care costs.

While DHH does submit all hospital UCC payment schedules for audit along with hospital cost reports and will make adjustments to agree UCC payments to final uncompensated care costs, DHH is still required to make all payments in accordance with the approved Medicaid state plan. Final audits and adjustments to actual uncompensated care costs can take up to three years from the time the UCC payment schedules and cost reports are submitted for audit.

DHH should ensure all UCC payments are made in accordance with the approved Medicaid state plan. Management concurred with the finding and provided a corrective action plan (see Appendix A, pages 2-3).

Inadequate Controls to Monitor Timely Filing and Prompt Payment of Medicaid Claims

For the second consecutive year, DHH failed to ensure compliance with Medicaid requirements for the timely filing and prompt payment of Medicaid claims under the Louisiana Behavioral Health Partnership. As a result, DHH may be paying the State Managing Organization, Magellan, for claims that do not meet federal regulations. Prior to December 2014, DHH did not obtain the original submission date for a claim from Magellan. DHH began requesting the date of original submission from Magellan after December 2014 but did not require it for all claims until September 2015. The amount of claims possibly paid in error could not be determined, because DHH did not obtain the original claim submission date for all claims. The date of original claim submission is needed to determine whether or not the claim met Medicaid regulations.

During this year under audit, DHH began obtaining the date of original submission for providers' claims. Even after DHH began receiving the claim submission date from Magellan, DHH did not actively monitor to ensure claims were submitted within one year and paid based on program timing requirements prior to paying Magellan for the claims. Without the claim submission date and without adequate monitoring, DHH cannot determine the length of time between the date of medical service and the date of submission of the claim, or the length of time between submission of the claim and payment by Magellan.

Medicaid regulations require claims to be filed within one year of the service date, with a few exceptions. The exceptions apply only when a claim is filed within the first year and denied. No exceptions exist for new claims initially filed later than the one-year period of availability. Federal regulations also require payment of 90% of all clean claims within 30 days of the date of receipt, 99% of all clean claims within 90 days of the date of receipt, and all other claims within 12 months of the date of receipt.

DHH should ensure that Magellan submits sufficient detail on claims, including the date of original claim submission, so that DHH can determine Medicaid compliance. DHH should also develop a process for monitoring to ensure Magellan claims meet all timely filing and prompt payment requirements. Management concurred with the finding and provided a corrective action plan (see Appendix A, pages 4-5).

Inadequate Controls over Quarterly Federal Expenditure Reporting

DHH failed to accurately complete the required quarterly reports of federal expenditures, including more than $532 million in errors that were not discovered by DHH's review before submission to the federal oversight agency. The federal expenditures reported in the quarterly reports are used to reconcile the draws of federal funds. Uncorrected errors in the quarterly expenditures reports increase the risk that federal funds will be overdrawn or underdrawn and place DHH in noncompliance with federal regulations.

Our review of the four quarterly expenditure reports applicable to state fiscal year (FY) 2015 noted the following errors:

- For the quarter ending September 2014, DHH did not properly complete the drug rebates schedule, excluding $92 million dollars for drug rebate invoices that should have been reported. The error was not detected and carried through all four quarters of FY15, resulting in a misstatement that remained uncorrected at the time of our review in October 2015. In addition, during the same quarter, DHH applied an adjustment for prior period expenditures for the Bayou Health program to the Louisiana Behavioral Health Partnership (LBHP) program, resulting in an understatement of LBHP expenditures of $306 million ($207 million in federal funds) and a corresponding overstatement of expenditures for Bayou Health. The error was subsequently corrected by DHH on the quarter ending June 2015.

- For the quarter ending December 2014, DHH was required by Centers for Medicare and Medicaid Services (CMS) to make revisions to the December quarterly expenditure report that included an adjustment to disproportionate share payments for prior periods. A portion of the revision was reported on the wrong line resulting in an overstatement of disproportionate share payments of $21.5 million ($13 million in federal funds) and an understatement of inpatient hospital services that remained uncorrected at the time we completed our testing, October 31, 2015.

- For the quarter ending June 2015, DHH reported current-period expenditures for LBHP on the wrong line, resulting in an understatement of LBHP by $113 million ($70 million in federal funds) and a corresponding overstatement of other care services that also remained uncorrected as of October 2015.

Medicaid requires quarterly reporting to CMS detailing expenditures by category of service for which states are entitled to federal reimbursement. CMS requires submission of the quarterly expenditure report 30 days after the end of each quarter and requires accurate reporting of Medicaid expenditures.

DHH should strengthen controls over preparation and review of the quarterly expenditure reports to ensure expenditures are accurately reported. Management elected not to respond to this finding.

Noncompliance with Medicaid Regulations for External Quality Review Reports - Louisiana Behavioral Health Partnership

For the second time in three years, DHH failed to provide an external quality review (EQR) report for Magellan, the state management organization for the Louisiana Behavioral Health Partnership (LBHP), as required by Medicaid regulations and the DHH Medicaid state plan. No EQR report has been submitted to the Centers for Medicare and Medicaid Services (CMS) for the period March 2013 through August 2015. The lack of the annual EQR report impairs DHH's ability to determine if Magellan complied with Medicaid managed care regulations. In addition, since Magellan is a private company and not audited by the Legislative Auditor, our ability to determine compliance with Medicaid regulations is hampered.

An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that a prepaid inpatient health plan furnishes to Medicaid beneficiaries. As of August 2015, Magellan has operated as the state manager for three years and six months. However, DHH has only submitted one annual EQR report to CMS. The EQR report for the first contract year was submitted to CMS in July 2014. In November 2014, Magellan was awarded a second contract, which expired on November 30, 2015.

DHH pays per member, per month (PMPM) payments to Magellan for all enrolled Medicaid recipients. Magellan then coordinates the care for Medicaid recipients and pays Medicaid claims to the health care providers. DHH paid $329,524,289 in fiscal year (FY) 14 and $396,772,330 in FY15 to Magellan for PMPM payments, fees, and services.

DHH has placed its reliance in the performance of Magellan without externally monitoring that performance. Failure to obtain the EQR report increases the risk that procedures and controls are not being applied in accordance with program intentions and regulations, which could result in errors and federal disallowances.

DHH management should obtain and timely submit to CMS the EQR report on Magellan as required by Medicaid regulations and the DHH Medicaid state plan to ensure that all managed care regulations and contract requirements are met. Management concurred in part with the finding and indicated an EQR report was submitted to CMS on September 3, 2015, for the period March 2013 through February 2014 (see Appendix A, page 6).

Additional Comments: CMS requests that all states have final EQR reports available to CMS and the public by April of each year for the data collected in the prior 15 months. The report submitted to CMS September 3, 2015, should have been submitted to CMS four months earlier, by April 30, 2015.

Inadequate Controls over Non-Emergency Medical Transportation Services

DHH paid claims totaling $349,085 ($216,607 in federal funds and $132,478 in state funds) to a provider of Non-Emergency Medical Transportation (NEMT) for services billed to Medicaid that were not provided in accordance with established policies, which we consider questioned costs for which the state may be liable. DHH allowed one transportation provider to maintain a contractual agreement with a medical services provider to be the exclusive transportation provider for the recipients of that medical service provider. This agreement is a possible violation of Medicaid regulations requiring recipient freedom of choice. A Medicaid recipient's freedom to have a choice of medical providers is a basic principle requirement in Medicaid. This is the second consecutive year that we have reported this questionable contractual agreement and the eighth consecutive year to report improper NEMT payments.

NEMT is defined as transportation for Medicaid recipients to and/or from a provider of Medicaid-covered services. The NEMT *Provider Manual* states that requests for transportation may be made by recipients, hemodialysis centers, non-profit transportation providers, or other DHH-approved sources. Transportation providers and other medical services providers are prohibited from initiating transports. Documentation from DHH's contracted dispatcher showed the transportation provider only accepted trips to the medical service provider with which it had the agreement. The documentation also shows that out of 10,324 trips to the medical service provider, 99% of recipients transported to the medical service provider were transported by the transportation provider with which it had the agreement, with 75% of those trips initiated by the medical service provider in violation of program requirements.

DHH failed to timely address the previously reported restrictions to freedom of choice, allowed the NEMT provider and the medical services provider to maintain a questionable contractual arrangement, and allowed its dispatcher to circumvent established policies. As a result of a prior-year audit finding, the transportation provider was no longer allowed to initiate trips on the recipients' behalf. However, DHH's contracted dispatcher allowed the medical service provider to initiate trip requests. DHH could not provide any documentation regarding DHH's approval of the medical service provider as an approved source to request transportation. The dispatch process should be a control to ensure a fair distribution of transportation services that gives all NEMT providers equitable opportunity to provide services, gives recipients a true freedom of choice, and gives the state a fair and competitive program.

DHH management should ensure that all NEMT rules and regulations are enforced and that Medicaid requirements for the recipient's true freedom of choice are strictly followed. DHH should also ensure that the contracted dispatcher follows all NEMT regulations to provide a fair and competitive program. Management concurred with the finding and provided a corrective action plan (see Appendix A, pages 7-8).

Inadequate Monitoring of Required Medical Loss Ratio Reporting

DHH failed to require audits of calendar year 2012 Medical Loss Ratio (MLR) data for the Bayou Health prepaid plans and the Louisiana Behavioral Health Partnership State Management Organization, Magellan. Bayou Health prepaid plan contracts and the Magellan contract require that a minimum of 85 percent of the per member, per month (PMPM) payments made by DHH for Louisiana Medicaid members are used to pay providers for services and certain allowed expenditures related to quality improvement and health information technology. Without proper audited MLR information, DHH does not have independent verification that the Bayou Health plans and Magellan met the 85 percent MLR requirement. If the requirement is not met, the Bayou Health plans or Magellan owe DHH a rebate.

According to their contracts, the Bayou Health plans and Magellan had the option to defer 2012 reporting until the next year. However, in that following year, the plans and Magellan must report the deferred year data separate from the current year. In a review of the independent MLR audit reports for the Bayou Health plans and Magellan, we determined:

- Two Bayou Health prepaid plans (Amerigroup Louisiana and Louisiana Healthcare Connections) reported calendar year 2012 data to DHH. However, DHH did not obtain independent audits of the plans' 2012 data.

- One Bayou Health prepaid plan (AmeriHealth Caritas Louisiana) chose to defer calendar year 2012 data until 2013. The plan improperly presented 2012 data combined with 2013 instead of as deferred from prior year.

- Magellan also reported calendar year 2012 data to DHH. However, DHH did not obtain an independent audit of the plan's 2012 data.

The Bayou Health plans and Magellan are required to submit annual MLR reports based on a calendar year by June 1 of the following year that summarize how the PMPM payments received from DHH were spent. The Louisiana Administrative Code requires DHH to have an independent audit of each Bayou Health plan's MLR report. DHH also contracts to have an independent audit performed on Magellan's MLR report.

DHH should ensure MLR reports are audited for the appropriate time period and information is presented in the appropriate format. DHH should use the Bayou Health plans' and Magellan's MLR reports in conjunction with the independent audit reports of the MLR to determine if the plans owe funds back to DHH. Management concurred with the finding and provided a corrective action plan (see Appendix A, page 9).

Noncompliance with Vendor Monitoring and Cost Containment Requirements

DHH, Office of Public Health (DHH/OPH) did not implement cost containment requirements and adequately monitor the Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC) program vendors. Failure to implement cost containment requirements and properly monitor vendors can result in inflated food costs, undetected vendor violations, and federal claims on the state agency to recover excess food funds. Without the proper procedures in place, it is unknown how much of the $116 million in food cost is at risk of noncompliance with program regulations. DHH/OPH has worked with United States Department of Agriculture's Food and Nutrition Service Agency (USDA FNS) federal regulators for the past two years to develop and implement policies and procedures for cost containment and monitoring to bring the program in line with federal policy. However, for the year under audit, required cost containment and monitoring procedures were not performed.

WIC vendors are authorized by DHH/OPH to provide supplemental foods to participants under a retail food delivery system. Audit procedures identified the following:

- DHH/OPH established required vendor groups but did not monitor vendor prices by group to ensure competitive pricing. DHH/OPH is required by federal regulations to establish a method for controlling cost, through development of a system that categorizes vendors into groups with similar vendors and reviews prices by group to ensure competitive prices.

- DHH/OPH did not perform procedures to identify high-risk vendors and did not perform required compliance investigations. DHH/OPH is required to identify high-risk vendors at least once each year using criteria developed by USDA FNS and perform compliance investigations on all identified high-risk vendors, up to an amount equal to 5% of the number of authorized vendors for the state.

- DHH/OPH did not monitor, using a required methodology, vendors that receive above 50% of their revenue from WIC food instruments. DHH/OPH is required by federal regulations to ensure that the prices charged by this group of vendors are not inflated from those of regular vendors by performing monitoring on a quarterly basis.

DHH/OPH should evaluate federal guidelines and OPH policies and procedures to ensure that cost containment requirements are implemented and vendors are monitored appropriately to ensure compliance with federal regulations. Management concurred with the finding and provided a corrective action plan (see Appendix A, page 10).

Inaccurate Annual Fiscal Report

For the second consecutive year, DHH submitted inaccurate financial information in the Annual Fiscal Report (AFR) for DHH Medical Vendor Payments. Failure to properly compile and review information included in the AFRs before submitting them to the Division of Administration, Office of Statewide Reporting and Accounting Policy (OSRAP) for inclusion in the state's CAFR increases the likelihood that errors and omissions, either intentional or unintentional, may occur and remain undetected.

In the AFR for Medicaid Vendor Payments, the following errors were noted:

- In *Note Y, Accounts Payable Adjustment*, DHH did not properly report payables related to Medicare Part D "Clawback" and disproportionate share audits, and did not report liabilities for federal disallowances. As a result, we noted the following misstatements:

    - Due to Federal Government (Full Accrual) was understated by $193.2 million.

    - Due to Federal Government (Modified Accrual) was understated by $1.3 million.

    - Due to Audits Payable (Full and Modified Accrual) was overstated by $30.3 million.

- In *Note Z, Accounts Receivable Adjustment*, DHH did not properly report receivables related to known fraud settlements and disproportionate share audits. As a result, we noted the following misstatements:

    - Due From Medical Providers and Third Parties (Full Accrual) was overstated by $12.9 million.

    - Due From Medical Providers and Third Parties (Modified Accrual) was overstated by $35.3 million.

DHH did not accept the proposed audit adjustment to accrue the federal disallowances. As a result, *Due to Federal Government (Full Accrual)* remained understated by $192 million. While DHH did not accept the proposed audit adjustment, OSRAP did accept the audit adjustment and made the needed corrections to the state's CAFR.

Good internal control over financial reporting should include adequate procedures to record, process, and transmit financial data needed to prepare an accurate and complete AFR and a review process that will identify preparation errors and correct those errors before submitting the AFR to OSRAP for inclusion in the state's CAFR.

DHH management should strengthen its internal control over the financial reporting process and ensure that all personnel are adequately trained and supervised. In addition, management should perform a thorough review of its AFRs to identify and correct errors before submission to OSRAP. Management elected not to respond to this finding.

Inadequate Monitoring of Vaccines

DHH/OPH did not perform adequate monitoring of vaccines within the Immunization Cooperative Agreements program. Failure to adequately monitor the storage and handling of vaccines could result in waste of vaccines or administration of potentially ineffective vaccines. We consider $294,049 in vaccines issued to be questioned costs.

The Department of Health and Human Services' Centers for Disease Control and Prevention (CDC) requires DHH/OPH monitor all active providers by performing compliance site visits every other year to evaluate the providers' safeguards and practices surrounding the use and storage of vaccines.

In a test of 40 providers, three (8%) providers in region five (central Louisiana) did not have compliance site visits performed by DHH/OPH in a two-year period. The value of vaccines issued to these providers was $294,049.

DHH/OPH should perform compliance site visits once every two years to ensure compliance with CDC requirements. Management concurred in part with the finding and provided a corrective action plan to ensure compliance site visits are conducted in a two-year period in order to comply with CDC mandates. Management did not concur that the lack of compliance site visits caused a lack of provider accountability over storage and handling of vaccines and noted other monitoring functions performed (see Appendix A, pages 11-15).

Additional Comment: The CDC requires the performance of compliance site visits every two years. As acknowledged in management's response, compliance site visits were not performed on the three providers in the required two-year period. While management noted that the three providers cited in the finding have since received compliance site visits, none of these site visits were performed during our year under audit which ended June 30, 2015. Management noted that the vaccine inventory control system provides additional monitoring over providers. However, compliance site visits differ from the inventory visits which are the result of inventory discrepancies discovered during the vaccine ordering process. Compliance visits would identify issues that may not be discovered during the ordering process and, therefore, would reduce the risk of waste or misuse. An effective inventory system is another monitoring function required by the CDC, but is not a substitute for the required provider compliance site visits. Both monitoring functions are needed to ensure program integrity and meet compliance with CDC guidance.

Improper Payments to Waiver Services Providers

For the fourth consecutive year, DHH paid New Opportunities Waiver (NOW) claims under Medicaid totaling $14,095 ($8,746 in federal funds and a $5,349 state match) for waiver services that were not documented and billed in accordance with established policies, which we consider to be questioned costs. NOW is administered by the DHH Office for Citizens with Developmental Disabilities. Improper payments for waivers services have been reported in 13 of the last 16 audits, totaling $595,019.

In a test including 41 claims totaling $49,188 paid to three providers, we noted 12 (29%) instances of inadequate documentation to support billed claims at two providers, including lack of supporting time sheets, progress notes, and service logs, and lack of proper approvals on documentation.

These conditions occurred because DHH paid waiver services claims even though the waiver services provider failed to follow established DHH policies and federal regulations for providing services. Regulations and requirements for the delivery of services and payment of claims for the waiver program are established through administrative rules and policy manuals developed by DHH. Providers are required to maintain documentation to support services provided and billed. Required documentation includes properly completed and approved time sheets, service logs, and progress notes.

DHH management should ensure all departmental policies and federal regulations are enforced, and that only appropriate claims for waiver services are paid to providers. Management concurred in part with the finding and provided a plan of corrective action. Management indicated that there may have been documentation available at the provider to support a portion of one of the claims examined (see Appendix A, page 16).

Additional Comments: Since all costs included in the claim were not supported, we questioned the accuracy and compliance of that claim and consider the entire claim amount as questioned costs.

Inadequate Controls over Reporting of Subrecipients

DHH/OPH's Schedule of Expenditures of Federal Awards (SEFA) did not contain an accurate listing of amounts provided to subrecipients for five federal awards, causing a net understatement of $17.2 million. Failure to properly compile and review the SEFA increases the likelihood that errors and omissions, either intentional or unintentional, may occur and remain undetected in the state's Single Audit.

DHH/OPH is required to identify and submit to the Office of Statewide Reporting and Accounting Policy (OSRAP) the total amount of federal dollars, by federal program, provided to subrecipients on the SEFA. DHH/OPH failed to properly identify certain contracts within the state contract system as subrecipients in accordance with agency policy. As a result, OPH used incomplete system reports when preparing the SEFA. In addition, OPH did not have an effective review process to ensure that all subrecipients were properly identified during the SEFA preparation and included in the schedule.

Management should ensure the SEFA, including subrecipient information, is complete and accurate prior to submission to OSRAP. Management concurred with the finding and provided a corrective action plan (see Appendix A, page 17).

Inadequate Monitoring of Subrecipient Audits

DHH/OPH did not adequately monitor Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC) program subrecipients. Failure to properly monitor subrecipients could result in noncompliance with program requirements and increases the likelihood of federal disallowed costs that the state may have to return to the federal grantor. The WIC program as a whole served a total monthly average of 130,000 participants with a total annual program cost of $105 million.

Our audit procedures identified that DHH/OPH did not ensure that contracted local agency subrecipients expending $500,000 or more received an audit in accordance with federal regulations. Four WIC contract agencies exceeded the $500,000 threshold individually. These subrecipients received a total of $2.4 million in federal award funds for their services and issued $17.3 million in redeemed food instruments. WIC subrecipients provide services for the program, including determining eligibility of participants and issuing food instruments. A food instrument is similar to a check or voucher but lists the WIC-approved food items that the WIC participant can purchase.

DHH/OPH is required to ensure that appropriate audits are completed for WIC contract agencies within nine months of the end of the subrecipient's audit period, issue a management decision on audit findings within six months of the receipt of the audit report, and ensure that the subrecipient takes timely and appropriate corrective action on all audit findings.

Management should implement procedures to ensure subrecipient audit reports are received and reviewed, management decisions are issued timely, and, if applicable, subrecipients have taken timely and appropriate corrective action as required by federal regulations. Management concurred with the finding and provided a corrective action plan (see Appendix A, page 18).

Lack of Controls over Federal Cash Management Requirements

For the third consecutive year, DHH did not have sufficient controls established to ensure federal cash management requirements were followed, including compliance with the Treasury State Agreement. This agreement defines the terms for the transfer of financial assistance funds between the federal government and the state to avoid an overdraw or underdraw of grant funds. Overdrawn grants put the state at risk for federal disallowances for which the state may be liable. Underdrawn grants indicate that the state funded expenditures using state General Fund when federal funds could have been used instead.

At DHH, the Medicaid and LaCHIP programs are included in the Treasury State Agreement. Our testing identified the following:

- DHH inappropriately held funds that were required to be returned to the federal government. DHH was directed by the Center for Medicare and Medicaid Services to return $52,574,430 for the Medicaid Federal Fiscal Year (FFY) 2014 grant and draw the funds from the FFY15 grant. DHH drew the funds from the

FFY15 grant on April 1, 2015, but did not return the FFY14 funds until April 13, 2015.

- DHH drew funds from the wrong grant on two occasions. On September 5, 2014, DHH drew $1,955,427 from the Medicaid program grant when the funds should have been drawn from the administrative grant. The error was not corrected until November 7, 2014. On December 30, 2014, DHH drew $4,834,487 from the Medicaid program grant when the funds should have been drawn from the administrative grant. The error was not corrected until January 8, 2015.

- DHH could not determine funding status. DHH did not draw federal funds from the Medicaid administrative grant for payroll/administration on April 29, 2015, as scheduled, because DHH could not determine if it was overdrawn or underdrawn at that time. DHH did not make the draw until May 14, 2015, when it made the next payroll/administration draw.

- DHH drew federal funds without a corresponding expenditure. On May 11, 2015, DHH drew $9,615,795 from the Medicaid program grant for a disproportionate share payment without a corresponding approved expenditure in the accounting system. The expenditure was not approved in the accounting system until July 14, 2015.

- DHH did not comply with the clearance pattern noted in the Treasury State Agreement for the Medicare Buy-In Program. On two Medicaid program grant draws, DHH did not make payments on Medicare Buy-In invoices the same day the state received federal funds. A draw for $14,984,033 was held for nine days and a draw for $14,946,624 held for one day.

- DHH made calculation errors that caused overdraws and underdraws. On six benefits draws reviewed, DHH improperly calculated LaCHIP expenditures and made errors on Drug Rebate calculations that caused DHH to have a net overdraw on the LaCHIP program grant of $1,660,670 and a net underdraw on the Medicaid program grant of $1,393,241. On three payroll draws reviewed, DHH had errors in cost allocation, drug rebates, and year-to-date revenue calculations that caused DHH to underdraw the Medicaid program grant by $456,542 and LaCHIP by $40,123.

- DHH did not ensure draws had proper approvals. Four transactions reviewed, totaling draws over $148 million, lacked proper reviewer approvals.

DHH must schedule the draw of federal funds so that funds are received and disbursed by DHH in accordance with methods and timeframes noted in the agreement known as clearance patterns. Noncompliance with clearance patterns puts the state at risk for interest liabilities and disallowances. DHH is required by the Cash Management Improvement Act to identify any overdraws of federal funds and return those promptly and is also required to retain support for all draws.

DHH should ensure that draws of federal funds are properly calculated, supported, approved, and follow federal cash management requirements, including compliance with the Treasury State Agreement. Management concurred with the finding and provided a corrective action plan (see Appendix A, page 19).

Comprehensive Annual Financial Report (CAFR) - State of Louisiana

As a part of our audit of the state of Louisiana's CAFR for the year ended June 30, 2015, we considered internal control over financial reporting and examined evidence supporting DHH's Medical Vendor Payments (Agency 306) non-payroll expenditures, federal revenues, Medicaid current and non-current accruals, and critical information systems and related user controls.

Based on the results of our procedures, we reported a finding related to inaccurate annual fiscal report. In addition, the account balance "Due to Federal Government (Full Accrual)" was materially understated by $192 million. While DHH did not accept the proposed audit adjustment to correct the understatement, the Office of Statewide Reporting and Accounting Policy did accept the audit adjustments and made the needed corrections to the state's CAFR. All other 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, 2015, we performed internal control and compliance testing as required by OMB Circular A-133 on DHH's major federal programs, as follows:

- Medicaid Cluster (Medicaid, CFDA 93.775, 93.777, 93.778);
- Children's Health Insurance Program (LaChip, CFDA 93.767);
- Immunization Cooperative Agreements (CFDA 93.268); and
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC, CFDA 10.557).

Those tests included evaluating the effectiveness of DHH's internal controls designed to prevent or detect material noncompliance with program requirements and tests to determine whether DHH complied with applicable program requirements. In addition, we performed procedures on information submitted by DHH to the Division of Administration's OSRAP 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 OMB Circular A-133.

Based on the results of those procedures, we reported findings related to noncompliance with third-party liability requirements, improper uncompensated care payments to two hospitals, inadequate controls to monitor timely filing and prompt payment of Medicaid claims, inadequate controls over quarterly federal expenditure reporting, noncompliance with Mediciad regulations for external quality review reports – Louisiana Behavioral Health Partnership, inadequate controls over non-emergency medical transportation services, inadequate monitoring of required medical loss ratio reporting, noncompliance with vendor monitoring and cost containment requirements, inadequate monitoring of vaccines, improper payments to waiver services providers, inadequate controls over reporting of subrecipients, inadequate monitoring of subrecipient audits, and lack of controls over federal cash management requirements that will also be included in the Single Audit for the year ended June 30, 2015. In addition, the SEFA information and the status of the prior-year findings submitted to OSRAP, as adjusted, are materially correct.

Other Report

Non-Emergency Medical Transportation Program - Department of Health and Hospitals

A performance audit report was issued on December 2, 2015, which provides the results of procedures relating to the Non-Emergency Medical Transportation (NEMT) program. Overall, auditors found that DHH did not always provide sufficient oversight of the NEMT program. Specifically, DHH has not routinely analyzed all claims data to monitor the program for potentially improper payments. In addition, DHH no longer conducts on-site monitoring of non-ambulance providers, and it has never monitored ambulance providers to ensure that support exists for their rides. The full report is available in the Audit Report Library on the Legislative Auditor's website at www.lla.la.gov.

Trend Analysis

We compared the most current and prior-year financial activity using DHH's annual fiscal reports and/or system-generated reports and obtained explanations from DHH management for any significant variances. We also prepared an analysis of the top five Medicaid program expenditures for fiscal year (FY) 15 and the previous five-year trend for those expenditures.

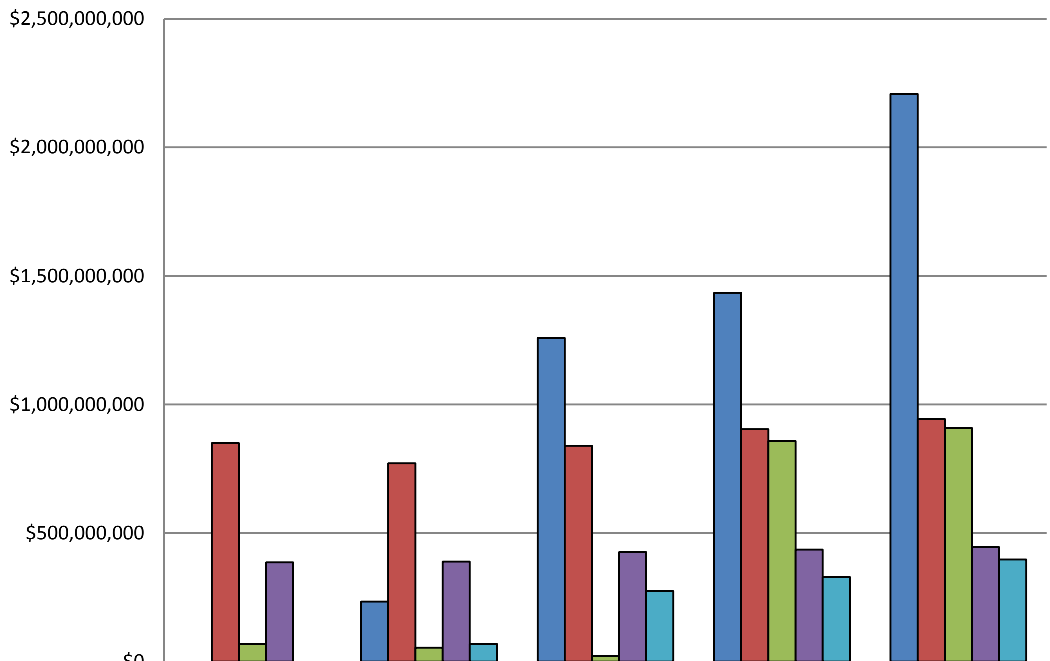
The top five Medicaid program expenditures in FY15 include:

Bayou Health	$2,208,214,296
Nursing Homes	$943,388,541
Private Hospital Disproportionate Share Hospitals (DSH)	$908,283,424
NOW Waiver	$444,685,378
Behavioral Health Partnership	$396,772,330

Bayou Health was implemented in FY12 and has experienced a 75% increase since FY13 (the first full year of operation), see Exhibit 1. In February 2015, DHH moved from two models (prepaid and shared) under Bayou Health to one prepaid model, which also contributed to the increase in FY15. The Behavioral Health Partnership was also implemented in FY12. The partnership has a 45% increase since its first full year of operation, FY13. In December 2015, DHH transitioned the partnership to Bayou Health. Nursing Homes and NOW Waivers, both services outside of managed care, have experienced 11% and 15% increases since FY11. Private Hospital DSH has experienced a 1,231% increase since FY11 mainly due to the privatization of the state charity hospital system.

Each fiscal year, DHH produces a report titled "Louisiana Medicaid Annual Report" that provides an overview of the entire Medicaid program including detail information on expenditures. The reports are available on DHH's website.

Exhibit 1
Medical Vendor Payments
FY15 Top Five Expenditures and Previous Five-Year Trend



	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Bayou Health		$233,296,450	$1,259,191,143	$1,434,485,927	$2,208,214,296
Nursing Homes	$849,705,179	$770,850,604	$839,758,337	$903,967,402	$943,388,541
Private Hospital DSH	$68,263,002	$54,160,042	$22,115,384	$857,932,502	$908,283,424
NOW Waiver	$385,631,546	$389,261,055	$425,977,996	$435,715,197	$444,685,378
Behavorial Health Partnership		$68,901,373	$273,823,482	$329,538,118	$396,772,330

Sources: FY14 and FY15 Year-End Financial Reports and Medicaid Annual Reports

The recommendations in this letter represent, in our judgment, those most likely to bring about beneficial improvements to the operations of DHH. The nature of the recommendations, their implementation costs, and their potential impact on the operations of DHH should be considered in reaching decisions on courses of action. The findings relating to DHH'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,

Daryl G. Purpera, CPA, CFE
Legislative Auditor

AC:BH:WDG:EFS:aa

DHH 2015

APPENDIX A: MANAGEMENT’S RESPONSES

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Management and Finance

November 2, 2015

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

Re: Non-compliance with Third Party Liability Requirements

Dear Mr. Purpera,

Management of the Department of Health and Hospitals (DHH) concurs with the finding relative to non-compliance with third party liability requirements. DHH had planned to migrate 100 percent of the Medicaid population to a managed care delivery model by early 2016 at which time the MCO plans would have been responsible for identifying and collecting from the TPL responsible for the medical services rendered. Even without the latest migration, 80 percent of the Medicaid recipients are enrolled in managed care plan, leaving only 20 percent of the population that warrants this finding. DHH did pursue an RFP for the services in question but it was canceled upon guidance and direction from the Division of Administration (DOA) in March 2015. Furthermore the funding associated with the aforementioned RFP was cut during budget cuts last year.

DHH will request funding to support a contract for TPL activities. DHH will then develop a request for proposals (RFP) that will meet the federal requirements for TPL activities to be released January 2016 with a start date of July 1, 2016. Chris Ourso is responsible for the corrective action. Ms. Ourso can be reached via e-mail at chris.ourso@la.gov or via phone at 225-342-6297.

Sincerely,

W. Jeff Reynolds
Undersecretary

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Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Management and Finance

November 23, 2015

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

Dear Mr. Purpera:

Please allow this response to serve as the official response for both the Management Letter and the Single Audit Report in reference to the finding regarding **Improper Uncompensated Care Payments to Two Hospitals.**

- DHH concurs with the finding.

- Corrective Action:

  Regarding the DSH paid to New Orleans East Hospital prior to obtaining the documentation required per the state plan, DHH will make procedural changes to make sure this required documentation is obtained prior to making the DSH payments.

  The required documentation has since been obtained and DHH has verified that the amount of DSH that has been paid to New Orleans East is not overstated.

  Regarding the DSH overpayment to Eastern Louisiana Mental Health System, DHH will make procedural changes to ensure that the most recently filed cost report is utilized to ensure that the DSH payment does not exceed 100% of the hospital's documented uncompensated care costs.

  DHH will adjust the DSH payment to Eastern Louisiana Mental Health System to reflect 100% of its uncompensated care costs based on the most recently filed cost report.

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The above corrective action plan is anticipated to be completed by December 31, 2015. You may contact Derek Stafford at (225) 342-3927 regarding the action to be taken related to this finding.

Sincerely,

W. Jeff Reynolds
Undersecretary

JR:DS

CC: Ruth Kennedy, Medicaid Director
Jen Steele, Deputy Medicaid Director
Pam Diez, Fiscal Director

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Behavioral Health

October 30, 2015

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

Dear Mr. Purpera,

Thank you for the opportunity to respond to your finding of **Inadequate Controls to Monitor Timely Filing and Prompt Payment of Medicaid Claims.** In response to the finding presented, the Office of Behavioral Health (OBH) offers the following response:

The finding states that the state failed to ensure timely filing of Medicaid claims under the Louisiana Behavioral Health Partnership (LBHP) due to failure to obtain the original submission date of the claim. OBH concurs with this finding and corrective action has already been implemented. Upon identification of this issue, the department notified the Statewide Management Organization contractor for the LBHP, Magellan, that in order to improve the efficiency of OBH's audit and validation of Magellan's compliance with the contract requirements for claims administration, Magellan is required to submit the claim received date on all encounters that are submitted to the Medicaid Fiscal Intermediary (Molina). In December of 2014, the submit date was available on encounter files going forward. The edit triggered an educational notification to Magellan when the received date was not submitted on Magellan encounters. Subsequently, as of March 1, 2015, testing was completed between Magellan and Molina on the edit. After the educational period passed, any encounter without a claim received date is denied per this system change effective September 1, 2015.

The second issue you assert is that the department did not conduct the necessary monitoring while the edit was set to "educational" instead of "deny" for the six month period of March 1 – August 31, 2015. As a result, the department has instituted the following corrective action plan:

> The department contracts with Myers and Stauffer to perform encounter validation as part of the External Quality Review audit function. Currently, Molina generates a weekly report to the department detailing encounters that do not meet timely filing based on the submission date compared to the date of service. Going forward, Myers and Stauffer will monitor this report as part of its encounter validation and include its findings and outcomes specific to timely filing as a supplement to its monthly report.

Thank you for your consideration and attention to this matter. Should you have any subsequent questions, please do not hesitate to contact Cindy Rives in my office at 225.342.1936.

Sincerely,

Rochelle Head-Dunham MD

Rochelle Head-Dunham, M.D.
Assistant Secretary/Medical Director

Cc: Kathy Kliebert, Secretary
Jeff Reynolds, Undersecretary
Pam Diez, Fiscal Director

RHD/jk

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Behavioral Health

September 18, 2015

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

Dear Mr. Purpera,

Thank you for the opportunity to respond to your finding of **Noncompliance with Medicaid Regulations for External Quality Review Reports – Louisiana Behavioral Health Partnership.** In response to the finding presented, the Office of Behavioral Health (OBH) offers the following response:

The finding states that no External Quality Review (EQR) report was submitted to the Centers for Medicare and Medicaid Services (CMS) for the period of March 2013 through August 2015. OBH concurs in part. On September 3, 2015, OBH transmitted the EQR report to CMS for the period of March 1, 2013 through February 28, 2014. Please see the enclosed transmittal letter for reference. The reports for the remaining time period of March 2014 through August 2015 are in the process of being completed and will be submitted to CMS timely.

Thank you for your consideration and attention to this matter. Should you have any subsequent questions, please do not hesitate to contact Karen Stubbs in my office at 225.342.1562.

Sincerely,

Rochelle Head-Dunham MD

Rochelle Head-Dunham, M.D.
Assistant Secretary/Medical Director

Cc: Kathy Kliebert, Secretary
Jeff Reynolds, Undersecretary
Pam Diez, Fiscal Director
Ruth Kennedy, Medicaid Director

Enclosure [1]

RHD/jk

Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

November 9, 2015

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

RE: Inadequate Controls over Non-Emergency Medical Transportation (NEMT) Services

Dear Mr. Purpera:

The Department of Health and Hospitals concurs with the above finding.

Pursuant to identification by LLA in 2014 of a questionable contract arrangement between the NEMT provider and a medical services provider, as well as possible violations of member freedom of choice, DHH staff met with the NEMT provider to discuss the findings. DHH communicated that neither the Department nor its transportation dispatch vendor recognizes any contractual relationship between and NEMT vendor and medical services provider. Our staff further advised that all Medicaid recipients enrolled in the fee-for-service delivery model must be given freedom to choose their provider. The NEMT transportation provider acknowledged and advised that future trips would be arranged accordingly.

Effective December 1 2015, NEMT services for all Medicaid enrollees will be arranged and provided by the five risk-bearing Bayou Health Plans and DHH will no longer operate a fee-for-service delivery system for NEMT. For services prior to that date, the following corrections actions will be taken to aid in identifying any payments for NEMT services that were made in violation of Medicaid rules and regulations governing recipient freedom of choice:

- By January 1, 2016, we will obtain written documentation that the prior contractual agreement referenced in the finding has been terminated as reported by the provider.
- By April 1, 2016 BHSF will initiate letters to each Medicaid enrollee for whom an NEMT claim was paid to the NEMT provider in question where there is a companion claim for same day services by the medical provider in question, requesting they contact us. We will ask whether they were afforded freedom to choose their NEMT provider to transport them to the medical service provider.
- By July 1, 2016, any identified payments made to the provider that are not in compliance with Medicaid NEMT rules and regulations in effect on the date of service, will be referred to DHH Program Integrity for initiation of recoupment.

The lead individual responsible for the above corrective actions is Mr. Jode Burkett, Medicaid Program Manager at (225) 342-2094 or jode.burkett@la.gov. John Korduner, Medicaid Program Manager and Chief of Medicaid Program Integrity will have responsibility for recoupment activity, if applicable.

If additional information is needed, you may contact Mr. Burkett or myself.

Sincerely,

J. Ruth Kennedy

J. Ruth Kennedy
Medicaid Director

JRK

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Management and Finance

August 20, 2015

Mr. Daryl G. Purpera, CPA, CFE
Office of the Legislative Auditor
1600 North Third Street
P.O. Box 94397
Baton Rouge, LA 70804-9397

RE: Inadequate Monitoring of Required Medical Loss Ratio

Dear Mr. Purpera,

The Department of Health and Hospitals (DHH) has reviewed the reportable audit finding titled "Inadequate Monitoring of Required Medical Loss Ratio Reporting" and we concur with the finding.

DHH will have the questioned audits completed by February 28, 2016.

If you have any questions or need any additional information, please contact me at 225-342-6726 or by e-mail at jeff.reynolds@la.gov.

Sincerely,

W. Jeff Reynolds
Undersecretary

c: Kathy H. Kliebert, Secretary

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Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Public Health

December 7, 2015

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

Dear Mr. Purpera:

Re: Noncompliance with Vendor Monitoring and Cost Containment Requirements

The DHH OPH WIC Program (WIC) concurs with the finding as presented in the audit report. This concurrence is based on identical findings noted in the 2013 Louisiana Legislative Auditor (LLA) Performance Report. As a result of the 2013 LLA Performance Report, the Louisiana WIC Program has been placed under a Federal Moratorium restricting the onboarding of new WIC approved Vendors pending improvement of cost containment, vendor management and vendor integrity practices. Under the federally imposed moratorium, USDA National headquarters and the regional office has provided close guidance, assistance and oversight since 2014 to ensure the Louisiana WIC Program has sustainable, data driven vendor operations processes in place.

The Louisiana WIC Program is working closely with USDA to revamp vendor peer group structure, developing a sustainable procedure for identifying high-risk vendors and establishing a procedure to more closely monitor above 50 (A50) Vendors. It is anticipated that all findings will be corrected and all updated procedures will be fully implemented by October 1, 2016. Monica McDaniels, Director of Nutrition Services, is responsible for ensuring the corrective actions are implemented by this date. She can be reached via email Monica.McDaniels@la.gov or via telephone at 225-342-7988.

Sincerely,

J.T. Lane
Assistant Secretary
Office of Public Health

Nutrition Services Bienville Building ▪ 628 N. 4th Street ▪ Bin#4 ▪ Baton Rouge, Louisiana 70802-3214
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Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals

December 4, 2015

Daryl G. Purpera, CPA, CFE
Legislative Auditor
P. O. Box 94397
Baton Rouge, Louisiana 70821

Dear Mr. Purpera:

In response to the November 25, 2015 letter from Barrett Hunter summarizing the audit conducted on the Department of Health and Hospitals, Office of Public Health (DHH/OPH) Immunization Program, I partially concur with the reportable audit finding related to "Inadequate Monitoring of Vaccines." Staffing shortages did delay a few compliance visits to Vaccines for Children (VFC) providers in OPH Region 5 in State Fiscal Year 2015. The OPH Immunization Program had focused on the required performance measure and not on the requirements for identifying and selecting providers. While the Immunization Program did not conduct several of the required compliance visits within the prescribed time period, I do not concur with the alleged finding that the program failed to adequately monitor the storage and handling of vaccines, as the program has other systems in place to ensure provider accountability.

The region's Immunization Consultant position responsible for the site visits transitioned among four staff between June 2013 and June 2015 as outlined below. Both OPH Region 5 and Immunization Program personnel posted, interviewed, hired, oriented, and trained all four individuals.

Name of VFC Staff Member	Dates of Service
Tiffany Shelton	06/03/13 to 08/23/13 (Resigned)
Shontae Blount	08/15/14 to 09/14/14 (Resigned)
Charlotte Fontenot	01/05/15 to 02/23/15 (End of Probationary Position)
Mary Celina Reed	06/15/15 to present

In collaboration with Region 5 administration, the Immunization Program has since worked diligently to recruit, train, and retain competent staff. In addition, we have continued our efforts to comply with all Centers for Disease Control and Prevention (CDC) mandates for visits. We are pleased to report that the current Immunization Consultant in OPH Region 5 responded very well to her training and is working efficiently.

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The three VFC providers identified in the audit have since received the mandated visits prior to being reviewed by the Legislative Auditors, as outlined below.

VFC Provider Identification Number and Provider Name	Recent Visit(s)
LAA000039 - Jacobs Family Medical Clinic	01/15/15 - Contact 09/10/15 - Compliance visit
LAA000641 - DeQuincy Medical Clinic	09/21/15 - Compliance visit
LAA000856 - Rachel Z. Chatters, MD	11/18/15 - Compliance visit

A discrepancy from the audit should be pointed out. In VFC operations, compliance visits are only one mechanism to assure vaccine accountability. Numerous other training and contact mechanisms are used to assure that vaccines are properly ordered, received, stored, utilized, accounted for, and managed by providers. Although the three OPH Region 5 provider sites in question were not subject to compliance visits during the audited period, vaccine integrity, accountability and efficacy were not compromised, as evidenced by other accountability mechanisms employed by the Program.

The DHH/OPH Immunization Program screens and trains VFC providers before they are approved for ordering vaccines. The following table shows the three VFC providers in OPH Region 5 were long-term participants in the VFC program during the audit. All visits have ensured vaccine accountability.

VFC Provider Identification Number and Provider Name	Visits
LAA000039 - Jacobs Family Medical Clinic	10/11/10 - Compliance 02/10/11 - Compliance follow-up 08/17/12 - Compliance 10/25/12 - Compliance follow-up 09/08/14 - Inventory visit/storage and handling issues 12/10/14 - Inventory visit 01/22/15 - Inventory visit 01/15/15 - Contact 09/10/15 - Compliance
LAA000641 - DeQuincy Medical Clinic	06/17/09 - Compliance 07/15/10 - Compliance 02/10/11 - Compliance follow-up 02/28/11 - Compliance follow-up 07/08/11 - Compliance 07/27/12 - Compliance 01/31/13 - Compliance follow-up 04/05/13 - Compliance follow-up

	09/21/15 - Compliance
LAA000856 - Rachel Z. Chatters, MD	05/11/11 - Compliance 06/23/11 - Compliance follow-up 05/30/12 - Compliance 06/13/12 - Compliance follow-up 07/02/14 - Inventory Visit 07/25/14 - Inventory Visit 09/08/14 - Inventory Visit 11/18/15 - Compliance

Our system for vaccine accountability, which is approved by CDC, is known as Vaccine Ordering Management System (VOMS). Our vaccine ordering process practice is part of order quantity improvement, which enables us to manage vaccine orders and distribution more effectively.

Prior to the VOMS system, like most state Immunization Programs across the nation, all orders were manually submitted. Louisiana OPH began electronic conversion with a pilot in June 2010, which was successfully completed in December 2011 with all active Vaccines for Children (VFC) provider practices. This represented the training of over 700 VFC sites and over 2,500 physicians, nurses, hospitals and other caregivers that are enrolled in the VFC Program. This training practice is still on-going as new VFC providers enroll.

VOMS usage, which is required as part of being a VFC provider, is an efficient accounting system that eliminates paper, fax, telephone ordering, doses administered/inventory forms and the burden of not knowing if the order was placed or got lost. As each and every VFC provider administers vaccine and uses VOMS in real time, each dose administered is accounted for and is reflected in the inventory which enables us to determine vaccine needs for the VFC practice in an effective and efficient way. Failure to use VOMS correctly jeopardizes VFC participation. Orders are approved based on their usage and inventories at hand. VOMS provides the Immunization Program and CDC constant visibility to the vaccine inventories held at the distributor locations and at provider locations.

Proper vaccine storage and handling practices play a very important role in protecting Louisiana's Federal vaccine allotment. The State uses many mechanisms to ensure the safety, security, and viability of our Immunization resources. Vaccine quality is the shared responsibility of many stakeholders from the time a vaccine is manufactured until it is administered. The DHH/OPH Immunization Program receives and utilizes national guidance for vaccine-storage units and thermometers, strategies for maintaining the cold chain, routine storage and handling practices, inventory management, and emergency procedures to assure the efficacy of vaccine inventories in the state.

Unfortunately, staffing shortages resulted in the DHH/OPH Immunization program being unable to visit all providers in Region 5 during the audited period. However, this deficiency was corrected prior to the audit, and we now have stable, dedicated staff within that Region. In addition, we have devised a visit accountability plan to ensure these situations do not happen again in any of OPH's nine administrative regions. Along with our newly devised visit accountability plan, the Immunization Program is using the CDC's electronic system, PEAR (Provider Education Assessment and Reporting). This tool will assist in visit accountability, allowing reporting by individual regions, by individual staff as well as the entire State.

We have enclosed for your review a corrective action plan for VFC compliance visits. If you have any questions or need additional information, please do not hesitate to contact Stacy Hall, OPH Immunization Program Director at stacy.hall@la.gov or 504-838-5300.

Sincerely,

J.T. Lane
Assistant Secretary
Office of Public Health

Legislative Audit Corrective Action Plan
Louisiana Department of Health and Hospitals
Office of Public Health Immunization Program
December 1, 2015

CONDITION: The Department of Health and Hospitals, Office of Public Health (DHH/OPH) did not perform adequate monitoring of vaccines within the Immunization Cooperative Agreements program.

RECOMMENDATION: DHH/OPH should perform compliance visits once every two years to ensure compliance with CDC requirements.

Corrective Action Planned	Responsible Staff Members, Positions	Anticipated Completion Date
Ensure the respective schedules of regional Immunization Consultant staff to conduct VFC compliance visits encompass every enrolled/active provider within a 2-year period.	Stacy Hall, Immunization Program Director Adrienne Whitney, VFC Program Manager Robert Starszak, AFIX Program Monitor	December 31, 2015
Review compliance-visit schedules with regional Immunization Consultant staff at each monthly staff meeting. Advising Immunization Consultant staff of any outstanding/due visits	Robert Starszak, AFIX Program Monitor Stephanie Press, Administrative Assistant 3 Regional VFC/AFIX Immunization Consultant staff	Monthly
Maintain proper monitoring at Immunization Program Headquarters of compliance visits conducted at each DHH/OPH region every month utilizing the CDC PEAR system	Robert Starszak, AFIX Program Monitor Stephanie Press, Administrative Assistant 3	Monthly
If needed, reassign Immunization Program staff to conduct all compliance visits within the mandated timeframe.	Stacy Hall, Immunization Program Director Robert Starszak, AFIX Program Monitor Regional VFC/AFIX Immunization Consultant staff	Monthly

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Citizens with Developmental Disabilities

November 2, 2015

Mr. Daryl G. Purpera, CPA, CFE
Legislative Auditor
1600 North Third Street
Baton Rouge, Louisiana 70804

Dear Mr. Purpera:

Re: Official Response to Legislative Auditor Finding

Our office is in receipt of the Single Audit Report mailed to Secretary Kliebert on October 20, 2015.

The Office for Citizens with Developmental Disabilities (OCDD) partially concurs with the Legislative Auditor finding of Improper Payments to Waiver Services. The report states that waiver services were not documented and billed in accordance with established policies. The report states that there was inadequate documentation to support billed claims at 2 of the 3 providers reviewed, including lack of timesheets, progress notes, and service logs, and lack of approvals on documentation.

In the review of one of the providers, the reviewers discounted an entire claim that covered a 2 week period, although all the required documentation may have been available for all except for one shift or for one day for this entire period. This is the part of the audit that we do not concur with.

Paul Rhorer, a Program Manager with OCDD, has contacted the Region V Local Government Entity to discuss the findings of Improper Payments to Waiver Providers and to have this office schedule a training with providers in their area to go over the report.

Thank you for your assistance with this matter. Should you have any questions and/or concerns, please contact Paul Rhorer at (225) 342-8804 or by email at paul.rhorer@la.gov.

Sincerely,

Mark A. Thomas

Mark A. Thomas
Assistant Secretary, OCDD

MAT:pr:eb

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Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

November 19, 2015

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

Re: Inadequate Controls over Reporting of Sub recipients

Dear Mr. Purpera,

Management of the Department of Health and Hospitals (DHH) concurs with the finding relative to inadequate controls over reporting of sub recipients. DHH management will review and update procedures to ensure future compliance.

Ms. Pam Diez, Fiscal Management Director, is responsible for corrective action. She can be reached at 225-342-1483 or via e-mail at pam.diez@la.gov.

Sincerely,

W. Jeff Reynolds
Undersecretary

Bienville Building • 628 North 4th Street • P.O. Box 629 • Baton Rouge, Louisiana 70821-0629
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GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

December 3, 2015

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

Re: Inadequate Monitoring of Sub recipient Audits

Dear Mr. Purpera,

Management of the Department of Health and Hospitals (DHH) concurs with the finding relative to inadequate monitoring of sub recipient audit. DHH management will review and update procedures to ensure future compliance.

Ms. Pam Diez, Fiscal Management Director, is responsible for corrective action. She can be reached at 225-342-1483 or via e-mail at pam.diez@la.gov.

Sincerely,

W. Jeff Reynolds
Undersecretary

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Phone #: 225/342-9509 • Fax #: 225/342-5568 • *WWW.DHH.LA.GOV*
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Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

11/5/2015

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

Re: Lack of Controls over Federal Cash Management Requirements

Dear Mr. Purpera,

Management of the Department of Health and Hospitals (DHH) concurs with the finding relative to lack of controls over Federal Cash Management Requirements. DHH management has updated procedures to ensure future compliance.

Ms. Pam Diez, Fiscal Management Director, is responsible for corrective action. She can be reached at 225-342-1483 or via e-mail at pam.diez@la.gov.

Sincerely,

W. Jeff Reynolds
Undersecretary

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APPENDIX B: SCOPE AND METHODOLOGY

We performed certain procedures at the Department of Health and Hospitals (DHH) for the period from July 1, 2014, through June 30, 2015, to provide assurances on financial information significant to the state of Louisiana and to evaluate relevant systems of internal control in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States. The procedures included inquiry, observation, and review of policies and procedures, and a review of relevant laws and regulations. Our procedures, summarized below, are a part of the audit of the state of Louisiana's Comprehensive Annual Financial Report (CAFR) and the Single Audit of the State of Louisiana (Single Audit) for the year ended June 30, 2015.

- We evaluated DHH'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 DHH.

- Based on the documentation of DHH's controls and our understanding of related laws and regulations, we performed procedures to provide assurances on DHH's account balances and classes of transactions to support the opinion on the state of Louisiana's CAFR.

- We performed procedures on the following federal programs for the year ended June 30, 2015, as a part of the 2015 Single Audit:

    - Medicaid Cluster (CFDA 93.775, 93.777, 93.778)

    - Children's Health Insurance Program (LaChip, CFDA 93.767)

    - Immunization Cooperative Agreements (CDFA 93.268)

    - Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) (CFDA 10.557)

- We performed procedures on federal expenditure information submitted by DHH for the preparation of the state's Schedule of Expenditures of Federal Awards, and on the status of prior-year findings used in the preparation of the state's Summary Schedule of Prior Audit Findings for the year ended June 30, 2015, as a part of the Single Audit.

- We compared the most current and prior-year financial activity using DHH's annual fiscal reports and/or system-generated reports to identify trends and obtained explanations from DHH management for significant variances.

The purpose of this report is solely to describe the scope of our work at DHH and not to provide an opinion on the effectiveness of DHH'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 DHH's Annual Fiscal Reports and, accordingly, we do not express an opinion on those reports. DHH's accounts are an integral part of the state of Louisiana's CAFR, upon which the Louisiana Legislative Auditor expresses opinions.